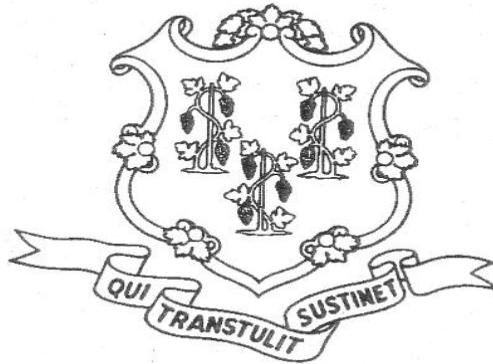


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2022

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

Rest Home with Nursing

Nursing Home only

Supervision only

(Specify)

(CCNH)

(RHNS)

Report for Year Beginning

10/1/2021

Report for Year Ending

9/30/2022

License Numbers:

CCNH

2034C

RHNS

2034C

(Specify)

Medicare Provider

07-5319

Medicaid Provider Numbers:

CCNH

2034C

RHNS

2034C

ICF-IID

### For Department Use Only

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

**General Information**

Name of Facility (as licensed) Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2022	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, 2021 and ending September 30, 2022, 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) Raymond Wilkens		Printed Name (Owner) Lawrence Santilli		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public) Comm. Expires / /	
Address of Notary Public				

(Notary Seal)

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**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 10/1/2021	To 9/30/2022
Address of Facility 225 Roberts Street Torrington, CT 06790			
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900	Date	
Item	Total	CCNH	RHNS (Specify)
1. Dietary wages paid	\$		
2. Laundry wages paid	\$		
3. Housekeeping wages paid	\$		
4. Nursing wages paid	\$		
5. All other wages paid	\$		
6. <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**

Phone No. of Facility 860-489-5801		Report for Year Ended 9/30/2022		Page 2	of 37
Name of Facility (as shown on license) Litchfield Woods Health Care Center		Address (No. & Street, City, State, Zip) 225 Roberts Street Torrington, CT 06790			
License Numbers:	CCNH 2034C	RHNS 2034C	(Specify)	Medicare Provider No. 07-5319	
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)		<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?			<input type="radio"/> Yes <input checked="" type="radio"/> No	If "Yes," explain fully.	
<hr/> <b>Administrator</b> <hr/> Name of Administrator Raymond Wilkens					
			Nursing Home Administrator's License No.:	1841	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		

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

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2022	Page of 3A   37
If this facility is owned or operated as a corporation, provide the following information:			
Legal Name of Corporation	Business Address	State(s) in Which Incorporated	
Highland View Manor, Inc.	225 Roberts St, Torrington, CT 06790	CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G. Santilli	225 Roberts St, Torrington, CT 06790	President	461.32
Michael E. Mosier	225 Roberts St, Torrington, CT 06790	Treasurer/Secretary	
Names of Stockholders Owning at Least 10% of Shares			
Lawrence G. Santilli	225 Roberts St, Torrington, CT 06790		461.32
Estate of John Nocera, Jr	225 Roberts St, Torrington, CT 06790		125
Conservators for Lawrence E. Santilli	225 Roberts St, Torrington, CT 06790		112.68

# **General Information and Questionnaire**

## **Individual Proprietorship**

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2022	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

## General Information and Questionnaire

### Related Parties\*

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2022	Page 4	of 37				
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> No			If "Yes," provide the Name/Address and complete the information on Page 11 of the report.					
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?			<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the following information:					
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	<50%	Management Fees	Pg 17	643,946	185,912
Laurel Ridge Health Care	642 Danbury Road, Ridgefield, CT 06877	<input checked="" type="radio"/>	<input type="radio"/>	>98%	Bank Charges	Pg 16, Ln m13	3,242	3,242
Athena Health Care Insurance	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Self Insured Employee Health & Dental Insu	Pg. 15, ln 1a5	1,193,607	1,193,607
Athena Health Care Assoc Inc. 401(K) Plan	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Facility participates in group 401(k) plan	Pg 15 ln 1a7		
Procare LTC.	111 Executive Blvd., Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Pharmacy	Pg. 20 5a2	680,218	680,218
CT Health Center of Torrington LP	225 Roberts St, Torrington, CT 06790	<input type="radio"/>	<input checked="" type="radio"/>		Lease of Facility & Equipment	Pg 22, Ln 9, 10b; Pg 27	1,381,298	1,381,298
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	<50%	Various: See attached	Pg. 34 B3		
Procare LTC - Note	111 Executive Blvd., Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Pharmacy		136,203	136,203
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.

