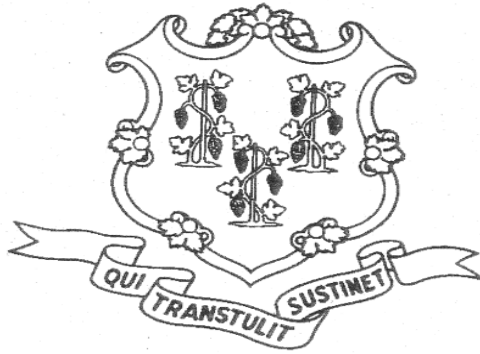


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Litchfield Woods Health Care Center	
Address (No. & Street, City, State, Zip Code) 225 Roberts Street Torrington, CT 06790	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

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

Medicaid Provider Numbers:	CCNH 2034C	RHNS 2034C	ICF-IID
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**For Department Use Only**

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

**General Information**

Name of Facility (as licensed) Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	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, 2020 and ending September 30, 2021, 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) James Murphy			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 10/1/2020	To 9/30/2021
Address of Facility 225 Roberts Street Torrington, CT 06790				
Report Prepared By Athena Health Care Associates, Inc		Phone Number (860) 751-3900	Date 2/15/2022	
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 9/30/2021	Page 2	of 37
Name of Facility (as shown on license) Litchfield Woods Health Care Center		Address (No. & Street, City, State, Zip ) 225 Roberts Street Torrington, CT 06790		
License Numbers:	CCNH 2034C	RHNS 2034C	(Specify)	Medicare Provider No. 07-5319
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)
Type of Ownership (Check appropriate box)				
<input type="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.				
<b>Administrator</b>				
Name of Administrator Timothy Flaherty		Nursing Home Administrator's License No.:	2115	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		



**General Information and Questionnaire  
 Corporate Owners**

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page 3A	of 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	





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

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page 4	of 37
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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 Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	<50%	Management Fees	Pg 17	777,134	302,459
Laurel Ridge Health Care	642 Danbury Road, Ridgefield, CT 06877	<input checked="" type="radio"/>	<input type="radio"/>	>98%	Bank Charges	Pg 16, Ln m13	4,754	4,754
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	1,363,418	1,363,418
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		
Procure LTC.	111 Executive Blvd., Farmingdale, NY 11735	<input type="radio"/>	<input checked="" type="radio"/>	>50%	Pharmacy	Pg. 20 5a2	740,619	740,649
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	1,174,074	11,740,174
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	<50%	Various: See attached			
		<input type="radio"/>	<input checked="" type="radio"/>					
		<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 9/30/2021	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item	Method of Allocation			
Dietary	Number of meals served to residents			
Laundry	Number of pounds processed			
Housekeeping	Number of square feet serviced			
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants			
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist ( <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? <input type="radio"/> Yes <input checked="" type="radio"/> No      If "No," explain fully why such allocation was not made.				
Patient Care Consults, Laundry, Housekeeping, Maintenance/Prop Costs, Admin - Alloc on Patient Days. Physical/Speech/Occupational Therapy - Allocated on % of Treatments. Administrative Nursing - Allocated on Direct Nursing Hours. Management Fees - Allocated based on methods above for each expense category				
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.				
Related company expenses were allocated on Methods above except as noted in 1 above.				
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)				
<input type="radio"/> Yes <input checked="" type="radio"/> No      If "No," explain fully why such allocation was not made.				
Not Applicable: No Non-Nursing Home Cost Centers				

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

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

Name of Facility Litchfield Woods Health Care Center		License No. 2034C		Report for Year Ended 9/30/2021			Page 6	of 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	1,278	
Leaf, PO Box 644066, Cincinnati, OH 45264	<input type="radio"/>	<input checked="" type="radio"/>	Copier	09/13/20	50 months	18,406	18,403	
Leaf, PO Box 644066, Cincinnati, OH 45264	<input type="radio"/>	<input checked="" type="radio"/>	Copier	10/10/20	41 months	715	715	
Leaf, PO Box 644066, Cincinnati, OH 45264	<input type="radio"/>	<input checked="" type="radio"/>	Copier	09/05/20	32 months	922	922	
	<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>							21,318	

\* 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 9/30/2021	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:  
 Accrual     Cash     Modified Cash

Is the accounting basis for this period the same as for the previous period?     Yes     No    If "No," explain.

