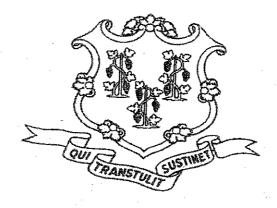
### **State of Connecticut**



### **Annual Report of Long-Term Care Facility**

Cost Year 2016

Name of Facility (as	,							
Spectrum Healthcare			*****					
Address (No. & Stree		- /						
225 Wyoming Ave T	orrington, CT	06790						
Type of Facility								
Chronic and C	Convalescent		Rest Home wi	th Nursing	•	•		
☑ Nursing Home	e only		Supervision or	nly		(Specify)		
(CCNH)			(RHNS)	•				
Report for Year Begi	nning		Report for Yea	r Ending				
10/1/2015			9/30/2016					
License Numbers:		COMI	DIDIG		(C : C.)		3.6-:	dia 15
License numbers.		CCNH 2333	RHNS		(Specify)			dicare Provider 07-5204
						я		
Medicaid Provider No	umbers:	CC	NH	RF	INS		ICI	F-IID
		20024						
For Department Use	*	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
Sequence Number	Signed and	Date	Sequence N	lumber	Signado	nd Notarize	l	Date Received
Assigned	Notarized	Received	Assign	ed	Signed a	iid Notaiize	cu	Date Received
					l		:	

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	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 IMPRISIONMENT 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 Spectrum Healthcare Torrington [facility name], for the cost report period beginning October 1, 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 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 Pacility. 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)  Powe	1	Date 2-3-17	Signed (Owner)	Date 2/3/1
Printed Name (Administrator) Robert Powers			Printed Name (Owner) Sean Murphy	
Subscribed and Sworn to before me:	State of Connecticut	Date -2-3-17	Signed (Notary Public) Unchea & Declusio	Comm. Expires
Address of Notary Public			-	1 - 0 1 3000
141 Veman St	West 1	Narche	ester C706042	·

(Notary Seal)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-1A Rev. 6/95

### State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adju	stm	ent		Page	of
				1A	37
Name of Facility		Period Cov	ered:	From	То
Spectrum Healthcare Torrington				10/1/2015	9/30/2016
Address of Facility 225 Wyoming Ave Torrington, CT 06790					
Report Prepared By Gennaro Evangelista		Phone Nun 860-871-54		Date 2/1/2017	
Item		Total	CCNH	RHNS	(Specify)
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.** 

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Annual Report of Long-Term Care Facility

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### **General Information and Questionnaire Type of Facility - Organization Structure**

				ility	Report for Ye	ar Ended	Page	of	
		860	482-8563		9/30/2016		2	37	
Name of Facility (as shown on license)					Street, City, Sta				
Spectrum Healthcare Torrington		· ·		ng A	ve Torrington,	CT 0679			
License Numbers:	CCNH		RHNS		(Specify)		Medicare P	rovider N	0.
Type of Facility (Check appropriate box(es))	2333			<u> </u>			07-5204		
· · · · · · · · · · · · · · · · · ·		_	. TT . 1.1 .		•				
Chronic and Convalescent Nursing Home only (CCNH)			t Home with lervision only			(Specify)			
Type of Ownership (Check appropriate box)									
O Proprietorship O LLC O P	artnership	0	Profit Corp.	0	Non-Profit Cor	р. О	Government	O Trus	it :
If this facility opened or closed during report	year provide	e:		Date	Opened	Date Clos	sed		
Has there been any change in ownership					<b>!</b>				
or operation during this report year?		0	Yes	•	No	If "Yes,"	explain fully	7.	
Administrator									
Name of Administrator					Nursing Ho				
Robert Powers					Administrat	l l	2012		
0.1 0 1 10	"	/C 11			License N	lo.:			
Other Operators/Owners who are assistant ad Name	ministrators	(Iuli	or part time)	of th		T			
Name					License N	10.:			
		· · ·							

### General Information and Questionnaire Partners/Members

Name of Facility		License No.	Report for Y	ear Ended	Page of
Spectrum Healthcare Torring	ton	233	3 9/30/2016		3 37
Legal Name of Par		Business		Which	l/or Town(s) in Registered
Spectrum Healthcare Torring	ton LLC	27 Naek Road, 06066	, Vernon, CT	Torrington, C	Γ
Name of Partners/Members	Business A	Address	,	Title	% Owned
Howard Dickstein	27 Naek Road, Verno	on, CT 06066	President &	CEO	65
Brian Dickstein	27 Naek Road, Verno	on, CT 06066	VP, Operation	ons	17.5
Sean Murphy	27 Naek Road, Verno	on, CT 06066	CFO		17.5
4	. 180				
- No. 10 - 1		Philip Annie A			

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3A Rev. 10/2005

### General Information and Questionnaire Corporate Owners

NTCTP***	T	1-		1
Name of Facility Spectrum Healthcare Torrington	License No.	Report for Year 9/30/2016	Ended	Page of
If this facility is owned or operated as a corp	The second secon		mation:	3A 37
Legal Name of Corporation		ess Address		ch Incorporated
20gui i aine di corporation	Bushi	ess Address	State(s) in Win	ch neorporated
		•		
Name of Directors, Officers	Busin	ess Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10% of Shares				
		v		

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3B Rev. 10/2005

### General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016	3B	37
If this facility is owned or operated as an individ-			ation:	
0	wner(s) of Facility			
	-Wi			
-	***************************************			
****				
	MP		·	
***************************************				
		-		
		***************************************		
		a .	d	
- Principle - Prin			<del></del> -	
			<del>.</del>	
				WA
		***************************************		
	***************************************			· · · · · · · · · · · · · · · · · · ·
	7.44			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

# General Information and Questionnaire Related Parties\*

Name of Facility Spectrum Healthcare Torrington	orrington	License No. 233	No. 2333	Report for Year Ended 9/30/2016		Page 4	of 37
Are any individuals recommarriage, ability to cont	Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?	se assoc	lated through	Yes © No	If "Yes," provide the Name/Address and complete the information on Page 11 of the report.	e Name/Ado	dress and ge 11 of the report.
					•		0
Are any individuals or c including the rental of p	Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility,	or servi to this fa	ces, cility,				
related through family a association to any of the	related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?	, control of this fa	or business cility?	O Yes O No	If "Yes," provide the following information:	e following	information:
					<b>T</b>		
		Also	Also Provides		Indicate Where		
;		Good	Goods/Services to		Costs are Included		
Name of Related Individual or Company	Business Address	Non-Re	Non-Related Parties Yes No %**	Description of Goods/Services Provided	in Annual Report Page #/Line#	Cost	Actual Cost to the Related Party
Spectrum Healthcare, LLC	27 Naek Rd., Vernon, CT 06066	0	•	Management Company	Page 16 Line 1m12		
Spectrum Healthcare, LLC	27 Naek Rd., Vernon, CT 06066	0	•	Admissions	Page 34 Line D7	27,789	27,789
Spectrum Healthcare Derby	Spectrum Healthcare Derby 211 Chatfield St Derby, CT 06418	0	•	Dietician	Page 34 Line 3	2.239	2.239
Spectrum Healthcare Manchester	565 Vernon St Manchester, CT 06040	0	•	Dietician	Page 34 Line 3	24,480	24,480
Spectrum Healthcare Derby	Spectrum Healthcare Derby 211 Chatfield St Derby, CT 06418	0	•	Social Services	Page 10 Line al 2m	16,370	16.370
		0	o O				
		0	0				
		0	0				
		, O	0				The state of the s

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Provide the percentage amount of revenue received from non-related parties.

### **General Information and Questionnaire Basis for Allocation of Costs**

Name of Facility	License No		Report for Year Ended	Page of
Spectrum Healthcare Torrington	2333		9/30/2016	5 37
If the facility is licensed as CDH and/or RCH o	r provides A	JDS or TBI	services with special Medicai	d rates, costs
must be allocated to CCNH and RHNS as follow				
Item			Method of Allocation	
Dietary		Number of	meals served to residents	
Laundry		Number of	pounds processed	
Housekeeping		Number of	square feet serviced	
		Number of	hours of routine care provided	by EACH
Nursing		employee c	lassification, i.e., Director (or	Charge Nurse),
•		Registered ?	Nurses, Licensed Practical Nu	rses, Aides and
		Attendants		
Direct Resident Care Consultants		Number of	hours of resident care provided	1 by EACH
		specialist (	See listing page 13)	÷
Maintenance and operation of plant		Square feet		
Property costs (depreciation)		Square feet		
Employee health and welfare		Gross salari	ies	
Management services			cost center involved	
All other General Administrative expenses		Total of Dir	rect and Allocated Costs	
The preparer of this report must answer the following	owing quest	ions applica	ble to the cost information pro	vided.
1. In the preparation of this Report, were all	O 37	O M.	If "No," explain fully why sucl	h allocation was
costs allocated as required?	⊙ Yes	O No	not made.	
74 a		,		
2. Explain the allocation of related company ex	penses and a	attach copy	of appropriate supporting data	•
3. Did the Facility appropriately allocate and se	lf-disallow o	lirect and ir	direct costs to non-nursing ho	me cost centers?
(e.g., Assisted Living, Home Health, Outpation	ent Services	, Adult Day	Care Services, etc.)	
	0.11	0 17	If "No," explain fully why sucl	h allocation was
	• Yes	O 110	not made.	