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

## **General Information and Questionnaire**

### **Basis for Allocation of Costs**

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2022	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.

## **General Information and Questionnaire**

### **Leases (Excluding Real Property)**

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

Name of Facility		License No.		Report for Year Ended			Page	of
Litchfield Woods Health Care Center		2034C		9/30/2022			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers			Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
		Yes	No					
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	<input type="radio"/>	<input checked="" type="radio"/>		Postal Equipment	11/01/13	automatic renewal	1,340	1,258
Leaf, PO Box 644066, Cincinnati, OH 45264	<input type="radio"/>	<input checked="" type="radio"/>		Copier	09/13/20	50 months	18,406	18,293
Leaf, PO Box 644066, Cincinnati, OH 45264	<input type="radio"/>	<input checked="" type="radio"/>		Copier	10/10/20	41 months	715	415
Leaf, PO Box 644066, Cincinnati, OH 45264	<input type="radio"/>	<input checked="" type="radio"/>		Copier	09/05/20	32 months	922	231
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		<b>Total ***</b>	20,197	

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

\*\* Attach copies of newly acquired leases.

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

# **General Information and Questionnaire**

## **Accounting Basis**

Name of Facility Litchfield Woods Health Care Cent	License No. 2034C	Report for Year Ended 9/30/2022	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      If "No," explain.  
 No

## **Independent Accounting Firm**

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1    Marcum LLP	555 Long Wharf Dr, 12th Floor, New Haven, CT 06511
2    MidCap Financial Services, LLC	7255 Woodmont Avenue, Bethesda, MD 20814
3    Marcum LLP	555 Long Wharf Dr, 12th Floor, New Haven, CT 06511
4    PKFOD	4 Corporate Dr, Shelton, CT 06484

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

1	PPP Loan Forgiveness Prep: Disallowed	\$	15,330
2	LOC Audit	\$	4,865
3	Medicare Cost Report	\$	2,730
4	Year End Audit & Statements: Allow	\$	6,800
		Charge for Services Provided	
		\$	29,725

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	203-899-8900 / 860-567-0451
2 MidCap Financial Services, LLC	301-760-7600
3 Office of the State Treasurer/State Marshall	860-702-3000
4 Pilicy & Ryan	860-274-0018
5 Murtha Cullina	860-240-6000

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

- 1 200 Connecticut Ave, Norwalk, CT 06854
- 2 7255 Woodmont Avenue, Bethesda, MD 20814
- 3 165 Capitol Avenue 2nd Fl, Hartford, CT 06106
- 4 365 Main Street, Watertown, CT 06795
- 5 280 Trumbull St 2nd Fl, Hartford, CT 06103

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

1	A/R Collections:Disallowed	\$	53,859
2	LOC Legal Fees:Disallowed	\$	1,272
3	A/R Collections:Disallowed	\$	1,000
4	A/R Collections:Disallowed	\$	230
5	General Matters:Disallowed	\$	911
		Charge for Services Provided	
		\$	57,272

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

② Yes      ③ No      Pg 15, Line 1e

## Schedule of Resident Statistics

Name of Facility Litchfield Woods Health Care Center			License No. 2034C			Report for Year Ended 9/30/2022				Page 8	of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	160	130	30		160	130	30					
B. On last day of THIS report period	160	130	30						160	130	30	
2. Number of Residents												
A. As of midnight of PREVIOUS report period	137	112	25		137	112	25					
B. As of midnight of THIS report period	153	128	25						153	128	25	
3. Total Number of Days Care Provided During Period												
A. Medicare	7,212	3,318	3,894		5,641	2,639	3,002		1,571	679	892	
B. Medicaid (Conn.)	34,068	33,041	1,027		24,613	23,963	650		9,455	9,078	377	
C. Medicaid (other states)												
D. Private Pay	5,298	4,142	1,156		4,337	3,481	856		961	661	300	
E. State SSI for RCH												
F. Other (Specify) Managed Care	6,175	2,668	3,507		4,471	1,855	2,616		1,704	813	891	
G. Total Care Days During Period (3A thru F)	52,753	43,169	9,584		39,062	31,938	7,124		13,691	11,231	2,460	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	18	16	2		2	2			16	14	2	
B. Other Bed Reserve Days	117	111	6		88	85	3		29	26	3	
<b>5. Total Resident Days (3G + 4A + 4B)</b>	<b>52,888</b>	<b>43,296</b>	<b>9,592</b>		<b>39,152</b>	<b>32,025</b>	<b>7,127</b>		<b>13,736</b>	<b>11,271</b>	<b>2,465</b>	

## Schedule of Resident Statistics (Cont'd)

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2022	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.

