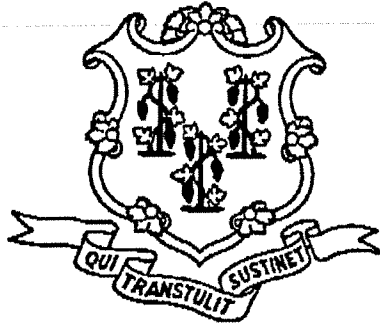


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2016

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 Nursing Home only (CCNH)	<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)
<input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH 2034C	RHNS 2034C	(Specify)	Medicare Provider No. 07-5319
------------------	---------------	---------------	-----------	-------------------------------------

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

For Department Use Only

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



**MYERS AND
STAUFFER** LLC
CERTIFIED PUBLIC ACCOUNTANTS

December 11, 2013

Mr. Michael E. Mosier
Chief Financial Officer
Athena Health Care Systems
135 South Road
Farmington, CT 06032

Subject: Alternative Annual Report Approval

Dear Mr. Mosier:

This letter is a follow-up to your verbal approval regarding your request for alternative annual report utilization. We have reviewed your request for approval of the Athena Health Care Systems version of the 2013 Annual Report for the State of Connecticut. Based on our review, your version of the annual report has been approved.

It is not necessary to request approval on an annual basis. This approval will remain in effect until modifications have been made to the Annual Report by the Department of Social Services. The provider community will be notified should such changes occur. At that time, you will be required to submit a new request for approval based on the modified annual report.

Should you have any questions, please feel free to contact me at (860) 687-0790.

Sincerely,

Brittany L. Hester, Administrative Assistant

CC: Claudette B. Pickens, CPA
CC: Chris Lavigne

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

7 Waterside Crossing, Ste 202 | Windsor, CT 06095
PH 860.687.0790 | PH 855.716.9377 | FX 860.687.0810
www.mslc.com

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	1	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 01, 2015 and ending September 30, 2016, 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 penalties 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
		2/15/17			2/15/17
Printed Name (Administrator)			Printed Name (Owner)		
Denise Quarles			Lawrence Santilli		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)		Comm. Expires
	Conn	2/15/17			3/31/17
Address of Notary Public					
41 Terrace Ln Bristol CT 06010					

(Notary Seal)

State of Connecticut
Department of Social Services
 25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Litchfield Woods Health Care Center	Period Covered:	From 10/1/2015	To 9/30/2016	
Address of Facility 225 Roberts Street Torrington, CT 06790				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900	Date 2/15/2017		
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 09/30/16	Page 2	of 37
--	--	------------------	-----------------

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 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="checkbox"/> PROPRIETORSHIP	<input type="checkbox"/> LLC	<input type="checkbox"/> PARTNERSHIP	<input checked="" type="checkbox"/> PROFIT CORP.
		<input type="checkbox"/> NON-PROFIT CORP.	<input type="checkbox"/> GOVERNMENT
<input type="checkbox"/> 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="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If "Yes," explain fully.
--	------------------------------	--	--------------------------

Administrator		
Name of Administrator Denise Quarles	Nursing Home Administrator's License No.:	001610

Other Operators/Owners who are assistant administrators (full or part time) of this facility.	
Name	License No.:
Not Applicable	

**General Information and Questionnaire
 Corporate Owners**

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	3A	37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
Highland View Manor, Inc.	225 Roberts St, Torrington, CT 06790	CT		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Lawrence G. Santilli	225 Roberts St, Torrington, CT 06790	President	416.5	
Michael E. Mosier	225 Roberts St, Torrington, CT 06790	Treasurer		
Debra M. Soucey	225 Roberts St, Torrington, CT 06790	Secretary		
Names of Stockholders Owning at Least 10% of Shares				
Lawrence G. Santilli	225 Roberts St, Torrington, CT 06790		416.5	
John Nocera, Jr	225 Roberts St, Torrington, CT 06790		125	

**General Information and Questionnaire
Individual Proprietorship**

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	3B	37

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

Owner(s) of Facility

Not Applicable

General Information and Questionnaire Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of		
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	4	37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 						
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="checkbox"/> Yes <input type="checkbox"/> No 						
If "Yes," provide the Name/Address and complete the information on Page 11 of the report.						
If "Yes," provide the following information:						
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report	Actual Cost to the Related Party
		Yes	No %**			
CT Health Center of Torrington LP	34 Prospect St, Waterbury, CT 06702	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Lease of Facility & Equipment	Pg 22, Ln 9, 10b; Pg 27 Ln 14	\$1,266,446
Laurel Ridge Health Care	642 Danbury Road, Ridgefield, CT 06877	<input checked="" type="checkbox"/>	>98%	Bank Charges	Pg 16, Ln m13	\$9,116
Athena Captive LLC	135 South Road, Farmington, CT 06032	<input type="checkbox"/>		Workers Comp Captive	Pg 15, ln 1a	\$756,911
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/>	>50%	Lobbying, Payroll Processing Fees, Data Processing Fees,	Pg 16 m13	\$17,911
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/>	>50%	Management Fees, Legal, Office Supplies, Furniture & Equipment	Pg 17, Pg 15 ln 1e, 1g, Pg 32 ln C5	\$873,266
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/>	>50%	Employee Relations, Education, Business Promotion, Memberships	Pg 16 ln L3 L5; Pg 16 m3, m8	\$3,454
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/>	>50%	Repairs & Maintenance, MDS Consultant, Physical Therapy	Pg 22 ln 6a, 6f; Pg 13 ln 11a2; Pg 13 ln 5a	\$17,756
Athena Health Care Assoc Inc. 401(K) Plan	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/>		Facility participates in group 401(k) plan	Pg 15 ln 1a7	
Shady Knoll Health Care	41 Skokorat Street, Seymour, CT 06483	<input checked="" type="checkbox"/>	>98%	SWAP Mortgage Interest Payments	Pg 22 Ln 9	\$8,138

* Use additional sheets if necessary.

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

Litchfield Woods Health Care Center
 RELATED PARTIES QUESTIONNAIRE
 PAGE 4

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No	%**				
Misc Facilities	Various	X		>98%	Interfacility loans	Pg 33, Ln A2		
Athena Health Care Insurance	135 South Road Farmington, CT 06032	X		>50%	Self Insured Employee Health & Dental Insurance	Pg 15, ln 1a5	\$1,579,472	\$1,574,088
Bayview Health Care Center	301 Rope Ferry Road Waterford, CT 06385	X		>98%	Software Settlement	Pg 16, m13	\$1,512	\$1,512
Procure LTC.	111 Executive Blvd. Farmingtondale, NY 11735	X			Pharmacy	Pg. 20 5a2	\$375,420	\$375,420

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	5	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 (See listing page 13)			
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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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.)				
<input type="checkbox"/> Yes <input type="checkbox"/> 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/2034C		9/30/2016		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="checkbox"/>	<input checked="" type="checkbox"/>	Postal Equipment	11/01/13	42 months	\$1,212	\$1,212
Leaf, PO Box 644066, Cincinnati, OH 45264	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Copier	06/19/13	35 months	\$7,075	\$7,075
Leaf, PO Box 644066, Cincinnati, OH 45264	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Copier	05/16/12	48 months	\$11,333	\$11,333
HP Financial Services, 200 Connell Drive, Suite 5000, Berkeley Heights, NJ 07922	<input type="checkbox"/>	<input type="checkbox"/>	PCC Equipment	08/21/13	60 months	\$7,844	
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
						Total ***	\$19,620