Annual Report of Long-Term Care Facility State of Connecticut CSP-6 Rev. 9/2002

### 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.			ese amounts.	italizeu, Bilol		or as needed re	ntals
Name of Facility			License No.	Report for Year Ended	ear Ended		Page of
Spectrum Healthcare Torrington			2333	9/30/2016			_
	Related * to	* to					
	Owners,	, S					
	Operators,	rs,				Annual	
	Officers	8		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Claimed
Accelerated Care Plus Corp 4850 Joule St Suite A-1 Reno, NV 89502	0	• •	PT Equipment	06/01/12			9,021
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0	The state of the s				
	0	0					
	0	0	· · · · · · · · · · · · · · · · · · ·				
	0	0					
Is a Mileage Log Book Maintained for All Leased Vehicles?	eased Vehi	icles?	O Yes	0	O No	Total ***	9.021

Is a Mileage Log Book Maintained for All Leased Vehicles?

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

<sup>\*\*</sup> Attach copies of newly acquired leases.

<sup>\*\*\*</sup> 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
Spectrum Healthcare Torrington	2333	9/30/2016		7	37
The records of this facility for the p	eriod covered by this re	port were maintained on the following basis:			
O Accrual O Cash O	Modified Cash				
Is the accounting basis for this					
period the same as for the •	Yes	If "No," explain.			
previous period? O	No	•			
Independent Accounting Firm					
Name of Accounting Firm		Address (No. & Street, City, State, Zip Cod	e)		
1 Blum, Shapiro & Company		29 So. Main St., W Hartford, CT 0612	7		
2 MidCap Funding					
3					
4					
Services Provided by This Firm (des	scribe fully)				
1 Reviewed Financial Statements, Tax 1	eturn preparation		\$	1,500	
2 Due Diligence Exam			\$	14,858	
3			\$		
4		•	\$		
			Charge fo	r Services Pr	rovided
			\$	16,358	.07200
Are These Charges Reflected in the Expend	iture Portion of This Report	? If Yes, Specify Expense Classification and Line No.	J 3	10,336	
	Page 15 line 1d	. If Test, specify Expense Classification and Line No.			
Legal Services Information					
Name of Legal Firm or Independent	Attorney		Telephone	- Number	
1 Treasurer, State of CT			1 C. Op.ioi.	, , , , , , , , , , , , , , , , , , , ,	
2 Michalik, Bauer, Silva & Cicca	rillo LLP		-		
3 Midcap Funding					
4 Donald W. Light		in a second of the second of t			.,
5 American Arbitration Associate	es.				
Address (No. & Street, City, State, 2			1		-
1 250 Constitution Plaza, Hartford	d, CT				
2 35 Pearl St Suite 300 New Brita	in, CT				
3					
4 204 Goodhosue Road, Litchfiel	d, CT	·			
5 One Center Plaza, Third Floor,	Boston, MA				
Services Provided by This Firm (des	cribe fully)				
1 Conservator Fees			\$	1,375	
2 Collections			\$	12,765	
3 Loan Amendments			\$	1,889	
4 Conservator Fees			\$	337	
5 Arbitration			\$	275	
J I HORBION				r Services Pr	Labira.
			T .		ovided
			\$	16,641	
		If Yes, Specify Expense Classification and Line No.			
• Yes O No	Page 15 Line 1e		٠		

State of Connecticut
Annual Report of Long-Term Care Facility
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### Schedule of Resident Statistics

Name of Facility Spectrum Healthcare Torrington			License No.	.No. 2333			Report for 9/30/2016	Report for Year Ended 9/30/2016	q		Page 8	of 37
						Period 10/1 Thru 6/30	1 Thru 6/	30		Period 7/1 Thru 9/30	Thru 9/3	0
	Total All	Total CCNH	Total RHNS	Total								
	Levels	Level	Level	(Specify)	Total	CCNH	RHINS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	126	126			126	126			126	126		
B. On last day of THIS report period	126	126			126	126			126	126		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	105	105			105	105	•		88	88		
B. As of midnight of THIS report period	66	66			88	88			66	66		
3. Total Number of Days Care Provided During Period										ì		
A. Medicare	4,297	4,297			3,347	3,347			950	950		
B. Medicaid (Conn.)	28,215	28,215			21,416	21,416			6.799	6.799		
C. Medicaid (other states)												
D. Private Pay	2,202	2,202			1,408	1,408			794	794		
E. State SSI for RCH												
F. Other (Specify)	1,241	1,241			992	992			249	249		
G. Total Care Days During Period (3A thru F)	35,955	35,955			27,163	27,163			8.792	8.792		
										1		
<ol> <li>for Which Revenue Was Received for Reserved Beds</li> </ol>												
A. Medicaid Bed Reserve Days										•		
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	35,955	35,955			27,163	27,163			8,792	8,792		

**Schedule of Resident Statistics (Cont'd)** 

Name of Faci	lity			Lice	nse No.				Repor	t for Year	Ended		Page	of
Spectrum He	althcare	Torring	ton		2333					9/30/201	16		9	37
4 177 11		,	* .1				-1					_		
			in the certified		apacity di	uring	the rep	ort yea	ar?	0	Yes	•	No	
If "YES"			llowing informa	tion:						1				
			f Change		C	nange	in Bed	ls		Ca	pacity Af	ter Change	_	
Date of	CCNH	RHNS	(Specify)		Lost			Gaine	d					
Change	(4)	(2)	(4)			l								
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason f	for Change
									*****					
						-	<u>                                     </u>		-				<del> </del>	
										<u> </u>			+	
		II								1		<u> </u>		-
5. If there v	vas any	change	in certified bed	capac	ity during	g the r	eport y	⁄ear (a	s repor	ted in iter	n 4 above	e) provide the m	amber of	
RESIDE	ENT DA	YS for 9	90 days followir	ng the	change.									
			Change in Ro	esider	t Days					CC	CNH	RHNS	(Spe	ecify)
1st chang	<u> </u>	••••												
2nd chan														
3rd chan														
4th changes 4th Ch		lanta an	d Rates on Septe	1_	20 -50-	-4 37 -			•••				<u></u>	w
o. Number	or Kesic	lents and	Medicare	mber	Medi		ar	ı —		S.	lf-Pay		Other Ste	ite Assisted
		ŀ	Wiedicare		Medi	Laiu		├─		1 30	II-ray		Outer sta	Assisted
	Item		CCNH	_	CND	DI	INIC	CC	יוואי	DI.	INS	(Smooif)	R.C.H.	ICF-MR
No. of Re			11	CCNH RHNS CCNH 74 14			RIT.	1149	(Specify)	K.C.n.	ICF-WIK			
Per Diem				74 14					-					
a. One b														
b. Two b	ed rms.		,	241.02 420-435										
c. Three	or more	•		241.02 420-435										
bed r	ms.								380.00					
				d						ų.		ļ	it.	
			1 Therapy Treat	ments	}					TO	ΓAL	CCNH	RHNS	(Specify)
		re - Part									5,546	5,546		
			usive of Part B) Treatments									0.50		
			Freatments								858	858	<del>                                     </del>	
	Other	orative .	Teatments								72	72	<del> </del>	
		hysical	Therapy Treatn	ients							6,476	6,476		
			Therapy Treatm											
<b>A</b> . 1	Medicar	re - Part	В								949	949		
			usive of Part B)											
			Treatments								11	11		
		orative 1	reatments											
	Other		7								76	76		
			herapy Treatme		1						1,036	1,036		
		ce - Part	tional Therapy 7	ream	ients						5,000	5.000		
			usive of Part B)								5,028	5,028		
			Treatments								761	761		
			Treatments							· · · · · · · ·	701	,01		
C. (	Other										88	88		
D. 2	Total O	ccupatio	onal Therapy Ti	reatm	ents						5,877	5,877		
											***************************************			

### Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Report of Ex	penditures	- Salam	T .			
Name of Facility	License No.		Report for Yea	r Ended	Page	of
Spectrum Healthcare Torrington	2333		9/30/2016		10	37
Are time records maintained by all individuals receiving con	npensation?	0	Yes	0	No	
7					110	
And the second s		1	Total Cost a	nd Hours	I	
T4	CONT		DID:	<b> </b>	(0,,,,10)	
A. Salaries and Wages*	CCNH	Hours	RHNS	Hours	(Specify)	Hours
1. Operators/Owners (Complete also Sec. I			100000	0.000		
of Schedule A1)						
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)	115,596	2.195				
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)					and the second second second second	
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	396,525	15,733				
5. Dietary Service						
a. Head Dietitian	41,569					
b. Food Service Supervisor	51,159					
c. Dietary Workers 6. Housekeeping Service	413,387	21,019				
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	51,235	2,118				
b. Other Maintenance Workers	33,646	2,286				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
Barber and Beautician Services     Protective Services	1					
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	207,718	4,361			COLUMN TO SERVICE SERV	
b. RN						
1. Direct Care	417,571	10,173				
2. Administrative**	163,671	4,206				
c. LPN						
1. Direct Care	1,159,331	39,405				
2. Administrative** d. Aides and Attendants	56,835 1,412,694	1,782 79,512				
e. Physical Therapists	14,721	663				
f. Speech Therapists	1-1,721	003				
g. Occupational Therapists						
h. Recreation Workers	124,043	6,191				
i. Physicians					0.000	
1. Medical Director						
2. Utilization Review						
Resident Care***      Other (Specify)						
4. Oner (specify)						
j. Dentists						
k. Pharmacists					_	
I. Podiatrists						
m. Social Workers/Case Management	96,777	3,985				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	A = = - = = =	101111				
A-13. Total Salary Expenditures	4,756,477	196,940				

