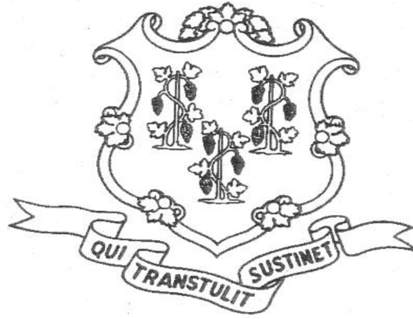
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2023

Name of Facility (as licensed) Litchfield Woods Health Care Center		
Address (No. & Street, City, State, Zip Code) 225 Robert Street Torrington, CT 06790		
Type of Facility ☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☐ (Specify)	☐ (Specify)
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023	

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

Medicaid Provider Numbers:	CCNH / RHNS	(Specify)	(Specify)
	2034C		

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Litchfield Woods Health Care Center [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, 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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Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment				Page 1A	of 37
Name of Facility Litchfield Woods Health Care Center		Period Covered:		From 10/1/2022	To 9/30/2023
Address of Facility 225 Robert Street Torrington, CT 06790					
Report Prepared By		Phone Number		Date	

Item		Total	CCNH / RHNS	(Specify)	(Specify)
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$				
5. All other wages paid	$				
6. ***Total Wages Paid***	$				
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
	9/30/2023	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Litchfield Woods Health Care Center	225 Robert Street Torrington, CT 06790

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

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined   ☐ (Specify)   ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship   ○ LLC   ○ Partnership   ⊙ Profit Corp.   ○ Non-Profit Corp.   ○ Government   ○ 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?   ○ Yes   ⊙ No   If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Raymond Wilkens	1841

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	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. Moiser	225 Roberts St. Torrington, CT 06790	easurer/Secreata	
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 Larence E. Santilli	225 Roberts St. Torrington, CT 06790		112.68

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⦿ 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? ⦿ Yes ○ 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 Rd, Farmington, CT 06032	⦿	○	>50%	Management Fees	Pg 17	858,594	553,161
Laurel Ridge Health Care	642 Danubury Road, Ridgefield, CT 06877	⦿	○	>50%	Bank Charges	Pg16, Ln m13	5,907	5,907
Athena Health care Insurance	135 South Rd, Farmington, CT 06032	○	⦿	>50%	Self Insured Employee Health & Dental Insu	Pg 15, ln 1a5	1,366,899	1,366,899
Athena Health Care Associates Inc. 401k Plan	135 South Rd, Farmington, CT 06032	○	⦿	>50%	Facility participates in group 401k plan	Pg 15 ln 1a7		
Pocare LTC	111 Executive Blvd, Farmingdale, NY 11735	⦿	○	>50%	Pharmacy	Pg 20 5a2	584,796	584,796
CT Health Center of Torrington LP	225 Roberts St. Torrington, CT 06790	○	⦿	<5%	Lease of Facility & Equipment	Pg 22, L9, 10b	1,370,216	1,370,216
Athena Health Care	135 South Rd, Farmington, CT 06032	⦿	○	<50%	Various: See Attached	Pg 34 B3		
Procare LTC - Note	111 Executive Blvd, Farmingdale, NY 11735	⦿	○	<5%	Pharmacy		103,193	103,193
		○	⦿					

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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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 (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

1. In the preparation of this Report, were all costs allocated as required? ○ 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
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
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Square footage of entire facility.	0

Outpatient Therapy

Does the Facility provide outpatient therapy services?	No

If yes, please complete the following:

	Square footage of therapy space.