Is a Mileage Log Book Maintained for All Leased Vehicles? Yes No **Total *****

* 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	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	7	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 Dworken, Hillman, LaMorte & Sterczala	Four Corporate Dr, Ste 488, Shelton, CT 06484
2 Marcum LLP	555 Long Wharf Dr, 12th Floor, New Haven, CT 06511
3 Dopkins & Company	200 International Dr., Buffalo, NY 14221-5794
4	

Services Provided by This Firm (describe fully)		
1 Audit, Year End Financials & Tax Return		\$ 14,000
2 Medicare Cost Report Preparation		\$ 2,650
3 Keybank loan modification: Disallow		\$ 131
4		\$ -
		Charge for Services Provided
		\$16,781

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No **Pg 15, Line1d**

Legal Services Information	
Name of Legal Firm or Independent Attorney	Telephone Number
1 Shipman & Goodwin, LLP	860-251-5000
2 Goldman, Gruder & Woods, LLC	203-899-8900
3 Murtha Cullina, LLP	860-240-6000
4 Schiff Hardin LLP	312-258-5500
5	

Address (No. & Street, City, State, Zip Code)	
1 One Constitution Plaza, Hartford, CT 06103	
2 200 Connecticut Ave, Norwalk, CT 06854	
3 185 Asylum Street, Hartford, CT 06103	
4 6600 Sears Tower, Chicago, IL 60606	
5	

Services Provided by This Firm (describe fully)		
1 General matters Disallowed		\$ 9,786
2 A/R Collections:Disallowed		\$ 601
3 Audit Legal Letter S656: Allow, General: S146 Disallowed		\$ 802
4 Loan modification:Disallowed		\$ 2,685
5		\$ -
		Charge for Services Provided
		\$13,874

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No **Pg 15, Line1e**

Schedule of Resident Statistics

Name of Facility	License No.		Report for Year Ended				Page	of	
	2034C/2034C		09/30/16				8	37	
			Period 10/1 Thru 6/30		Period 7/1 Thru 9/30				
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	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	160	130	30
B. On last day of THIS report period.....	160	130	30		160	130	160	130	30
2. Number of Residents									
A. As of midnight of PREVIOUS report period.....	156	128	28		158	129	156	128	28
B. As of midnight of THIS report period.....	150	121	29		156	126	150	121	29
3. Total Number of Days Care Provided During Period									
A. Medicare.....	11,215	3,350	7,865		8,503	2,693	2,712	657	2,055
B. Medicaid (Conn.).....	41,353	40,293	1,060		30,947	30,031	10,406	10,262	144
C. Medicaid (other states).....									
D. Private Pay.....	2,887	1,785	1,102		2,167	1,397	720	388	332
E. State SSI for RCH.....									
F. Other (Specify) Managed Care	231	231			184	184	47	47	
G. Total Care Days During Period (3A thru F).....	55,686	45,659	10,027		41,801	34,305	13,885	11,354	2,531
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds									
A. Medicaid Bed Reserve Days.....	73	58	15		69	54	4	4	
B. Other Bed Reserve Days.....	13	8	5		8	8	5	5	
5. Total Resident Days (3G + 4A + 4B).....	55,772	45,725	10,047		41,878	34,367	13,894	11,358	2,536

Schedule of Resident Statistics (Cont'd)

Name of Facility Litchfield Woods Health Care Center			License No. 2034C/2034C			Report for Year Ended 9/30/2016			Page 9		of 37		
<p>4. Were there any changes in the certified bed capacity during the report year? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "YES", provide the following information:</p>													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH	RHNS	(Specify)	
				(1)	(2)	(3)	(1)	(2)	(3)				
<p>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.</p>													
Change in Resident Days								CCNH	RHNS	(Specify)			
1st change.....													
2nd change.....													
3rd change.....													
4th change.....													
<p>6. Number of Residents and Rates on September 30 of Cost Year</p>													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	28	110			2	1	9						
Per Diem Rate													
a. One bed rm.	585.97	232.96	175.00	542.00	517.00	495.79							
b. Two bed rms.	585.97	232.96	175.00	507.00	497.00	495.79							
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								11,719	11,719				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								1,020	571	449			
2. Restorative Treatments													
C. Other								32,813	15,453	17,360			
D. Total Physical Therapy Treatments								45,552	27,743	17,809			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								1,879	1,879				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								41	22	19			
2. Restorative Treatments													
C. Other								3,732	2,010	1,722			
D. Total Speech Therapy Treatments								5,652	3,911	1,741			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								10,226	10,226				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								749	352	397			
2. Restorative Treatments													
C. Other								29,608	13,293	16,315			
D. Total Occupational Therapy Treatments								40,583	23,871	16,712			

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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)	133,036	1,710	29,232	376		
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	322,289	12,751	70,815	2,802		
5. Dietary Service						
a. Head Dietitian	46,435	1,149	10,203	253		
b. Food Service Supervisor	43,934	1,737	9,654	382		
c. Dietary Workers	349,423	26,040	76,777	5,722		
6. Housekeeping Service						
a. Head Housekeeper	46,209	1,759	10,153	386		
b. Other Housekeeping Workers	195,428	16,614	42,941	3,650		
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	51,856	1,906	11,394	419		
b. Other Maintenance Workers	31,604	1,798	6,944	395		
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	81,267	6,996	17,856	1,537		
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	145,105	3,061	39,663	836		
b. RN						
1. Direct Care	622,823	16,922	86,712	2,686		
2. Administrative**	486,415	15,475	132,959	4,231		
c. LPN						
1. Direct Care	973,070	35,936	400,009	14,748		
2. Administrative**						
d. Aides and Attendants	1,663,091	111,946	421,025	27,614		
e. Physical Therapists	606,177	16,459	389,122	10,566		
f. Speech Therapists	107,996	2,369	48,075	1,054		
g. Occupational Therapists	336,609	9,058	235,659	6,342		
h. Recreation Workers	117,607	6,573	25,842	1,445		
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	213,621	7,368	46,938	1,619		
n. Marketing						
o. Other (Specify)						
<i>A-13. Total Salary Expenditures</i>	6,573,995	297,627	2,111,973	87,063		

* 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)

Position	\$ CCNH	Hours CCNH	\$ RHNS	Hours RHNS	\$ (Specify)	Hours (Specify)
Total	\$ -	-	\$ -	-	\$ -	-

Schedule of Physician: Other Fees (Page 13)

Service	\$ CCNH	Hours CCNH	\$ RHNS	Hours RHNS	\$ (Specify)	Hours (Specify)
Total	\$ -	-	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	\$ CCNH	Hours CCNH	\$ RHNS	Hours RHNS	\$ (Specify)	Hours (Specify)
Total	\$ -	-	\$ -	-	\$ -	-

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		License No.		Report for Year Ended		Page	of		
Litchfield Woods Health Care Center		2034C/2034C		9/30/2016		11	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.