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

<sup>\*\*\*</sup> 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)

	CC	NH	RH	NS	(Spec	rify)
Position	\$	Hours	\$	Hours	\$	Hours
	D Name of the Control		A CONTROL OF THE CONT			
			1			
			The state of the s			
		Carrie Manifelation of the section o				4 341 341 441 441 441 441 441 441 441 44
	A CONTRACTOR OF THE PROPERTY O					
			N. 8-34 (MBO) 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1			
от приста в при съще и принципринци в чени на вост <del>ори на и</del> ливни.	2707 00 12 05 60 00					
	5 6 0 0 0 0					
	0.0000000000000000000000000000000000000				55.40.50 (Bluit ji) ji	
					100000000000000000000000000000000000000	2010 (100 miles 100 miles
			Language of the Control			
Total	\$		\$		\$ -	

### Schedule of Other Fees (Page 13)

	CC	NH	RF	INS	(Spe	cify)
Service .	\$	Hours	\$	Hours	S	Hours
Physician Services	\$ 14,364	192	Control of the contro			
			CONTRACTOR	eraniuminidanen 1	Total Marie Marie	Herologia a a
				adaikudisting		
en in Carlon de la companya de <u>la manda de la companya de la companya de la companya de la companya de la comp</u> La companya de la comp					1000 0000000000000000000000000000000000	
					Lighter State of	cress as a second
	on the Salah Estat	digi yesin		องเมืองสูง (รักษาสารเก		
					100000000000000000000000000000000000000	
				soloulus as re		
				endivênçeni û		
		um cauco con				
		respication to the second				
				hahalaha k	a sold federal	
			165000000		a da dhuchada da	addition of the
			i ilia in companyana			100
		diense di Ci			To the state of th	
	of deals televi	sullaboration in the				
			er perpektetiblijk			
Total	\$ 14,364	192	\$ -		\$ -	

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\*

		`	TOTOTOT	) incriminate 7	A 1991 State of Authorities and Office and Office allies	ואכומוב	A L ALLIES			
Name of Facility				License No.		Report for	Report for Year Ended		Page	of
Spectrum Healthcare Torrington				2333		9/30/2016			· =	37
		Salary Paid	þ							
Name	CCNH	RHNS	(Specify)	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
Section I - Operators/Owners			*							POLICONI.
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).			,							
			,4							
					1 1 1					

<sup>\*</sup> No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

<sup>\*\*</sup> 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\*

		H	SSIStall	Administra	Assistant Administrators and Other Related Parties*	Kelated	Parties*			
Name of Facility (as licensed)				License No.		Report for Year Ended	ear Ended		Page	of
Spectrum Healthcare Torrington				2333		9/30/2016			12	37
		Salary Paid								
				Fringe Benefits and/or Other		Total	Line Where		Total	
Name	CCNH	RHNS	(Specify)	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section III - Administrators***										
llene Berkon-Cardello PTO Adjustment	-3,138					-64 A2	A2			
Kimberly Coleman 10/01/2015- 05/13/2016	89,039			Standard	Responsible for daily operations of facility.	1,705 A2	A2			
Robert Powers 06/27/20116- 09/30/2016	29,695			Standard	Responsible for daily operations of facility.	554 A2	A2			
Section IV - Assistant Administrators										
				1111						
				. •						

\*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.

### **Annual Report of Long-Term Care Facility**

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.		Report for Y		Page	of
Spectrum Healthcare Torrington	1	33	9/30/2016	cai Ended	13	37
			Total Cost	and Houre	1 13	<u> </u>
	<b>*</b>		Total Cost	did Hours	1	]
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee			Street was a second		(1)	
for service basis in lieu of salary	and English the					
(For all such services complete Schedule B1)					Section 1	
1. Dietitian						
2. Dentist						
3. Pharmacist	28,157	376				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	417,999	6,968				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	107,900	1,440				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
Infection Control Committee						
(Quarterly meetings) 2. Pharmaceutical Committee						
(Quarterly meetings)						
3. Staff Development Committee						
(Once annually)						
e. Other (Specify)						
9. Speech Therapist					cos property	
a. Resident Care	115,878	. 1,544				
b. Other						
10. Occupational Therapist						
a. Resident Care	396,069	5,280				-
b. Other				·		
11. Nurses and aides and attendants					***	
a. RN						
1. Direct Care	28,392	516				
2. Administrative***						
b. LPN						
1. Direct Care	5,523	122				
2. Administrative***						
c. Aides	10,450	418				
d. Other						
12. Other (Specify)						
See Attached Schedule	14,364	192				
B-13 Total Fees Paid in Lieu of Salaries  * Do not include in this section management consultants or services which	1,124,733	16,856				

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

<sup>\*\*\*</sup> 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 Spectrum Healthcare Torrington	License No. 2333		Report for Y 9/30/2016	ear Ended	Page 14	of 37
Name & Address of Individual	Full Explanation of Service		* to Owners, rs, Officers	Expla	nation of Rel	
Prohealth Physicians, 52 Peck Rd., Torrington, CT 06790	Medical Director	0	0			
The Nurse Network-5 Central Ave, E Hartford, CT 06150	Pool Nursing	0	0			
Pharamerica, PO Box 409251, Atlanta, GA 30384	Pharmacy Consultant	0	0			
Amor C. Lomibao, MD., 6 Frey Rd., Canton, CT 06019	Medical Director	0	0			
Steven Yoelson, 161 Mansfield Rd., Harwinton, CT 06791	Medical Staff	0	0			
Accuscript Consulting Services-276 Cedar Bridge Ave., Lakewild, NJ 08701	Pharmacy Consultant	0	0		•••	
Select Rehabilitation, Inc., 550 Frontage Rd., Suite 2415 Northfield, IL 60093	Contract Therapy	0	0			
Dr. Joseph Brenes-The Hospitalist Company-PO Box 844929, Los Angles, CA 90084-4929	Medical Director	0	0			
Dr. Richard Krinsky-1215 New Litchfield St., Torrington, CT 06790	Pulmonary Consultant	0	0			
Favorite Healthcare Staffing-PO Box 803356, Kansas City, MI 64180-3356	Pool Nursing	0	0			
Ready Nurse-2602 Highlands Blvd. N. Palm Harbor, FL 34684	Pool Nursing	0	0			
HealthDrive Dental Group-888 Worchester St., Wellesley. MA 02482-3744	Dental Consultant	0	•			
		0	0			
		0	0			
		0	0		н	
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

CSP-15 Rev. 10/2005

### C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Spectrum Healthcare Torrington	2333		9/30/2016		15	37
Item			Total	CCNH	RHNS	(Specify)
Administrative and General				001121	10111	(Specify)
a. Employee Health & Welfare Bene	fits		-15 10 10	Note: Note: 6		
Workmen's Compensation		\$	133,066	133,066		
2. Disability Insurance		\$				-
3. Unemployment Insurance		\$	103,525	103,525		
4. Social Security (F.I.C.A.)		\$		357,858		
5. Health Insurance		\$	741,003	741,003		
6. Life Insurance (employees only	v)		7.1.3000	1 12,000		
(not-owners and not-operators)		\$				
7. Pensions (Non-Discriminatory		<u> </u>		243,715		
(not-owners and not-operators)	•	•		,		
8. Uniform Allowance		\$	21,761	21,761		
9. Other (Specify)		\$	30,459	30,459		
See Attached Schedule		•		,		
b. Personal Retirement Plans, Pension	ns. and	\$			-	
Profit Sharing Plans for Owners ar						
Operators (Discriminatory)*						
c. Bad Debts*		\$	360,000	360,000		
d. Accounting and Auditing	,	\$	16,358	16,358		
e. Legal (Services should be fully des	cribed on Page 7)	\$	16,641	16,641		
f. Insurance on Lives of Owners and	- 3 /	\$	,	10,071		
Operators (Specify)*		·				
g. Office Supplies		\$	17,494	17,494		
h. Telephone and Cellular Phones						
1. Telephone & Pagers		\$	26,948	26,948		
2. Cellular Phones		\$	,			
i. Appraisal (Specify purpose and		\$				
attach copy)*						
200						
j. Corporation Business Taxes (franc	hise tax)	\$				33.
k. Other Taxes (Not related to proper	<u> </u>					
1. Income*		\$				
2. Other (Specify)		\$				
See Attached Schedule						a a managa
3. Resident Day User Fee		\$	645,818	645,818		
Subtotal		\$	2,714,647	2,714,647		
* Facility should self-disallow the expense on Pa	20 -fd - C+ D				als forward to	

<sup>\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

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

Spectrum Healthcare Torrington 9/30/2016

Attachment Page 15

### **Schedule of Other Employee Benefits**

Description	CCNH	RHNS	(Specify)
Union Training Fund	\$ 30,459		
		auseralis pina pinaria pinanjaran Sepanjah salah pinan apinaria Sepanjaran da salah pinaria	
		e persone de l'entre production Despression de la personal de l'entre de l'e L'entre de l'entre de	
		Endostropadoppodentos Extendostropado filodenio Extendospidostropadopedo	
Total	\$ 30,459	\$	Surfreendighter

### **Schedule of Other Taxes**

Description	CCNH	RHNS	(Specify)
		en com periode estado e como en En estado estado en entre el sentido en	
	THE RESIDENCE OF THE PARTY OF T		
Total		\$	\$ 100