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	17	103	4	11	3	15		
Per Diem Rate								
a. One bed rm.	501.00	271.00	271.00	682.00	657.00	433.00		
b. Two bed rms.	501.00	271.00	271.00	647.00	637.00	433.00		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	TOTAL	CCNH	RHNS	(Specify)
	16,395	16,395		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	2,001	1,818	183	
2. Restorative Treatments				
C. Other	26,450	26,450		
D. <b>Total Physical Therapy Treatments</b>	44,846	44,663	183	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	TOTAL	CCNH	RHNS	(Specify)
	1,611	1,611		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	372	354	18	
2. Restorative Treatments				
C. Other	5,289	5,289		
D. <b>Total Speech Therapy Treatments</b>	7,272	7,254	18	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	TOTAL	CCNH	RHNS	(Specify)
	11,193	11,193		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,300	1,133	167	
2. Restorative Treatments				
C. Other	25,370	25,370		
D. <b>Total Occupational Therapy Treatments</b>	37,863	37,696	167	

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		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)	107,562	1,677	23,830	371	
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	362,442	12,254	80,297	2,715	
5. Dietary Service					
a. Head Dietitian	61,931	1,411	13,720	313	
b. Food Service Supervisor	39,380	1,229	8,725	272	
c. Dietary Workers	451,321	23,808	99,988	5,275	
6. Housekeeping Service					
a. Head Housekeeper	75,014	2,172	16,619	481	
b. Other Housekeeping Workers	350,718	22,190	77,700	4,916	
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	60,004	1,796	13,293	398	
b. Other Maintenance Workers	41,447	2,226	9,182	493	
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	287	13	64	3	
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	198,343	2,760	13,208	184	
b. RN					
1. Direct Care	930,466	17,950	9,979	178	
2. Administrative**	594,952	16,773	39,621	1,117	
c. LPN					
1. Direct Care	1,126,444	27,837	220,016	6,009	
2. Administrative**					
d. Aides and Attendants	2,242,404	92,915	134,072	6,093	
e. Physical Therapists	985,095	25,746	4,036	105	
f. Speech Therapists	158,407	3,297	393	8	
g. Occupational Therapists	682,095	17,947	3,022	80	
h. Recreation Workers	157,923	6,824	34,987	1,512	
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	279,906	8,386	62,012	1,858	
n. Marketing					
o. Other (Specify) See Attached Schedule					
<i>A-13. Total Salary Expenditures</i>	8,906,141	289,211	864,764	32,381	

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

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

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

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

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

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

State of Connecticut

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

CSP-11 Rev. 10/2005

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

Name of Facility Litchfield Woods Health Care Center			License No. 2034C		Report for Year Ended 9/30/2022			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

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

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

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page <span style="float: right;">of</span>	
Litchfield Woods Health Care Center				2034C		9/30/2022			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Timothy Flaherty (10/1/2021 - 11/26/2021)	23,253	5,151		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	453	A2			
Lavonn Davis (11/26/2021 - 12/13/2021)	3,924	869		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	79	A2			
See Attached	80,385	17,810		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	1,516	A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2022		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</b> (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist	3,326	16	737	4	
3. Pharmacist	14,863	99	3,293	22	
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker	524	4	116	1	
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	66,310	385	14,690	85	
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**	36,417	122			
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	2,873	9	7		
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	429,603	3,526			
2. Administrative***					
b. LPN					
1. Direct Care	1,181,264	13,492			
2. Administrative***					
c. Aides	1,480,444	28,677			
d. Other					
12. Other (Specify)					
See Attached Schedule					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	3,215,624	46,330	18,843	112	