Meals on Wheels

Does the facility provide Meals on Wheels?	No

If yes, please complete the following:

	Square footage of kitchen	
	Number of meals served per week	
No	Are meals included in meals served on page 18 of the Annual Report?	
No	Are direct costs included in the Annual Report?	
	If yes, please state where costs are reported.	
No	Are drivers for the program included in the facility's payroll?	
	If yes, please complete the following:	
		Amount Reported
		Annual Report page and line
	Please state the salary amounts of specific cooks and/or dietary aides	
	Please state where the cooks and/or dietary aides are reported in the Annual Report	

Apartments, Independent Living, Assisted Living

Does the facility have apartments, independent living, and/or assisted living?	No

If yes, please complete the following:

	Square footage of apartments
	Square footage of independent living
	Square footage of assisted living
	Please identify the services provided:

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
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Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care?	No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH / RHNS Level	Total	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	160	160			160	160						
B. On last day of THIS report period	160	160							160	160		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	153	153			153	153						
B. As of midnight of THIS report period	140	140							140	140		
3. Total Number of Days Care Provided During Period												
A. Medicare	10,265	10,265			8,211	8,211			2,054	2,054		
B. Medicaid (Conn.)	38,768	38,768			29,132	29,132			9,636	9,636		
C. Medicaid (other states)												
D. Private Pay	2,153	2,153			1,745	1,745			408	408		
E. State SSI for RCH												
F. Other (Specify) Managed Care	300	300			136	136			164	164		
G. Total Care Days During Period (3A thru F)	51,486	51,486			39,224	39,224			12,262	12,262		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	34	34			26	26			8	8		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	51,520	51,520			39,250	39,250			12,270	12,270		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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)	(Specify)	Lost			Gained			CCNH / RHNS	(Specify)	(Specify)	
	(1)	(2)	(3)	(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)	(Specify)
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 / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	15	108		6			11	
Per Diem Rate								
a. One bed rm.	510.41	######		712.00			488.86	
b. Two bed rms.	510.41	######		677.00			488.86	
c. Three or more bed rms.								

Item	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
7. Total Number of Physical Therapy Treatments					
A. Medicare - Part B	17,247	17,247			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	1,750	1,750			
2. Restorative Treatments					
C. Other	18,030	18,030			
D. ***Total Physical Therapy Treatments***	37,027	37,027			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	453	453			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	151	151			
2. Restorative Treatments					
C. Other	1,500	1,500			
D. ***Total Speech Therapy Treatments***	2,104	2,104			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	12,422	12,422			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	1,179	1,179			
2. Restorative Treatments					
C. Other	17,528	17,528			
D. ***Total Occupational Therapy Treatments***	31,129	31,129			

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	10	37

Are time records maintained by all individuals receiving compensation? ⦿ Yes ○ No

Item	Total Cost and Hours								
	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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)	160,038		2,158						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	410,744		13,530						
5. Dietary Service									
a. Head Dietitian	67,256		1,493						
b. Food Service Supervisor	59,321		1,937						
c. Dietary Workers	592,676		30,176						
6. Housekeeping Service									
a. Head Housekeeper	84,486		2,312						
b. Other Housekeeping Workers	464,641		26,989						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	139,607		3,249						
b. Other Maintenance Workers	45,765		2,002						
8. Laundry Service									
a. Supervisor	8,889		592						
b. Other Laundry Workers									
9. Barber and Beautician Services									
10. Protective Services									
11. Accounting Services									
a. Head Accountant									
b. Other Accountants									
12. Professional Care of Residents									
a. Directors and Assistant Director of Nurses	225,981		3,957						
b. RN									
1. Direct Care	1,145,584		20,962						
2. Administrative**	884,119		22,701						
c. LPN									
1. Direct Care	1,922,647		45,305						
2. Administrative**									
d. Aides and Attendants	3,003,137		124,400						
e. Physical Therapists	981,089		24,164						
f. Speech Therapists	108,867		2,020						
g. Occupational Therapists	670,631	(670,631)	17,100	Disallowed					
h. Recreation Workers	204,120		9,153						
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	324,954	(5,315)	9,441	Marketing Disa					
n. Marketing									
o. Other (Specify) See Attached Schedule									
A-13. Total Salary Expenditures	11,504,552	(675,946)	363,641						

* 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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

	CCNH / RHNS			(Specify)			(Specify)		
Position	$	Adjustment	Hours	$	Adjustment	Hours	$	Adjustment	Hours
Total	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-

Schedule of Other Fees (Page 13)

	CCNH / RHNS			(Specify)			(Specify)		
Service	$	Adjustment	Hours	$	Adjustment	Hours	$	Adjustment	Hours
Total	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	(Specify)							
Section I - Operators/Owners										
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).										