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

Name of Facility	License No.		Report for	Year Ended	Page	of
Spectrum Healthcare Torrington	2333		9/30/2016		16	37
Item			Total	CCNH	RHNS	(Specify)
	als Brought Forwe	ard:	2,714,647	2,714,647		
1. Travel and Entertainment						100000000
Resident Travel and Entertainment		\$	4,795	4,795		
2. Holiday Parties for Staff		\$	852	852		
3. Gifts to Staff and Residents		\$	470	470		
4. Employee Travel		\$	2,791	2,791		
<ol><li>Education Expenses Related to Seminars a</li></ol>		\$	1,728	1,728	•	
6. Automobile Expense (not purchase or dep	reciation)	\$	1,000	1,000		
7. Other (Specify)		\$				
See Attached Schedule					0.000	
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expens		\$				
2. Advertising Telephone Directory (all such	expenses )***	\$	7 11 11 11 11			
3. Advertising Other (Specify)***		\$	9,546	9,546		
See Attached Schedule						a desirable
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service	is supplied	\$				-
directly and not by contract or fee for servi	ce)***					
7. Postage		\$	10,223	10,223		
* 8. Dues and Membership Fees to Professiona	1	\$	9,721	9,721		
Associations (Specify)						
See Attached Schedule	ęs		Mark Cours			
8a. Dues to Chamber of Commerce & Other Non-A	Allowable Org.***	\$				
9. Subscriptions		\$				
10. Contributions***		\$				
See Attached Schedule						
11. Services Provided by Contract (Specify and	l Complete	\$	47,076	47,076		
Schedule C-2, Page 21 for each firm or ind	lividual)					
12. Administrative Management Services**		\$				
13. Other (Specify)		\$	46,018	46,018		
See Attached Schedule						
C-14 Total Administrative & General Expenditures		\$	2,848,868	2,848,868		

<sup>\*</sup> Do not include Subscriptions, which should go in item 9.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

### Schedule of Other Travel and Entertainment

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	MARKED AZIDA GARANIA	
tu en calcala	***************************************	u 100 00 00 00 00 00 00 00 00 00 00 00 00
	\$ .	S -
****		

### Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising-Promotional	\$ 1.250		
Marketing Expenses	\$ 8,296		
Total Other Advertising	\$ 9,546	\$	\$ -

### Schedule of Dues

Description	CCNH	RHNS	(Specify)
	Name of the last o	Ciliania remember de la compa	
Dues	\$ 9,721		
Dues			
			Electronic de la constante de
		161111111111111111	
	and the decision		
			Street, Street, St.
Total Dues	\$ 9,721	\$ -	\$

### Schedule of Contributions

Description	CCNH	RHNS	(Specify)
			or official discussion
Total Contributions	S -	\$ -	\$ -

### Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)	
Licenses	\$ 1,960	and the same of the same		
Employee Backgroud Check	\$ 3,690	ese usie official		
Bank Fees	\$ 39,496		Servinalnin	
Licenses	\$ 450			
Miscellaneous	60			
	5 362		iin the should	
		COLUMBIA	di ne un	
		100		
	return at ministration between			
			100000000000000000000000000000000000000	
Total Other Administrative and General	\$ 46,018	S -	5 -	

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

### **Schedule C-1 - Management Services\***

Name of Facility Spectrum Healthcare Torrington	License No. 2333	Report for Year Ended 9/30/2016	Page of 17   37
	Cost of	J9/30/2016	17   37   Indicate Where Costs
Name & Address of Individual or Company Supplying Service	Management Service	Full Description of Mgmt. Service Provided	are Included in Annual Report Page #/Line #
Spectrum Health Care PO Box 2417 Vernon, CT 06066		Home Office, Human Resource, Treasury Management and Financial Oversight	Page 16 line 1m12

<sup>\*</sup> 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)

Mar	ne of Facility		Licens		age 5)	Tn.	C X	and Dudad	I Dana	
	ctrum Healthcare Torrington		Licens			Report for Year Ended			Page	of
Spe	cum reamcare formgion			233	33	<u> </u>	9/30/2016	) 	18	37
	Item				Total		CCNH	RHNS	(S	pecify)
2.	Dietary									
	a. In-House Preparation & Service							44888488		
	1. Raw Food		\$	3	265,127	200	265,127			
	2. Non-Food Supplies		9	3	30,006		30,006			
	3. Other (Specify)		_	3						
	b. Purchased Services (by contract other		\$	3						
	than through Management Services)									
	(Complete Schedule C-2 att. Page 21)									
	c. Management Services**		<u> </u>							
	d. Other (Specify)		. \$		1,050	KER SETTINGS	1,050			
	Equipment Rental									
	Small Equipment Purchase			10.00						
2E.	Total Dietary Expenditures $(2a + b + c + d)$		\$	<u> </u>	296,183	<u> </u>	296,183			
2F.	Dietary Questionnaire				Total		CCNH	RHNS	(S <sub>1</sub>	pecify)
G.	Resident Meals: Total no. of meals served per of	day	/:*							
Н.	Is cost of employee meals included in 2E?	0	Yes	•	0	No	)			
I.	Did you receive revenue from employees?	0	Yes		•	No	)	If yes, specify amt.		
J.	Where is the revenue received reported in the C	Cos	t Repor	t? (P	age/Line	Iten	n)			
	Is cost of meals provided to persons other							rc		
Κ	than employees or residents (i.e., Board	С	Yes		. •	No	)	If yes, specify		
	Members, Guests) included in 2E?							cost.		
L.	Is any revenue collected from these people?	C	Yes		•	No	)	If yes, specify amt.		
M.	Where is the revenue received reported in the C	Cos	t Repor	t? (P	age/Line	Iten	n)			
	Is cost of food (other than meals, e.g.,				8					·····
Ň.	snacks at monthly staff meetings, hoard	C	Yes		•	No	,	If yes, specify cost.		
o.	Is any revenue collected from employees?	<b>)</b>	Yes		•	No	•	If yes, specify amt.		
P.	Where is the revenue received reported in the C	os	t Repor	t? (P	age/Line	Iten	n)			

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

<sup>\*\*</sup> 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)

		License		Report for		Page	of
Spectrum Healthcare Torrington			2333	9/30/2016	)	19	37
	Item		Total	CCNH	RHNS	(S <sub>1</sub>	pecify)
3.	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs. Amt. \$	57	57			
	2. Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.					
	processed.***	Amt. \$					
	3. Personal clothing of residents	Lbs.					
	washed, ironed, and/or processed.***	Amt. \$					
	4. Repair and/or purchase of linens.***	Lbs.					
	<ul> <li>b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)</li> <li>c. Management Services**</li> <li>d. Other (Specify)</li> </ul>	Amt. \$ \$ \$ \$	8,940 238,110			erginder i der erdert verse der erdert in	«
3E.	Total Laundry Expenditures (3a + b + c + d)	\$	247,106	247,106			
3F.	Laundry Questionnaire	. ΨΙ	2-17,100	247,100		<u> </u>	
G.	Is cost of employee laundry included in 3E? O	Yes	•	No	If yes, specify cost.		p#
H.	Did you receive revenue from employees?	Yes	•	No	If yes, specify amt.		
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?	Yes	•	No	If yes, specify cost.		
K.	<u> </u>	Yes	•	No	If yes, specify amt.		
L.	Where is the revenue received reported in the Cost	Report?		(Page/Line	Item)		

<sup>\*</sup> 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.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> 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)

1		License No.	Rep	ort for Year E	nded	Page	of
Spe	Spectrum Healthcare Torrington 2333			9/30/2016		20	37
							1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
l	Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced					
	a. In-House Care	by Personnel					
	1. Supplies - Cleaning (Mops,	Amt.	\$	664	664		
	pails, brooms, etc.)						
	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att.	Amt.	\$	253,229	253,229		
	Page 21)						
	c. Management Services*		\$				
	d. Other (Specify)		\$				
				out and the			
4E.	Total Housekeeping Expenditures (4a +	b+c+d)	\$	253,893	253,893		
5.	Resident Care (Supplies)**			i de la company	as garaga		<b>的数字形态</b> 导展
	a. Prescription Drugs***						
	1. Own Pharmacy		\$				
	2. Purchased from		\$	291,939	291,939		
				-		-	all the fields by
	b. Medicine Cabinet Drugs		\$	15,990	15,990		
	c. Medical and Therapeutic Supplies		\$	171,129	171,129		
	d. Ambulance/Limousine***		\$				
	e. Oxygen	п		100			
	1. For Emergency Use		\$	***************************************		***************************************	**************************************
	2. Other***		\$	79,694	79,694		
	f. X-rays and Related Radiological		\$	38,231	38,231		•••
	Procedures***						
	g. Dental (Not dentists who should be incl	luded under	\$				20.000
· .	salaries or fees)						
	h. Laboratory***		\$	28,386	28,386		
	i. Recreation		\$	15,012	15,012		
	j. Other (Specify)****		\$	245,556	245,556		
	See Attached Schedule						
5K.	Total Resident Care Expenditures (5a - 5	j)	\$	885,937	885,937		

<sup>\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 29 of the Cost Report.

<sup>\*\*\*\*</sup> ICFMR's should provide a detailed schedule of all Day Program Costs.