**Independent Accounting Firm**

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 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	

Services Provided by This Firm (*describe fully*)

1 Loan Forgiveness Prep: Disallowed	\$ 9,270
2 LOC Audit	\$ 3,418
3 Medicare Cost Report	\$ 2,700
4	\$
	Charge for Services Provided
	\$ 15,388

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    Pg 15, Line 1d

**Legal Services Information**

Name of Legal Firm or Independent Attorney	Telephone Number
1 Goldman, Gruder & Woods, LLC/Donald W. Light/Treasurer CT/Senior Planning Services	203-899-8900 / 860-567-0451
2 MidCap Financial Services, LLC	301-760-7600
3 Office of the State Treasurer	860-702-3000
4 Pilicy & Ryan	860-274-0018
5 Marino Ellen Cormier / Coverys/ Murtha Cullina	

Address ( <i>No. &amp; Street, City, State, Zip Code</i> )
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

Services Provided by This Firm (*describe fully*)

1 A/R Collections:Disallowed	\$ 5,849
2 LOC Legal Fees:Disallowed	\$ 32
3 CT Corporation Annual Report:Disallowed	\$ 660
4 A/R Collections:Disallowed	\$ 115
5 A/R Collections:Disallowed	\$ 6,653
	Charge for Services Provided
	\$ 13,309

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    Pg 15, Line 1e

### Schedule of Resident Statistics

Name of Facility Litchfield Woods Health Care Center		License No. 2034C			Report for Year Ended 9/30/2021				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	128	114	14		128	114	14					
B. As of midnight of THIS report period	137	112	25						137	112	25	
3. Total Number of Days Care Provided During Period												
A. Medicare	7,999	4,222	3,777		6,172	3,572	2,600		1,827	650	1,177	
B. Medicaid (Conn.)	30,271	30,110	161		22,294	22,212	82		7,977	7,898	79	
C. Medicaid (other states)												
D. Private Pay	4,303	3,702	601		3,029	2,634	395		1,274	1,068	206	
E. State SSI for RCH												
F. Other (Specify) Managed Care	4,656	2,127	2,529		3,437	1,670	1,767		1,219	457	762	
G. Total Care Days During Period (3A thru F)	47,229	40,161	7,068		34,932	30,088	4,844		12,297	10,073	2,224	
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	40	38	2		26	24	2		14	14		
5. <b>Total Resident Days (3G + 4A + 4B)</b>	47,269	40,199	7,070		34,958	30,112	4,846		12,311	10,087	2,224	

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

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

Name of Facility Litchfield Woods Health Care Center			License No. 2034C			Report for Year Ended 9/30/2021			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH	RHNS	(Specify)	
				(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change													
2nd change													
3rd change													
4th change													
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)	R.C.H.	ICF-MR			
No. of Residents	23		84			10	1	19					
Per Diem Rate													
a. One bed rm.	526.89		282.89	213.07		652.00	627.00	367.74					
b. Two bed rms.	526.89		282.89	213.07		617.00	607.00	367.74					
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									7,366	7,366			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									2,433	2,425	8		
2. Restorative Treatments													
C. Other									26,830	26,830			
D. <b>Total Physical Therapy Treatments</b>									36,629	36,621	8		
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									350	350			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									126	126			
2. Restorative Treatments													
C. Other									3,126	3,126			
D. <b>Total Speech Therapy Treatments</b>									3,602	3,602			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									4,599	4,599			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									1,574	1,562	12		
2. Restorative Treatments													
C. Other									27,621	27,621			
D. <b>Total Occupational Therapy Treatments</b>									33,794	33,782	12		

