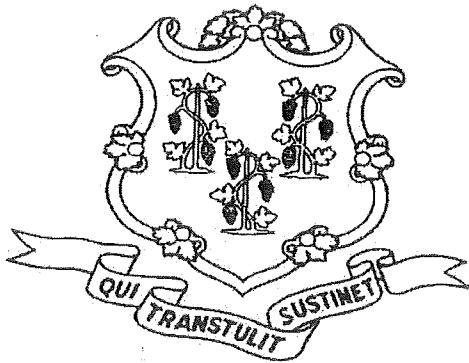


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2019

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  Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)      Rest Home with Nursing <input checked="" type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 2034C	RHNS 2034C	(Specify)	Medicare Provider 07-5319
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Medicaid Provider Numbers:	CCNH 2034C	RHNS 2034C	ICF-IID
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### For Department Use Only

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

### General Information

Name of Facility (as licensed) Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019	Page 1	of 37
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### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Litchfield Woods Health Care Center [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)	Date	Signed (Owner)	Date	
Printed Name (Administrator) Denise Quarles		Printed Name (Owner) Lawrence Santilli		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	
Address of Notary Public				

(Notary Seal)

State of Connecticut

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

CSP-1 Rev.9/2002

**General Information**

Name of Facility (as licensed) <i>Litchfield Woods Health Care Center</i>	License No. <i>2034 C</i>	Report for Year Ended <i>9/30/2019</i>	Page <i>1</i>	of <i>37</i>
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**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* [facility name], for the cost report period beginning 10/1/2018 and ending 9/30/2019, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator) <i>Dennis Quarles</i>	Date <i>2/17/2020</i>	Signed (Owner) <i>Wendy Santilli</i>	Date <i>2/17/2020</i>
Printed Name (Administrator) <i>Dennis Quarles</i>		Printed Name (Owner) <i>Wendy Santilli</i>	
Subscribed and Sworn to before me:	State of <i>CT</i>	Date <i>2/17/2020</i>	Signed (Notary Public) <i>[Signature]</i>
Comm. Expires <i>8/1/2020</i>			
Address of Notary Public <i>38 Linda Dr. Plainville CT 06062</i>			

(Notary Seal)

# Table of Contents

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

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

<b>Data Required for Real Wage Adjustment</b>		Page 1A	of 37
Name of Facility Litchfield Woods Health Care Center	Period Covered:	From 10/1/2018	To 9/30/2019
Address of Facility 225 Roberts Street Torrington, CT 06790			
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900	Date 2/14/2020	
Item	Total	CCNH	RHNS
1. Dietary wages paid	\$		
2. Laundry wages paid	\$		
3. Housekeeping wages paid	\$		
4. Nursing wages paid	\$		
5. All other wages paid	\$		
6. <b>Total Wages Paid</b>	\$		
7. Total salaries paid	\$		
8. <b>Total Wages and Salaries Paid</b> (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

## **General Information and Questionnaire Partners/Members**

State of Connecticut

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

CSP-3A Rev. 10/2005

**General Information and Questionnaire**  
**Corporate Owners**

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019	Page of 3A   37
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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	461.32
Michael E. Mosier	225 Roberts St, Torrington, CT 06790	Treasurer/Secretary	

Names of Stockholders Owning at Least 10% of Shares			
Lawrence G. Santilli	225 Roberts St, Torrington, CT 06790		461.32
John Nocera, Jr	225 Roberts St, Torrington, CT 06790		125
Conservators for Lawrence E. Santilli	225 Roberts St, Torrington, CT 06790		112.68

# **General Information and Questionnaire**

## **Individual Proprietorship**

**General Information and Questionnaire**  
**Related Parties\***

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019	Page 4	Page of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> No						
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 type="radio"/> Yes <input checked="" type="radio"/> No						
If "Yes," provide the following information:						
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties Yes    No    %**	Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
Athena Health Care	135 South Road, Farmington, CT 06032	○    ○    <50%	Management Fees	Pg 17	858,594	362,126
Laurel Ridge Health Care	642 Danbury Road, Ridgefield, CT 06877	○    ○    >98%	Bank Charges	Pg 16, Ln m13	6,521	6,521
Athena Health Care Insurance	135 South Road, Farmington, CT 06032	○    ○    ○	Self Insured Employee Health & Dental Insu	Pg. 15, ln 1a5	1,598,288	1,598,288
Athena Health Care Assoc Inc. 401(K) Plan	135 South Road, Farmington, CT 06032	○    ○    ○	Facility participates in group 401(k) plan	Pg 15 ln 1a7		
Procare LTC.	111 Executive Blvd., Farmingdale, NY 11735	○    ○    >50%	Pharmacy	Pg. 20 5a2	476,647	476,647
CT Health Center of Torrington LP	225 Roberts St, Torrington, CT 06790	○    ○    ○	Lease of Facility & Equipment	Pg 22, Ln 9, 10b; Pg 21	1,247,778	1,247,778
Athena Health Care	135 South Road, Farmington, CT 06032	○    ○    <50%	Various: See attached			
		○    ○    ○				
		○    ○    ○				