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/2034C		9/30/2016		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***									
Denise Quarles (10/1/2015 - 9/30/2016)	133,036	29,232	Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,086	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	License No.	Report for Year Ended		Page	of	
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016		13	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.....						
2. Dentist.....	14,246	52	3,130	11		
3. Pharmacist.....	12,202	96	2,681	21		
4. Podiatrist.....						
5. Physical Therapy						
a. Resident Care.....	3,064	51	1,967	32		
b. Other.....						
6. Social Worker.....						
7. Recreation Worker.....						
8. Physicians						
a. Medical Director (entire facility).....	75,754	191	16,646	42		
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**.....	(11,345)					
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.....	747	2	333	1		
b. Other.....						
10. Occupational Therapist						
a. Resident Care.....						
b. Other.....						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	1,563	25	428	7		
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides.....						
d. Other.....						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	96,231	416	25,185	115		

* 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*

Name of Facility		License No.	Report for Year Ended		Page	of
Litchfield Woods Health Care Center		2034C/2034C	9/30/2016		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
John Dempsey Hospital, 263 Farmington Ave, PO Box 4033	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Cardiology PC, PO Box 848758, Boston, MA 02284	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Prohealth Physicians/Dr Yoelson, PO Box 150483, Hartford, CT 06115	Medical Director & Assistant Medical Director	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Omnicare, PO Box 78000, Detroit, MI 48278	Pharmacist	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Yale New Haven Hospital, PO Box 1403, New Haven, CT 06505	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Athena Health Care Systems 135 South Road, Farmington, CT 06032	MDS Fill In	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Owners		
Litchfield Hills Orthopedic, 245 Alvord Park Rd, Torrington, CT 06790	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Healthdrive Dental Group, 888 Worcester St, Wellesley, MA 02482	Dentist	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Access Therapies, PO Box 823461, Philadelphia, PA 19182-3461	Physical Therapist	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Torrington Radiologists, 57 Commercial Blvd, Torrington, CT 06790	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
PDT of Ocala FL Inc., 101 Teak Rd, Ocala, FL 34472	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Jefferson Radiology, PO Box 95000-3655, Philadelphia, PA 19195	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
SDX Swallowing Diagnostics, PO Box 484, Avon, CT 06001	Speech Therapy	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Procure LTC, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Owners		
Dr. Armen Babigian MD, 61 Commercial Blvd, Torrington, CT 06790	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Healthdrive Audiology Group, 888 Worcester, St., Wellesley, MA 02482	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Lakewood Path, PO Box 841830, Dallas, TX 75284	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
New England Orthopaedic Center, 18 Terrace Dr., Avon, CT 06001	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
NWCT Emergency Medicine, PO Box 4110, Woburn, MA 01888	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
University Physicians, PO Box 1440, Hartford, CT 06143	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation.....	\$ 756,911	572,870	184,041		
2. Disability Insurance.....	\$				
3. Unemployment Insurance.....	\$ 173,599	131,389	42,210		
4. Social Security (F.I.C.A.).....	\$ 645,360	488,442	156,918		
5. Health Insurance.....	\$ 1,388,266	1,050,712	337,554		
6. Life Insurance (employees only) (not-owners and not-operators).....	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators).....	\$ 48,162	36,451	11,711		
8. Uniform Allowance.....	\$				
9. Other (<i>Specify</i>)..... See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*.....	\$ 11,573	(917)	12,490		
d. Accounting and Auditing.....	\$ 16,781	13,758	3,023		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 13,874	11,375	2,499		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*.....	\$				
g. Office Supplies.....	\$ 81,564	66,870	14,694		
h. Telephone and Cellular Phones.....					
1. Telephone & Pagers.....	\$ 47,352	38,822	8,530		
2. Cellular Phones.	\$ 2,820	2,312	508		
i. Appraisal (<i>Specify purpose and attach copy</i>)*.....	\$				
j. Corporation Business Taxes (<i>franchise tax</i>). k. Other Taxes (<i>Not related to property - See Page 22</i>)	\$				
1. Income*.....	\$ 250	205	45		
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 936,588	767,867	168,721		
Subtotal	\$ 4,123,100	3,180,156	942,944		

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

(Carry Subtotals forward to next page)

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016		16	37
Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		4,123,100	3,180,156	942,944	
l. Travel and Entertainment					
1. Resident Travel and Entertainment.....	\$				
2. Holiday Parties for Staff.....	\$	8,593	7,045	1,548	
3. Gifts to Staff and Residents.....	\$	30,444	24,960	5,484	
4. Employee Travel.....	\$	4,741	3,887	854	
5. Education Expenses Related to Seminars and Conventions	\$	9,565	7,842	1,723	
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>).....	\$	8,886	7,285	1,601	
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)***.....	\$	37,474	30,723	6,751	
See Attached Schedule					
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)***.....	\$	55	45	10	
7. Postage.....	\$	14,762	12,103	2,659	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	11,346	9,302	2,044	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions.....	\$	1,269	1,040	229	
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**.....	\$	555,013	455,030	99,983	
13. Other (<i>Specify</i>) See Attached Schedule	\$	123,778	101,481	22,297	
C-14 Total Administrative & General Expenditures	\$	4,929,026	3,840,899	1,088,127	

* 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	\$ 30,723	\$ 6,751	
Total Other Advertising	\$ 30,723	\$ 6,751	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM	\$ 129	\$ 31	
CAHCF	\$ 9,173	\$ 2,013	
Total Dues	\$ 9,302	\$ 2,044	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Lobbying Fees	\$ 4,393	\$ 965	
Bank Charges	\$ 10,195	\$ 2,240	
Payroll Processing Fees	\$ 24,134	\$ 5,303	
Employee Physicals	\$ 19,759	\$ 4,341	
Compliance Consulting	\$ 23,018	\$ 5,058	
Data Processing	\$ 17,155	\$ 3,769	
Licenses	\$ 1,761	\$ 387	
CMS penalty Case No. 2016-01-LTC-193	\$ 1,066	\$ 234	
Total Other Administrative and General	\$ 101,481	\$ 22,297	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	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	\$771,466	Contract Attached to a Prior Year	See Below
Allocation of the above	\$509,168 \$123,435 \$138,863	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 18, Line 2C Pg 20, Line 5J
Athena Health Care Assoc., Inc. 135 South Road Farmington, CT 06032	\$45,845	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.