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

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

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

## Report of Expenditures

## Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis\*

Name of Facility Litchfield Woods Health Care Center		License No. 2034C	Report for Year Ended 9/30/2022		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
CT Mental Health Specialists, Sudhakar Shetty, 270 Farmington Ave Ste 309, Farmington CT	Psychologist/Psychiatrist	<input type="radio"/>	<input checked="" type="radio"/>			
Norton Healthcare Staffing, 34 Elm Street., Cohasset, MA 02025	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Stephen Yoelson/ Dr. Stephen Bryant, 52 Peck Rd. Torrington, CT 06790	Medical Director & Assistant Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Procare LTC, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners: Minority Interest		
ProHealth Partners, Kateri Crossley APRN, 324 Elm Street Suite 202B, Monroe, CT 06468	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>			
Athena Health Care Systems 135 South Road, Farmington, CT 06032	MDS Fill In	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners		
Healthdrive, One Prestige Dr., Suite 107, Meriden, CT 06456	Dentist	<input type="radio"/>	<input checked="" type="radio"/>			
Claim LLC, 76 Batterson Park Road, Suite 106, Farmington, CT 06032	Medical Director & Assistant Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Nurse Network. 653 Main Street, Plantsville, CT 06479	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
SambaCare, 410 Melville Ave, Lakewood, NJ 08701	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Solomon Page, 260 Madison Avenue 4th Fl, New York, NY 10016	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
All American Healthcare Services, 494 Broad St 4th Fl, Newark, NJ 07102	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Headcount Management, PO Box 742890, Atlanta, GA 30374	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			

\* 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 9/30/2022		Page 15	of 37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	619,811	564,955	54,856	
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	86,337	78,695	7,642	
4. Social Security (F.I.C.A.)	\$	692,143	630,886	61,257	
5. Health Insurance	\$	1,060,013	966,198	93,815	
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	63,888	58,234	5,654	
8. Uniform Allowance	\$	369	336	33	
9. Other (Specify) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$	395,722	349,253	46,469	
d. Accounting and Auditing	\$	29,725	24,334	5,391	
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$	57,272	46,885	10,387	
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$	89,240	73,054	16,186	
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	71,249	58,327	12,922	
2. Cellular Phones	\$	1,260	1,031	229	
i. Appraisal ( <i>Specify purpose and attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$				
k. Other Taxes ( <i>Not related to property - See Page 22</i> )					
1. Income*	\$				
2. Other (Specify) See Attached Schedule	\$				
3. Resident Day User Fee	\$	830,311	679,722	150,589	
<b>Subtotal</b>	\$	3,997,340	3,531,910	465,430	

\* 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**

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

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**Schedule of Other Taxes**

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

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**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 9/30/2022	Page 16	of 37
Item	Total	CCNH	RHNS	(Specify)
<b><i>Subtotals Brought Forward:</i></b>	3,997,340	3,531,910	465,430	
I. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$	3,920	3,209	711
3. Gifts to Staff and Residents	\$	32,803	26,854	5,949
4. Employee Travel	\$	1,668	1,365	303
5. Education Expenses Related to Seminars and Conventions	\$	57,125	46,765	10,360
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> )	\$	18,180	14,883	3,297
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$			
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	16,378	13,408	2,970
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	\$	5,322	4,357	965
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	7,921	6,484	1,437
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$	600	491	109
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**	\$	580,719	475,398	105,321
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	208,298	170,522	37,776
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$	4,930,274	4,295,646	634,628

\* 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>	\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Promotional	\$ 13,408	\$ 2,970	
<b>Total Other Advertising</b>	\$ 13,408	\$ 2,970	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 5,174	\$ 1,147	
AHCA	\$ 1,310	\$ 290	
<b>Total Dues</b>	\$ 6,484	\$ 1,437	\$ -

**Schedule of Contributions**

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

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Bank Charges	\$ 23,189	\$ 5,137	
Payroll Processing Fees	\$ 20,236	\$ 4,483	
Employee Physicals	\$ 23,817	\$ 5,276	
Senior Planning/Medicaid Assessments	\$ 16,340	\$ 3,620	
Data Processing	\$ 65,888	\$ 14,597	
Licenses	\$ 995	\$ 220	
CMS Penalty# 2022-01-LTC-022/311	\$ 20,057	\$ 4,443	
<b>Total Other Administrative and General</b>	\$ 170,522	\$ 37,776	\$ -

