State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Litchfield Woods Health Care Center
Address (No. & Street, City, State, Zip Code) 225 Roberts Street Torrington, CT 06790
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☑ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Report for Year Beginning	Report for Year Ending
10/1/2016	9/30/2017

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-MR
	2034C	2034C	

For Department Use Only

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

MYERS AND STAUFFER LLC
CERTIFIED PUBLIC ACCOUNTANTS

December 11, 2013

Mr. Michael E. Mosier
Chief Financial Officer
Athena Health Care Systems
135 South Road
Farmington, CT 06032

Subject: Alternative Annual Report Approval

Dear Mr. Mosier:

This letter is a follow-up to your verbal approval regarding your request for alternative annual report utilization. We have reviewed your request for approval of the Athena Health Care Systems version of the 2013 Annual Report for the State of Connecticut. Based on our review, your version of the annual report has been approved.

It is not necessary to request approval on an annual basis. This approval will remain in effect until modifications have been made to the Annual Report by the Department of Social Services. The provider community will be notified should such changes occur. At that time, you will be required to submit a new request for approval based on the modified annual report.

Should you have any questions, please feel free to contact me at (860) 687-0790.

Sincerely,

Brittany L. Hester

Brittany L. Hester, Administrative Assistant

CC: Claudette B. Pickens, CPA
CC: Chris Lavigne

7 Waterside Crossing, Ste 202 | Windsor, CT 06095
PH 860.687.0790 | PH 855.716.9377 | FX 860.687.0810
www.mslc.com

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General Information

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Litchfield Woods Health Care Center	**2034C/2034C**	**9/30/2017**	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 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 01, 2016** and ending **September 30, 2017**, 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 penalities 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
Denise Quarles	2-9-18		2-9-18
Printed Name (Administrator) **Denise Quarles**		Printed Name (Owner) **Lawrence Santilli**	
Subscribed and Sworn to before me: State of CT	Date 2-9-18	Signed (Notary Public) Tina Seaquist	Comm. Expires 6/30/21
Address of Notary Public		505 Pentfield Hill Rd Portland, CT 06480	

(Notary Seal)

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State of Connecticut
Department of Social Services
25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility **Litchfield Woods Health Care Center**	Period Covered:		From **10/1/2016**	To **9/30/2017**
Address of Facility **225 Roberts Street Torrington, CT 06790**				
Report Prepared By **Athena Health Care Associates, Inc**	Phone Number **(860) 751-3900**		Date **2/8/2018**	

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. ***Total Wages Paid***..... $				
7. Total salaries paid..... $				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report) $				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-489-5801	**09/30/17**	2	37

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

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

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☑ Rest Home with Nursing Supervision only (RHNS) ☐ (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.:
Denise Quarles	**001610**

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

Name	License No.:
Not Applicable	

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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
Not Applicable			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Highland View Manor, Inc.	**225 Roberts St, Torrington, CT 06790**	**CT**

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G. Santilli	**225 Roberts St, Torrington, CT 06790**	**President**	**449.86**
Michael E. Mosier	**225 Roberts St, Torrington, CT 06790**	**Treasurer**	
Debra M. Soucey	**225 Roberts St, Torrington, CT 06790**	**Secretary**	
Names of Stockholders Owning at Least 10% of Shares			
Lawrence G. Santilli	**225 Roberts St, Torrington, CT 06790**		**449.86**
John Nocera, Jr	**225 Roberts St, Torrington, CT 06790**		**125**
Conservators for Lawrence E. Santilli	**225 Roberts St, Torrington, CT 06790**		**108.64**

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

Not Applicable

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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	%**				
CT Health Center of Torrington LP	**34 Prospect St, Waterbury, CT 06702**	☐	☑		**Lease of Facility & Equipment**	**Pg 22, Ln 9, 10b; Pg 27 ln 14**	**$1,254,457**	**$1,254,457**
Laurel Ridge Health Care	**642 Danbury Road, Ridgefield, CT 06877**	☑	☐	**>98%**	**Bank Charges**	**Pg 16, Ln m13**	**$7,443**	**$7,443**
Athena Captive LLC	**135 South Road, Farmington, CT 06032**	☐	☑		**Workers Comp Captive**	**Pg 15, ln 1a**	**$716,924**	**$716,924**
Misc Facilities	**Various**	☑	☐	**>98%**	**Interfacility loans**	**Pg. 33, Ln A2**		
Athena Health Care	**135 South Road, Farmington, CT 06032**	☑	☐	**<50%**	**Management Fees**	**Pg 17**	**$862,037**	**$302,762**
Athena Health Care Insurance	**135 South Road, Farmington, CT 06032**	☐	☑		**Self Insured Employee Health & Dental Insurance**	**Pg. 15, ln 1a5**	**$1,793,612**	**$1,234,340**
Athena Health Care Assoc Inc. 401(K) Plan	**135 South Road, Farmington, CT 06032**	☑	☐		**Facility participates in group 401(k) plan**	**Pg 15 ln 1a7**		
Shady Knoll Health Care	**41 Skokorat Street, Seymour, CT 06483**	☑	☐	**>98%**	**SWAP Mortgage Interest Payments**	**Pg 22 Ln 9**	**$2,881**	**$2,881**
Procare LTC.	**111 Executive Blvd., Farmingdale, NY 11735**	☑	☐	**>50%**	**Pharmacy**	**Pg. 20 5a2**	**$466,799**	**$466,799**

* Use additional sheets if necessary.