Annual Report of Long-Term Care Facility

CSP-18 Rev. 9/2002

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
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016		18	37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food.....	\$ 346,906	284,413	62,493		
2. Non-Food Supplies.....	\$ 50,758	41,614	9,144		
3. Other (Specify) _____	\$ 208	171	37		
Dishes = \$208					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Management Services**.....	\$ 123,435	101,199	22,236		
d. Other (Specify) _____	\$				
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 521,307	427,397	93,910		
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)	
G. Resident Meals: Total no. of meals served per day:*	456	374	82		
H. Is cost of employee meals included in 2E?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
I. Did you receive revenue from employees?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, specify amount.		
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, specify cost. = \$7365		
L. Is any revenue collected from these people?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, specify amount. = \$211		
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)	Pg. 18, ln 2a1				
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, specify cost.		
O. Is any revenue collected from employees?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, specify amount.		
P. 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.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016		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. \$	20,698	16,969	3,729	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Management Services**	\$				
d. Other (Specify) Supplies = \$7,812	\$	7,812	6,405	1,407	
3E. Total Laundry Expenditures (3a + b + c + d)	\$	28,510	23,374	5,136	
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.		
I. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.		
L. 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 3E.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 *** 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	
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	20	37	
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	44,653	36,609	8,044	
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. Management Services*	\$				
d. Other (<i>Specify</i>)	\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)....	\$	44,653	36,609	8,044	
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy.....	\$				
2. Purchased from Omni Care \$242,753 Procure \$375,420	\$	530,918	530,918		
b. Medicine Cabinet Drugs.....	\$	31,825	26,092	5,733	
c. Medical and Therapeutic Supplies.....	\$	315,425	258,604	56,821	
d. Ambulance/Limousine***.....	\$	7,108	7,108		
e. Oxygen					
1. For Emergency Use.....	\$				
2. Other***.....	\$	63,241	51,849	11,392	
f. X-rays and Related Radiological Procedures***.....	\$	85,214	85,214		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>).....	\$				
h. Laboratory***.....	\$	96,488	96,488		
i. Recreation.....	\$	24,507	20,092	4,415	
j. Other (Specify)**** See Attached Schedule	\$	262,547	202,861	59,686	
5K. Total Resident Care Expenditures (5a - 5j).....	\$	1,417,273	1,279,226	138,047	

* 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)
Management Fee Direct	\$ 113,848	\$ 25,015	
Medical Equip Rentals-Medicaid	\$ 24,643	\$ 5,415	
Physical Therapy Supplies	\$ 30,223	\$ 19,401	
OT Supplies	\$ 4,894	\$ 3,427	
Oxygen Concentrator Rentals	\$ 7,865	\$ 1,728	
Cable TV Fees	\$ 11,502	\$ 2,527	
Medical Equip Rentals-Other	\$ 9,886	\$ 2,173	
Total Other Resident Care	\$ 202,861	\$ 59,686	\$ -

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

Name of Facility		License No.		Report for Year Ended		Page of				
Litchfield Woods Health Care Center		2034C/2034C		9/30/2016		21 37				
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADP	100 Corporate Drive, Windsor, CT 06095	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Payroll Processing	24,139	5,298		16	m13
USA Hauling	PO Box 808, East Windsor, CT 06088	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Rubbish Removal	30,279	6,647		22	6f
Harmony Healthcare	430 Boston St, Suite 104, Topsfield, MA 01983	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Compliance Consulting	23,022	5,054		16	m13
Value Health Care/Omni Care	Knottier Drive, Cheshire, CT 06410	<input checked="" type="checkbox"/>	<input type="checkbox"/>		Pharmacy	618,173			20	5a2
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							

* 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	License No.	Report for Year Ended			Page of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016			22 37
Item	Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance..... \$	103,734	85,047	18,687		
b. Heat..... \$	161,445	132,362	29,083		
c. Light & Power..... \$	131,628	107,916	23,712		
d. Water..... \$	52,652	43,167	9,485		
e. Equipment Lease (<i>Provide detail on page 6</i>)..... \$	19,620	16,086	3,534		
f. Other (<i>itemize</i>)..... \$	116,396	95,429	20,967		
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)..... \$	585,475	480,007	105,468		
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements..... \$					
b. Building & Building Improvements..... \$					
c. Non-Movable Equipment..... \$	15,171	12,326	2,845		
d. Movable Equipment..... \$	82,857	67,321	15,536		
*7e. Total Depreciation Costs (7a + b + c + d)..... \$	98,028	79,647	18,381		
8. Amortization (<i>Complete att. Schedule Page 24*</i>)					
a. Organization Expense..... \$					
b. Mortgage Expense..... \$					
c. Leasehold Improvements..... \$	203,007	164,943	38,064		
d. Other (<i>Specify</i>)..... \$					
*8e. Total Amortization Costs (8a + b + c + d)..... \$	203,007	164,943	38,064		
9. Rental payments on leased real property less real estate taxes included in item 10b..... \$	966,999	785,687	181,312		
10. Property Taxes					
a. Real estate taxes paid by owner..... \$					
b. Real estate taxes paid by lessor..... \$	197,586	160,539	37,047		
c. Personal property taxes..... \$	29,958	24,341	5,617		
11. Total Property Expenses (7e + 8e + 9 + 10)..... \$	1,495,578	1,215,157	280,421		

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

Depreciation Schedule

Name of Facility		License No.		Report for Year Ended				Page	of
Litchfield Woods Health Care Center		2034C/2034C		9/30/2016				23	37
Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
									Yes
A. Land Improvements									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
A-4. Subtotal.....									
B. Building and Building Improvements									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
B-4. Subtotal.....									
C. Non-Movable Equipment									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal.....									
D. Movable Equipment									
1. Motor Vehicles (Specify name, model and year of each vehicle)									
a.									
b.									
c.									
d.									
2. Movable Equipment									
a. Acquired prior to this report period									
b. Disposals (attach schedule)									
c. Acquired during this report period (attach schedule)									
D-3. Subtotal.....									
E. Total Depreciation									
								82,857	
								2,050	
								15,171	
								80,807	
								2,050	
								98,028	

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Land Improvements		\$ -		\$ - *
Deletions:				
Total deletions for Land Improvements		\$ -		\$ - **

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Building Improvements		\$ -		\$ - *
Deletions:				
Total deletions for Building Improvements		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Non-Movable Equipment		\$ -		\$ - *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

LITCHFIELD WOODS
LEASEHOLD IMPROVEMENTS # 1942
FYE 9/30/16

DATE	VENDOR	DESCRIPTION	YEARS	AMOUNT
10/1/2015	BEGINNING BALANCE			3,772,936.66
ACQUISITIONS:				
10/31/2015	PRECISION PLUMBING	HOT WATER STORAGE TANK	20	2,393.00
11/30/2015	RAINTECH	DATA BOARD FOR NURSE CALL SYSTEM	10	2,963.66
11/30/2015	WRITE WAY SIGNS	SIGNS	10	4,206.14
2/29/2016	OTIS ELEVATOR	HYDRAULIC PLUNGER	10	4,779.37
3/31/2016	WRITE WAY SIGNS	Awning	15	5,423.85
4/30/2016	Legacy Fire Protection	Sprinkler Head	25	1,563.10
5/31/2016	Kamco	Metal Door	20	2,042.98
5/31/2016	TNT Refrigeration	Install 30k BTU ductless system	20	4,126.38
6/30/2016	Kamco	Wood Door	15	1,333.63
6/30/2016	PRECISION PLUMBING	Water Heater	10	3,323.00
6/30/2016	Emcor Services	Air Conditioner Cooling Chaises	10	3,659.50
7/31/2016	Shalom Sahar	Install New Exterior Railings	15	21,243.00
7/30/2016	Emcor Services	Replace Condensing Unit	15	3,342.58
8/31/2016	Proline	Replaced hot water booster dish machine	5	1,504.20
8/31/2016	Emcor Services	Replaced fan motor	5	2,322.86
8/31/2016	IDN Hardware Sales	Wood Door	15	1,269.53
ACQUISITIONS @ 9/30/16				65,496.78
BALANCE @ 9/30/16 per G/L				3,838,433.44

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended		Page	of			
		9/30/2016	24			37		
Litchfield Woods Health Care Center	2034C/2034C							
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
A. Organization Expense								
1.								
2.								
3.								
A-4. Subtotal.....								
B. Mortgage Expense								
1.								
2. Finance Fees-Refinance 2007	6	2007	5 yrs	12,500	SL	0		
3. Finance Fees-	9	2012		16,429				
B-4. Subtotal.....								
C. Leasehold Improvements and Other (Specify)								
1. Acquired prior to this report period	9	2015	Various	5,163,442	SL	Var	200,345	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal.....	9	2016	Various	65,495	SL	Var	2,662	
D. Total Amortization								203,007
								203,007

* 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.