### **Schedule of Other Resident Care**

Description		CCNH	RHNS	(Specify)
IV Therapy		\$ 86,864	autorio biante e bescoio Cipripi de altre di 190	
Outside Medical Services		\$ 15,626		
Respiratory Therapy		\$ 143,066	u nongorumenga ali iti. Kali magana ali eti eti al	
			had bearing the basis	
			udenkali Salibuk ta	
	Committee of the subsection of	Elis En chainniút Santa		
			weginggreek value is cau of	
		Part Control of Contro		
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			despression de de la com	
		balanch korolonika skullba	and distribution out	The distance we us
			e de la companya de La companya de la co	
		radional distribution		
THE PROPERTY OF THE PROPERTY O		ester es de de la compa		
Total Other Resident Care		\$ 245,556	\$ 1000 000	\$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

Name of Facility Spectrum Healthcare Torrington	u u			License No.	Report for Year Ended				Page of
200				CCC-7	0107/05/2				21 37
		Related ** to Owners	Owners						
		Operators, Officers	Officers				Fotal Cost	Total Cost/Page Ref.***	
Name of Individual or Company	Address	Yes.	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Pg Line
ADP		0	0		Payroll Processing	26,320			9
MDI Achieve		0	•		Data Processing	18,853			16 m11
Tool 4 Data		0	0		Computer Maintenance	25,947			22 6f
Lafferty Enterprises		0	•		Ground Maintenance	16,750			22 6f
Healthcare Services Group		0	•		Laundry Services	238,110			19 36
Healthcare Services Group		0	•		Housekeeping Services	253,229			20 4b
USA Hauling & Recycling			•		Trash Removal	12,785			22 6f
		0	0						
2004		0	0						
		0	0						
7.744.1	and the state of the state of	0	0			-			
		0	0						
		0	0						
		0	0						

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

<sup>\*\*</sup> Refer to Page 4 for definition of related.

<sup>\*\*\*</sup> 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 Y	ear Ended		Page	of
Spectrum Healthcare Torrington	2333	9/30/2016			22	37
Item		Total	CCNH	RHNS	(Spe	cify)
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	25,637	25,637			
b. Heat	\$	69,183	69,183			
c. Light & Power	\$	135,592	135,592			
d. Water	\$	42,086	42,086			
e. Equipment Lease (Provide detail on	page 6) \$	9,021	9,021			
f. Other (itemize)	\$	85,588	85,588			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a	- 6f) \$	367,108	367,108			
7. Depreciation (complete schedule page 2	3*)					
a. Land Improvements	\$					
b. Building & Building Improvements	\$	128,824	128,824			
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$	53,763	53,763			
*7e. Total Depreciation Costs (7a + b + c +	d) \$	182,587	182,587			
8. Amortization (Complete att. Schedule Po	age 24*)			<del></del>		
a. Organization Expense	\$					
b. Mortgage Expense	\$	7,665	7,665			
c. Leasehold Improvements	\$					
d. Other (Specify)	\$					
*8e. Total Amortization Costs (8a + b + c +	d) \$	7,665	7,665	c4	Ţ,	
9. Rental payments on leased real property	less					
real estate taxes included in item 10b	\$	483,174	483,174			
10. Property Taxes						
a. Real estate taxes paid by owner	\$	100,652	100,652			
b. Real estate taxes paid by lessor	\$			***		
c. Personal property taxes	\$	11,881	11,881			
11. Total Property Expenses (7e + 8e + 9 +	10) \$	785,959	785,959			

<sup>\*</sup> 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

<b>Description</b>	CCNH	RHNS	(Specify)
Trash Removal	\$ 12,785		
Hazardous Waste Removal	\$ 5,629		
Service Contracts	\$ 19,569		
Grounds Maintenance	\$ 16,750	retires nel matroir dibula	engazakot dan e
Grounds Landscaping	\$ 2,763		
Purchase Services	\$ 1,872		
Software Maintenance	\$ 272	este ejterfrinjer (britis di	
Computer Maintenance	\$ 25,947	e doud, valeria e a septemb	
	in the transfer in the last of the second	Personal Communication of the	besiter probabil
	25 salt men er sammen sammen det sammen	and the second second	ibaji pilita wakasana
Total Other Repairs and Maintenance	\$ 85,588	\$ -	8 -

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			Deprec	Depreciation Schedule	hedule					
Name of Facility			License No.			Report for Year Ended	nded		Page	Jo
Spectrum Healthcare Lorrington		o .	2333	33		9/30/2016			23	37
			Historical Cost	Less	Cost to Be	Accumulated Depreciation to	Method of	1.1006.1		
Property Item			Land	Value	Depreciated	Peginning of Year's Operations	Depreciation	Life	Deprectation for This Year	Totals
A. Land Improvements										
<ol> <li>Acquired prior to this report period</li> </ol>										
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	th schedule)									
A-4. Subtotal										
B. Building and Building Improvements										
<ol> <li>Acquired prior to this report period</li> </ol>			1,259,340		1,259,340	582,040	SL	Var	128.824	
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	h schedule)									
B-4. Subtotal										128 824
C. Non-Movable Equipment										120,021
1. Acquired prior to this report period										
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	h schedule)									
C-4. Subtotal										
	i.									
	ls a mileage logbook	Date of	,			Accumulated				
	maintained?	Acquisition	Historical Cost	Less		Depreciation to	Method of			
			Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	,
D Monoblo Equipment	res No	Month Year	Land	vanue	Depreciated	Year's Operations	Depreciation	Life	tor This Year	Totals
•										
I. Motor Vehicles (Specify name, model										
and year of each vehicle)										
13. 7.										
							7,747			
2 Movahle Eminment										
			711 101			000 444				
t. Discontinuo pitor to tins report period			011,101		011,181	344,779			53,333	
c. Acquired during this report period		Towns of the second								
(attach schedule)			7,846		7,846				430	
~i										53,763
E. Total Depreciation										182,587

Heaful

Spectrum Healthcare Torrington 9/30/2016

### Schedule of Land Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
			i muroprije bili	
Control of the Contro	ii aga na marangan kang isang meleberah dalah			
			777777777777777777777777777777777777777	
			20 10 10 10 10 10 10 10 10 10 10 10 10 10	
Bolton and response to the second				
otal additions for Land Imp	rovements	<b>S</b> 5		¢
Peletions:				
en ree				
BOULDER OF THE PROPERTY OF THE				THE STORY AND THE ROYET WANTER CONTRACTOR AND
Name to the second second section (S.			34 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	
				\$
otal deletions for Land Impu	ovements			4

<sup>\*</sup>Ties to Page 23, Line A3

### ${\bf Schedule\ of\ Building\ Improvements\ Acquired\ during\ this\ report\ period}$

			Useiui	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
Market of the Control				ile illustration accepted
			The state of the state of	
Total additions for	Building Improvements	S -		\$ .
Deletions:			100111111111111111111111111111111111111	2334720000000000000000000000000000000000
			5 6 6 6	
***************************************				CO CC 3/200 CONTINUES OF COMPLEX AND
Fotal deletions for	Building Improvements	\$ -		3 -
		and the second s		The state of the second

<sup>\*</sup>Ties to Page 23, Line B3

### Schedule of Non-Movable Equipment Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
		a Sipeliudu Partecharia da d	minej et ditali	SIRBIO SE SER IÑO
		rentra Cronwittana		a spoket in
				A sission de tito
		ika taukitiki kualika kaikitura 📲 ura 1200 kiji rapigit pi propinci propinci propinci propinci propinci propin		G16546 (B40)
otal additions for Non-Mov	able Equipment	5.000		\$
eletions:	**CONTROL OF THE PARTY OF THE P		2	
de como perceptada	i i ja pri provincio si pri pri pri pri pri pri pri pri pri pr			
				B0000000000000000000000000000000000000
				Subulation supplies
de la composiçõe de designação	india da cara cara da alemando esta esta de la cara de l	u di estateci sonolinguata con		
A or a lawy page and the				ata atanih dibaka
otal deletions for Non-Mov	able Equipment	5.00		S and the second

<sup>\*</sup>Ties to Page 23, Line C3

<sup>\*\*</sup>Ties to Page 23, Line A2

<sup>\*\*</sup>Ties to Page 23, Line B2

<sup>\*\*</sup>Ties to Page 23, Line C2

### Schedule of Movable Equipment Acquired during this report period

			Useiui	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
10/27/2015	Computer	\$ 1,031	5	\$ 206
04/26/2016	Slicer	\$ 1,510	5	\$ 151
9/14/2016	Computers		5	\$ 57
09/19/2016	2 Pressure Mattresses	\$ 1,914	10	\$ 16
\$10 DESIGNATION				
		* (\$12) \$12, \$2, \$2, \$2, \$2, \$2, \$2, \$2, \$2, \$2, \$		
Fotal additions for	Movable Equipment	\$ 7,846		\$ 430
Deletions:				
		e de la companya de		
	espektiving Barting all of the present the second special second			Bull-south Heal
Baltinia di dici				
Fotal deletions for	Movable Equipment			\$ -

<sup>\*</sup>Ties to Page 23, Line D2c \*\*Ties to Page 23, Line D2b

### Schedule of Leasehold Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
			ger of a constant of the	
Total additions for Leasehold I	mprovement	\$ .		\$ -
Deletions:				
randocure contes between the				
			intervaluation contracts of minutes and	
		A NAMES OF BUILDING PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PARTY OF THE		
Andrew Committee Com				
Fotal deletions for Leasehold In	pprovement	Alle San		5 -

<sup>\*</sup>Ties to Page 24, Line C3 \*\*Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility CSP-24 Rev. 10/2006 State of Connecticut

### Amortization Schedule\*

Nan	Name of Facility		I joneoi I		Donott for 17 22			4	
Spe	Spectrum Healthcare Torrington		2333	33	neport for rear Ended 9/30/2016	r Ended	<u> </u>	rage 24	ot 37
					Accumulated				
		Date of			Amort. to				
		Acquisition	.1		Beginning of	Basis for	•		
			Length of	Cost to Be	Year's	Computing	Rate 2	Rate Amortization	
	Item	Month Year	r   Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A.	Organization Expense								
	1.	લ							
	2.								· · · · · · · · · · · · · · · · · · ·
	3.					-			4
A-4	A-4. Subtotal								
B.	Mortgage Expense								
	1. Deferred Finance Line of Credit	7 2013	3	30,666	23,001	SL		7.665	
	2,								
	3.								
B-4.	. Subtotal								7.665
ပ	Leasehold Improvements and Other								
	1. Acquired prior to this report period	o	****						
	2. Disposals (attach schedule)				THE PROPERTY OF THE PROPERTY O				
	3. Acquired during this report period								
	(attach schedule)								
C-4.	. Subtotal								
Ω	Total Amortization								7,665
	* Ctoriothe line months of money land				And the street of the street o	Y			, , , , , , , , , , , , , , , , , , , ,

\* 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; ORC. Remaining Life of Lease; ORD. Actual Life if owned by Related Party.