* 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.

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	12	37

Name	Salary Paid CCNH / RHNS	(Specify)	(Specify)	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Section III - Administrators* **										
Raymond Wilkens	82,726			Health & Life insurances, Payroll Taxes	Day to day operations of the nursing home facility	1,074	A2			
Elise Cecil	48,077			Health & Life insurances, Payroll Taxes	Day to day operations of the nursing home facility	800	A2			
Joel Carmicahel	29,235			Health & Life insurances, Payroll Taxes	Day to day operations of the nursing home facility	284	A2			
Section IV - Assistant Administrators										

*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
** Include **all** other employment worked during the cost year.
*** If more than one Administrator is reported, include dates of employment for each.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	13	37

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)									
1. Dietitian									
2. Dentist	974		33						
3. Pharmacist	14,049		314						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	59,832		285						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**	(3,370)	3,370		Disallowed					
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	711		2						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	82,225		639						
2. Administrative***									
b. LPN									
1. Direct Care	99,244		1,096						
2. Administrative***									
c. Aides	68,974		1,677						
d. Other									
12. Other (Specify) See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	322,639	3,370	4,046						

* 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 in the Adjustment column.
*** 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	14	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	⦿	○	
Norton Healthcare Staffing, 34 Elm Street., Cohasset, MA 02025	Nurse Pool	⦿	○	
Athena Health Care Assoc Inc, 135 South Rd Farmington CT, 06032	Admin/Gen - Other	⦿	○	
Dr Stephen Yoelson/ Dr. Stephen Bryant, 52 Peck Rd. Torrington, CT 06790	Medical Director & Assistant Medical Director	○	⦿	
Procare LTC, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist	⦿	○	Common Owners: Minority Interest
ProHealth Partners, Kateri Crossley APRN, 324 Elm Street Suite 202B, Monroe, CT 06468	Physician Services	○	⦿	
Athena Health Care Systems 135 South Road, Farmington, CT 06032	MDS Fill In	⦿	○	Common Owners
Healthdrive, One Prestige Dr., Suite 107, Meriden, CT 06456	Dentist	○	⦿	
Claim LLC, 76 Batterson Park Road, Suite 106, Farmington, CT 06032	Medical Director & Assistant Medical Director	○	⦿	
Nurse Network. 653 Main Street, Plantsville, CT 06479	Nurse Pool	○	⦿	
The Hospital of central Connecticut 100 Grand Street New Britain Ct 06050	Hospital	○	⦿	
Solomon Page, 260 Madison Avenue 4th Fl, New York, NY 10016	Nurse Pool	○	⦿	
Charlotte Hungerford Hospital P.O. Box 988 540 Litchfield Street Torrington CT 06790	Hospital	○	⦿	
Compassionate Nursing LLC 34 Saddle Hill Road Manchester CT 06040	Nurse Pool	○	⦿	
Delta T-Group Hartford Inc. P.O. Box 884 Bryn Mawr, PA 19010	Nurse Pool	○	⦿	
Dedicated Nursing Assoc. 6536 William Penn HwyRt 22 Suite 201 Delmont PA 15626	Nurse Pool	○	⦿	
Paramount Healthcare 3 Courthouse Lane, Unit 2 Chelmsford MA 08124	Nurse Pool	○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	

* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	15	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	547,504	547,504					
2. Disability Insurance	$							
3. Unemployment Insurance	$	117,136	117,136					
4. Social Security (F.I.C.A.)	$	823,608	823,608					
5. Health Insurance	$	1,138,337	1,138,337					
6. Life Insurance (employees only) (not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	177,496	177,496					
8. Uniform Allowance	$	(183)	(183)					
9. Other (*Specify*) See Attached Schedule	$							
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$		703,054	(703,054)	Disallowed			
d. Accounting and Auditing	$	10,235	17,731	(7,496)	Disallowed			
e. Legal (*Services should be fully described on Page 15b)*	$		88,712	(88,712)	Disallowed			
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	84,732	84,732					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	59,719	59,719					
2. Cellular Phones	$	720	1,320	(600)	Disallowed			
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*	$							
2. Other (*Specify*) See Attached Schedule	$							
3. Resident Day User Fee	$	867,180	867,180					
Subtotal	$	3,826,484	4,626,346	(799,862)				

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Total	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Other Taxes

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Total	$ -	$ -	$ -	$ -	$ -	$ -

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Cent	2034C	9/30/2023	15b	37

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

◉ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? ◉ Yes ○ No

If "No," explain.

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

	Service	$	Amount
1	LOC Audit: Disallowed	$	7,496
2	Medicare Cost Report	$	2,835
3	Year End Audit & Statements: Allow	$	7,400
4		$	
	Charge for Services Provided	$	17,731

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	Jackson Lewis	

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. PO Box 416019 Boston, MA 02241

Services Provided by This Firm (*describe fully*)

	Service	$	Amount
1	A/R Collections:Disallowed	$	56,416
2	LOC Legal Fees:Disallowed	$	12,825
3	Conservatorship:Disallowed	$	1,655
4	PPP Loan: Disallowed	$	2,816
5	Purch Agreement: Disallowed	$	15,000
	Charge for Services Provided	$	88,712

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

◉ Yes ○ No Page 15 Line 1e

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

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	16	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:		3,826,484	4,626,346	(799,862)				
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$	3,920	3,920					
3. Gifts to Staff and Residents	$		17,418	(17,418)	Disallowed			
4. Employee Travel	$	4,335	4,335					
5. Education Expenses Related to Seminars and Conventions	$	28,179	28,179					
6. Automobile Expense (*not purchase or depreciation*)	$							
7. Other (*Specify*) See Attached Schedule	$							
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (*all such expenses*)	$	15,150	15,150					
2. Advertising Telephone Directory (*all such expenses*)***	$							
3. Advertising Other (*Specify*)*** See Attached Schedule	$		2,185	(2,185)				
4. Fund-Raising***	$							
5. Medical Records	$							
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$							
7. Postage	$	3,856	3,856					
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	11,499	11,499					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$	1,503	1,503					
10. Contributions*** See Attached Schedule	$	200	200					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$							
12. Administrative Management Services**	$	379,133	580,719	(201,586)				
13. Other (*Specify*) See Attached Schedule	$	441,577	475,787	(34,210)				
C-14 Total Administrative & General Expenditures	$	4,715,836	5,771,097	(1,055,261)				

* 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 expensein the Adjustment column.

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Promotional	$ 2,185	$ (2,185)	Disallowed			
Total Other Advertising	$ 2,185	$ (2,185)	$ -	$ -	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF	$ 9,730					
CAHCF - Long Term	$ 1,602					
Chamber of Commerce	$ 167					
Total Dues	$ 11,499	$ -	$ -	$ -	$ -	$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Misc	$ 200					
Total Contributions	$ 200	$ -	$ -	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Bank Charges	$ 34,210	$ (34,210)	Disallowed			
Payroll Processing Fees	$ 27,784					
Employee Physicals	$ 14,993					
Senior Planning/Medicaid Assessments	$ 301,750					
Data Processing	$ 96,419					
Licenses	$ 631					
Total Other Administrative and General	$ 475,787	$ (34,210)	$ -	$ -	$ -	$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Litchfield Woods Health Care Center	2034C	9/30/2023	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 Associates Inc	817,278	Contract attached to prior year	See below
135 South Rd	539,403	Admin/Gen 66%	Pg 16 Line 12
Farmington, CT 06032	130,764	Indirect 16%	Page 18 Line 2c
	147,111	Direct 18%	Page 20 Line 5J
Allocation of the Above	41,316	Admin/Gen Other Exp	Page 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
Litchfield Woods Health Care Center	2034C	9/30/2023	18	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	536,977	536,977					
2. Non-Food Supplies	$	80,382	80,382					
3. Other (*Specify*)______________________ Dishes	$	2,969	2,969					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*)___________________________ Management Services	$	130,764	130,764					
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	751,092	751,092					