### Report of Expenditures - Salaries & Wages

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page 10	of 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
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)						
	147,652	1,900	25,968	334		
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)						
	342,100	11,788	60,167	2,073		
5. Dietary Service						
a. Head Dietitian						
	62,750	1,453	11,036	255		
b. Food Service Supervisor						
	48,137	1,720	8,466	303		
c. Dietary Workers						
	416,548	25,539	73,260	4,492		
6. Housekeeping Service						
a. Head Housekeeper						
	9,999	296	1,758	52		
b. Other Housekeeping Workers						
	299,048	21,929	52,595	3,857		
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
	62,082	1,885	10,919	332		
b. Other Maintenance Workers						
	33,660	1,951	5,919	343		
8. Laundry Service						
a. Supervisor						
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						
	156,095	2,876	21,868	402		
b. RN						
1. Direct Care						
	686,950	14,731	15,043	358		
2. Administrative**						
	472,396	16,293	66,179	2,283		
c. LPN						
1. Direct Care						
	788,936	27,049	263,471	8,498		
2. Administrative**						
d. Aides and Attendants						
	1,567,838	72,971	239,725	11,700		
e. Physical Therapists						
	940,878	24,841	205	5		
f. Speech Therapists						
	119,877	2,377				
g. Occupational Therapists						
	609,968	15,852	216	5		
h. Recreation Workers						
	171,348	8,502	30,135	1,496		
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						
	260,063	7,871	45,739	1,384		
n. Marketing						
o. Other (Specify)						
See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>						
	7,196,325	261,824	932,669	38,172		

\* 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 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	9/30/2021				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)							
<b>Section I - Operators/Owners</b>										
Not Applicable										
<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>										
Not Applicable										

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

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

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Litchfield Woods Health Care Center				2034C		9/30/2021			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>										
Marisa Jones (10/1/2021 - 6/2/2021)	114,492	20,136		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	1,711	A2			
Timothy Flaherty (5/30/2021 - 9/30/2021)	33,160	5,832		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	680	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	License No.	Report for Year Ended	Page	of		
Litchfield Woods Health Care Center	2034C	9/30/2021	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian	442	6	78	1		
2. Dentist	14,777		2,599			
3. Pharmacist	15,071		2,651			
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	70,841	400	12,459	70		
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	1,386					
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	1,785	6				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	165,227	1,590				
2. Administrative***						
b. LPN						
1. Direct Care	735,857	8,492				
2. Administrative***						
c. Aides	1,360,977	21,899				
d. Other						
12. Other (Specify) See Attached Schedule						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>2,366,363</b>	<b>32,393</b>	<b>17,787</b>	<b>71</b>		

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

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

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

**Report of Expenditures**  
**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 9/30/2021	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"/>			
Procure LTC, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist	<input type="radio"/>	<input checked="" 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 type="radio"/>	<input checked="" 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"/>			
		<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"/>			
		<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	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2021	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 326,888	289,383	37,505	
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 80,179	70,980	9,199	
4. Social Security (F.I.C.A.)	\$ 586,882	519,547	67,335	
5. Health Insurance	\$ 1,226,701	1,085,957	140,744	
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 22,637	20,040	2,597	
8. Uniform Allowance	\$			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 309,586	220,028	89,558	
d. Accounting and Auditing	\$ 15,388	13,086	2,302	
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 13,309	11,318	1,991	
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 85,324	72,562	12,762	
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 94,250	80,153	14,097	
2. Cellular Phones	\$ 1,200	1,021	179	
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*	\$ 11,500	9,780	1,720	
2. Other ( <i>Specify</i> ) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 727,586	618,761	108,825	
<b>Subtotal</b>	\$ 3,501,430	3,012,616	488,814	

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

(Carry Subtotals forward to next page)



**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	9/30/2021		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>	3,501,430	3,012,616	488,814		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 6,780	5,766	1,014		
3. Gifts to Staff and Residents	\$ 19,598	16,667	2,931		
4. Employee Travel	\$ 2,994	2,546	448		
5. Education Expenses Related to Seminars and Conventions	\$ 17,515	14,895	2,620		
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> )	\$ 30,120	25,615	4,505		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 9,185	7,811	1,374		
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	\$ 3,460	2,942	518		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 21,550	18,327	3,223		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 1,667	1,418	249		
9. Subscriptions	\$ 2,248	1,912	336		
10. Contributions*** See Attached Schedule	\$ 500	425	75		
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$				
12. Administrative Management Services**	\$ 525,785	447,143	78,642		
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 129,439	110,080	19,359		
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 4,272,271	3,668,163	604,108		

\* 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	\$ 7,811	\$ 1,374	
<b>Total Other Advertising</b>	\$ 7,811	\$ 1,374	\$ -

## Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 16,894	\$ 2,971	
AHCA	\$ 1,361	\$ 239	
ALTCFM	\$ 72	\$ 13	
<b>Total Dues</b>	\$ 18,327	\$ 3,223	\$ -

## Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Miscellaneous	\$ 425	\$ 75	
<b>Total Contributions</b>	\$ 425	\$ 75	\$ -

## Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	\$ 17,172	\$ 3,020	
Payroll Processing Fees	\$ 18,368	\$ 3,230	
Employee Physicals	\$ 14,509	\$ 2,552	
	\$ -	\$ -	
	\$ -	\$ -	
Data Processing	\$ 58,016	\$ 10,203	
Licenses	\$ 2,015	\$ 354	
<b>Total Other Administrative and General</b>	\$ 110,080	\$ 19,359	\$ -



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

Name of Facility	License No.	Report for Year Ended	Page of
Litchfield Woods Health Care Center	2034C	9/30/2021	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	739,261	Contract Attached to a Prior Year	See Below
Allocation of the above	8,282,133,067	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12Pg 18, Li
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	37,873	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
Litchfield Woods Health Care Center		2034C	9/30/2021		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 425,799	362,112	63,687		
2.	Non-Food Supplies	\$ 65,094	55,358	9,736		
3.	Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Other (Specify) _____		\$				
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>		\$ 490,893	417,470	73,423		
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)	
F.	Resident Meals: Total no. of meals served per day:*	388	330	58		
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 9/30/2021		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. \$	24,564	20,890	3,674	
b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )		\$				
c. Other ( <i>Specify</i> ) Supplies		\$	20,334	17,293	3,041	
3D. <b>Total Laundry Expenditures</b> (3a + b + c)		\$	44,898	38,183	6,715	
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		License No.	Report for Year Ended		Page	of
Litchfield Woods Health Care Center		2034C	9/30/2021		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	56,514	48,061	8,453	
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> ) Temp Help		\$ 19,398	16,497	2,901	
<b>4D.</b>	<b>Total Housekeeping Expenditures (4a + b + c)</b>		\$ 75,912	64,558	11,354	
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from Procure LTC	\$	688,073	688,073		
b.	Medicine Cabinet Drugs	\$	101,053	85,939	15,114	
c.	Medical and Therapeutic Supplies	\$	415,368	353,241	62,127	
d.	Ambulance/Limousine***	\$	25,012	25,012		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	35,968	30,588	5,380	
f.	X-rays and Related Radiological Procedures***	\$	35,982	35,982		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h.	Laboratory***	\$	169,491	169,491		
i.	Recreation	\$	7,795	6,630	1,165	
j.	Direct Management Services*	\$	133,067	113,164	19,903	
k.	Indirect Management Services*	\$	118,282	100,591	17,691	
l.	Other (Specify)**** See Attached Schedule	\$	107,586	95,543	12,043	
<b>5M.</b>	<b>Total Resident Care Expenditures (5a - 5j)</b>		\$ 1,837,677	1,704,254	133,423	

\* 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**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
Medical Equip Rentals-Medicaid	\$ 10,573	\$ 1,860	
Physical Therapy Supplies	\$ 20,076	\$ 4	
OT Supplies	\$ 7,040	\$ 3	
Oxygen Concentrator Rentals	\$ 32,453	\$ 5,708	
Cable TV Fees	\$ 18,906	\$ 3,325	
Medical Equip Rentals-Other	\$ 6,495	\$ 1,143	
<b>Total Other Resident Care</b>	<b>\$ 95,543</b>	<b>\$ 12,043</b>	<b>\$ -</b>

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**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 9/30/2021			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	Line
ADP	100 Corporate Drive, Windsor, CT 06095	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	58,016	10,203		16	m13
USA Hauling	PO Box 808, East Windsor, CT 06088	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal	41,422	7,285		22	6f
S&T Landscaping	147 Cirlce Dr., Torrington, CT 06790	<input type="radio"/>	<input checked="" type="radio"/>		Snow Removal	25,409	4,469		22	6f
Diversified Sweeping & Landscaping, LLC	14 Milford St, Burlington, CT 06013	<input type="radio"/>	<input checked="" type="radio"/>		Groundskeeping	13,128	2,309		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"/>			6,053	1,065		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"/>							