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

Name of Facility Spectrum Healthcare Torrington	License No.	Report for Year E	nded		Page of
Spectrum Heatingare Torrington	2333	9/30/2016			25   37
11. Property Questionnaire					
Part A					
Is the property either owned by t		O Yes	⊙ 1	No.	If "Yes," complete Part B.
or leased from a Related Party?*	•	O 10s	<b>O</b> 1	NU	If "No," complete Part C.
*If any owner or operator of this f	acility is related by famil	y, marriage, ownership, ab	oility to control or		
business association to any person a related party transaction.	or organization from wl	nom buildings are leased, t	hen it is considered		
Description		Total			
Date Land Purchased		10121			
2. Date Structure Completed					
3. If NOT Original Owner, Dat	te of Purchase				
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	7	120	6		danas arabasan berek
Square Footage		30,96		346964	
7. Acquisition Cost					
a. Land			5940 Au (516) Aug	THE RESIDENCE	
b. Building					
Part B - Owner and Related Pa	arties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g.,	fixed, variable)				
b. Date Mortgage Obtained	X7				
c. Interest Rate for the Cost d. Term of Mortgage (numb					
e. Amount of Principal Born					
f. Principal balance outstan					
Complete if Mortgage was					
During Current Cost Ye					
g. Type of Financing (e.g.,					
h. Date of Refinancing	,,				
i. New Interest Rate					
j. Term of Mortgage (numb	er of years)				
k. Amount of Principal Born	owed				
<ol> <li>Principal Outstanding on</li> </ol>	Note Paid-Off				
Part C - Arms-Length Leas		y Improvements Onl	·		
Name and Address of Lesso		roperty Leased			Annual Amount of Lease
Care Capital Properties	225 Wy	oming Ave Torrington	12/05/10 7	'	483,174
		<del></del>			
			1		TAME.

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
Spectrum Healthcare Torrington	2333		9/30/2016			26	37
_							
Item			Total	CCNH	RHNS	(Spec	cify)
12. Interest	ont Pa Non Mariata	_					
A. Building, Land Improven Equipment	iem & Non-Movaoi	е					
1. First Mortgage		\$	3				
Name of Lender		Rate	Carlo San Hari				
			rejens bedent 196 Span Sattories				
Address of Lender							
2. Second Mortgage		\$					
Name of Lender	-	Rate					
						1419 00	
Address of Lender		<u>'</u>	<b>超级电影</b>				
		-	used subsequent				
3. Third Mortgage		\$					VAN-144-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-
Name of Lender		Rate					
Address of Lender							
radioss of Lander							
4. Fourth Mortgage		\$					
Name of Lender		Rate	ž.				
Address of Lender							
B. CHEFA Loan Information	. ar						
Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expen	se			THE PERSON OF TH			
12 B7. Total Building Interest Expen	se (A1 - A4 + B5)	\$					
	······································	<u>-</u> 1	(Cana	Subtotals f	are usud to m		

(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			Dago of
Spectrum Healthcare Torrington	2333			9/30/2016			Page of 27   37
Spectrum freatmente formigion	2333			9/30/2010		1	21   31
Ite	m			Total	CCNH	RHNS	(Specify)
		Broug	tht Forward:		001122	10.2112	(Special)
12. C. Movable Equipment		<u>,</u>					
1. Automotive Equipme	ent		\$				
A. Item	R	ate	Amount	egine Karangangan masi	计多数记录器 数据安格格务	transki district Geografia	
Lender	<b>_</b>						
Address of Lender							
							The second
2. Other (Specify)			\$				
A. Item	Ra	ate	Amount				
Lender		<u>l</u>					
Address of Lender							Charles Sergi Charles
B. Item	Ra	ate	Amount	A Sales		n de filologie Leithere Establis	
Lender	1	I ,					
Address of Lender							
12. C. 3. Total Movable Equip	ment Interest	<u>.</u> .					
Expense $(C1 + 2)$			\$				
12. D. Other Interest Expense (S			. \$	344,862	344,862		
Working Capital and Ver	ndor Interest			94504 6 6 9	and the state of		
13. Total All Interest Expense (1	.2B7 + 12C3 +	12D)	\$	344,862	344,862		
14. Insurance			¢.	54000	54060		
<ul><li>a. Insurance on Property (b)</li><li>b. Insurance on Automobile</li></ul>			<u>\$</u>	74,868	74,868		
c. Insurance other than Prop		iod cL					
1. Umbrella ( <i>Blanket Co</i>							
2. Fire and Extended Co							
3. Other ( <i>Specify</i> )							
2 (~p+009) )			\$				
						ter senan	
14d. Total Insurance Expenditure		)	\$	74,868	74,868		
15. Total All Expenditures (A-13	3 thru C-14)		\$	11,985,992	11,985,992		

### D. Adjustments to Statement of Expenditures

Name	e of Fa	acility		Ιi	cense No.	Report for Ye	ar Ended	Page	of
1			care Torrington		2333	9/30/2016	ar Enaca	28	37
				<del></del>	Total	12.20.2010			
Item	Page	Line			Amount of				
No.	No.	į.	Item Description		Decrease	CCNH	RHNS	(Spe	cify)
			es and Wages		20010000	001121	142110	Соро	U11))
1.			Outpatient Service Costs	\$				•	
2.			Salaries not related to Resident Care	\$					
3.			Occupational Therapy	\$					
4.		- "	Other - See attached Schedule	\$					
Page	13 - F	rofes	sional Fees	<u>-</u>					
5.			Resident Care Physicians **	\$					
6.			Occupational Therapy	\$					
7.		,	Other - See attached Schedule	\$					
Pages	s 15 &	16 -	Administrative and General	<del></del> .					
8.			Discriminatory Benefits	\$					
9.	15	1c	Bad Debts	\$	360,000	360,000			
10.			Accounting & Legal	\$					
11.			Telephone	\$					
12.			Cellular Telephone	\$					
13.			Life insurance premiums on the life		and the second second	a company a provide			
			of Owners, Partners, Operators	\$					
14.			Gifts, flowers and coffee shops	\$				<u> </u>	
15.			Education expenditures to colleges or						
			universities for tuition and related costs						
			for owners and employees	\$	4.12				and the same of the same
16.			Travel for purposes of attending						
			conferences or seminars outside the						
			continental U.S. Other out-of-state					10000000	
			travel in excess of one representative	\$					
17.			Automobile Expense (e.g. personal use)	\$	•				
18.	16	m3	Unallowable Advertising *	\$	9,546	9,546			
19.			Income Tax / Corporate Business Tax	\$		. ,			
20.			Fund Raising / Contributions	\$					
21.			Unallowable Management Fees	\$					
22.			Barber and Beauty	\$	,				
23.			Other - See attached Schedule	\$	60	60			
Page	18 - D	ietary	Expenditures						
24.	- 1		Meals to employees, guests and others			4 1 1 1 1			
	Ì		who are not residents	\$	***				
Page .	19 - L	aundi	ry Expenditures						
25.			Laundry services to employees, guests			dustrianis is desi			
			and others who are not residents	\$					
Page .	$\overline{20-H}$		keeping Expenditures					50.50	
26.			Housekeeping services to employees, guests			16 0 0 6 00			
			and others who are not residents	\$	and the second second				
			Subtotal (Items 1 - 26)	\$	369,606	369,606			
			Vontadii	<u></u>		Subtotal fo		L	

<sup>\*</sup> All except "Help Wanted".