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

Litchfield Woods Health Care Center
RELATED PARTIES QUESTIONNAIRE
PAGE 4

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No	%**				
Athena Health Care	135 South Road Farmington, CT 06032	X		<50%	Data Processing, Education, Help Wanted, Employee Relations Lobbying, Payroll, Insurance Maintenance, MDS Fill-In, Marketing	Pg. 16, M13, M3 Pg. 16 L3 Pg. 15 1 Pg. 13, B11a2, Pg. 22, 6a	$40,808	$40,808

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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.

Not Applicable:No Non-Nursing Home Cost Centers

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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
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	☐	☑	**Postal Equipment**	**11/01/13**	**automatic renewal**	**$1,340**	**$1,340**
Leaf, PO Box 644066, Cincinnati, OH 45264	☐	☑	**Copier**	**07/13/16**	**50 months**	**$18,406**	**$18,406**
Leaf, PO Box 644066, Cincinnati, OH 45264	☐	☑	**Copier**	**05/10/17**	**41 months**	**$715**	**$179**
HP Financial Services, 200 Connell Drive, Suite 5000, Berkeley Heights, NJ 07922	☐	☑	**PCC Equipment**	**08/21/13**	**60 months**	**$7,844**	**$1,900**
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Is a Mileage Log Book Maintained for All Leased Vehicles ? **Not Applicable - No Vehicles** ☐ Yes ☐ No **Total *** $21,825

* 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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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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The records of this facility for the period covered by this report were maintained on the following basis:

☑ Accrual ☐ Cash ☐ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 **Dworken, Hillman, LaMorte & Sterczala**	**Four Corporate Dr, Ste 488, Shelton, CT 06484**
2 **Marcum LLP**	**555 Long Wharf Dr, 12th Floor, New Haven, CT 06511**
3	
4	

Services Provided by This Firm (*describe fully*)

1	**Audit, Year End Financials & Tax Return**	**$ 9,500**
2	**Medicare Cost Report Preparation**	**$ 2,700**
3		$ -
4		$ -
	Charge for Services Provided	**$12,200**

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

☑ Yes ☐ No **Pg 15, Line1d**

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 **Law Office of Eric Brown**	**888-579-4222**
2 **Goldman, Gruder & Woods, LLC**	**203-899-8900**
3 **Murtha Cullina, LLP**	**860-240-6000**
4 **Schiff Hardin LLP**	**312-258-5500**
5 **various see attached**	**various see attached**

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

1 **12 Brick Walk Ln, Farmington, CT 06032**
2 **200 Connecticut Ave, Norwalk, CT 06854**
3 **185 Asylum Street, Hartford, CT 06103**
4 **6600 Sears Tower, Chicago, IL 60606**
5 **various see attached**

Services Provided by This Firm (*describe fully*)

1	**General matters Disallowed**	**$ 3,000**
2	**A/R Collections:Disallowed**	**$ 2,818**
3	**Sec of State filing & audit letter (allow) $703// Misc matters (disallow) $3,483**	**$ 4,186**
4	**Loan modification:Disallowed**	**$ 450**
5	**A/R Collections:Disallowed**	**$ 3,090**
	Charge for Services Provided	**$13,544**

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

☑ Yes ☐ No **Pg 15, Line1e**

Litchfield Woods Health Care Center
LEGAL SERVICES INFORMATION
PAGE 7

	Name of Legal Firm or Independent Attorney	Address	Telephone Number
5	Franklin G. Pilicy P.C.	PO Box 760 365 Main st, Watertown, CT 06795	860-274-0018
6	Treasurer State of CT		
7	Richter & Associates, Inc.	8948 Canyon Falls Blvd Suite 400, Twinsburg, OH 44087	866-593-7140
8	Senior Planning	100 Boulevard of the Americas, Lakewood, NJ 08701	855-775-2664

	Services Provided by This Firm	Charge for Service Provided
5	A/R collections disallowed	115
6	Conservator appliciation disallowed	225
7	General Matters disallowed	250
8	CT Medicaid application disallowed	2,500

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Schedule of Resident Statistics

