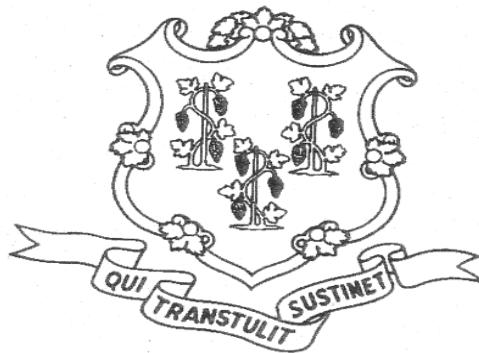


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Litchfield Woods Health Care Center	
Address (No. & Street, City, State, Zip Code) 225 Roberts Street Torrington, CT 06790	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input checked="" type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 2034C	RHNS 2034C	(Specify)	Medicare Provider 07-5319
------------------	---------------	---------------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 2034C	RHNS 2034C	ICF-IID
----------------------------	---------------	---------------	---------

For Department Use Only

Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Number Assigned	Signed and Notarized	Date Received

General Information

Name of Facility (as licensed) Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page 1	of 37
---	----------------------	------------------------------------	-----------	----------

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Litchfield Woods Health Care Center [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)	Date	Signed (Owner)	Date
Printed Name (Administrator) James Murphy		Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Leases	6
General Information and Questionnaire - Accounting Basis	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

State of Connecticut
Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Litchfield Woods Health Care Center	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 225 Roberts Street Torrington, CT 06790				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900	Date 2/15/2022		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

	Phone No. of Facility 860-489-5801	Report for Year Ended 9/30/2021	Page 2
Name of Facility (as shown on license) Litchfield Woods Health Care Center		Address (No. & Street, City, State, Zip) 225 Roberts Street Torrington, CT 06790	
License Numbers:	CCNH 2034C	RHNS 2034C	(Specify)
Medicare Provider No. 07-5319			
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes <input checked="" type="radio"/> No	If "Yes," explain fully.
Administrator			
Name of Administrator Timothy Flaherty		Nursing Home Administrator's License No.:	2115
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name		License No.:	

General Information and Questionnaire Partners/Members

General Information and Questionnaire
Corporate Owners

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page of 3A 37
If this facility is owned or operated as a corporation, provide the following information:			
Legal Name of Corporation Highland View Manor, Inc.	Business Address 225 Roberts St, Torrington, CT 06790	State(s) in Which Incorporated CT	
Name of Directors, Officers Lawrence G. Santilli	Business Address 225 Roberts St, Torrington, CT 06790	Title President	No. Shares Held by Each 461.32
Michael E. Mosier	225 Roberts St, Torrington, CT 06790	Treasurer/Secretary	
Names of Stockholders Owning at Least 10% of Shares Lawrence G. Santilli	225 Roberts St, Torrington, CT 06790		461.32
Estate of John Nocera, Jr	225 Roberts St, Torrington, CT 06790		125
Conservators for Lawrence E. Santilli	225 Roberts St, Torrington, CT 06790		112.68

General Information and Questionnaire

Individual Proprietorship

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page 3B	of 37
---	----------------------	------------------------------------	------------	----------

If this facility is owned or operated as an individual proprietorship, provide the following information:

General Information and Questionnaire

Related Parties*

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.				
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the following information:				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party	
		Yes	No	%**				Description of Goods/Services Provided
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	<50%	Management Fees	Pg 17	777,134	302,459
Laurel Ridge Health Care	642 Danbury Road, Ridgefield, CT 06877	<input checked="" type="radio"/>	<input type="radio"/>	>98%	Bank Charges	Pg 16, Ln m13	4,754	4,754
Athena Health Care Insurance	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Self Insured Employee Health & Dental Insu	Pg. 15, ln 1a5	1,363,418	1,363,418
Athena Health Care Assoc Inc. 401(K) Plan	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Facility participates in group 401(k) plan	Pg 15 ln 1a7		
Procare LTC.	111 Executive Blvd., Farmingdale, NY 11735	<input type="radio"/>	<input checked="" type="radio"/>	>50%	Pharmacy	Pg. 20 5a2	740,619	740,649
CT Health Center of Torrington LP	225 Roberts St, Torrington, CT 06790	<input type="radio"/>	<input checked="" type="radio"/>		Lease of Facility & Equipment	Pg 22, Ln 9, 10b; Pg 27	1,174,074	11,740,174
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	<50%	Various: See attached			
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

** Provide the percentage amount of revenue received from non-related parties.

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page 5	of 37
---	----------------------	------------------------------------	-----------	----------

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (<i>See listing page 13</i>)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required? Yes No If "No," explain fully why such allocation was not made.