\* 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				
Athena Health Care	135 South Road Farmington, CT 06032	X		<50% Data Processing Business Promotion Equipment Maintenance MDS Fill In Postage	Pg. 16, M13 Pg. 16, M13 Pg. 22, 7D Pg. 22, 6A Pg. 13, 11 Pg. 16 M7	\$4,129 \$2,212 \$11,600 \$10,774 \$23,859 \$398	\$4,129 \$2,212 \$11,600 \$10,774 \$23,859 \$398

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

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

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

Not Applicable: No Non-Nursing Home Cost Centers

## General Information and Questionnaire Leases (Excluding Real Property)

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

\*\* Attach copies of newly acquired leases

\*\* Amount should agree to Page 22 Line 6.

תְּמִימָנָה שְׁלֹמֹה בֶּן יַעֲקֹב זֶה, לְמִינָה:

## General Information and Questionnaire Accounting Basis

Name of Facility Litchfield Woods Health Care Cent	License No. 2034C	Report for Year Ended 9/30/2019	Page 7	of 37
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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 MidCap Financial Services, LLC	7255 Woodmont Avenue, Bethesda, MD 20814
4	

Services Provided by This Firm (*describe fully*)

1	Audit, Year End Financials & Tax Return	\$	10,100
2	Medicare Cost Report Preparation	\$	2,700
3	LOC Audit: Disallowed	\$	3,253
4		\$	
		Charge for Services Provided	
		\$	16,053

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

Yes  No Pg 15, Line 1d

## Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Goldman, Gruder & Woods, LLC/Donald W. Light/Treasurer CT/Senior Planning Services	203-899-8900 / 860-567-0451
2 MidCap Financial Services, LLC	301-760-7600
3 Murtha Cullina, LLP	860-240-6000
4 Pilicy & Ryan	860-274-0018
5	

Address (No. & Street, City, State, Zip Code)

1 200 Connecticut Ave, Norwalk, CT 06854  
2 7255 Woodmont Avenue, Bethesda, MD 20814  
3 185 Asylum Street, Hartford, CT 06103  
4 365 Main Street, Watertown, CT 06795  
5

**Services Provided by This Firm (*describe fully*)**

1	A/R Collections:Disallowed	\$	2,111
2	LOC Legal Fees:Disallowed	\$	219
3	CT Corporation Annual Report:Disallowed	\$	2,517
4	Employee Matters:Disallowed	\$	115
5		\$	
		Charge for Services Provided	
		\$	4,962

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

Pg 15, Line 1

**Schedule of Resident Statistics**

Name of Facility	License No. 2034C	Report for Year Ended 9/30/2019						Report for Year Ended 9/30/2019		Page 8 of 37	
		Period 10/1 Thru 6/30			Period 7/1 Thru 9/30						
		Total All Levels	Total CCNH Level	Total RHNS Level (Specify)	Total	CCNH	RHNS (Specify)	Total	CCNH	RHNS	
1. Certified Bed Capacity											
A. On last day of PREVIOUS report period	160	130	30		160	130	30		160	130	30
B. On last day of THIS report period	160	130	30		160	130	30		160	130	30
2. Number of Residents											
A. As of midnight of PREVIOUS report period	156	127	29		156	127	29		157	129	28
B. As of midnight of THIS report period	156	127	29		157	129	28		156	127	29
3. Total Number of Days Care Provided During Period											
A. Medicare	7,388	2,700	4,688		5,727	2,040	3,687		1,661	660	1,001
B. Medicaid (Conn.)	41,816	40,178	1,638		30,930	29,831	1,099		10,886	10,347	539
C. Medicaid (other states)											
D. Private Pay	3,841	2,043	1,798		2,889	1,439	1,450		952	604	348
E. State SSI for RCH											
F. Other (Specify) Managed Care	3,131	1,436	1,695		2,337	849	1,488		794	587	207
G. Total Care Days During Period (3A thru F)	56,176	46,357	9,819		41,883	34,159	7,724		14,293	12,198	2,095
Total Number of Days Not Included in Figures in 3G											
4. for Which Revenue Was Received for Reserved Beds											
A. Medicaid Bed Reserve Days	441	409	32		317	291	26		124	118	6
B. Other Bed Reserve Days	65	40	25		50	29	21		15	11	4
5. <b>Total Resident Days (3G + 4A + 4B)</b>	56,682	46,806	9,876		42,250	34,479	7,771		14,432	12,327	2,105

## Schedule of Resident Statistics (Cont'd)

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?  Yes  No

If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	16	112	4	5	8	11		
Per Diem Rate								
a. One bed rm.	566.31	242.08	182.30	622.00	597.00	437.09		
b. Two bed rms.	566.31	242.08	182.30	587.00	577.00	437.09		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B