Amortization Schedule - Detail of Leasehold Improvements & Other

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	24A	37
C. Leasehold Improvements (Specify)				
1. Acquired prior to this report period	Various	2,179,864 SL	200,345	
2. Disposals (attach schedule)				
3. Acquired during this report period	Various	65,495 SL	2,662	
C-4. Subtotal.....				203,007
C. Other (Specify)				
1. Bed License Purchase	15 yrs	741,000 SL		0
2. Bed License Purchase	None	56,593 None		
C-4. Subtotal.....				
Total Acquired prior to this report period	Various	2,977,457 SL	200,345	
Total Disposals				
Total Acquired during this report period	Various	65,495 SL	2,662	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	25	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	1988				
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	8,985,315			
f. Principal balance outstanding as of 9/30/2016	7,711,940			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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			Page	of
Litchfield Woods Health Care Center		2034C/2034C	9/30/2016			26	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			Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016			27	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).....	\$	44,994	36,558	8,436		
Vendor Interest = \$2,081; Key Bank Note Interest & Fees = \$38,651; Line of Credit Interest = \$4,262						
13. Total All Interest Expense (12B7 + 12C3 + 12D).....	\$	44,994	36,558	8,436		
14. Insurance						
a. Insurance on Property (buildings only).....	\$	107,695	87,502	20,193		
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)...	\$	107,695	87,502	20,193		
15. Total All Expenditures (A-13 thru C-14).....	\$	17,981,895	14,096,955	3,884,940		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Litchfield Woods Health Care Center			2034C/2034C	9/30/2016	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs.....	\$			
2.			Salaries not related to Resident Care....	\$			
3.	10	A12g	Occupational Therapy.....	\$ 572,268	336,609	235,659	
4.	Var	Var	Other - See attached Schedule.....	\$ 63,817	52,321	11,496	
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **.....	\$ (11,345)	(11,345)		
6.			Occupational Therapy.....	\$			
7.			Other - See attached Schedule.....	\$			
Pages 15 & 16 - Administrative and General							
8.	15	1a9	Discriminatory Benefits.....	\$			
9.	15	1c	Bad Debts.....	\$ 11,573	(917)	12,490	
10.	15	1d&e	Accounting & Legal.....	\$ 13,349	10,944	2,405	
11.	30	IV3	Telephone.....	\$			
12.	15	1h2	Cellular Telephone.....	\$ 1,680	1,377	303	
13.			Life insurance premiums on the life of Owners, Partners, Operators.....	\$			
14.	16	l3	Gifts, flowers and coffee shops.....	\$ 30,444	24,960	5,484	
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees.....	\$			
16.	16	L5	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&3	Unallowable Advertising *.....	\$ 37,474	30,723	6,751	
19.	15	1j&kl &2	Income Tax / Corporate Business Tax...	\$ 250	205	45	
20.			Fund Raising / Contributions.....	\$			
21.	16	m12	Unallowable Management Fees.....	\$ 346,500	284,080	62,420	
	18	2c		\$ 84,000	68,868	15,132	
	20	5j		\$ 94,500	77,476	17,024	
22.	16	m6	Barber and Beauty.....	\$ 55	45	10	
23.	Var	Var	Other - See attached Schedule.....	\$ 48,681	39,912	8,769	
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents.....	\$ 7,365	6,038	1,327	
Page 19 - Laundry Expenditures							
25.	19	3d	Laundry services to employees, guests and others who are not residents.....	\$			
Page 20 - Housekeeping Expenditures							
26.	20	4d	Housekeeping services to employees and others who are not residents.....	\$			
Subtotal (Items 1 - 26)				\$ 1,300,611	921,296	379,315	

* 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	52,321	11,496	
Total Other Salaries Adjustment			\$ 52,321	\$ 11,496	\$ -

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	M13	Bank Charges	10,195	2,240	
16	M13	Lobbying Fees	4,393	965	
16	M13	Compliance Consulting	23,018	5,058	
16	M13	CMS Penalty	1,066	234	
16	M13	Bayview Software settlement	1,240	272	
Total Other A&G Adjustments			\$ 39,912	\$ 8,769	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Litchfield Woods Health Care Center			2034C/2034C	9/30/2016	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,300,611	921,296	379,315	
Page 20 - Resident Care Supplies ***							
27.	20	5a1&2	Prescription Drugs.....	\$ 530,918	530,918		
28.	20	5d	Ambulance/Limousine.....	\$ 7,108	7,108		
29.	20	5f	X-rays, etc.....	\$ 85,214	85,214		
30.	20	5h	Laboratory.....	\$ 96,488	96,488		
31.	20	5c	Medical Supplies.....	\$ 18,646	15,287	3,359	
32.	20	5e2	Oxygen (non emergency).....	\$ 63,241	51,849	11,392	
33.	20	5j	Occupational Therapy.....	\$ 8,321	4,894	3,427	
34.	Var	Var	Other - See Attached Schedule.....	\$ 12,059	9,887	2,172	
Page 22 - Maintenance and Property							
35.	Var	Var	Excess Movable Equipment Depreciation See Attached Schedule.....	\$ 5,127	4,166	961	
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.....	\$			
Page 27 - Insurance							
40.			Mortgage Insurance.....	\$			
41.			Property Insurance.....	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities.....	\$			
43.	20	5j	Radio and Television Revenue.....	\$ 10,429	8,550	1,879	
44.			Vending Machine Revenue.....	\$			
45.			Purchase Discounts and Allowances.....	\$			
46.			Duplications of functions or services....	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest.....	\$			
48.	30	rvs	Interest Income on Accounts Rec.....	\$ 18	15	3	
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule.....	\$			
Not For Profit Providers Only							
50.	Var	Var	Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule.....	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 2,138,180	1,735,672	402,508	

*** 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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental	9,887	2,172	
Total Other Ancillary Costs			\$ 9,887	\$ 2,172	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7f	Movable Equip Depr Carryforward AJE	4,166	961	
Total Excess Movable Equipment Depreciation			4,166	961	