Patient Care Consults, Laundry, Housekeeping, Maintenance/Prop Costs, Admin - Alloc on Patient Days. Physical/Speech/Occupational Therapy - Allocated on % of Treatments. Administrative Nursing - Allocated on Direct Nursing Hours. Management Fees - Allocated based on methods above for each expense category

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.

Related company expenses were allocated on Methods above except as noted in 1 above.

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

Yes No If "No," explain fully why such allocation was not made.

Not Applicable: No Non-Nursing Home Cost Centers

General Information and Questionnaire

Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

Name of Facility		License No.		Report for Year Ended			Page of
Litchfield Woods Health Care Center		2034C		9/30/2021			6 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	<input type="radio"/>	<input checked="" type="radio"/>	Postal Equipment	11/01/13	automatic renewal	1,340	1,278
Leaf, PO Box 644066, Cincinnati, OH 45264	<input type="radio"/>	<input checked="" type="radio"/>	Copier	09/13/20	50 months	18,406	18,403
Leaf, PO Box 644066, Cincinnati, OH 45264	<input type="radio"/>	<input checked="" type="radio"/>	Copier	10/10/20	41 months	715	715
Leaf, PO Box 644066, Cincinnati, OH 45264	<input type="radio"/>	<input checked="" type="radio"/>	Copier	09/05/20	32 months	922	922
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		Total ***	21,318

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.

General Information and Questionnaire

Accounting Basis

Name of Facility Litchfield Woods Health Care Cent	License No. 2034C	Report for Year Ended 9/30/2021	Page 7	of 37
---	----------------------	------------------------------------	-----------	----------

The records of this facility for the period covered by this report were maintained on the following basis:

⊕ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? Yes No If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Marcum LLP	555 Long Wharf Dr, 12th Floor, New Haven, CT 06511
2 MidCap Financial Services, LLC	7255 Woodmont Avenue, Bethesda, MD 20814
3 Marcum LLP	555 Long Wharf Dr, 12th Floor, New Haven, CT 06511
4	

Services Provided by This Firm (*describe fully*)

1	Loan Forgiveness Prep: Disallowed	\$	9,270
2	LOC Audit	\$	3,418
3	Medicare Cost Report	\$	2,700
4		\$	
		Charge for Services Provided	
		\$	15,388

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.

Yes No Pg 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Goldman, Gruder & Woods, LLC/Donald W. Light/Treasurer CT/Senior Planning Services	203-899-8900 / 860-567-0451
2 MidCap Financial Services, LLC	301-760-7600
3 Office of the State Treasurer	860-702-3000
4 Pilicy & Ryan	860-274-0018
5 Marino Ellen Corpier / Coverys/ Murtha Cullina	

5. Marine Ench Commer / Coverys/ Martha

Address (Av. & Street, City, State, Zip Code)
1 200 Connecticut Ave, Norwalk, CT 06854
2 7255 Woodmont Avenue, Bethesda, MD 20814
3 165 Capitol Avenue 2nd Fl, Hartford, CT 06106
4 365 Main Street, Watertown, CT 06795
5

Services Provided by This Firm (*describe fully*)

1	A/R Collections:Disallowed	\$	5,849
2	LOC Legal Fees:Disallowed	\$	32
3	CT Corporation Annual Report:Disallowed	\$	660
4	A/R Collections:Disallowed	\$	115
5	A/R Collections:Disallowed	\$	6,653
		Charge for Services Provided	
		\$	12,200

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.

Are These Charges Reflected in the Expenditure Portion of the
Pg 15, Line 1e

Schedule of Resident Statistics

Name of Facility Litchfield Woods Health Care Center			License No. 2034C				Report for Year Ended 9/30/2021				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	160	130	30		160	130	30					
B. On last day of THIS report period	160	130	30						160	130	30	
2. Number of Residents												
A. As of midnight of PREVIOUS report period	128	114	14		128	114	14					
B. As of midnight of THIS report period	137	112	25						137	112	25	
3. Total Number of Days Care Provided During Period												
A. Medicare	7,999	4,222	3,777		6,172	3,572	2,600		1,827	650	1,177	
B. Medicaid (Conn.)	30,271	30,110	161		22,294	22,212	82		7,977	7,898	79	
C. Medicaid (other states)												
D. Private Pay	4,303	3,702	601		3,029	2,634	395		1,274	1,068	206	
E. State SSI for RCH												
F. Other (Specify) Managed Care	4,656	2,127	2,529		3,437	1,670	1,767		1,219	457	762	
G. Total Care Days During Period (3A thru F)	47,229	40,161	7,068		34,932	30,088	4,844		12,297	10,073	2,224	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	40	38	2		26	24	2		14	14		
5. Total Resident Days (3G + 4A + 4B)	47,269	40,199	7,070		34,958	30,112	4,846		12,311	10,087	2,224	

Schedule of Resident Statistics (Cont'd)

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page 9	of 37
---	----------------------	------------------------------------	-----------	----------