TOTAL CCNH RHNS (Specify)

7,782 7,782

B. Medicaid (Exclusive of Part B)

822 500 322

1. Maintenance Treatments

2. Restorative Treatments

C. Other

17,262 17,262

D. Total Physical Therapy Treatments

25,866 25,544 322

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B

844 844

B. Medicaid (Exclusive of Part B)

39 39

1. Maintenance Treatments

2. Restorative Treatments

C. Other

1,705 1,705

D. Total Speech Therapy Treatments

2,588 2,588

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B

6,553 6,553

B. Medicaid (Exclusive of Part B)

757 523 234

1. Maintenance Treatments

2. Restorative Treatments

C. Other

16,879 16,879

D. Total Occupational Therapy Treatments

24,189 23,955 234

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of
Litchfield Woods Health Care Center	2034C	9/30/2019		10	37
Are time records maintained by all individuals receiving compensation?	<input type="radio"/> Yes <input checked="" type="radio"/> No				
		Total Cost and Hours			
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	137,187	1,798	28,946	379	
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	332,868	12,756	70,235	2,692	
5. Dietary Service					
a. Head Dietitian	58,366	1,410	12,315	298	
b. Food Service Supervisor	44,454	1,698	9,380	358	
c. Dietary Workers	377,990	26,017	79,755	5,489	
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers	251,221	20,273	53,007	4,277	
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	63,298	1,934	13,356	408	
b. Other Maintenance Workers	33,610	1,757	7,092	371	
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	52,607	4,439	11,100	937	
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	165,922	3,158	42,345	806	
b. RN					
1. Direct Care	715,167	16,111	96,293	2,377	
2. Administrative**	432,279	13,846	110,322	3,533	
c. LPN					
1. Direct Care	974,311	35,757	402,783	14,234	
2. Administrative**					
d. Aides and Attendants	1,906,305	110,336	415,445	25,023	
e. Physical Therapists	930,558	25,577	11,731	322	
f. Speech Therapists	169,714	3,415			
g. Occupational Therapists	587,676	16,161	5,740	158	
h. Recreation Workers	141,987	7,801	29,960	1,646	
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	220,801	7,441	46,589	1,570	
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
A-13. Total Salary Expenditures	7,596,321	311,685	1,446,394	64,878	

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

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

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

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

**Schedule of Other Salaries and Wages (Page 10)**

**Schedule of Other Fees (Page 13)**

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

\*\* 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\***

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

\*\*\* If more than one administrator is recorded include dates of

**B. Report of Expenditures - Professional Fees**

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019		Page 13	of 37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>					
1. Dietitian					
2. Dentist	15,610	87	3,294	18	
3. Pharmacist	14,465	183	3,052	39	
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	69,942	264	14,758	56	
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**	6,280				
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	3,885	6			
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	8,267	672			
2. Administrative***	19,275	6	4,919	2	
b. LPN					
1. Direct Care	6,691	261			
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify)					
See Attached Schedule					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>144,415</b>	<b>1,479</b>	<b>26,023</b>	<b>114</b>	

\* 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

\* Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019		Page 15	of 37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	644,344	541,280	103,064	
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	112,188	94,243	17,945	
4. Social Security (F.I.C.A.)	\$	631,939	530,860	101,079	
5. Health Insurance	\$	1,385,471	1,163,863	221,608	
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	44,085	37,034	7,051	
8. Uniform Allowance	\$				
9. Other (Specify) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$	131,466	106,023	25,443	
d. Accounting and Auditing	\$	16,053	13,256	2,797	
e. Legal (Services should be fully described on Page 7)	\$	4,962	4,097	865	
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$	98,434	81,284	17,150	
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	80,910	66,813	14,097	
2. Cellular Phones	\$	2,460	2,031	429	
i. Appraisal (Specify purpose and attach copy)*	\$				
j. Corporation Business Taxes (franchise tax)	\$				
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$	8,860	7,316	1,544	
2. Other (Specify) See Attached Schedule	\$				
3. Resident Day User Fee	\$	970,346	801,278	169,068	
<b>Subtotal</b>	\$	4,131,518	3,449,378	682,140	

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

## **Schedule of Other Employee Benefits**

### Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
<b>Total</b>	\$ -	\$ -	\$ -

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
	<b><i>Subtotals Brought Forward:</i></b>	4,131,518	3,449,378	682,140	
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	7,852	6,484	1,368	
3. Gifts to Staff and Residents	\$	32,972	27,227	5,745	
4. Employee Travel	\$	5,228	4,317	911	
5. Education Expenses Related to Seminars and Conventions	\$	23,707	19,576	4,131	
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> )	\$	11,636	9,609	2,027	
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	22,867	18,883	3,984	
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	4,931	4,072	859	
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	8,827	7,289	1,538	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	3,417	2,822	595	
9. Subscriptions	\$	2,310	1,908	402	
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**	\$	563,931	465,674	98,257	
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	120,962	99,886	21,076	
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$	4,940,158	4,117,125	823,033	