2E. Dietary Questionnaire	Total	CCNH / RHNS	(Specify)	(Specify)
F. Resident Meals: Total no. of meals served per day:*				

	Question	Yes	No	
G.	Is cost of employee meals included in 2D?	◉ Yes	○ No	
H.	Did you receive revenue from employees?	○ Yes	◉ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	○ Yes	◉ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	◉ 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?	○ Yes	◉ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	◉ 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	19	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.							
	Amt. $							
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. $	26,985	26,985					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	12,865	12,865					
c. Other (*Specify*) Supplies	$	12,572	12,572					
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	52,422	52,422					

3E. Laundry Questionnaire			
F. Is cost of employee laundry included in 3D?	○ Yes	⦿ No	If yes, specify cost.
G. Did you receive revenue from employees?	○ Yes	⦿ 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?	○ Yes	⦿ No	If yes, specify cost.
J. Did you receive revenue from these people?	○ Yes	⦿ No	If yes, specify amt.
K. Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	20	37

Item			Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4. Housekeeping	Sq. Ft. Serviced								
a. In-House Care	by Personnel								
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	69,200	69,200					
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel								
(*Complete Schedule C-2 att. Page 21*)	Amt.	$							
C. Other (*Specify*)		$							
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	69,200	69,200					
5. Resident Care (Supplies)**									
a. Prescription Drugs***									
1. Own Pharmacy		$							
2. Purchased from Procare LTC		$		542,725	(542,725)	Disallowed			
b. Medicine Cabinet Drugs		$	19,666	44,566	(24,900)	Disallowed El			
c. Medical and Therapeutic Supplies		$	308,938	341,588	(32,650)	Disallowed			
d. Ambulance/Limousine***		$		10,121	(10,121)	Disallowed			
e. Oxygen									
1. For Emergency Use		$							
2. Other***		$		31,833	(31,833)	Disallowed			
f. X-rays and Related Radiological Procedures***		$		45,458	(45,458)	Disallowed			
g. Dental (*Not dentists who should be included under salaries or fees*)		$							
h. Laboratory***		$		206,946	(206,946)	Disallowed			
i. Recreation		$	12,954	12,954					
j. Direct Management Services*		$	(54,978)		(54,978)				
k. Indirect Management Services*		$	(48,869)		(48,869)				
l. Cable TV		$							
m. Other (Specify)**** See Attached Schedule		$	225,095	251,673	(26,578)				
n. Physical Therapy Expense		$							
o. Speech Therapy Expense		$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)		$	462,806	1,487,864	(1,025,058)				

* 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 in the Adjustment column.
**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Management Fee Direct	$ 147,111					
Medical Equip Rentals-Medicaid	$ 17,595					
Physical Therapy Supplies	$ 13,471					
Oxygen Concentrator Rentals	$ 43,318					
Cable TV Fees	$ 26,275	$ (22,675)	Disallowed			
Medical Equip - Non Medicaid	$ 3,903	$ (3,903)	Disallowed			
Total Other Resident Care	$ 251,673	$ (26,578)	$ -	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	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)	(Specify)	Pg	Line
ADP	100 Corporate Drive, Windsor, CT 06095	○	⦿		Payroll Processing	23,253			16	m13
USA Hauling	PO Box 808, East Windsor, CT 06088	○	⦿		Rubbish Removal	66,083			22	6f
Boulder Ridge	62 Long Horizon Rd, Bethlehem CT, 06790	○	⦿		Snow Removal	39,988			22	6f
Diversified Sweeping & Landscaping, LLC	14 Milford St, Burlington, CT 06013	○	⦿		Groundskeeping	16,277			22	6f
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	⦿	○	Common Owners: Minority Interest	Pharmacy	584,796			20	5a2
Otis Elevator	1 Farm Springs, Farmington, CT 06032	○	⦿		Elevator Maintenace	15,076			22	6a
		○	⦿							
		○	⦿							
		○	⦿							
		○	⦿							
		○	⦿							
		○	⦿							
		○	⦿							
		○	⦿							

* 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).