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Property Adjustments					

Schedule of Other Adjustments

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>).....	\$ 21,108,387	20,575,572	532,815			
b. Medicaid Room and Board Contractual Allowance **.....	\$ (11,507,521)	(11,162,035)	(345,486)			
2. a. Medicaid (<i>All other states</i>).....	\$					
b. Other States Room and Board Contractual Allowance **.....	\$					
3. a. Medicare Residents (<i>all inclusive</i>).....	\$ 4,706,177	1,555,106	3,151,071			
b. Medicare Room and Board Contractual Allowance **.....	\$ 1,098,244	194,573	903,671			
4. a. Private-Pay Residents and Other.....	\$ 2,189,581	1,228,709	960,872			
b. Private-Pay Room and Board Contractual Allowance **.....	\$ (94,107)	(24,019)	(70,088)			
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare.....	\$ 649,755	275,778	373,977			
b. Prescription Drugs - Medicare Contractual Allowance **.....	\$ (649,755)	(275,778)	(373,977)			
c. Prescription Drugs - Non-Medicare.....	\$ 182,894	69,158	113,736			
d. Prescription Drugs - Non-Medicare Contractual Allowance **.....	\$ (183,183)	(69,158)	(114,025)			
2. a. Medical Supplies - Medicare.....	\$ 18,498	9,536	8,962			
b. Medical Supplies - Medicare Contractual Allowance **.....	\$ (7,219)	(903)	(6,316)			
c. Medical Supplies - Non-Medicare.....	\$ 42,480	38,076	4,404			
d. Medical Supplies - Non-Medicare Contractual Allowance **.....	\$ (41,698)	(38,076)	(3,622)			
3. a. Physical Therapy - Medicare.....	\$ 1,616,548	689,392	927,156			
b. Physical Therapy - Medicare Contractual Allowance **.....	\$ (1,330,528)	(515,194)	(815,334)			
c. Physical Therapy - Non-Medicare.....	\$ 307,903	126,805	181,098			
d. Physical Therapy - Non-Medicare Contractual Allowance **.....	\$ (146,468)	(126,805)	(19,663)			
4. a. Speech Therapy - Medicare.....	\$ 500,900	266,702	234,198			
b. Speech Therapy - Medicare Contractual Allowance **.....	\$ (409,037)	(203,135)	(205,902)			
c. Speech Therapy - Non-Medicare.....	\$ 80,527	40,443	40,084			
d. Speech Therapy - Non-Medicare Contractual Allowance **.....	\$ (80,527)	(40,443)	(40,084)			
5. a. Occupational Therapy - Medicare.....	\$ 1,583,593	635,688	947,905			
b. Occupational Therapy - Medicare Contractual Allowance **.....	\$ (1,329,072)	(485,978)	(843,094)			
c. Occupational Therapy - Non-Medicare.....	\$ 288,464	114,994	173,470			
d. Occupational Therapy - Non-Medicare Contractual Allowance **.....	\$ (288,464)	(114,994)	(173,470)			
6. a. Other (<i>Specify</i>) - Medicare.....	\$					
b. Other (<i>Specify</i>) - Non-Medicare.....	\$ 133	133				
III Total Resident Revenue (Section I thru Section II).....	\$ 18,306,505	12,764,147	5,542,358			
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>).....	\$ 129,104	105,847	23,257			
6. Private Duty Nurses' Fees.....	\$					
7. Barber, Coffee, Beauty and Gift shops.....	\$					
8. Other (<i>Specify</i>).....	\$ 5,935	4,866	1,069			
V. Total Other Revenue (1 thru 8).....	\$ 135,039	110,713	24,326			
VI. Total All Revenue (III + V).....	\$ 18,441,544	12,874,860	5,566,684			

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp		CCNH	RHNS	(Specify)
Page Ref	Description			
N/A	Retroactives	\$ 133		
Total Other Resident Revenue		\$ 133	\$ -	\$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
pg 31, L A2	Interest on A/R		\$ 15	\$ 3	
pg 34, Ln B3	Interest Income on Related Party Note		\$ 105,832	\$ 23,254	
Total Interest Income			\$ 105,847	\$ 23,257	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
NA	Bad Debt Recoveries	\$ 4,866	\$ 1,069	
Total Other Revenue		\$ 4,866	\$ 1,069	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>).....			\$	205,173
2. Resident Accounts Receivable (Less Allowance for Bad Debts).....			\$	1,517,393
3. Other Accounts Receivable (Excluding Owners or Related Parties).....			\$	
4. Inventories.....			\$	30,018
5. Prepaid Expenses.....			\$	213,272
a. Prepaid Insurance	199,845			
b.				
c. Other Prepaid Expenses	13,427			
d.				
6. Interest Receivable.....			\$	150,865
7. Medicare Final Settlement Receivable.....			\$	
8. Other Current Assets (<i>itemize</i>).....			\$	232,224
A/R Non-Related Facilities	66			
A/R Related Party Facilities	227,346			
Medicaid cost settlement	4,812			
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,348,945
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.....	3,889,172	\$	1,506,299
	Accum. Depreciation	(2,382,873) Net.....		
5. Non-Movable Equipment	*Historical Cost.....	484,412	\$	36,145
	Accum. Depreciation	(448,267) Net.....		
6. Movable Equipment	*Historical Cost.....	1,798,220	\$	315,523
	Accum. Depreciation	(1,482,697) Net.....		
7. Motor Vehicles	*Historical Cost.....		\$	
	Accum. Depreciation	Net.....		
8. Minor Equipment-Not Depreciable.....			\$	
9. Other Fixed Assets (<i>itemize</i>).....			\$	19,526
Excluded Movable Equipment	19,526			
	-			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,877,493

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

Litchfield Woods
Other Prepaid Expenses #1580
9/30/16

Schiff Hardin LLP \$13,426.79

Balance at 9/30/19 \$13,426.79

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	32	37
Account			Amount	
Total Brought Forward:			\$	4,226,438
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>)			\$	
Name and Address		Amount	Loan Date	
7. Other Assets (<i>itemize</i>).....			\$	60,341
Deposits IRS		30,152		
Project Development		30,189		
D-8. Total Investments and Other Assets (Lines D1 thru 7).....			\$	611,341
D-9. Total All Assets (Lines A9 + B10 + C8 + D8).....			\$	4,837,779

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

Annual Report of Long-Term Care Facility

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center		2034C/2034C	9/30/2016	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable.....				\$	1,450,718
2. Notes Payable (<i>itemize</i>).....				\$	(967,000)
Due from Related Party			(1,037,000)		
Line of Credit			70,000		
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>).....				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>).....				\$	420,022
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>).....				\$	
6. Accrued Payroll Taxes Payable.....				\$	18,695
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>).....				\$	1,487
11. Accrued Income Taxes*.....				\$	
12. Other Current Liabilities (<i>itemize</i>).....				\$	250,428
Acc'd Operating Expenses			14,631		
Acc'd Expense - CT Sales Tax			752		
Due to Medicaid-Provider Tax			235,045		
A-13. Total Current Liabilities (Lines A1 thru 12).....				\$	1,174,350

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

(Carry Total forward to next page)

** Interest Bearing - Do Not Include in Return on Equity Calculation.

LITCHFIELD WOODS
ACCRUED EXPENSES
9/30/2016

<u>VENDOR</u>	<u>AMOUNT</u>
HEALTH INS.	\$ (1,802.55)
WAGE ENHANCEMENT	\$ (11,000.00)
MANAGEMENT FEES TRUE UP	\$ (12,221.25)
DHLS 9/30/16 AUDIT FEE	\$ 14,000.00
PITNEY BOWES	\$ (335.00)
TORRINGTON WATER	\$ 5,906.31
FOOD REBATE	\$ (1,916.64)
TOTAL	<u>\$ (7,369.13)</u>