\* 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)
<b>Total Other Travel and Entertainment</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 18,883	\$ 3,984	
<b>Total Other Advertising</b>	<b>\$ 18,883</b>	<b>\$ 3,984</b>	<b>\$ -</b>

## Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 7,289	\$ 1,538	
<b>Total Dues</b>	<b>\$ 7,289</b>	<b>\$ 1,538</b>	<b>\$ -</b>

## Schedule of Contributions

Description	CCNH	RHNS	(Specify)
<b>Total Contributions</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
<b>Bank Charges</b>	<b>\$ 15,836</b>	<b>\$ 3,341</b>	
<b>Payroll Processing Fees</b>	<b>\$ 20,703</b>	<b>\$ 4,368</b>	
<b>Employee Physicals</b>	<b>\$ 29,903</b>	<b>\$ 6,309</b>	
<b>Compliance Consulting</b>	<b>\$ 2,064</b>	<b>\$ 436</b>	
<b>Data Processing</b>	<b>\$ 30,666</b>	<b>\$ 6,471</b>	
<b>Licenses</b>	<b>\$ 714</b>	<b>\$ 151</b>	
<b>Total Other Administrative and General</b>	<b>\$ 99,886</b>	<b>\$ 21,076</b>	<b>\$ -</b>

State of Connecticut

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

CSP-17 Rev. 10/97

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	791,841	Contract Attached to a Prior Year	See Below
Allocation of the above	522,615	Admin/Gen 66%	Pg 16, Line 12
	126,695	Indirect 16%	Pg 20, Line 5K
	142,531	Direct 18%	Pg 20, Line 5J
Athena Health Care Assoc., Inc. 135 South Road Farmington, CT 06032	41,316	Admin/Gen - Other Exp	Pg 16, Line 12

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

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019		Page 18   37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 362,296	299,171	63,125	
2. Non-Food Supplies	\$ 58,455	48,270	10,185	
3. Other (Specify) _____	\$ _____			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ _____			
c. Other (Specify) _____	\$ _____			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 420,751</b>	<b>347,441</b>	<b>73,310</b>	
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	462	381	81	
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No				If yes, specify cost.
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019		Page 19	of 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. \$	26,063	21,522	4,541	
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$				
c. Other ( <i>Specify</i> ) Supplies	\$	8,914	7,361	1,553	
<b>3D. Total Laundry Expenditures (3a + b + c )</b>	\$	34,977	28,883	6,094	
3E. Laundry Questionnaire					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 71,419	58,975	12,444	
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
Amt.	\$				
C. Other ( <i>Specify</i> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>71,419</b>	<b>58,975</b>	<b>12,444</b>	
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Procare LTC	\$	462,366	462,366		
b. Medicine Cabinet Drugs	\$	121,319	100,181	21,138	
c. Medical and Therapeutic Supplies	\$	295,304	243,852	51,452	
d. Ambulance/Limousine***	\$	35,034	35,034		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	72,354	59,747	12,607	
f. X-rays and Related Radiological Procedures***	\$	50,482	50,482		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	82,157	82,157		
i. Recreation	\$	27,002	22,297	4,705	
j. Direct Management Services*	\$	142,531	117,697	24,834	
k. Indirect Management Services*	\$	126,695	104,620	22,075	
l. Other ( <i>Specify</i> )****	\$	71,774	64,037	7,737	
See Attached Schedule					
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>1,487,018</b>	<b>1,342,470</b>	<b>144,548</b>	

\* 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**

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

\* Refer to Page 4 for definition of related.

\*\* Please cross reference amount to the amount on the document or memo.

YOUNG ADULTS' CONCERN FOR CLIMATE CHANGE

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	95,448	78,817	16,631		
b. Heat	\$	128,886	106,430	22,456		
c. Light & Power	\$	149,449	123,410	26,039		
d. Water	\$	39,804	32,869	6,935		
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$	21,050	17,383	3,667		
f. Other ( <i>itemize</i> )	\$	137,043	113,167	23,876		
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$	571,680	472,076	99,604		
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$	3,823	3,106	717		
d. Movable Equipment	\$	83,261	67,650	15,611		
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$	87,084	70,756	16,328		
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$	620	504	116		
c. Leasehold Improvements	\$	135,287	109,920	25,367		
d. Other ( <i>Specify</i> )	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$	135,907	110,424	25,483		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	969,651	787,841	181,810		
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	218,996	177,934	41,062		
c. Personal property taxes	\$	32,622	26,505	6,117		
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$	1,444,260	1,173,460	270,800		