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2022	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	817,278	Contract Attached to a Prior Year	See Below
Allocation of the above	0,764147,111	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12Pg 18, Li
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	License No.	Report for Year Ended		Page of
		9/30/2022		18   37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 468,164	383,256	84,908	
2. Non-Food Supplies	\$ 81,029	66,333	14,696	
3. Other (Specify) _____ Dishes	\$ 2,343	1,918	425	
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>\$ 551,536</b>	<b>451,507</b>	<b>100,029</b>	
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	434	355	79	
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 9/30/2022		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. \$	19,927	16,313	3,614	
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$	4,979	4,076	903	
c. Other ( <i>Specify</i> ) Supplies	\$	10,755	8,804	1,951	
<b>3D. Total Laundry Expenditures (3a + b + c )</b>	\$	35,661	29,193	6,468	
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 9/30/2022		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 75,323	61,662	13,661	
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel				
	Amt.	\$			
C. Other ( <i>Specify</i> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>75,323</b>	<b>61,662</b>	<b>13,661</b>	
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Procare LTC	\$	647,788	647,788		
b. Medicine Cabinet Drugs	\$	77,543	63,479	14,064	
c. Medical and Therapeutic Supplies	\$	292,170	239,181	52,989	
d. Ambulance/Limousine***	\$	25,719	25,719		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	47,823	39,472	8,351	
f. X-rays and Related Radiological Procedures***	\$	41,560	41,560		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	157,523	157,523		
i. Recreation	\$	15,941	13,050	2,891	
j. Direct Management Services*	\$	147,111	120,430	26,681	
k. Indirect Management Services*	\$	130,764	107,048	23,716	
l. Other ( <i>Specify</i> )**** See Attached Schedule	\$	83,963	72,627	11,336	
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>1,667,905</b>	<b>1,527,877</b>	<b>140,028</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**

Description	CCNH	RHNS	(Specify)
Medical Equip Rentals-Medicaid	\$ 6,448	\$ 1,429	
Physical Therapy Supplies	\$ 17,109	\$ 70	
OT Supplies	\$ 4,761	\$ 21	
Oxygen Concentrator Rentals	\$ 27,661	\$ 6,128	
Cable TV Fees	\$ 16,648	\$ 3,688	
<b>Total Other Resident Care</b>	<b>\$ 72,627</b>	<b>\$ 11,336</b>	<b>\$ -</b>

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

Name of Facility Litchfield Woods Health Care Center				License No. 2034C	Report for Year Ended 9/30/2022				Page of 21   37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	
ADP	100 Corporate Drive, Windsor, CT 06095	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	16,278	3,606		16	m13
USA Hauling	PO Box 808, East Windsor, CT 06088	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal	51,350	11,376		22	6f
The Winterberry Group	2070 West S, Southington, CT 06489	<input type="radio"/>	<input checked="" type="radio"/>		Snow Removal	29,879	6,620		22	6f
Diversified Sweeping & Landscaping, LLC	14 Milford St, Burlington, CT 06013	<input type="radio"/>	<input checked="" type="radio"/>		Groundskeeping	11,266	2,496		22	6f
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners: Minority Interest	Pharmacy	740,619			20	5a2
Otis Elevator	1 Farm Springs, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>			6,132	1,359		22	6a
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

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

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

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

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2022			Page 22   37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 96,929	79,350	17,579		
b. Heat	\$ 135,860	111,219	24,641		
c. Light & Power	\$ 128,778	105,422	23,356		
d. Water	\$ 52,037	42,599	9,438		
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 20,197	16,534	3,663		
f. Other ( <i>itemize</i> )	\$ 181,315	148,432	32,883		
See Attached Schedule					
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 615,116	503,556	111,560		
7. Depreciation ( <i>complete schedule page 23*</i> )					
a. Land Improvements	\$				
b. Building & Building Improvements	\$				
c. Non-Movable Equipment	\$ 1,657	1,346	311		
d. Movable Equipment	\$ 59,575	48,405	11,170		
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 61,232	49,751	11,481		
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )					
a. Organization Expense	\$				
b. Mortgage Expense	\$ 6,620	5,379	1,241		
c. Leasehold Improvements	\$ 110,753	89,987	20,766		
d. Other ( <i>Specify</i> )	\$				
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$ 117,373	95,366	22,007		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 929,637	755,330	174,307		
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 276,480	224,640	51,840		
c. Personal property taxes	\$ 37,352	30,348	7,004		
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 1,422,074	1,155,435	266,639		