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

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	22	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	83,668	83,668					
b. Heat	$	107,294	107,294					
c. Light & Power	$	118,715	118,715					
d. Water	$	49,371	49,371					
e. Equipment Lease (*Provide detail on page 22b*)	$	22,226	22,226					
f. Other (*itemize*)	$	169,997	169,997					
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	551,271	551,271					
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$							
b. Building & Building Improvements	$							
c. Non-Movable Equipment	$	1,304	1,304					
d. Movable Equipment	$	39,427	39,630	(203)	Disallowed			
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	40,731	40,934	(203)				
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$	6,620	6,620					
c. Leasehold Improvements	$	108,313	108,313					
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	114,933	114,933					
9. Rental payments on leased real property less real estate taxes included in item 10b	$	903,951	903,951					
10. Property Taxes								
a. Real estate taxes paid by owner	$							
b. Real estate taxes paid by lessor	$	281,311	281,311					
c. Personal property taxes	$	33,677	33,677					
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,374,603	1,374,806	(203)				

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

Schedule of Other Repairs and Maintenance

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Groundskeeping	$ 21,190					
Rubbish Removal	$ 66,884					
Snow Removal	$ 39,988					
Supplies	$ 41,935					
Total Other Repairs and Maintenance	$ 169,997	$ -	$ -	$ -	$ -	$ -

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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	9/30/2023	22b	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	○	⦿	Postal Equipment	11/01/13	automatic renewal	1,258	1,258
Leaf, PO Box 644066, Cincinnati, OH 45264	○	⦿	Copier	07/13/16	50 months	18,406	12,618
	○	⦿					
Wells Fargo	○	⦿	Copier	04/20/23	48 months	20,039	8,350
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					

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

Total *** 22,226

* 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.

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	72,073			54,642				
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	484,414			480,346	SL	Various	1,304	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								1,304

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	22	2,146,511			1,949,731	SL	Various	38,555	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative												
d. Standard Resident					19,956						1,075	
e. Specialized Resident												
Total Acquired during this report period					19,956						1,075	
D-3. Subtotal												39,630
E. ***Total Depreciation***												40,934

Schedule of Land Improvements Acquired during this report period

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

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

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

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

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

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
	See Schedule	Standard Resident	$ 19,956	Various	$ 1,075	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			$ 19,956		$ 1,075	*
Deletions:						
Total deletions for Movable Equipment			$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
	See Schedule	$ 27,052	Various	$ 837	
Total additions for Leasehold Improvement		$ 27,052		$ 837	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	24	37

Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. **Organization Expense**									
1. Bed License Purchase	12	1998	15 Years	1,140,000	741,000	SL	1		
2. Bed License Purchase	10	1993	None	199,767	56,593	None			
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1. Finance Fees	6	2007	5 Years	12,500	12,500		0		
2. Finance Fees	1	2021		19,146	11,851			6,620	
3.									
B-4. Subtotal									6,620
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	22	Various	3,938,291	3,179,589	SL	Variou	107,476	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				27,052				837	
C-4. Subtotal									108,313
D. ***Total Amortization***									114,933

* 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.