\* 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**

## Depreciation Schedule

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

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

**Schedule of Building Improvements Acquired during this report period**

**\*Ties to Page 23, Line B3**

\*\*Ties to Page 23, Line B2

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

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
Various	See attached	\$ 73,612		\$ 4,830
<b>Total additions for Movable Equipment</b>		\$ 73,612		\$ 4,830
<b>Deletions:</b>				*
<b>Total deletions for Movable Equipment</b>		\$ -		\$ -

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
2/1/2019	vinyl flooring	\$ 20,865	10	\$ 1,043
4/1/2019	vinyl flooring	\$ 18,323	10	\$ 916
6/1/2019	vinyl flooring	4571	10	229
<b>Total additions for Leasehold Improvement</b>		\$ 43,759		\$ 2,188 *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ -

\*Ties to Page 24, Line C3

**\*\*Ties to Page 24, Line C2**

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
Oct-18	heat exchanger	\$ 5,530	10	\$ 277
Oct-18	control box	\$ 4,944	10	\$ 247
Jan-19	laptop	\$ 912	3	\$ 152
Apr-19	laptop	\$ 861	3	\$ 144
May-19	laptop	\$ 1,401	3	\$ 234
May-19	desktops	\$ 697	3	\$ 116
May-19	ice machine water pump	\$ 828	10	\$ 41
Jun-19	desktop	\$ 711	3	\$ 119
Jun-19	ice & water dispenser	\$ 5,351	10	\$ 268
Jun-19	cheftop oven	\$ 15,650	10	\$ 783
Jul-19	laptop	\$ 590	3	\$ 98
Jul-19	overbed tables	\$ 668	15	\$ 22
Jul-19	overbed tables	\$ 668	15	\$ 22
Jul-19	medical records software	\$ 7,800	3	\$ 1,300
Aug-19	nurse's station	\$ 23,577	15	\$ 786
Aug-19	laptop	\$ 590	3	\$ 98
Aug-19	refrigerator	\$ 811	10	\$ 41
Aug-19	hvac circulation pump	\$ 863	10	\$ 43
Sep-19	bedside dresser	\$ 1,160	15	\$ 39
<b>Total additions for Movable Equipment</b>		<b>\$ 73,612</b>		<b>\$ 4,830</b>

## Amortization Schedule\*

Name of Facility			License No.			Report for Year Ended			Page	
Litchfield Woods Health Care Center			2034C			9/30/2019			24 of 37	
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate of Amortization for This Year	Totals		
	Month	Year								
A. Organization Expense										
1.										
2.										
3.										
A-4. Subtotal										
B. Mortgage Expense										
1. Finance Fees-Refinance 2007	6	2007	5 yrs	12,500	12,500	SL				
2. Finance Fees-	9	2012		16,429	4,342					620
3.										
B-4. Subtotal										620
C. Leasehold Improvements and Other										
1. Acquired prior to this report period	9	2018	Various	5,266,952	3,528,695	SL	Var	133,099		
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	9	2019	Various	43,759	SL	Var	2,188			
C-4. Subtotal										
D. <i>Total Amortization</i>										135,907

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.

B. Life of mortgage; OR

C. Remaining Life of Lease; OR

D. Actual Life if owned by Related Party.

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019	Page 25	of 37
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#### 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	14,712,000			
f. Principal balance outstanding as of	12,808,522			

##### **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.

State of Connecticut

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

CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended 9/30/2019			Page of 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					
<b>12 B7. Total Building Interest Expense (A1 - A4 + B5)</b>	<b>\$</b>				

(Carry Subtotals forward to next page )

State of Connecticut

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

CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended 9/30/2019			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment			\$			
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)			\$			
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			\$			
12. D. Other Interest Expense (Specify) Vendor Interest = \$19,602; Line of Credit Interest = \$8,12			\$	27,727	22,529	5,198
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>			\$	27,727	22,529	5,198
14. Insurance						
a. Insurance on Property (buildings only)			\$	92,390	75,067	17,323
b. Insurance on Automobiles			\$			
c. Insurance other than Property (as specified above)			\$			
1. Umbrella ( <i>Blanket Coverage</i> )			\$			
2. Fire and Extended Coverage			\$			
3. Other (Specify)			\$			
14d. <b>Total Insurance Expenditures (14a + b + c)</b>			\$	92,390	75,067	17,323
15. <b>Total All Expenditures (A-13 thru C-14)</b>			\$	18,303,533	15,378,762	2,924,771