4. Were there any changes in the certified bed capacity during the report year?

 Yes No

If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change	
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)		
				(1)	(2)	(3)	(1)	(2)	(3)					

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

1st change	Change in Resident Days			CCNH	RHNS	(Specify)
	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)
2nd change						
3rd change						
4th change						

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	23	84		10	1		19	
Per Diem Rate								
a. One bed rm.	526.89	282.89	213.07	652.00	627.00	367.74		
b. Two bed rms.	526.89	282.89	213.07	617.00	607.00	367.74		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		7,366	7,366		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		2,433	2,425	8	
2. Restorative Treatments					
C. Other		26,830	26,830		
D. Total Physical Therapy Treatments		36,629	36,621	8	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		350	350	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments		126	126	
2. Restorative Treatments				
C. Other		3,126	3,126	
D. Total Speech Therapy Treatments		3,602	3,602	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		4,599	4,599	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments		1,574	1,562	12
2. Restorative Treatments				
C. Other		27,621	27,621	
D. Total Occupational Therapy Treatments		33,794	33,782	12

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		2034C	9/30/2021	10	37
Are time records maintained by all individuals receiving compensation?		<input type="radio"/> Yes		<input checked="" type="radio"/> No	
		Total Cost and Hours			
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	147,652	1,900	25,968	334	
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	342,100	11,788	60,167	2,073	
5. Dietary Service					
a. Head Dietitian	62,750	1,453	11,036	255	
b. Food Service Supervisor	48,137	1,720	8,466	303	
c. Dietary Workers	416,548	25,539	73,260	4,492	
6. Housekeeping Service					
a. Head Housekeeper	9,999	296	1,758	52	
b. Other Housekeeping Workers	299,048	21,929	52,595	3,857	
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	62,082	1,885	10,919	332	
b. Other Maintenance Workers	33,660	1,951	5,919	343	
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers					
9. Barber and Beautician Services					
10. Protective Services					
11. Accounting Services					
a. Head Accountant					
b. Other Accountants					
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	156,095	2,876	21,868	402	
b. RN					
1. Direct Care	686,950	14,731	15,043	358	
2. Administrative**	472,396	16,293	66,179	2,283	
c. LPN					
1. Direct Care	788,936	27,049	263,471	8,498	
2. Administrative**					
d. Aides and Attendants	1,567,838	72,971	239,725	11,700	
e. Physical Therapists	940,878	24,841	205	5	
f. Speech Therapists	119,877	2,377			
g. Occupational Therapists	609,968	15,852	216	5	
h. Recreation Workers	171,348	8,502	30,135	1,496	
i. Physicians					
1. Medical Director					
2. Utilization Review					
3. Resident Care***					
j. Dentists					
k. Pharmacists					
l. Podiatrists					
m. Social Workers/Case Management	260,063	7,871	45,739	1,384	
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
<i>A-13. Total Salary Expenditures</i>	7,196,325	261,824	932,669	38,172	

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and

Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

*** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

**Schedule A1 - Salary Information for Operators/Owners; Administrators,
Assistant Administrators and Other Related Parties***

Name of Facility Litchfield Woods Health Care Center			License No. 2034C		Report for Year Ended 9/30/2021			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Not Applicable										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
Not Applicable										

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include all employment worked during the cost year.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

**Schedule A1 - Salary Information for Operators/Owners; Administrators,
Assistant Administrators and Other Related Parties***

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Litchfield Woods Health Care Center				2034C		9/30/2021			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Marisa Jones (10/1/2021 - 6/2/2021)	114,492	20,136		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	1,711	A2			
Timothy Flaherty (5/30/2021 - 9/30/2021)	33,160	5,832		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	680	A2			
Section IV - Assistant Administrators										

*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include all other employment worked during the cost year.

*** If more than one Administrator is reported, include dates of employment for each.

B. Report of Expenditures - Professional Fees

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021		Page 13	of 37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)					
1. Dietitian	442	6	78	1	
2. Dentist	14,777		2,599		
3. Pharmacist	15,071		2,651		
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	70,841	400	12,459	70	
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**	1,386				
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
9. Speech Therapist					
a. Resident Care	1,785	6			
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	165,227	1,590			
2. Administrative***					
b. LPN					
1. Direct Care	735,857	8,492			
2. Administrative***					
c. Aides	1,360,977	21,899			
d. Other					
12. Other (Specify)					
See Attached Schedule					
B-13 Total Fees Paid in Lieu of Salaries	2,366,363	32,393	17,787	71	

* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

*** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

Report of Expenditures
Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis*

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page 15	of 37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 326,888	289,383	37,505	
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 80,179	70,980	9,199	
4. Social Security (F.I.C.A.)	\$ 586,882	519,547	67,335	
5. Health Insurance	\$ 1,226,701	1,085,957	140,744	
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 22,637	20,040	2,597	
8. Uniform Allowance	\$			
9. Other (Specify) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 309,586	220,028	89,558	
d. Accounting and Auditing	\$ 15,388	13,086	2,302	
e. Legal (Services should be fully described on Page 7)	\$ 13,309	11,318	1,991	
f. Insurance on Lives of Owners and Operators (Specify)*	\$			
g. Office Supplies	\$ 85,324	72,562	12,762	
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 94,250	80,153	14,097	
2. Cellular Phones	\$ 1,200	1,021	179	
i. Appraisal (Specify purpose and attach copy)*	\$			
j. Corporation Business Taxes (franchise tax)	\$			
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$ 11,500	9,780	1,720	
2. Other (Specify) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 727,586	618,761	108,825	
Subtotal	\$ 3,501,430	3,012,616	488,814	

* Facility should self-disallow the expense on Page 28 of the Cost Report.

(Carry Subtotals forward to next page)

***** DO NOT Include Holiday Parties / Awards / Gifts to Staff**

Attachment Page 15

Schedule of Other Employee Benefits

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Total	\$ -	\$ -	\$ -

C. Expenditures Other Than Salaries (cont'd) - Administrative and General

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		3,501,430	3,012,616	488,814	
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	6,780	5,766	1,014	
3. Gifts to Staff and Residents	\$	19,598	16,667	2,931	
4. Employee Travel	\$	2,994	2,546	448	
5. Education Expenses Related to Seminars and Conventions	\$	17,515	14,895	2,620	
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	30,120	25,615	4,505	
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	9,185	7,811	1,374	
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	3,460	2,942	518	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	21,550	18,327	3,223	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	1,667	1,418	249	
9. Subscriptions	\$	2,248	1,912	336	
10. Contributions*** See Attached Schedule	\$	500	425	75	
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$	525,785	447,143	78,642	
13. Other (<i>Specify</i>) See Attached Schedule	\$	129,439	110,080	19,359	
<i>C-14 Total Administrative & General Expenditures</i>	\$	4,272,271	3,668,163	604,108	

* Do not include Subscriptions, which should go in item 9.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

*** Facility should self-disallow the expense on Page 28 of the Cost Report.

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 7,811	\$ 1,374	
Total Other Advertising	\$ 7,811	\$ 1,374	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 16,894	\$ 2,971	
AHCA	\$ 1,361	\$ 239	
ALTCFM	\$ 72	\$ 13	
Total Dues	\$ 18,327	\$ 3,223	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Miscellaneous	\$ 425	\$ 75	
Total Contributions	\$ 425	\$ 75	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	\$ 17,172	\$ 3,020	
Payroll Processing Fees	\$ 18,368	\$ 3,230	
Employee Physicals	\$ 14,509	\$ 2,552	
	\$ -	\$ -	
	\$ -	\$ -	
Data Processing	\$ 58,016	\$ 10,203	
Licenses	\$ 2,015	\$ 354	
Total Other Administrative and General	\$ 110,080	\$ 19,359	\$ -

Schedule C-1 - Management Services*

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	739,261	Contract Attached to a Prior Year	See Below
Allocation of the above	8,282133,067	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12Pg 18, Li
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	37,873	Admin/Gen - Other Exp	Pg 16, Line 12

* In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.

C. Expenditures Other Than Salaries (cont'd) - Dietary Basis for Allocation of Costs (See Note on Page 5)

Name of Facility	License No.	Report for Year Ended		Page of
		9/30/2021		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 425,799	362,112	63,687	
2. Non-Food Supplies	\$ 65,094	55,358	9,736	
3. Other (Specify) _____	\$ _____			
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ _____			
c. Other (Specify) _____	\$ _____			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 490,893	417,470	73,423	
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	388	330	58	
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No			If yes, specify cost.	
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.	
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

C. Expenditures Other Than Salaries (cont'd) - Laundry Basis for Allocation of Costs
(See Note on Page 5)

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021		Page of 19 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
	Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
	Amt. \$			
4. Repair and/or purchase of linens.***	Lbs.			
	Amt. \$	24,564	20,890	3,674
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (Specify) Supplies	\$	20,334	17,293	3,041
3D. Total Laundry Expenditures (3a + b + c)	\$	44,898	38,183	6,715
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

*** Pounds of Laundry only required for multi-level facilities.

C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care
Basis for Allocation of Costs (See Note on Page 5)