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center		2034C/2034C	9/30/2016	34	37
Account				Amount	
				Total Brought Forward:	
				1,174,350	
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>).....\$ 388,882					
Name and Address of Lender		Amount	Loan Date		
Due to Related Party		388,882	None		
4. Other Long-Term Liabilities (<i>itemize</i>).....\$ 394,838					
<u>Note Payable</u>			392,077		
<u>SWAP Valuation</u>			2,761		
B-5. Total Long-Term Liabilities (Lines B1 thru 4).....\$ 783,720					
C. Total All Liabilities (Lines A-13 + B-5).....\$ 1,958,070					

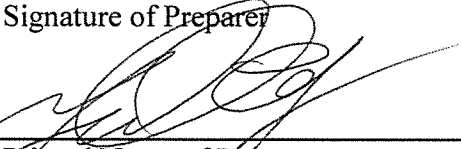
G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	35	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.....			\$	(2,761)
5. Cumulated Earnings.....			\$	2,421,821
6. Gain or Loss for Period			\$	459,649
	10/1/2015	thru	9/30/2016	
7. Total Net Worth.....			\$	2,879,709
C. Total Reserves and Net Worth			\$	2,879,709
D. Total Liabilities, Reserves, and Net Worth			\$	4,837,779

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2015			\$	2,575,922
B. Total Revenue (From Statement of Revenue Page 30)			\$	18,441,544
C. Total Expenditures (From Statement of Expenditures Page 27)			\$	17,981,895
D. Net Income or Deficit.....			\$	459,649
E. Balance.....			\$	3,035,571
F. Additions				
1. Additional Capital Contributed (itemize)				
	(164,705)			
SWAP Adjustment	8,845			
Rounding	(2)			
2. Other (itemize)				
F-3. Total Additions.....			\$	(155,862)
G. Deductions				
1. Drawings of Owners/Operators/Partners (Specify).....			\$	
Name and Address (No., City, State, Zip)		Title	Amount	
2. Other Withdrawings (Specify).....			\$	
Purpose		Amount		
3. Total Deductions.....			\$	
H. Balance at End of Period			\$	2,879,709
	09/30/16			

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C/2034C	9/30/2016	37	37
<i>Check appropriate category</i>				
CCNH	RHNS	Other (<i>Specify</i>)		
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
Preparer/Reviewer Certification				
<p>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.</p>				
Signature of Preparer	Title	Date Signed		
	CFO	2-15-17		
Printed Name of Preparer				
Athena Health Care Associates, Inc				
Address		Phone Number		
135 South Road Farmington, CT 06032		(860) 751-3900		

Cost report forms generated by Athena Health Care Associates, Inc as approved in letter dated 12/11/2013.

Name of Facility	License No.	Report for Year Ended	Page
Litchfield Woods Health Care Center	2198-C/2198-C	9/30/2016	ERROR REPORT

INCOME/EXPENSE STATEMENT

ERROR CHECK LIST

RED CELLS INDICATE POSSIBLE ERROR

*** REVIEW THE FOLLOWING FOR POSSIBLE ERRORS ***

RECONCILIATION OF COST REPORT PAGES TO INTERFACE:

(NUMBERS FROM INTERFACE MUST EQUAL COST REPORT PAGES)

	TOTAL	CCNH	RHNS	OTHER: (Specify)
PG 1A PER INTERFACE				N/A
PG 1A PER COST REPORT				N/A
DIFFERENCE				
PG 10 PER INTERFACE	8,685,968	6,573,995	2,111,973	
PG 10 PER COST REPORT	8,685,968	6,573,995	2,111,973	
DIFFERENCE				
PG 1A PER COST REPORT				N/A
PG 10 PER COST REPORT				N/A
DIFFERENCE				
PG 13 PER INTERFACE	121,416	96,231	25,185	
PG 13 PER COST REPORT	121,416	96,231	25,185	
DIFFERENCE				
PG 15 & 16 PER INTERFACE	4,929,026	3,840,899	1,088,127	
PG 15 & 16 PER COST REPORT	4,929,026	3,840,899	1,088,127	
DIFFERENCE				
PG 18 PER INTERFACE	521,307	427,397	93,910	
PG 18 PER COST REPORT	521,307	427,397	93,910	
DIFFERENCE				
PG 19 PER INTERFACE	28,510	23,374	5,136	
PG 19 PER COST REPORT	28,510	23,374	5,136	
DIFFERENCE				
PG 20 PER INTERFACE	1,461,926	1,315,835	146,091	
PG 20 PER COST REPORT	1,461,926	1,315,835	146,091	
DIFFERENCE				
PG 22 PER INTERFACE	2,081,053	1,695,164	385,889	
PG 22 PER COST REPORT	2,081,053	1,695,164	385,889	
DIFFERENCE				
PG 26 & 27 PER INTERFACE	152,689	124,060	28,629	
PG 26 & 27 PER COST REPORT	152,689	124,060	28,629	
DIFFERENCE				
TOTAL EXPENSES PER INTERFACE	17,981,895	14,096,955	3,884,940	
TOTAL EXPENSES PER COST REPORT	17,981,895	14,096,955	3,884,940	
DIFFERENCE				
TOTAL REVENUES PER INTERFACE	18,441,544	12,874,860	5,566,684	
TOTAL REVENUES PER COST REPORT	18,441,544	12,874,860	5,566,684	
DIFFERENCE				
EQUIPMENT LEASES PER PAGE 6	19,620			
EQUIPMENT LEASES PER PAGE 22,LINE 6e	19,620			
DIFFERENCE				

Name of Facility	License No.	Report for Year Ended	Page
Litchfield Woods Health Care Center	2198-C/2198-C	9/30/2016	ERROR REPORT

BALANCE SHEET ERROR CHECK LIST

*** REVIEW THE FOLLOWING FOR POSSIBLE ERRORS ***

RECONCILIATION OF COST REPORT PAGES TO INTERFACE:
(NUMBERS FROM INTERFACE MUST EQUAL COST REPORT PAGES)