## **D. Adjustments to Statement of Expenditures**

Name of Facility Litchfield Woods Health Care Center				License No. 2034C	Report for Year Ended 9/30/2019		Page 28   of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b><i>Page 10 - Salaries and Wages</i></b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 593,416	587,676	5,740	
4.			Other - See attached Schedule	\$ 53,826	53,826		
<b><i>Page 13 - Professional Fees</i></b>							
5.	13	B8c	Resident Care Physicians **	\$ 6,280	6,280		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b><i>Pages 15 &amp; 16 - Administrative and General</i></b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 131,466	106,023	25,443	
10.	15	1d&e	Accounting	\$ 3,253	2,686	567	
10a.			Legal	\$ 4,962	4,098	864	
11.	30	IV3	Telephone	\$ 1,320	1,090	230	
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	13	Gifts, flowers and coffee shops	\$ 32,972	27,227	5,745	
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m2&3	Unallowable Advertising *	\$ 22,867	18,883	3,984	
19.	15	1j&k	Income Tax / Corporate Business Tax	\$ 8,860	7,316	1,544	
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$ 327,669	327,669		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 25,094	25,094		
<b><i>Page 18 - Dietary Expenditures</i></b>							
24.	18	2a1	Meals to employees, guests and others who are not residents	\$ 30	25	5	
<b><i>Page 19 - Laundry Expenditures</i></b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b><i>Page 20 - Housekeeping Expenditures</i></b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 1,212,015	1,167,893	44,122	

\* 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	\$ 53,826		
<b>Total Other Salaries Adjustment</b>			\$ 53,826	\$ -	\$ -

**Schedule of Fees Adjustments**

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

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	8n	Disallowed Dues	\$ 3,417		
16	M13	Bank Charges	\$ 19,177		
16	M13	Compliance Consulting	\$ 2,500		
<b>Total Other A&amp;G Adjustments</b>			\$ 25,094	\$ -	\$ -

State of Connecticut

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

CSP-29 Rev. 9/2018

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

Name of Facility Litchfield Woods Health Care Center			License No. 2034C	Report for Year Ended 9/30/2019		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 1,212,015	1,167,893	44,122	
			<b><i>Page 20 - Resident Care Supplies***</i></b>				
27.	20	5a1&	Prescription Drugs	\$ 462,366	462,366		
28.	20	5d	Ambulance/Limousine	\$ 35,034	35,034		
29.	20	5f	X-rays, etc	\$ 50,482	50,482		
30.	20	5h	Laboratory	\$ 82,157	82,157		
31.	20	5c	Medical Supplies	\$ 19,072	15,749	3,323	
32.	20	5e2	Oxygen (non emergency)	\$ 72,354	59,747	12,607	
33.	20	5j	Occupational Therapy	\$ 7,992	7,915	77	
34.			Other - See Attached Schedule	\$ 38,860	34,752	4,108	
			<b><i>Page 22 - Maintenance and Property</i></b>				
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 13,565	11,022	2,543	
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	\$			
			<b><i>Page 27 - Insurance</i></b>				
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
			<b><i>Other - Miscellaneous</i></b>				
42.			Other - Indirect	\$			
43.	30	IV5	Interest Income on Account Rec.	\$ 63	52	11	
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$ 89,364	89,364		
46.			Management Fees Indirect	\$ 79,435	79,435		
47.			Other - Direct	\$			
			<b><i>Not For Profit Providers Only</i></b>				
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49.			<b><i>Total Amount of Decrease (Items 1 - 48)</i></b>	\$ 2,162,759	2,095,968	66,791	

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

### **Schedule of Other Ancillary Costs**

### Schedule of Excess Movable Equipment Depreciation

**Schedule of Other Property Adjustments**

### **Schedule of Other - Indirect Adjustments**

				age 29
<b>Total Other Adjustments</b>	\$ -	\$ -	\$ -	

**Schedule of Other - Miscellaneous Administrative Adjustments**

**Schedule of Other - Direct Adjustments**

Attachment Page 29

**Schedule of Unallowable Building Interest**

**F. Statement of Revenue**

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019			Page 30	of 37
Item		Total	CCNH	RHNS	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 24,644,942	23,689,927	955,015			
b. Medicaid Room and Board Contractual Allowance **	\$ (14,715,533)	(14,060,584)	(654,949)			
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 4,245,118	1,572,275	2,672,843			
b. Medicare Room and Board Contractual Allowance **	\$ 440,427	53,563	386,864			
4. a. Private-Pay Residents and Other	\$ 3,675,309	2,150,990	1,524,319			
b. Private-Pay Room and Board Contractual Allowance **	\$ (403,905)	(314,132)	(89,773)			
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 326,738	325,431	1,307			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (326,738)	(325,431)	(1,307)			
c. Prescription Drugs - Non-Medicare	\$ 250,724	237,789	12,935			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (250,724)	(237,789)	(12,935)			
2. a. Medical Supplies - Medicare	\$ 3,072	2,881	191			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (2,035)	(1,844)	(191)			
c. Medical Supplies - Non-Medicare	\$ 4,716	4,273	443			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (1,926)	(1,881)	(45)			
3. a. Physical Therapy - Medicare	\$ 1,764,590	1,756,063	8,527			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (1,410,868)	(1,406,745)	(4,123)			
c. Physical Therapy - Non-Medicare	\$ 503,448	487,310	16,138			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (503,448)	(487,310)	(16,138)			
4. a. Speech Therapy - Medicare	\$ 416,470	416,470				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (331,746)	(331,746)				
c. Speech Therapy - Non-Medicare	\$ 162,445	162,445				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (162,445)	(162,445)				
5. a. Occupational Therapy - Medicare	\$ 1,568,668	1,562,854	5,814			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (1,258,290)	(1,255,478)	(2,812)			
c. Occupational Therapy - Non-Medicare	\$ 491,065	479,365	11,700			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (491,065)	(479,365)	(11,700)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$					
b. Other ( <i>Specify</i> ) - Non-Medicare	\$					
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 18,639,009	13,836,886	4,802,123			
<b>IV. Other Revenue*</b>						
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> )	\$ 120,396	99,419	20,977			
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 55,782	46,063	9,719			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 176,178	145,482	30,696			
<b>VI. Total All Revenue</b> (III +V)	\$ 18,815,187	13,982,368	4,832,819			