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2021		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 56,514	48,061	8,453	
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel				
	Amt.	\$			
C. Other (<i>Specify</i>)	\$	19,398	16,497	2,901	
Temp Help					
4D. Total Housekeeping Expenditures (4a + b + c)	\$	75,912	64,558	11,354	
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Procare LTC	\$	688,073	688,073		
b. Medicine Cabinet Drugs	\$	101,053	85,939	15,114	
c. Medical and Therapeutic Supplies	\$	415,368	353,241	62,127	
d. Ambulance/Limousine***	\$	25,012	25,012		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	35,968	30,588	5,380	
f. X-rays and Related Radiological Procedures***	\$	35,982	35,982		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	169,491	169,491		
i. Recreation	\$	7,795	6,630	1,165	
j. Direct Management Services*	\$	133,067	113,164	19,903	
k. Indirect Management Services*	\$	118,282	100,591	17,691	
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	107,586	95,543	12,043	
5M. Total Resident Care Expenditures (5a - 5j)	\$	1,837,677	1,704,254	133,423	

* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Medical Equip Rentals-Medicaid	\$ 10,573	\$ 1,860	
Physical Therapy Supplies	\$ 20,076	\$ 4	
OT Supplies	\$ 7,040	\$ 3	
Oxygen Concentrator Rentals	\$ 32,453	\$ 5,708	
Cable TV Fees	\$ 18,906	\$ 3,325	
Medical Equip Rentals-Other	\$ 6,495	\$ 1,143	
Total Other Resident Care	\$ 95,543	\$ 12,043	\$ -

Report of Expenditures
Schedule C-2 - Individuals or Firms Providing Services by Contract *

* List all contracted services over \$10,000. Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

C. Expenditures Other Than Salaries (cont'd) - Maintenance and Property

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	98,906	84,113	14,793		
b. Heat	\$	116,433	99,018	17,415		
c. Light & Power	\$	145,697	123,905	21,792		
d. Water	\$	40,778	34,679	6,099		
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	21,318	18,129	3,189		
f. Other <i>(itemize)</i>	\$	146,644	124,710	21,934		
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	569,776	484,554	85,222		
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$	2,332	1,895	437		
d. Movable Equipment	\$	75,622	61,443	14,179		
*7e. Total Depreciation Costs (7a + b + c + d)	\$	77,954	63,338	14,616		
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$	5,231	4,250	981		
c. Leasehold Improvements	\$	126,647	102,901	23,746		
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$	131,878	107,151	24,727		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	744,375	604,805	139,570		
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	270,791	220,018	50,773		
c. Personal property taxes	\$	34,168	27,761	6,407		
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	1,259,166	1,023,073	236,093		

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	\$ 13,128	\$ 2,309	
Rubbish Removal	\$ 41,422	\$ 7,285	
Snow Removal	\$ 25,409	\$ 4,469	
Supplies	\$ 44,751	\$ 7,871	
Total Other Repairs and Maintenance	\$ 124,710	\$ 21,934	\$ -

Depreciation Schedule

Schedule of Land Improvements Acquired during this report period

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
3/1/2021	Ductwork	\$ 21,031	10	\$ 1,052
Total additions for Leasehold Improvemen		\$ 21,031		\$ 1,052 *
Deletions:				
Total deletions for Leasehold Improvemen		\$ -		\$ - **

***Ties to Page 24, Line C3**

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Litchfield Woods Health Care Center			License No. 2034C		Report for Year Ended 9/30/2021			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Finance Fees-Refinance 2007	6	2007	5 yrs	12,500	12,500	SL	0		
2. Finance Fees-Refinance 2020	9	2021		19,146				5,231	
3.									
B-4. Subtotal									5,231
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	9	2020	Various	5,336,929	3,794,424	SL	Var	125,595	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
	9	2021	Various	21,031		SL	Var	1,052	
C-4. Subtotal									126,647
D. Total Amortization									131,878

* Straight-line method must be used.

** Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

C. Expenditures Other Than Salaries (cont'd) - Property Questionnaire

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page 25	of 37
---	----------------------	------------------------------------	------------	----------

11. Property Questionnaire

Part A

Is the property either owned by the Facility
or leased from a Related Party?*

Yes

No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed	01/01/88			
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure	05/11/88			
5. Total Licensed Bed Capacity	160			
6. Square Footage				
7. Acquisition Cost				
a. Land	29,039			
b. Building	7,151,576			

Part B - Owner and Related Parties

1st Mortgage 2nd Mortgage 3rd Mortgage 4th Mortgage

1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	03/29/12			
c. Interest Rate for the Cost Year	3.22%			
d. Term of Mortgage (number of years)	35			
e. Amount of Principal Borrowed	14,712,000			
f. Principal balance outstanding as of _____				

Complete if Mortgage was Refinanced

During Current Cost Year

g. Type of Financing (e.g., fixed, variable)	HUD			
h. Date of Refinancing	12/30/20			
i. New Interest Rate	295.00%			
j. Term of Mortgage (number of years)	30			
k. Amount of Principal Borrowed	12,652,300			
l. Principal Outstanding on Note Paid-Off	12,449,094			

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

C. Expenditures Other Than Salaries (cont'd) - Interest

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount		\$				
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$				

(Carry Subtotals forward to next page)