RED CELLS INDICATE POSSIBLE ERROR

TOTAL

PG 31 CURRENT ASSETS PER INTERFACE	2,348,945
PG 31 CURRENT ASSETS PER COST REPORT	2,348,945
DIFFERENCE	<hr/>
PG 31 FIXED ASSETS PER INTERFACE	1,877,493
PG 31 FIXED ASSETS PER COST REPORT	1,877,493
DIFFERENCE	<hr/>
PG 32 LEASED ASSETS PER INTERFACE	
PG 32 LEASED ASSETS PER COST REPORT	
DIFFERENCE	<hr/>
PG 32 OTHER ASSETS PER INTERFACE	611,341
PG 32 OTHER ASSETS PER COST REPORT	611,341
DIFFERENCE	<hr/>
PG 32 TOTAL ASSETS PER INTERFACE	4,837,779
PG 32 TOTAL ASSETS PER COST REPORT	4,837,779
DIFFERENCE	<hr/>
PG 33 CURRENT LIABS PER INTERFACE	1,174,350
PG 33 CURRENT LIABS PER COST REPORT	1,174,350
DIFFERENCE	<hr/>
PG 34 LONG TERM LIABS PER INTERFACE	783,720
PG 34 LONG TERM LIABS PER COST REPORT	783,720
DIFFERENCE	<hr/>
PG 34 TOTAL LIABS PER INTERFACE	1,958,070
PG 34 TOTAL LIABS PER COST REPORT	1,958,070
DIFFERENCE	<hr/>
PG 35 RESERVES PER INTERFACE	
PG 35 RESERVES PER COST REPORT	
DIFFERENCE	<hr/>
PG 35 NET WORTH PER INTERFACE	2,879,709
PG 35 NET WORTH PER COST REPORT	2,879,709
DIFFERENCE	<hr/>
PG 35 TOTAL LIAB & WORTH PER INTERFACE	4,837,779
PG 35 TOTAL LIAB & WORTH PER COST REPORT	4,837,779
DIFFERENCE	<hr/>
PG 32 TOTAL ASSETS PER COST REPORT	4,837,779
PG 35 TOTAL LIAB & WORTH PER COST REPORT	4,837,779
DIFFERENCE	<hr/>
NET INCOME PER BALANCE SHEET	459,649
NET INCOME PER INCOME STATEMENT	459,649
DIFFERENCE	<hr/>
PG 35 NET WORTH PER COST REPORT	2,879,709
TOTAL NET WORTH PER PG 36	2,879,709
DIFFERENCE	<hr/>

Name of Facility	License No.	Report for Year Ended	Page
Litchfield Woods Health Care Center	2198-C/2198-C	9/30/2016	ERROR REPORT

**INFORMATIONAL PAGES
ERROR CHECK LIST**

*****RED CELLS INDICATE POSSIBLE ERROR*****

***** REVIEW THE FOLLOWING FOR POSSIBLE ERRORS *****

**RECONCILIATION OF COST REPORT PAGES TO INTERFACE INPUT:
(NUMBERS FROM INTERFACE MUST EQUAL COST REPORT PAGES)**

	TOTAL	CCNH	RHNS	OTHER: (Specify)
PG 7 TOTAL LEGAL FEES DETAIL	13,874	NOT APPLICABLE		
PG 15, LINE 1e LEGAL FEES PER COST REPORT	13,874	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
PG 7 TOTAL ACCOUNTING FEES DETAIL	16,781	NOT APPLICABLE		
PG 15, LINE 1d ACCOUNTING FEES PER C/RPT	16,781	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
PG 11 OWNER'S SALARY PER COST REPORT	-			
PG 10 OWNER'S SALARY PER COST REPORT	-			
DIFFERENCE				
PG 12 ADMINISTRATOR'S SALARY PER C/RPT	162,268	133,036	29,232	
PG 10 ADMINISTRATOR'S SALARY PER C/RPT	162,268	133,036	29,232	
DIFFERENCE				
PG 12 ASST ADMIN'S SALARY PER COST REPORT	-			
PG 10 ASST ADMIN'S SALARY PER COST REPORT	-			
DIFFERENCE				
PT TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	45,552	NOT APPLICABLE		
HORIZONTAL TOTALS	45,552	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
ST TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	5,652	NOT APPLICABLE		
HORIZONTAL TOTALS	5,652	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
OT TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	40,583	NOT APPLICABLE		
HORIZONTAL TOTALS	40,583	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
NO. OF CERTIFIED BEDS RECONCILIATION:				
NUMBER OF BEDS-BEG OF REPORT PERIOD(PG 8)	160	130	30	
ADDITIONS/DELETIONS DURING PERIOD(PG 9)	-			
CALCULATED CERT. BEDS AT END OF PERIOD	160	130	30	
ACTUAL CERT. BEDS END OF PERIOD(PG 8)	160	130	30	
DIFFERENCE				

COMPARISON OF ACTUAL PATIENT DAYS TO MAXIMUM POSSIBLE PATIENT DAYS:

AVERAGE CERTIFIED BEDS	160.00000	130.00000	30.00000
MAXIMUM PATIENT DAYS	58,560	47,580	10,980
ACTUAL PATIENT DAYS	55,772	45,725	10,047
PERCENT OCCUPIED(NOT TO EXCEED 100%)	95.2391%	96.1013%	91.5027%

Name of Facility	License No.	Report for Year Ended	Page
Litchfield Woods Health Care Center	2198-C/2198-C	9/30/2016	ERROR REPORT

**DEPRECIATION TIE-IN
ERROR CHECK LIST**

*****RED CELLS INDICATE POSSIBLE ERROR*****

***** REVIEW THE FOLLOWING FOR POSSIBLE ERRORS *****

**RECONCILIATION OF COST REPORT BALANCE SHEET TO DEPRECIATION PAGES:
(BOOK VALUE NUMBERS FROM EACH COLUMN BELOW MUST EQUAL)**

FIXED ASSET CATEGORY	BOOK VALUE PG 23 OR 24	BOOK VALUE PG 31 OR 32	Difference
LAND IMPROVEMENTS	-	-	-
BUILDING AND BUILDING IMPROVEMENTS	-	-	-
LEASEHOLD IMPROVEMENTS	1,506,299	1,506,299	-
NON-MOVEABLE EQUIPMENT	36,145	36,145	-
MOTOR VEHICLES	-	-	-
MOVEABLE EQUIPMNT(NET OF LEASED EQUIP)	335,048	315,523	
LEASED MOVEABLE EQUIPMENT	-	-	-
ORGANIZATION/START-UP	-	-	-
OTHER-PG 24	542,174	N/A **	

FIXED ASSET CATEGORY	EXPENSE PG 23 OR 24	EXPENSE PG 22	Difference
LAND IMPROVEMENTS	-	-	-
BUILDING AND BUILDING IMPROVEMENTS	-	-	-
NON-MOVEABLE EQUIPMENT	15,171	15,171	-
MOVEABLE EQUIPMENT(NET OF LEASED EQUIP) & MOTOR VEHICLES	82,857	82,857	-
LEASED MOVEABLE EQUIPMENT	-	N/A *	
ORGANIZATION/START-UP	-	-	-
FINANCE FEES	-	-	-
LEASEHOLD IMPROVES	203,007	203,007	-
OTHER AMORTIZATION	-	-	-

* NOT APPLICABLE BECAUSE THERE IS NO CORRESPONDING LINE ON PAGE 22.

**NOT APPLICABLE BECAUSE THERE IS NO CORRESPONDING LINE ON PAGES 31 OR 32.

FIXED ASSET CATEGORY		PG 23a/24a	PG 23/24	Difference
COMPARE DETAIL ADDITIONS TO PAGES 23 & 24				
LAND IMPROVEMENTS	ADDITIONS	-	-	-
	DEPREC	-	-	-
BUILDING IMPROVEMENTS	ADDITIONS	-	-	-
	DEPREC	-	-	-
NON-MOVEABLE EQUIPMENT	ADDITIONS	-	-	-
	DEPREC	-	-	-
MOVE EQUIP(NET OF LEASED EQUIP&VEHICLES	ADDITIONS	24,190	24,190	-
	DEPREC	2,050	2,050	-
LEASEHOLD IMPROVES	ADDITIONS	65,495	65,495	-
	DEPREC	2,662	2,662	-