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

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

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

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

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

Page Ref	Description	CCNH	RHNS	(Specify)
	<b>Total Other Resident Revenue</b>	\$ -	\$ -	\$ -

**Interest Income****Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
pg 31, L A1	Interest on A/R	63	\$ 52	\$ 11	
pg 33, Ln A	Interest Income on Related Party Note	3,391,412	\$ 99,367	\$ 20,966	
	<b>Total Interest Income</b>		\$ 99,419	\$ 20,977	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
NA	Bad Debt Recoveries	\$ 46,063	\$ 9,719	
	<b>Total Other Revenue</b>	\$ 46,063	\$ 9,719	\$ -

## G. Balance Sheet

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$ 14,976	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,941,877	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$ 25,745	
5. Prepaid Expenses			\$ 473,064	
a. Prepaid Insurance	450,590			
b. Prepaid Health Insurance	9,047			
c. Other Prepaid Expenses	13,427			
d. See Schedule				
6. Interest Receivable			\$ 306,473	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$ 226,412	
A/R Non-Related Facilities	66			
A/R Related Party Facilities	226,346			
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 2,988,547	
B. Fixed Assets			\$	
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Depreciation	Net		
3. Buildings	*Historical Cost		\$	
	Accum. Depreciation	Net		
4. Leasehold Improvements	*Historical Cost	5,310,713	\$ 1,646,729	
	Accum. Depreciation	3,663,984	Net	
5. Non-Movable Equipment	*Historical Cost	484,412	\$ 11,219	
	Accum. Depreciation	473,193	Net	
6. Movable Equipment	*Historical Cost	2,022,819	\$ 287,552	
	Accum. Depreciation	1,735,267	Net	
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$ 32,025	
Excluded Movable Equipment	32,025			
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$ 1,977,525	

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

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

Page Ref	Line Ref	Description	
<b>Total Other Current Assets (Itemize)</b>			<b>\$</b> <u>        </u>

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

Page Ref	Line Ref	Description	
<b>Total Other Other Fixed Assets (Itemize)</b>			<b>\$</b> -

**Schedule of Other Assets Page 32 Line D7**

Schedule of Notes Payable (Itemize) Page 33 Line A2

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$</b> _____

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

Litchfield Woods  
Other Prepaid Expenses #1580  
9/30/19

Legal Fees 13,426.79

BALANCE @ 9/30/19 13,426.79

**Litchfield Woods Health Care Center**

**Accrued Operating Expense - 2170**

**September 30, 2019**

<b>DESCRIPTION</b>	<b>BALANCE</b>
Health Insurance	(\$56,465.21)
Management Fee	\$11,115.19
Worker's Comp Audit Premium	(\$14,440.08)
Audit Fee	(\$10,100.00)
	\$0.00
	\$0.00
	<b>(\$69,890.10)</b>





\$ 75	\$ 4
\$ 1,064	\$ 44
\$ 5	\$ 5
\$ 988	\$ 39
\$ 76	\$ 5
\$ 912	\$ 34
\$ 76	\$ 5
\$ 86	\$ 29
\$ 76	\$ 5
\$ 760	\$ 24
\$ 76	\$ 5
\$ 694	\$ 19
\$ 76	\$ 5
\$ 698	\$ 14
\$ 76	\$ 5
\$ 532	\$ 9
\$ 76	\$ 5
\$ 456	\$ 4
\$ 76	\$ 4
\$ 380	\$ -
\$ 76	\$ -
\$ 394	\$ -
\$ 76	\$ -
\$ 238	\$ -
\$ 76	\$ -
\$ 132	\$ -
\$ 76	\$ -
\$ 76	\$ -

022

State of Connecticut  
**Annual Report of Long-Term Care Facility**  
CSP-32 Rev. 6/95