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

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

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Litchfield Woods Health Care Center	2034C	9/30/2021			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 98,906	84,113	14,793			
b. Heat	\$ 116,433	99,018	17,415			
c. Light & Power	\$ 145,697	123,905	21,792			
d. Water	\$ 40,778	34,679	6,099			
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 21,318	18,129	3,189			
f. Other ( <i>itemize</i> )	\$ 146,644	124,710	21,934			
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 569,776</b>	<b>484,554</b>	<b>85,222</b>			
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$ 2,332	1,895	437			
d. Movable Equipment	\$ 75,622	61,443	14,179			
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 77,954</b>	<b>63,338</b>	<b>14,616</b>			
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 5,231	4,250	981			
c. Leasehold Improvements	\$ 126,647	102,901	23,746			
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 131,878</b>	<b>107,151</b>	<b>24,727</b>			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 744,375	604,805	139,570			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 270,791	220,018	50,773			
c. Personal property taxes	\$ 34,168	27,761	6,407			
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 1,259,166</b>	<b>1,023,073</b>	<b>236,093</b>			

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





### Depreciation Schedule

Name of Facility Litchfield Woods Health Care Center			License No. 2034C			Report for Year Ended 9/30/2021			Page 23	of 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			
<b>A. Land Improvements</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal													
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period			484,414		484,414	476,358	SL	Various	2,332				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal										2,332			
		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								
<b>D. Movable Equipment</b>													
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	2020	2,069,462		2,069,462	1,814,859	S/L	Various	72,140	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)				9	2021	49,590		14,618		S/L	Various	3,482	
D-3. Subtotal													75,622
<b>E. Total Depreciation</b>													77,954

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Land Improvement</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Land Improvement</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Building Improvement</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Building Improvement</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
	See attached	\$ 49,590		\$ 3,482
<b>Total additions for Movable Equipmen</b>		\$ 49,590		\$ 3,482 *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipmen</b>		\$ -		\$ - **

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
3/1/2021	Ductwork	\$ 21,031	10	\$ 1,052
<b>Total additions for Leasehold Improvemen</b>		\$ 21,031		\$ 1,052 *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvemen</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

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

CSP-24 Rev. 10/2006

**Amortization Schedule\***

Name of Facility			License No.		Report for Year Ended			Page	of
Litchfield Woods Health Care Center			2034C		9/30/2021			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							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<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	9	2021		19,146				5,231	
3.									
B-4. Subtotal									5,231
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period	9	2020	Various	5,336,929	3,794,424	SL	Var	125,595	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2021	Various	21,031		SL	Var	1,052	
C-4. Subtotal									126,647
<b>D. Total Amortization</b>									131,878

\* 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 9/30/2021	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> 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 <b>NOT</b> 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		
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)		HUD		
b. Date Mortgage Obtained		03/29/12		
c. Interest Rate for the Cost Year		3.22%		
d. Term of Mortgage (number of years)		35		
e. Amount of Principal Borrowed		14,712,000		
f. Principal balance outstanding as of				
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
g. Type of Financing (e.g., fixed, variable)		HUD		
h. Date of Refinancing		12/30/20		
i. New Interest Rate		295.00%		
j. Term of Mortgage (number of years)		30		
k. Amount of Principal Borrowed		12,652,300		
l. Principal Outstanding on Note Paid-Off		12,449,094		
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
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	9/30/2021			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. <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
Litchfield Woods Health Care Center	2034C	9/30/2021			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)	\$	8,386	6,814	1,572		
Vendor Interest						
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>	\$	8,386	6,814	1,572		
14. Insurance						
a. Insurance on Property (buildings only)	\$	165,151	134,185	30,966		
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. <b>Total Insurance Expenditures (14a + b + c)</b>	\$	165,151	134,185	30,966		
15. <b>Total All Expenditures (A-13 thru C-14)</b>	\$	19,237,274	17,103,942	2,133,332		

### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center				2034C	9/30/2021	28	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	\$ 610,184	609,968	216	
4.			Other - See attached Schedule	\$ 59,006	50,181	8,825	
<b>Page 13 - Professional Fees</b>							
5.	13	B8c	Resident Care Physicians **	\$ 1,386	1,386		
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	\$ 309,586	220,028	89,558	
10.	15	Bd	Accounting	\$ 9,270	7,884	1,386	
10a.			Legal	\$ 13,309	11,318	1,991	
11.			Telephone	\$			
12.	30	IV3	Cellular Telephone	\$ 120	102	18	
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	13	Gifts, flowers and coffee shops	\$ 19,598	16,667	2,931	
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&k	Unallowable Advertising *	\$ 9,185	7,811	1,374	
19.	15	1j&k	Income Tax / Corporate Business Tax	\$ 11,500	9,780	1,720	
20.			Fund Raising / Contributions	\$ 500	425	75	
21.			Unallowable Management Fees	\$ 313,285	266,427	46,858	
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 21,859	18,590	3,269	
<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.	18	2a1	Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 1,378,788	1,220,567	158,221	

\* 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	\$ 50,181	\$ 8,825	
<b>Total Other Salaries Adjustment</b>			\$ 50,181	\$ 8,825	\$ -

**Schedule of Fees Adjustments**

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

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	8n	Disallowed Dues	\$ 1,418	\$ 249	
16	M13	Bank Charges	\$ 17,172	\$ 3,020	
<b>Total Other A&amp;G Adjustments</b>			\$ 18,590	\$ 3,269	\$ -

**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	9/30/2021	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,378,788	1,220,567	158,221	
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a1&	Prescription Drugs	\$ 688,073	688,073		
28.	20	5d	Ambulance/Limousine	\$ 25,012	25,012		
29.	20	5f	X-rays, etc	\$ 35,982	35,982		
30.	20	5h	Laboratory	\$ 169,491	169,491		
31.	20	5c	Medical Supplies	\$ 16,000	13,607	2,393	
32.	20	5e2	Oxygen (non emergency)	\$ 35,968	30,588	5,380	
33.	20	5j	Occupational Therapy	\$ 7,043	7,040	3	
34.			Other - See Attached Schedule	\$ 46,912	42,978	3,934	
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 12,855	10,445	2,410	
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.	\$ 1,232	1,048	184	
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$ 75,948	64,588	11,360	
46.			Management Fees Indirect	\$ 85,441	72,662	12,779	
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>				\$ 2,578,745	2,382,081	196,664	

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

## Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental	\$ 6,496	\$ 1,142	
20	5b	Ebox	\$ 20,638	\$ 5	
20	5j	Radio and Television Revenue	\$ 15,844	\$ 2,787	
<b>Total Other Ancillary Costs</b>			\$ 42,978	\$ 3,934	\$ -

## Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7f	Movable Equip Depr Carryforward AJE	\$ 10,445	\$ 2,410	
<b>Total Excess Movable Equipment Depreciation</b>			\$ 10,445	\$ 2,410	\$ -

## Schedule of Other Property Adjustments

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

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

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

## F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Litchfield Woods Health Care Center	2034C	9/30/2021			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> )	\$ 18,729,413	18,618,935	110,478			
b. Medicaid Room and Board Contractual Allowance **	\$ (10,775,856)	(10,698,225)	(77,631)			
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 4,823,864	2,526,065	2,297,799			
b. Medicare Room and Board Contractual Allowance **	\$ (33,585)	(26,788)	(6,797)			
4. a. Private-Pay Residents and Other	\$ 4,627,357	3,259,522	1,367,835			
b. Private-Pay Room and Board Contractual Allowance **	\$ (619,845)	(536,958)	(82,887)			
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 362,014	362,014				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (362,014)	(362,014)				
c. Prescription Drugs - Non-Medicare	\$ 270,790	269,993	797			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (270,790)	(269,993)	(797)			
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$ 4,715	4,715				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (4,715)	(4,715)				
3. a. Physical Therapy - Medicare	\$ 1,543,087	1,542,947	140			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (1,251,452)	(1,251,376)	(76)			
c. Physical Therapy - Non-Medicare	\$ 693,721	691,221	2,500			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (692,571)	(690,071)	(2,500)			
4. a. Speech Therapy - Medicare	\$ 226,956	226,956				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (200,041)	(200,041)				
c. Speech Therapy - Non-Medicare	\$ 156,320	156,320				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (156,220)	(156,220)				
5. a. Occupational Therapy - Medicare	\$ 1,292,275	1,292,145	130			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (1,125,862)	(1,125,791)	(71)			
c. Occupational Therapy - Non-Medicare	\$ 661,656	659,406	2,250			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (660,806)	(658,556)	(2,250)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$					
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 131,399	131,399				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 17,369,810	13,760,890	3,608,920			
<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> )	\$ 115,165	97,940	17,225			
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 1,895,143	1,611,688	283,455			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 2,010,308	1,709,628	300,680			
<b>VI. Total All Revenue</b> (III +V)	\$ 19,380,118	15,470,518	3,909,600			

\* 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.



### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2021	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	42,081
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,403,850
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(361,711)
4. Inventories			\$	26,394
5. Prepaid Expenses			\$	255,791
a. Prepaid Insurance	201,093			
b. Prepaid Health Insurance	10,255			
c. Other Prepaid Expenses	44,443			
d. See Schedule				
6. Interest Receivable			\$	537,598
7. Medicare Final Settlement Receivable			\$	(412,165)
8. Other Current Assets ( <i>itemize</i> )			\$	587,185
A/R Non-Related Facilities	66			
A/R Related Party Facilities	587,119			
See Schedule				
<b>A-9. Total Current Assets (Lines A1 thru 8)</b>			<b>\$</b>	<b>3,079,023</b>
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 <u>5,357,962</u>		\$	1,436,889
	Accum. Depreciation <u>3,921,073</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>484,412</u>		\$	5,724
	Accum. Depreciation <u>478,688</u>	Net		
6. Movable Equipment	*Historical Cost <u>2,111,783</u>		\$	221,302
	Accum. Depreciation <u>1,890,481</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	7,268
Excluded Movable Equipment	7,268			
See Schedule				
<b>B-10. Total Fixed Assets (Lines B1 thru 9)</b>			<b>\$</b>	<b>1,671,183</b>

\* 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

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

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	
		A/R Related Party	\$ (6,026)
<b>Total Other Assets</b>			\$ (6,026)

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			\$ -

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>			\$ -



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

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	2034C	9/30/2021	32	37
Account			Amount	
Total Brought Forward:			\$	4,750,206
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>			\$	449,066
Deposits IRS		23,020		
Project Development		432,072		
See Schedule		<b>(6,026)</b>		
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	1,021,785
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	5,771,991

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

## Annual Report of Long-Term Care Facility

CSP-33 Rev. 6/95

## G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center		2034C	9/30/2021	33	37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	4,474,248
2. Notes Payable ( <i>itemize</i> )				\$	(6,301,567)
Due from Related Party					(646,322)
Line of Credit					(5,655,245)
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> )				\$	323,634
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	417,932
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> )				\$	1,757,748
Acc'd Operating Expenses		474,852			
Acc'd Expense - CT Sales Tax		187			
Due to Medicaid-Provider Tax		1,274,611			
Acc'd Health Insurance		8,098	See Schedule		
A-13. <b>Total Current Liabilities</b> (Lines A1 thru 12)				\$	711,095

\* 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 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			711,095	
<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> )				\$ 1,203,017
Name and Address of Lender	Amount	Loan Date		
Due to Related Party	1,203,017			
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 1,203,017
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 1,914,112

**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	9/30/2021	35	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			\$	3,171,861
6. Gain or Loss for Period	10/1/2020	thru 9/30/2021	\$	142,844
7. Total Net Worth			\$	3,315,705
<b>C. Total Reserves and Net Worth</b>			\$	3,315,705
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	5,229,817

### H. Changes in Total Net Worth

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2020			\$	2,185,219
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	19,380,118
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	19,237,274
D. Net Income or Deficit			\$	142,844
E. Balance			\$	2,328,063
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2020 Adjustment/Health Insurance	(94,597)			
2. Other <i>(itemize)</i>				
Deferred HHS Funds 2020	1,082,239			
F-3. Total Additions			\$	987,642
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>				
Name and Address <i>(No., City, State, Zip)</i>	Title	Amount		
2. Other Withdrawings <i>(Specify)</i>				
Purpose	Amount			
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	3,315,705

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

Name of Facility Litchfield Woods Health Care Center	License No. 2034C	Report for Year Ended 9/30/2021	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)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Athena Health Care Associates, Inc				
Address Address			Phone Number	
135 South Road Farmington, CT 06032			(860) 751-3900	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Sean Harrison			(860) 751-3900	
Contact Email Address				
sharrison@athenahealthcare.com				