C. Expenditures Other Than Salaries (cont'd) - Interest and Insurance

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$	8,386	6,814	1,572	
Vendor Interest						
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$	8,386	6,814	1,572	
14. Insurance						
a. Insurance on Property (buildings only)		\$	165,151	134,185	30,966	
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$				
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$				
14d. Total Insurance Expenditures (14a + b + c)		\$	165,151	134,185	30,966	
15. Total All Expenditures (A-13 thru C-14)		\$	19,237,274	17,103,942	2,133,332	

D. Adjustments to Statement of Expenditures

Name of Facility Litchfield Woods Health Care Center				License No. 2034C	Report for Year Ended 9/30/2021		Page 28 of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<i>Page 10 - Salaries and Wages</i>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 610,184	609,968	216	
4.			Other - See attached Schedule	\$ 59,006	50,181	8,825	
<i>Page 13 - Professional Fees</i>							
5.	13	B8c	Resident Care Physicians **	\$ 1,386	1,386		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 309,586	220,028	89,558	
10.	15	Bd	Accounting	\$ 9,270	7,884	1,386	
10a.			Legal	\$ 13,309	11,318	1,991	
11.			Telephone	\$			
12.	30	IV3	Cellular Telephone	\$ 120	102	18	
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	I3	Gifts, flowers and coffee shops	\$ 19,598	16,667	2,931	
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m2&	Unallowable Advertising *	\$ 9,185	7,811	1,374	
19.	15	1j&k	Income Tax / Corporate Business Tax	\$ 11,500	9,780	1,720	
20.			Fund Raising / Contributions	\$ 500	425	75	
21.			Unallowable Management Fees	\$ 313,285	266,427	46,858	
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 21,859	18,590	3,269	
<i>Page 18 - Dietary Expenditures</i>							
24.			Meals to employees, guests and others who are not residents	\$			
<i>Page 19 - Laundry Expenditures</i>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<i>Page 20 - Housekeeping Expenditures</i>							
26.	18	2a1	Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 1,378,788	1,220,567	158,221	

* All except "Help Wanted".

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12m	Community Coordinator:Salary & Benefits	\$ 50,181	\$ 8,825	
Total Other Salaries Adjustment			\$ 50,181	\$ 8,825	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Fees Adjustments			\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	8n	Disallowed Dues	\$ 1,418	\$ 249	
16	M13	Bank Charges	\$ 17,172	\$ 3,020	
Total Other A&G Adjustments			\$ 18,590	\$ 3,269	\$ -

D. Adjustments to Statement of Expenditures (cont'd)

Name of Facility Litchfield Woods Health Care Center			License No. 2034C	Report for Year Ended 9/30/2021		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 1,378,788	1,220,567	158,221	
<i>Page 20 - Resident Care Supplies***</i>							
27.	20	5a1&	Prescription Drugs	\$ 688,073	688,073		
28.	20	5d	Ambulance/Limousine	\$ 25,012	25,012		
29.	20	5f	X-rays, etc	\$ 35,982	35,982		
30.	20	5h	Laboratory	\$ 169,491	169,491		
31.	20	5c	Medical Supplies	\$ 16,000	13,607	2,393	
32.	20	5e2	Oxygen (non emergency)	\$ 35,968	30,588	5,380	
33.	20	5j	Occupational Therapy	\$ 7,043	7,040	3	
34.			Other - See Attached Schedule	\$ 46,912	42,978	3,934	
<i>Page 22 - Maintenance and Property</i>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 12,855	10,445	2,410	
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
<i>Page 27 - Insurance</i>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<i>Other - Miscellaneous</i>							
42.			Other - Indirect	\$			
43.	30	IV5	Interest Income on Account Rec.	\$ 1,232	1,048	184	
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$ 75,948	64,588	11,360	
46.			Management Fees Indirect	\$ 85,441	72,662	12,779	
47.			Other - Direct	\$			
<i>Not For Profit Providers Only</i>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49.	<i>Total Amount of Decrease (Items 1 - 48)</i>		\$ 2,578,745	2,382,081	196,664		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Schedule of Other Ancillary Costs