**G. Balance Sheet (cont'd)**

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2019	32	37
Account				Amount
Total Brought Forward:				\$ 4,966,072
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
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				\$
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>				\$
<b>D. Investment and Other Assets</b>				
1. Deferred Deposits				\$
2. Escrow Deposits				\$
3. Organization Expense	*Historical Cost	Accum. Depreciation	Net	\$
4. Goodwill (Purchased Only)				\$ 8,826
5. Investments Related to Resident Care ( <i>itemize</i> )				\$
6. Loans to Owners or Related Parties ( <i>itemize</i> )				\$ 1,859
Name and Address	Amount	Loan Date		
Deferred Finance fees	1,859			
<b>7. Other Assets (<i>itemize</i>)</b>				\$ 33,053
Deposits IRS	29,049			
Project Development	10,030			
See Schedule	(6,026)			
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>				\$ 43,738
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>				\$ 5,009,810

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

### G. Balance Sheet (cont'd)

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019	Page 33	of 37
Account			Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable			\$ 3,168,237	
2. Notes Payable ( <i>itemize</i> )			\$ (3,701,676)	
Due from Related Party			18,000	
Line of Credit			(3,719,676)	
See Schedule				
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> )			\$ 257,537	
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$	
6. Accrued Payroll Taxes Payable			\$ 9,177	
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable ( <i>Current Portion</i> )			\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )			\$	
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities ( <i>itemize</i> )			\$ 331,222	
Acc'd Operating Expenses			69,890	
Acc'd Expense - CT Sales Tax			164	
Due to Medicaid-Provider Tax			252,052	
Acc'd Health Insurance			9,116 See Schedule	
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>			\$ 64,497	

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

(Carry Total forward to next page)

### G. Balance Sheet (cont'd)

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019	Page 34	of 37
Account				Amount
Total Brought Forward:				64,497
<b>Liabilities (cont'd)</b>				
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> )				\$ 910,987
Name and Address of Lender	Amount	Loan Date		
Due to Related Party	910,987	None		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 44,893
Note Payable - McKesson	44,893			
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 955,880
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 1,020,377

State of Connecticut

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

CSP-35 Rev. 6/95

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019	Page 35	of 37
Account				Amount
<b>A. Reserves</b>				
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>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	3,476,779
6. Gain or Loss for Period	10/1/2018	thru	9/30/2019	\$ 511,654
7. Total Net Worth			\$	3,989,433
<b>C. Total Reserves and Net Worth</b>				\$ 3,989,433
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 5,009,810

State of Connecticut

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

CSP-36 Rev. 6/95

**H. Changes in Total Net Worth**

Name of Facility	License No.	Report for Year Ended	Page of
Litchfield Woods Health Care Center	2034C	9/30/2019	36   37
Account			Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2018			\$ 3,616,619
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$ 18,815,187
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$ 18,303,533
D. Net Income or Deficit			\$ 511,654
E. Balance			\$ 4,128,273
F. Additions			
1. Additional Capital Contributed ( <i>itemize</i> )			
2018 Adjustment/Health Insurance			(200,000)
			61,160
2. Other ( <i>itemize</i> )			
F-3. Total Additions			\$ (138,840)
G. Deductions			
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )			\$
Name and Address (No., City, State, Zip)		Title	Amount
2. Other Withdrawings ( <i>Specify</i> )			\$
Purpose		Amount	
3. Total Deductions			\$
H. <b>Balance at End of Period</b>			\$ 3,989,433

## Error Check

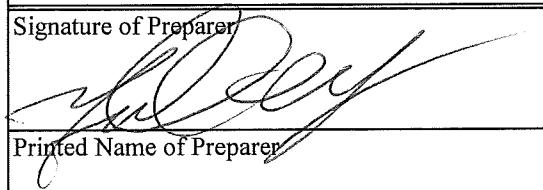
Level	Item	Reported as	
	Page 23 - Historical Cost of Non-Movable Eq.	484,414	is inconsistent with Page 31
	Page 23 - Historical Cost of Movable Eq.	2,054,844	is inconsistent with Page 31
	Page 23 - Accumulated Dep. of Non-Movable Eq.	473,195	is inconsistent with Page 31
	Page 23 - Accumulated Dep. of Movable Eq.	1,735,266	is inconsistent with Page 31
	Page 24 - Historical Cost of Leasehold Imp.	5,310,711	is inconsistent with Page 31
	Page 24 - Accumulated Amort. of Leasehold Imp.	3,663,982	is inconsistent with Page 31

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2019	Page 37 of 37
<i>Check appropriate category</i>			
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)	

### Preparer/Reviewer Certification

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

Signature of Preparer 	Title CFO	Date Signed 2/17/2020
Printed Name of Preparer Sean Harrison		
Athena Health Care Associates, Inc		
Address 135 South Road Farmington, CT 06032		Phone Number (860) 751-3900
Contacted Person Regarding Additional Information Needed Regarding This Report Sean Harrison		Phone Number (860) 751-3900
Contact Email Address sharrison@athenahealthcare.com		