\* 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	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
<b>Additions:</b>					
11/1/2021	Dishwasher	Standard Resident	\$ 27,941	10	\$ 1,397
6/1/2022	Over Bed Tables	Standard Resident	\$ 1,203	15	\$ 40
7/1/2022	Over Bed Tables	Standard Resident	\$1,203	15	\$40
8/1/2022	Air Conditioners (2)	Standard Resident	\$3,664	5	\$366
		PICK A CATEGORY			
		PICK A CATEGORY			
<b>Total additions for Movable Equipment</b>			\$ 34,011		\$ 1,843 *
<b>Deletions:</b>					
	Dryer		\$ (6,552)		
<b>Total deletions for Movable Equipment</b>			\$ (6,552)		\$ - **

\*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	Depreciation
				Life	
<b>Additions:</b>					
11/1/2021	Hot Water Storage Tank		\$ 4,694	15	\$ 156
9/1/2022	Catch Basin		\$ 5,800	15	\$ 193
<b>Total additions for Leasehold Improvement</b>			\$ 10,494		\$ 349 *
<b>Deletions:</b>					
	Vinyl Flooring		\$ (18,323)		
<b>Total deletions for Leasehold Improvement</b>			\$ (18,323)		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility Litchfield Woods Health Care Center			License No. 2034C		Report for Year Ended 9/30/2022			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
<b>A-4. Subtotal</b>									
<b>B. Mortgage Expense</b>									
1. Finance Fees-Refinance 2007	6	2007	5 yrs	12,500	12,500	SL	0		
2. Finance Fees-Refinance 2020	1	2021		19,146	5,231			6,620	
3.									
<b>B-4. Subtotal</b>									6,620
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period	9	2021	Various	5,357,960	3,921,071	SL		110,404	
2. Disposals (attach schedule)				(18,323)					
3. Acquired during this report period (attach schedule)									
	9	2022	Various	10,494				349	
<b>C-4. Subtotal</b>									110,753
<b>D. Total Amortization</b>									117,373

\* 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 9/30/2022	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	01/01/88			
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure	05/11/88			
5. Total Licensed Bed Capacity	160			
6. Square Footage				
7. Acquisition Cost				
a. Land	29,039			
b. Building	7,151,576			

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	12/30/20			
c. Interest Rate for the Cost Year	2.95%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	12,652,300			
f. Principal balance outstanding as of	12,194,430			

Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount		\$				
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$				

(Carry Subtotals forward to next page )

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

Name of Facility	License No.	Report for Year Ended			Page	of
		9/30/2022			27	37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$	22,537	18,311	4,226	
Vendor Interest						
<b>13. Total All Interest Expense (12B7 + 12C3 + 12D)</b>		\$	22,537	18,311	4,226	
14. Insurance						
a. Insurance on Property (buildings only)		\$	181,815	147,725	34,090	
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)		\$				
<b>14d. Total Insurance Expenditures (14a + b + c)</b>		\$	181,815	147,725	34,090	
<b>15. Total All Expenditures (A-13 thru C-14)</b>		\$	22,507,613	20,312,677	2,194,936	

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

Name of Facility Litchfield Woods Health Care Center			License No. 2034C	Report for Year Ended 9/30/2022		Page 28 of 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 685,117	682,095	3,022	
4.			Other - See attached Schedule	\$ 4,780	3,913	867	
<b>Page 13 - Professional Fees</b>							
5.	13	B8c	Resident Care Physicians **	\$ 36,417	36,417		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 395,722	349,253	46,469	
10.	15	Bd	Accounting	\$ 20,195	16,532	3,663	
10a.			Legal	\$ 57,272	46,885	10,387	
11.			Telephone	\$			
12.	30	IV3	Cellular Telephone	\$ 600	491	109	
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	I3	Gifts, flowers and coffee shops	\$ 32,803	26,854	5,949	
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&j	Unallowable Advertising *	\$ 16,378	13,408	2,970	
19.	15	1j&k	Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$ 302,303	247,476	54,827	
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 72,786	59,586	13,200	
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 1,624,373	1,482,910	141,463		

\* 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	\$ 3,913	\$ 867	
<b>Total Other Salaries Adjustment</b>			\$ 3,913	\$ 867	\$ -

**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	M13	Bank Charges	\$ 23,189	\$ 5,137	
16	M13	Senior Planning/Medicaid Assessments	16340	3620	
16	M13	CMS Penalty# 2022-01-LTC-022/311	20057	4443	
<b>Total Other A&amp;G Adjustments</b>			\$ 59,586	\$ 13,200	\$ -