<sup>(</sup>Carry Subtotal forward to next page)

<sup>\*\*</sup> 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		Description	CCNH	RHNS	(Specify)
				i de duscum un un la come u	
				distribution de la constanta	
maga sa sa s			Anna cadedera y enclose control y cura y a new y	I y description of the first production of sold as a section of the section of th	wave we wis pressed to war our other throad or stold
			Cartel 11 11 11 12 12 12 12 12 12 12 12 12 12		and not be derigation of and a property of
				Contractor with the contractor	
Fotal Other	Salaries A		si arang paga	\$	\$ 2

#### Schedule of Fees Adjustments

Page Ref		Description	CCNH	RHNS	(Specify)
		The state of the property of the state of th			
CANALON ACTORDANCE			AMALIAN ENGLESSES		
Keller eess a to be a markey open over the					
and of the				-9,000-89,000-00-0	
English and the					
			eleternatuere becatae	control of the second	
	r Fees Adi	E. E. C.	s -	\$ 5 5 5 5 5 5	\$

#### Schedule of Other A&G Adjustments

	CCNH	RHNS	(Specify)
16 m13 Miscellaneous	\$ 60	initaliana il	
AND ADDRESS OF THE PARTY OF THE			
	pedje elit sija spedje je	andreline along	. Journal of the second second
	Property Controllers		
		TOTAL TOTAL	
Total Other A&G Adjustments	\$ 60	S	8 -

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

			D. Adjustments to Statemen	nt	of Expend				
1	e of Fa	-		Lic	ense No.	Report for Y	Year Ended	Page	of
Speci	trum F	lealth	care Torrington		2333	9/30/2016		29	37
					Total				
Item	Page	Line			Amount of				
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	(S	pecify)
			Subtotals Brought Forward	\$	369,606	369,606			
	20 - K	Reside	nt Care Supplies***				10.0		12101
27.			Prescription Drugs	\$					
28.			Ambulance/Limousine	\$					
29.			X-rays, etc	\$					
30.			Laboratory	\$					
31.			Medical Supplies	\$					
32.			Oxygen (non emergency)	\$					
33.			Occupational Therapy	\$					
34.			Other - See Attached Schedule	\$					
	22 - N	<i><b>Lainte</b></i>	enance and Property				600 1000 000		
35.			Excess Movable Equipment Depreciation						
			See Attached Schedule	\$			,		
36.			Depreciation on Unallowable			a court on an a	and the second		
			Motor Vehicles	\$				N	
37.			Unallowable Property and Real			promontro d			
			Estate Taxes	\$					
38.			Rental of Building Space or Rooms	\$					
39.			Other - See Attached Schedule	\$					
Page	27 - II	ısura	nce				A Company		
40.			Mortgage Insurance	\$					
41.			Property Insurance	\$					
Other	- Mis	cellar	1eous						
42.			Research or Experimental Activities	\$					
43.			Radio and Television Revenue	\$					
44.			Vending Machine Revenue	\$					
45.			Purchase Discounts and Allowances	\$					
46.			Duplications of functions or services	\$		·			
47.			Expenditures made for the protection,						
		l.	enhancement or promotion of the		医医肠管前肢	and a grade			
			providers interest	\$					
48.			Interest Income on Accounts Rec	\$					
49.			Other (include personnel and other		la marije				
		ı	costs unrelated to resident care) - See		10.00				
			Attached Schedule	\$	89,033	89,033	ZATACH KALLANDON WAR ZANA ZANA ZANA ZANA ZANA ZANA ZANA ZA		
Not F	or Pro	fit Pr	oviders Only						
50.	$\Box$		Building/Non Movable Eq. Depreciation						
			Unallowable Building Interest -						
<u> </u>			See Attached Schedule	\$					
51.	Total 2	4mou	nt of Decrease (Items 1 - 50)	\$	458,639	458,639			

<sup>\*\*\*</sup> 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		Description	CCNH	RHNS	(Specify)
			erenderen belorden bilderen Staffar finleren bilder bilder bilder		
			and the second s	Appropriate the second	EDITORIA DEL PROPERTO DE CONTROLO
				otata vara kalendari kalendari otata vara kalendari kalendari	State Control of Contr
			neralistici de la circa. Agidan, el cultura		
				a erasinataninis	
				Andra Geri	
SPPERIOR PROPERTY STATE					
			ared hither hited and his total continue development of the continue development of th		#17173.0011178.0130171817.0121718 #17173.0011178.0130171817.0121718
Fotal Other	Ancillary		8 -	\$	\$

Schedule of Excess Movable Equipment Depreciation

Page Ref		Description	CCNH	RHNS	(Specify)
					ar engigen e
MCINCO-HUMAN					
State designation of the contract of			na a anaana		
Richard Control of the Control					
			sale stantininans		
			200 120 per 12		
Total Exces	s Movable	Equipment Depreciation	\$	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
			hasaganka Status	ABORD EKTRORES	
					0.000
Mando die loito dit			la se a a se a como a a como		1000000
		and supplied and the control of the			
				engungan pada balan	15 05 05 05 05 05
preparateurici ci ci ci ci			ondischarality sission		
			de de constante de la constante	ugosa ar goldini	rejoriteitajos pi
<b>Fotal Other</b>	r Property	Adjustments	\$	\$	\$

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12d	Vendor Interest	\$ 89,033		
			nijaje siaučuje si		graninali de la
				**************************************	
Total Othe	r Adjustme	ents	\$ 89,033	\$ -	\$

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		The state of the s			
outros carrollo		Table 1 to the control of the contro			
				distribution of	
					Coloradorio
			ag ag abrebreise		
ac disease to				elelele (i i i i i	
Total Unall	owable Bı		\$ <b>-</b>	\$ -	\$ -

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### F. Statement of Revenue

Name of Facility	License No.		Report for Y	ear Ended		Page	of
Spectrum Healthcare Torrington	2333		9/30/2016	our Endod		30	37
	Item		Total	CCNH	RHNS	(Spec	ify)
I. Resident Room, Board & Routine							,
1. a. Medicaid Residents (CT only	ν)	\$	11,297,303	11,297,303			
b. Medicaid Room and Board C		\$	(4,461,470)	(4,461,470)			
2. a. Medicaid (All other states)	- Communication	<u> </u>		(4,501,570)			
b. Other States Room and Boar	d Contractual Allowance **	\$				,	
3. a. Medicare Residents (all inch		<u> </u>		1,815,620			
b. Medicare Room and Board C		\$		647,929			
4. a. Private-Pay Residents and O		<u> </u>		1,351,911			
b. Private-Pay Room and Board		\$		(6,531)			
II. Other Resident Revenue	Contractan Thowance	Ψ.	(0,001)	(0,551)			4 N. F. S. S.
i		ተ	206.261	200.201			
a. Prescription Drugs - Medicar      Drugs - Medicar      Drugs - Medicar			296,261	296,261			
b. Prescription Drugs - Medicar		\$	(296,261)	(296,261)			••••
c. Prescription Drugs - Non-Me		\$	1	133,099			
	edicare Contractual Allowance **	\$	(133,099)	(133,099)			
2. a. Medical Supplies - Medicare		\$					
b. Medical Supplies - Medicare		\$					
c. Medical Supplies - Non-Med		\$					
d. Medical Supplies - Non-Med		\$					
3. <u>a. Physical Therapy - Medicare</u>	· · · · · · · · · · · · · · · · · · ·	\$	867,314	867,314			
b. Physical Therapy - Medicare		. \$	(695,085)	(695,085)			
c. Physical Therapy - Non-Med		\$	204,896	204,896			
d. Physical Therapy - Non-Med	licare Contractual Allowance **	\$	(204,896)	(204,896)			
4. a. Speech Therapy - Medicare		\$	211,094	211,094			
b. Speech Therapy - Medicare C		\$	(131,725)	(131,725)			
c. Speech Therapy - Non-Medic		\$	39,426	39,426			
d. Speech Therapy - Non-Medic	care Contractual Allowance **	\$	(39,426)	(39,426)			
5. a. Occupational Therapy - Med	licare	\$	817,350	817,350			
b. Occupational Therapy - Med	licare Contractual Allowance **	\$	(660,250)	(660,250)			
c. Occupational Therapy - Non	-Medicare	\$	182,931	182,931			
d. Occupational Therapy - Non	-Medicare Contractual Allowance **	\$	(182,931)	(182,931)			
6. a. Other (Specify) - Medicare		\$					
b. Other (Specify) - Non-Medic	are	\$					
III. Total Resident Revenue (Section	I. thru Section II.)	\$	11,053,458	11,053,458			
IV. Other Revenue*							
Meals sold to guests, employees	& others	\$					
2. Rental of rooms to non-residents		\$					
3. Telephone		\$					
Rental of Television and Cable S	Services	\$					
5. Interest Income (Specify)	·	\$	47	47			
6. Private Duty Nurses' Fees		\$	7/	71			
7. Barber, Coffee, Beauty and Gift	shons	\$					
8. Other (Specify)	9110p0	\$	46	46			
V. Total Other Revenue (1 thru 8)		\$				•	
			93	93			
VI. Total All Revenue (III +V)		\$	11,053,551	11,053,551	-		

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

<sup>\*\*</sup> Facility should report all contractual allowances and/or payer discounts.