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 30	of 37
		Item	Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)		\$ 18,729,413	18,618,935	110,478		
b. Medicaid Room and Board Contractual Allowance **		\$ (10,775,856)	(10,698,225)	(77,631)		
2. a. Medicaid (<i>All other states</i>)		\$				
b. Other States Room and Board Contractual Allowance **		\$				
3. a. Medicare Residents (<i>all inclusive</i>)		\$ 4,823,864	2,526,065	2,297,799		
b. Medicare Room and Board Contractual Allowance **		\$ (33,585)	(26,788)	(6,797)		
4. a. Private-Pay Residents and Other		\$ 4,627,357	3,259,522	1,367,835		
b. Private-Pay Room and Board Contractual Allowance **		\$ (619,845)	(536,958)	(82,887)		
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare		\$ 362,014	362,014			
b. Prescription Drugs - Medicare Contractual Allowance **		\$ (362,014)	(362,014)			
c. Prescription Drugs - Non-Medicare		\$ 270,790	269,993	797		
d. Prescription Drugs - Non-Medicare Contractual Allowance **		\$ (270,790)	(269,993)	(797)		
2. a. Medical Supplies - Medicare		\$				
b. Medical Supplies - Medicare Contractual Allowance **		\$				
c. Medical Supplies - Non-Medicare		\$ 4,715	4,715			
d. Medical Supplies - Non-Medicare Contractual Allowance **		\$ (4,715)	(4,715)			
3. a. Physical Therapy - Medicare		\$ 1,543,087	1,542,947	140		
b. Physical Therapy - Medicare Contractual Allowance **		\$ (1,251,452)	(1,251,376)	(76)		
c. Physical Therapy - Non-Medicare		\$ 693,721	691,221	2,500		
d. Physical Therapy - Non-Medicare Contractual Allowance **		\$ (692,571)	(690,071)	(2,500)		
4. a. Speech Therapy - Medicare		\$ 226,956	226,956			
b. Speech Therapy - Medicare Contractual Allowance **		\$ (200,041)	(200,041)			
c. Speech Therapy - Non-Medicare		\$ 156,320	156,320			
d. Speech Therapy - Non-Medicare Contractual Allowance **		\$ (156,220)	(156,220)			
5. a. Occupational Therapy - Medicare		\$ 1,292,275	1,292,145	130		
b. Occupational Therapy - Medicare Contractual Allowance **		\$ (1,125,862)	(1,125,791)	(71)		
c. Occupational Therapy - Non-Medicare		\$ 661,656	659,406	2,250		
d. Occupational Therapy - Non-Medicare Contractual Allowance **		\$ (660,806)	(658,556)	(2,250)		
6. a. Other (<i>Specify</i>) - Medicare		\$				
b. Other (<i>Specify</i>) - Non-Medicare		\$ 131,399	131,399			
III. Total Resident Revenue (Section I. thru Section II.)		\$ 17,369,810	13,760,890	3,608,920		
IV. Other Revenue*						
1. Meals sold to guests, employees & others		\$				
2. Rental of rooms to non-residents		\$				
3. Telephone		\$				
4. Rental of Television and Cable Services		\$				
5. Interest Income (<i>Specify</i>)		\$ 115,165	97,940	17,225		
6. Private Duty Nurses' Fees		\$				
7. Barber, Coffee, Beauty and Gift shops		\$				
8. Other (<i>Specify</i>)		\$ 1,895,143	1,611,688	283,455		
V. Total Other Revenue (1 thru 8)		\$ 2,010,308	1,709,628	300,680		
VI. Total All Revenue (III +V)		\$ 19,380,118	15,470,518	3,909,600		

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
	Total Other Resident Revenue - Medicare	\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Misc Revenue from CRF Funds	\$ 145,538		
0	Retroactives	\$ (14,139)		
	Total Other Resident Revenue	\$ 131,399	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
pg 31, L A	Interest on A/R	1,232	\$ 1,048	\$ 184	
pg 33, Ln A	Interest Income on Related Party Note	3,391,412	\$ 96,892	\$ 17,041	
	Total Interest Income		\$ 97,940	\$ 17,225	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
NA	Bad Debt Recoveries	\$ 80,913	\$ 14,230	
NA	PPP Loan Forgiveness	\$ 1,530,775	\$ 269,225	
	Total Other Revenue	\$ 1,611,688	\$ 283,455	\$ -

G. Balance Sheet

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$ 42,081	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 2,403,850	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$ (361,711)	
4. Inventories			\$ 26,394	
5. Prepaid Expenses			\$ 255,791	
a. Prepaid Insurance	201,093			
b. Prepaid Health Insurance	10,255			
c. Other Prepaid Expenses	44,443			
d. See Schedule				
6. Interest Receivable			\$ 537,598	
7. Medicare Final Settlement Receivable			\$ (412,165)	
8. Other Current Assets (<i>itemize</i>)			\$ 587,185	
A/R Non-Related Facilities	66			
A/R Related Party Facilities	587,119			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$ 3,079,023	
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Depreciation	Net		
3. Buildings	*Historical Cost		\$	
	Accum. Depreciation	Net		
4. Leasehold Improvements	*Historical Cost	5,357,962	\$	1,436,889
	Accum. Depreciation	3,921,073 Net		
5. Non-Movable Equipment	*Historical Cost	484,412	\$	5,724
	Accum. Depreciation	478,688 Net		
6. Movable Equipment	*Historical Cost	2,111,783	\$	221,302
	Accum. Depreciation	1,890,481 Net		
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	7,268
Excluded Movable Equipment	7,268			
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,671,183

* Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref Line Ref Description

Total Prepaid Expenses		\$ -

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref Line Ref Description

Total Other Current Assets (Itemize)		\$ -

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref Line Ref Description

Total Other Other Fixed Assets (Itemize)		\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

Total Other Assets		\$ (6,026)

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref Line Ref Description

Total Notes Payable		\$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)		\$ -

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)		\$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
		9/30/2021	32 37
Account		Amount	
		Total Brought Forward:	\$ 4,750,206
C. Leasehold or like property recorded for Equity Purposes.			
1. Land			\$
2. Land Improvements	*Historical Cost _____ Accum. Depreciation _____	Net	\$
3. Buildings	*Historical Cost _____ Accum. Depreciation _____	Net	\$
4. Non-Movable Equipment	*Historical Cost _____ Accum. Depreciation _____	Net	\$
5. Movable Equipment	*Historical Cost _____ Accum. Depreciation _____	Net	\$
6. Motor Vehicles	*Historical Cost _____ Accum. Depreciation _____	Net	\$
7. Minor Equipment-Not Depreciable			\$
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$
D. Investment and Other Assets			
1. Deferred Deposits			\$
2. Escrow Deposits			\$
3. Organization Expense	*Historical Cost _____ Accum. Depreciation _____	Net	\$
4. Goodwill (Purchased Only)			\$ 551,000
5. Investments Related to Resident Care (<i>itemize</i>)			\$
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$ 21,719
Name and Address	Amount	Loan Date	
Deferred Finance Fees	21,719		
7. Other Assets (<i>itemize</i>)			\$ 449,066
Deposits IRS	23,020		
Project Development	432,072		
See Schedule	(6,026)		
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 1,021,785
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 5,771,991

* Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of										
Litchfield Woods Health Care Center	2034C	9/30/2021	33	37										
Account				Amount										
Liabilities														
A. Current Liabilities														
1. Trade Accounts Payable				\$ 4,474,248										
2. Notes Payable (<i>itemize</i>)				\$ (6,301,567)										
Due from Related Party				(646,322)										
Line of Credit				(5,655,245)										
See Schedule														
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$										
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Name of Lender</th> <th style="text-align: left;">Purpose</th> <th style="text-align: left;">Amount</th> <th style="text-align: left;">Date Due</th> <th></th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td></td></tr> </tbody> </table>					Name of Lender	Purpose	Amount	Date Due						
Name of Lender	Purpose	Amount	Date Due											
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$ 323,634										
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$										
6. Accrued Payroll Taxes Payable				\$ 417,932										
7. Medicare Final Settlement Payable				\$										
8. Medicare Current Financing Payable				\$										
9. Mortgage Payable (<i>Current Portion</i>)				\$										
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$										
11. Accrued Income Taxes*				\$ 39,100										
12. Other Current Liabilities (<i>itemize</i>)				\$ 1,757,748										
Acc'd Operating Expenses				474,852										
Acc'd Expense - CT Sales Tax				187										
Due to Medicaid-Provider Tax				1,274,611										
Acc'd Health Insurance				8,098 See Schedule										
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 711,095										

* Business Income Tax (not that withheld from employees). Attach copy of owner's Federal Income Tax Return.

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			711,095	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)			\$	1,203,017
Name and Address of Lender	Amount	Loan Date		
Due to Related Party	1,203,017			
4. Other Long-Term Liabilities (<i>itemize</i>)			\$	
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	1,203,017
C. Total All Liabilities (Lines A-13 + B-5)			\$	1,914,112

G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page 35	of 37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	3,171,861
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ 142,844
7. Total Net Worth			\$	3,315,705
C. Total Reserves and Net Worth			\$	3,315,705
D. Total Liabilities, Reserves, and Net Worth			\$	5,229,817

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Litchfield Woods Health Care Center	2034C	9/30/2021	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ 2,185,219		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 19,380,118		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 19,237,274		
D. Net Income or Deficit				\$ 142,844		
E. Balance				\$ 2,328,063		
F. Additions						
1. Additional Capital Contributed (<i>itemize</i>)						
2020 Adjustment/Health Insurance				(94,597)		
2. Other (<i>itemize</i>)						
Deferred HHS Funds 2020				1,082,239		
F-3. Total Additions				\$ 987,642		
G. Deductions						
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$		
Name and Address (No., City, State, Zip)		Title	Amount			
2. Other Withdrawings (<i>Specify</i>)				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. Balance at End of Period				\$ 3,315,705		
Report for Year Ended 09/30/21						

I. Preparer's/Reviewer's Certification

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Athena Health Care Associates, Inc		
Address		Phone Number
135 South Road Farmington, CT 06032		(860) 751-3900
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Sean Harrison		(860) 751-3900
Contact Email Address		
sharrison@athenahealthcare.com		