State of Connecticut

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

Name of Facility			License No.	Report for Year Ended		Page	of
Litchfield Woods Health Care Center			2034C	9/30/2022		29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 1,624,373	1,482,910	141,463	
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a1&	Prescription Drugs	\$ 647,788	647,788		
28.	20	5d	Ambulance/Limousine	\$ 25,719	25,719		
29.	20	5f	X-rays, etc	\$ 41,560	41,560		
30.	20	5h	Laboratory	\$ 157,523	157,523		
31.	20	5c	Medical Supplies	\$ 24,979	20,449	4,530	
32.	20	5e2	Oxygen (non emergency)	\$ 47,823	39,472	8,351	
33.	20	5j	Occupational Therapy	\$ 4,782	4,761	21	
34.			Other - See Attached Schedule	\$ 36,471	33,355	3,116	
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 6,165	5,009	1,156	
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>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.	30	IV5	Interest Income on Account Rec.	\$ 751	615	136	
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$ 82,446	67,493	14,953	
46.			Management Fees Indirect	\$ 73,285	59,994	13,291	
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 2,773,665	2,586,648	187,017	

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

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

## Schedule of Excess Movable Equipment Depreciation

### **Schedule of Other Property Adjustments**

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

Attachment Page 29

### **Schedule of Other - Miscellaneous Administrative Adjustments**

### **Schedule of Other - Direct Adjustments**

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

## **Schedule of Unallowable Building Interest**

**F. Statement of Revenue**

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2022			Page 30   37
Item		Total	CCNH	RHNS	(Specify)
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 22,057,764	21,403,340	654,424		
b. Medicaid Room and Board Contractual Allowance **	\$ (12,641,269)	(12,228,052)	(413,217)		
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 4,543,208	2,066,678	2,476,530		
b. Medicare Room and Board Contractual Allowance **	\$ (188,688)	(44,109)	(144,579)		
4. a. Private-Pay Residents and Other	\$ 6,294,650	4,222,569	2,072,081		
b. Private-Pay Room and Board Contractual Allowance **	\$ (797,747)	(751,272)	(46,475)		
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 281,484	281,484			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (281,484)	(281,484)			
c. Prescription Drugs - Non-Medicare	\$ 437,004	427,280	9,724		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (437,004)	(427,280)	(9,724)		
2. a. Medical Supplies - Medicare	\$ 8,979	8,979			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (1,979)	(1,979)			
c. Medical Supplies - Non-Medicare	\$ 1,293	1,293			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (1,239)	(1,239)			
3. a. Physical Therapy - Medicare	\$ 1,681,541	1,675,652	5,889		
b. Physical Therapy - Medicare Contractual Allowance **	\$ (1,285,485)	(1,281,212)	(4,273)		
c. Physical Therapy - Non-Medicare	\$ 752,192	742,642	9,550		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (752,192)	(742,642)	(9,550)		
4. a. Speech Therapy - Medicare	\$ 299,075	298,832	243		
b. Speech Therapy - Medicare Contractual Allowance **	\$ (257,137)	(256,997)	(140)		
c. Speech Therapy - Non-Medicare	\$ 243,425	241,025	2,400		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (243,425)	(241,025)	(2,400)		
5. a. Occupational Therapy - Medicare	\$ 1,430,148	1,425,271	4,877		
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (1,151,947)	(1,148,297)	(3,650)		
c. Occupational Therapy - Non-Medicare	\$ 742,227	733,477	8,750		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (742,227)	(733,477)	(8,750)		
6. a. Other ( <i>Specify</i> ) - Medicare	\$				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 1,696,295	1,696,295			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 21,687,462	17,085,752	4,601,710		
<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> )	\$ 111,301	91,115	20,186		
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 151,956	124,397	27,559		
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 263,257	215,512	47,745		
<b>VI. Total All Revenue</b> (III +V)	\$ 21,950,719	17,301,264	4,649,455		

\* 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)
N/A	Misc Revenue from CRF Funds	\$ 1,713,894		
0	Retroactives	\$ (17,599)		
	<b>Total Other Resident Revenue</b>	\$ 1,696,295	\$ -	\$ -

**Interest Income****Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
pg 31, L A	Interest on A/R	751	\$ 615	\$ 136	
pg 33, Ln A	Interest Income on Related Party Note	3,391,412	\$ 90,500	\$ 20,050	
	<b>Total Interest Income</b>		\$ 91,115	\$ 20,186	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
NA	Bad Debt Recoveries	\$ 124,397	\$ 27,559	
	<b>Total Other Revenue</b>	\$ 124,397	\$ 27,559	\$ -