#### Schedule of Other Resident Revenue - Medicare

#### Related Exp

	Description	CCNH	RHNS	(Specify)
		The county bearing the second		
Accessed in a control of				
Total Othe	r Resident Revenue - Medicare	S. C.	•	\$ -

#### Schedule of Other Non-Medicare Resident Revenue

#### Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
Alabian varia e resea es				
			HEREALDS CONTRACTOR FOR ALLAN	in an an include
		cilianabiles relates context security team	1925 1921 1921 1921 1921 1921 1921 1921	
Total Oth	ni Risident Rovenna		<b>S</b>	\$ 1100000000000000000000000000000000000

#### **Interest Income**

#### Account

Page Ref Account	Balance	CCNH	RHNS	(Specify)
		\$ 47		
		ereningen chagen		
	1001			
Total Interest Income		\$ 47	\$ -	\$ " -

#### Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
				de de de de de de de
	Medical Records	\$ 46	edhaling dr.a.	
		di desarreció		
		president de la comp		A Commence
				of the second of the second
ua ciledos				
100	ARTHOUGH IN CO. T. C.		n numerous critical science in	
			EMMERSION CO.C.	
Lotal Othe		\$ 46	C108101010101010101010101010101010101010	\$ -
		y SU	<b>D</b> armin = ==================================	

## G. Balance Sheet

Name of Facility	License No.		for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/20	16	31	37
	Account				Amount
Assets					
A. Current Assets					
1. Cash (on hand and in b		····		\$	(139,274)
2. Resident Accounts Rec	`			\$	2,819,221
3. Other Accounts Received	able (Excluding Owners	or Related I	Parties)	\$	4,685
4 Inventories				\$	266 702
5. Prepaid Expenses			<b>5</b> 600	\$	366,793
a. Prepaid-Expenses			7,600		
b. Prepaid - Insurance	<del></del>		359,193		
c. d.					
6. Interest Receivable				dr.	1111
7. Medicare Final Settlem	ant Dagairrahla			\$ \$	
8. Other Current Assets (in				\$	36,580
Deposits - Other	emize)		36,580	2	30,360
	· · · · · · · · · · · · · · · · · · ·		20,200		
A-9. Total Current Assets (Line	s A1 thru 8)			\$	3,088,004
B. Fixed Assets	DITT UNIT OF			Ψ	3,000,001
1. Land				\$	
2. Land Improvements	*Historical Cost			\$	
	Accum. Deprecia	tion	Net	ľ	
3. Buildings	*Historical Cost	•	259,340	\$	548,476
	Accum. Deprecia		710,864 Net	ľ	,
4. Leasehold Improvemen	——————————————————————————————————————		,	\$	
•	Accum, Deprecia	tion	Net		
5. Non-Movable Equipme				\$	
	Accum. Deprecia	tion	Net		
6. Movable Equipment	*Historical Cost	•	519,027	\$	220,485
	Accum. Deprecia	tion 3	398,542 Net		•
7. Motor Vehicles	*Historical Cost			\$	
	Accum. Deprecia	tion	Net		
8. Minor Equipment-Not I	Depreciable			\$	
9. Other Fixed Assets (iten	nize)			\$	<del> </del>
· · · · · · · · · · · · · · · · · · ·					
B-10. Total Fixed Assets (Lin	as P1 thm; 0\			Φ.	7.00.061
B-10. Total Fixed Assets (Lir	ומאסו וווווא)			\$	768,961

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

## G. Balance Sheet (cont'd)

		f Facility	License No.	Report for Year Ended	Page	of
Spec	etrur	n Healthcare Torrington	2333	9/30/2016	 32	37
·			Account		Am	ount
				Total Brought Forward:	\$ 	3,856,965
C.	Le	easehold or like property recor-	ded for Equity Purpose	s.		
		Land			\$ 	
	2.	Land Improvements	*Historical Cost			
			Accum. Depreciation	ı Net	\$	
	3.	Buildings	*Historical Cost			
			Accum. Depreciation	n Net	\$	
	4.	Non-Movable Equipment	*Historical Cost			
			Accum. Depreciation	Net	\$ 	
	5.	Movable Equipment	*Historical Cost			
			Accum. Depreciation	n Net	\$	
	6.	Motor Vehicles	*Historical Cost			
			Accum. Depreciation	Net	\$	
	7.	Minor Equipment-Not Depre	eciable		\$	
C-8	To	tal Leasehold or Like Proper	ties (C1 thru 7)		\$	
D.	Iņv	vestment and Other Assets				
	1.	Deferred Deposits			\$ 	
	2.	Escrow Deposits			\$	
	3.	Organization Expense	*Historical Cost	30,666		
			Accum. Depreciation	30,666 Net	\$	
	4.	Goodwill (Purchased Only)			\$	
	5.	Investments Related to Resid	lent Care (itemize)		\$	***************************************
			·			
	6.	Loans to Owners or Related	Parties (itemize)		\$	3,009,092
		Name and Address	Amount	Loan Date		
		Winsted/Spectrum	3,009,092			
	7.	Other Assets (itemize)			\$	
D-8.	To	tal Investments and Other As	sets (Lines D1 thru 7)		\$	3,009,092
		tal All Assets (Lines A9 + B1			\$	6,866,058

<sup>\*</sup> 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 Fac	•		License No.	Report for Year I	Ended	Page	of
Spectrum He	ealthc	are Torrington	2333	9/30/2016		33	37
			Account			Am	ount
Liabilities							
A.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable			\$		1,218,667
	2.	Notes Payable (itemize)			\$		
		T D 11. C D '		·			
	3.	Loans Payable for Equipm			\$		
		Name of Lender	Purpose	Amount	Date Due		
							100000000000000000000000000000000000000
	4.	Accrued Payroll (Exclusive	of Owners and/or	Stockholders only)	\$		411,570
	5.	Accrued Payroll (Owners a	ind/or Stockholders	only)	\$		
	6.	Accrued Payroll Taxes Pay	able		\$		6,440
	7.	Medicare Final Settlement			\$		
ď	8.	Medicare Current Financin	g Payable		\$		
'	9.	Mortgage Payable (Current	t Portion)		\$		
	10.	Interest Payable (Exclusive	of Owner and/or R	elated Parties)	\$		
		Accrued Income Taxes*			\$		
*	12.	Other Current Liabilities (in	temize)		\$		1,121,810
		Accrued Property Taxes	242,	766 Accrue State Provider T	a 202,023		
		Accrued Interest	17,	524 Property Liability Insura	ar 197,197		
		Accrued Other Expenses	291,	471 Accrued Rent	193,830		
		Resident Refunds	(27,	465) Prepaid-Other Expenses	4,465		
A-13.	Tot	al Current Liabilities (Line	es A1 thru 12)		\$		2,758,487

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

# G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year	r Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016		34	37
	Account			Am	ount
	tht Forward:		2,758,487		
Liabilities (cont'd)					
B. Long-Term Liabilities					
Loans Payable-Equipmen	···, · · · · · · · · · · · · · · · · ·		\$		
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable			\$		-
3. Loans from Owners or Re	lated Parties (itemize)		\$		2,877,036
Name and Address of Lender	Amount	Loan D	980000		
					-
Hartford	2,827,303				
•	, , , , , , , , , , , , , , , , , , , ,				
Derby/Manchester/Ansoni		3F			
a	49,733				
	12,733				
4. Other Long-Term Liabiliti	es (itemize)	1	\$		2,212,508
Working Capital Line of C		2,225,387			, <b></b> ,
Due Prior Owner		(12,879)		and a substitution	
		, , , , , , , , , , , , , , , , , , , ,			
B-5. Total Long-Term Liabilities (			\$		5,089,545
C. Total All Liabilities (Lines A-	13 + B-5)		\$		7,848,032

State of Connecticut

Annual Report of Long-Term Care Facility

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

	ne of Facility	License No.	Report for	Year Ended	Page	of
Spe	ctrum Healthcare Torrington	2333	9/30/2016		35	37
		Account			A	mount
A.	Reserves					
	1. Reserve for value of leased	land			\$	
	2. Reserve for depreciation val	lue of leased build	ings and appurt	enances		
	to be amortized				\$	1,205,140
	3. Reserve for depreciation val	lue of leased perso	nal property (E	quity)	\$	207,904
	4. Reserve for leasehold real p	roperties on which	ı fair rental valu	ie is based	\$	
	5. Reserve for funds set aside a	as donor restricted			\$	
	6. Total Reserves				\$	1,413,044
B.	Net Worth					
	1. Owner's Capital	5-1			\$	
	2. Capital Stock				\$	e dan M
	3. Paid-in Surplus		····	•	\$	
	4. Treasury Stock			a.	\$	
	5. Cumulated Earnings				\$	(1,462,577)
	6. Gain or Loss for Period	10/1/20	15 thru	9/30/2016	\$	(932,441)
	7. Total Net Worth				\$	(2,395,018)
C.	Total Reserves and Net Worth				\$	(981,974)
D.	Total Liabilities, Reserves, and	Net Worth	-		\$	6,866,058

# H. Changes in Total Net Worth

Name of Facility	License No.	Report for Yea	r Ended	Page	of
Spectrum Healthcare Torrington	n 2333	9/30/2016		36	37
	Account			An	10unt
A. Balance at End of Prior Po	eriod as shown on Report o	f 09/30/2015		\$	(1,477,123)
	tement of Revenue Page 30		5	\$	11,053,551
	i Statement of Expenditures	Page 27)	9	\$	11,985,992
D. Net Income or Deficit				\$	(932,441)
E. Balance			9	\$	(2,409,564)
F. Additions 1. Additional Capital Co 2. Other (itemize)	ntributed (itemize)				
F-3. Total Additions					
G. Deductions					
1. Drawings of Owners/0	Operators/Partners (Specify)	)	9	\$	
Name and Address (A	Vo., City, State, Zip)	Title	Amount		
		4	4		
2. Other Withdrawings (A			9	3	
Purp	ose	Amo	ount		
3. Total Deductions	00/00	11.6	\$		(0.400.50.0
H. Balance at End of Period	09/30	/16		<u> </u>	(2,409,564)

### I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016	37	37
Check appropriate category				
Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)		
	Preparer/Reviewer Certificat	ion		
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		<del> </del>
Derms Englist	Accounting Manager	2/1/	17	
Printed Name of Preparer				
Gennaro Evangelista				
Addres Address		Phone Number		
27 Naek Rd., Vernon, CT 06066		860-871-5454		