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CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page of
Litchfield Woods Health Care Center	2034C	9/30/2023	25 | 37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ No

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	07/06/00
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 ___________	11,932,851			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	26	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
12. Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage	$							
Name of Lender	Rate							
Address of Lender								
2. Second Mortgage	$							
Name of Lender	Rate							
Address of Lender								
3. Third Mortgage	$							
Name of Lender	Rate							
Address of Lender								
4. Fourth Mortgage	$							
Name of Lender	Rate							
Address of Lender								
B. CHEFA Loan Information								
1. Original Loan Amount	$							
2. Loan Origination Date								
3. Interest Rate %								
4. Term								
5. CHEFA Interest Expense								
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)	$							

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Cent	2034C	9/30/2023	27	37

Item				Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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			$	53,185	53,185					
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	53,185	53,185					
14. Insurance a. Insurance on Property (buildings only)			$	187,386	187,386					
b. Insurance on Automobiles			$							
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*)			$							
2. Fire and Extended Coverage			$							
3. Other (*Specify*)			$							
14d. ***Total Insurance Expenditures (14a + b + c)***			$	187,386	187,386					
15. ***Total All Expenditures (A-13 thru C-14)***			$	19,372,416	22,125,514	(2,753,098)				

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Litchfield Woods Health Care Center	2034C	9/30/2023	30 | 37

Item		Total	CCNH / RHNS	(Specify)	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	26,051,895	26,051,895		
b. Medicaid Room and Board Contractual Allowance **	$	(15,137,141)	(15,137,141)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	3,271,134	3,271,134		
b. Medicare Room and Board Contractual Allowance **	$	(171,766)	(171,766)		
4. a. Private-Pay Residents and Other	$	4,383,001	4,383,001		
b. Private-Pay Room and Board Contractual Allowance **	$	(841,755)	(841,755)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	230,220	230,220		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(230,220)	(230,220)		
c. Prescription Drugs - Non-Medicare	$	381,495	381,495		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(381,495)	(381,495)		
2. a. Medical Supplies - Medicare	$	16,650	16,650		
b. Medical Supplies - Medicare Contractual Allowance **	$	(2,380)	(2,380)		
c. Medical Supplies - Non-Medicare	$	1,439	1,439		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(1,367)	(1,367)		
3. a. Physical Therapy - Medicare	$	1,522,191	1,522,191		
b. Physical Therapy - Medicare Contractual Allowance **	$	(1,138,080)	(1,138,080)		
c. Physical Therapy - Non-Medicare	$	642,832	642,832		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(640,832)	(640,832)		
4. a. Speech Therapy - Medicare	$	158,840	158,840		
b. Speech Therapy - Medicare Contractual Allowance **	$	(134,742)	(134,742)		
c. Speech Therapy - Non-Medicare	$	137,025	137,025		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(137,025)	(137,025)		
5. a. Occupational Therapy - Medicare	$	1,228,615	1,228,615		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(948,681)	(948,681)		
c. Occupational Therapy - Non-Medicare	$	596,961	596,961		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(595,336)	(595,336)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	67,983	67,983		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	18,329,461	18,329,461		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	57,954	59,306	(1,352)	
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	462,384	462,384		
V. Total Other Revenue (1 thru 8)	$	520,338	521,690	(1,352)	
VI. Total All Revenue (III +V)	$	18,849,799	18,851,151	(1,352)	

* *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)	(Specify)
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	Telehealth Services	$ 6,951		
	Retroactives	$ 51,394		
	Mcr Retro	$ 9,638		
Total Other Resident Revenue		$ 67,983	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH / RHNS	(Specify)	(Specify)
	Interest on A/R		$ 1,352	$ (1,352)	Disallowed
	0				
	ERC Interest		$ 57,954		
Total Interest Income			$ 59,306	$ (1,352)	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	Bad Debt Recoveries	$ 462,384		
Total Other Revenue		$ 462,384	$ -	$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page of
Litchfield Woods Health Care Center	2034C	9/30/2023	31 | 37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 78,748
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,262,362
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 35,810
5. Prepaid Expenses				$ 255,957
a. Prepaid Insurance		175,854		
b. Prepaid Expenses		80,103		
c.				
d. See Schedule				
6. Interest Receivable				$ 648,148
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 3,281,025
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	72,073		$ 17,431
	Accum. Depreciation	54,642	Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	3,965,345		$ 677,441
	Accum. Depreciation	3,287,904	Net	
5. Non-Movable Equipment	*Historical Cost	484,414		$ 2,764
	Accum. Depreciation	481,650	Net	
6. Movable Equipment	*Historical Cost	2,165,566		$ 176,207
	Accum. Depreciation	1,989,359	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 900
Excluded Moveable Equipment		900		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 874,743