**G. Balance Sheet**

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2022	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$ 32,007	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 2,778,265	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$ 28,319	
5. Prepaid Expenses			\$ 299,454	
a. Prepaid Insurance	199,060			
b. Prepaid Health Insurance	11,118			
c. Other Prepaid Expenses	89,276			
d. See Schedule				
6. Interest Receivable			\$ 648,148	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 3,786,193	
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	5,350,133	\$	1,318,307
	Accum. Depreciation	4,031,826	Net	
5. Non-Movable Equipment	*Historical Cost	484,412	\$	4,067
	Accum. Depreciation	480,345	Net	
6. Movable Equipment	*Historical Cost	2,145,406	\$	195,677
	Accum. Depreciation	1,949,729	Net	
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation	_____	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	1,103
Excluded Movable Equipment		1,103		
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$ 1,519,154	

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

(Carry Total forward to next page )

**Schedule of Prepaid Expenses Page 31 Line A5**

Page Ref	Line Ref	Description	
<b>Total Prepaid Expenses</b>			\$ -

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

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

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

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

Page Ref	Line Ref	Description	
<b>Total Other Assets</b>			\$ -

**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>			\$ -

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

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

## G. Balance Sheet (cont'd)

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2022	Page 32	of 37
Account		Amount		
		Total Brought Forward:		\$ 5,305,347
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements	*Historical Cost Accum. Depreciation	Net	\$	
3. Buildings	*Historical Cost Accum. Depreciation	Net	\$	
4. Non-Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
5. Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
6. Motor Vehicles	*Historical Cost Accum. Depreciation	Net	\$	
7. Minor Equipment-Not Depreciable			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense	*Historical Cost Accum. Depreciation	Net	\$	
4. Goodwill (Purchased Only)			\$	551,000
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	21,719
Name and Address		Amount	Loan Date	
Deferred Finance Fees	21,719			
7. Other Assets ( <i>itemize</i> )			\$	458,453
Deposits IRS	16,400			
Project Development	442,053			
See Schedule				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	1,031,172
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	6,336,519

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2022	33	37
Account			Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable			\$ 6,090,953	
2. Notes Payable ( <i>itemize</i> )			\$ (7,694,367)	
Line of Credit			(7,694,367)	
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> )			\$ 427,277	
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$	
6. Accrued Payroll Taxes Payable			\$ 455,597	
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable ( <i>Current Portion</i> )			\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )			\$	
11. Accrued Income Taxes*			\$ 39,100	
12. Other Current Liabilities ( <i>itemize</i> )			\$ 2,326,564	
Acc'd Operating Expenses	208,752			
Acc'd Expense - CT Sales Tax	146			
Due to Medicaid-Provider Tax	2,104,922			
Acc'd Health Insurance	12,744	See Schedule		
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)			\$ 1,645,124	

\* 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 9/30/2022	Page 34	of 37
Account			Amount	
Total Brought Forward:			\$ 1,645,124	
<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> )			\$ 481,396	
Name and Address of Lender	Amount	Loan Date		
Due to Related Party	481,396			
4. Other Long-Term Liabilities ( <i>itemize</i> )			\$ 547,300	
Notes Payable			\$ 547,300	
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)			\$ 1,028,696	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)			\$ 2,673,820	

## G. Balance Sheet (cont'd)

### Reserves and Net Worth

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2022	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			\$	3,676,419
6. Gain or Loss for Period	10/1/2021	thru	9/30/2022	\$ <span style="color: red;">(556,894)</span>
7. Total Net Worth			\$	3,120,525
<b>C. Total Reserves and Net Worth</b>			\$	3,120,525
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	5,794,345

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Litchfield Woods Health Care Center	2034C	9/30/2022	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ 3,315,705		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 21,950,719		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 22,507,613		
D. Net Income or Deficit				\$ (556,894)		
E. Balance				\$ 2,758,811		
F. Additions						
1. Additional Capital Contributed ( <i>itemize</i> )						
2. Other ( <i>itemize</i> )						
Deferred HHS Funds 2021			361,714			
F-3. Total Additions				\$ 361,714		
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				\$		
<b>H. Balance at End of Period</b>				<b>\$ 3,120,525</b>		

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2022	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

### Preparer/Reviewer Certification

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

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