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			$ -

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

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Project Development	$ 477,331
Total Other Assets			$ 477,331

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Litchfield Woods Health Care Center	2034C	9/30/2023	32 | 37

Account				Amount
			Total Brought Forward:	$ 4,155,768
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$ 551,000
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 508,830
Deferred Finance Fees		1,417		
Deposits - Taxes		30,082		
See Schedule		477,331		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 1,059,830
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 5,215,598

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 4,309,073
2. Notes Payable (*itemize*)				$ (3,903,411)
Line of Credit		(3,903,411)		
See Schedule				
3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 432,567
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 401,018
7. Medicare Final Settlement Payable				$
8. Medicare Current Financing Payable				$
9. Mortgage Payable (*Current Portion*)				$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
11. Accrued Income Taxes*				$ 39,100
12. Other Current Liabilities (*itemize*)				$ 2,878,768
Acc'd Operating Expenses		(93,406)		
Acc'd CT Sales and Use Tax		72		
Due to Medicaid - Provider Tax		2,972,102		
See Schedule				
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 4,157,115

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Litchfield Woods Health Care Center	2034C	9/30/2023	34 | 37

Account	Amount
Total Brought Forward:	4,157,115
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ (2,156,882)

Name and Address of Lender	Amount	Loan Date
Related Party	(2,156,882)	

Account		Amount
4. Other Long-Term Liabilities (*itemize*)		$ 450,288
Note Payable	450,288	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ (1,706,594)
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 2,450,521

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

Name of Facility	License No.	Report for Year Ended	Page of
Litchfield Woods Health Care Center	2034C	9/30/2023	35 | 37

Account				Amount
A. **Reserves**				
1. Reserve for value of leased land				$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				$
3. Reserve for depreciation value of leased personal property (*Equity)*				$
4. Reserve for leasehold real properties on which fair rental value is based				$
5. Reserve for funds set aside as donor restricted				$
6. Total Reserves				$
B. **Net Worth**				
1. Owner's Capital				$
2. Capital Stock				$ 1,000
3. Paid-in Surplus				$
4. Treasury Stock				$
5. Cumulated Earnings				$ 6,053,672
6. Gain or Loss for Period	10/1/2022	thru	9/30/2023	$ (3,289,595)
7. Total Net Worth				$ 2,765,077
C. ***Total Reserves and Net Worth***				$ 2,765,077
D. ***Total Liabilities, Reserves, and Net Worth***				$ 5,215,598

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page of
Litchfield Woods Health Care Center	2034C	9/30/2023	36 | 37

Account			Amount	
A.	Balance at End of Prior Period as shown on Report of 09/30/2022		$	3,120,525
B.	Total Revenue (*From Statement of Revenue Page 30*)		$	18,851,151
C.	Total Expenditures (*From Statement of Expenditures Page 27*)		$	22,140,746
D.	Net Income or Deficit		$	(3,289,595)
E.	Balance		$	(169,070)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	PY ERC Adj	2,934,149		
	Roundng	(2)		
	2. Other (*itemize*)			
F-3.	Total Additions		$	2,934,147
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)		$	

Name and Address (*No., City, State, Zip*)	Title	Amount

2. Other Withdrawings *(Specify)*	$	

Purpose	Amount

	3. Total Deductions		$	
H.	***Balance at End of Period***	09/30/23	$	2,765,077

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2023	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☐ (Specify)	☐ (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	
Addres Address	Phone Number
135 South Rd, Farmington CT 06032	(860) 751 - 3900
Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Amanda Doncet	860-751-3900
Contact Email Address	
adoncet@athenahealthcare.com	