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	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		160	130	30	
B. On last day of THIS report period.....	160	130	30		160	130	30		160	130	30	
2. Number of Residents												
A. As of midnight of PREVIOUS report period.....	150	121	29		156	126	30		150	121	29	
B. As of midnight of THIS report period.....	156	127	29		156	127	29		156	127	29	
3. Total Number of Days Care Provided During Period												
A. Medicare.....	9,707	3,031	6,676		7,505	2,493	5,012		2,202	538	1,664	
B. Medicaid (Conn.).....	40,807	39,866	941		30,239	29,592	647		10,568	10,274	294	
C. Medicaid (other states).....												
D. Private Pay.....	3,352	1,970	1,382		2,430	1,329	1,101		922	641	281	
E. State SSI for RCH.....												
F. Other (Specify) Managed Care	1,586	524	1,062		1,017	313	704		569	211	358	
G. Total Care Days During Period (3A thru F).....	55,452	45,391	10,061		41,191	33,727	7,464		14,261	11,664	2,597	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days.....	191	171	20		101	96	5		90	75	15	
B. Other Bed Reserve Days.....	59	25	34		59	25	34					
5. ***Total Resident Days*** **(3G + 4A + 4B).....**	55,702	45,587	10,115		41,351	33,848	7,503		14,351	11,739	2,612	

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

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 CCNH	Medicaid CCNH	Medicaid RHNS	Self-Pay CCNH	Self-Pay RHNS	Self-Pay (Specify)	Other State Assisted R.C.H.	Other State Assisted ICF-MR
No. of Residents	28	112	2	5	1	8		
Per Diem Rate								
a. One bed rm.	615.43	232.81	174.85	562.00	527.00	504.96		
b. Two bed rms.	615.43	232.81	174.85	537.00	517.00	504.96		
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,110	1,110		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	341	51	290	
2. Restorative Treatments				
C. Other	3,300	3,300		
D. ***Total Physical Therapy Treatments***	4,751	4,461	290	
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	155	155		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	10	10		
2. Restorative Treatments				
C. Other	457	457		
D. ***Total Speech Therapy Treatments***	622	622		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,309	1,309		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	247	26	221	
2. Restorative Treatments				
C. Other	3,156	3,156		
D. ***Total Occupational Therapy Treatments***	4,712	4,491	221	

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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/2034C**	**9/30/2017**	10	37

Are time records maintained by all individuals receiving compensation? ☑ Yes ☐ No

Item	Total Cost and Hours					
	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	125,975	1,696	27,952	376		
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	301,567	12,390	66,913	2,749		
5. Dietary Service						
a. Head Dietitian	53,057	1,317	11,772	292		
b. Food Service Supervisor	42,674	1,693	9,469	376		
c. Dietary Workers	351,033	25,786	77,888	5,721		
6. Housekeeping Service						
a. Head Housekeeper	46,519	1,794	10,322	398		
b. Other Housekeeping Workers	192,924	16,579	42,807	3,678		
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	52,470	1,869	11,642	415		
b. Other Maintenance Workers	30,934	1,733	6,864	385		
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	76,505	6,723	16,975	1,492		
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	141,049	2,947	37,398	781		
b. RN						
1. Direct Care	580,806	15,278	122,675	4,041		
2. Administrative**	469,413	15,292	124,464	4,054		
c. LPN						
1. Direct Care	957,403	36,208	352,254	12,645		
2. Administrative**						
d. Aides and Attendants	1,625,738	109,760	394,003	26,521		
e. Physical Therapists	863,870	23,443	56,159	1,524		
f. Speech Therapists	131,730	2,790				
g. Occupational Therapists	508,339	14,318	25,016	704		
h. Recreation Workers	134,806	7,234	29,911	1,605		
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	215,049	7,372	47,716	1,636		
n. Marketing						
o. Other (Specify)						
A-13. Total Salary Expenditures	6,901,861	306,222	1,472,200	69,393		

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Physician: Other Fees (Page 13)

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

Schedule of Other Fees (Page 13)

Service	$ CCNH	Hours CCNH	$ RHNS	Hours RHNS	$ (Specify)	Hours (Specify)
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/2034C**	**9/30/2017**	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)							
Section I - Operators/Owners										
Not Applicable										
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).										
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.

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CSP-12 Rev. 10/2005

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/2034C**	**9/30/2017**	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)							
Section III - Administrators* **										
Denise Quarles (10/1/2015 - 9/30/2016)	125,975	27,952		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,072	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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CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.		Report for Year Ended		Page	of
Litchfield Woods Health Care Center	**2034C/2034C**		**9/30/2017**		13	37
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	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	14,221	72	3,155	16		
3. Pharmacist	11,773	268	2,613	59		
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	75,621	234	16,779	52		
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	1,786					
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	2,160	3				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	94,176	979	4,935	62		
2. Administrative***	3,147	6	835	2		
b. LPN						
1. Direct Care	63,522	1,144	2,457	52		
2. Administrative***						
c. Aides	378	16				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	266,784	2,722	30,774	243		

* 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.

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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/2034C**	**9/30/2017**	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
SDX Swallowing Diagnostics, PO Box 484, Avon, CT 06001	Speech Therapy	☐	☑	
Nurse Network, 405 Park Ave., New York, NY 10022	Nurse Pool	☐	☑	
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
Access Therapies, PO Box 823461, Philadelphia, PA 19182-3461	Physical Therapist	☐	☑	
Athena Health Care Systems 135 South Road, Farmington, CT 06032	MDS Fill In	☑	☐	Common Owners
Litchfield Hills Orthopedic, 245 Alvord Park Rd, Torrington, CT 06790	Physician Services	☐	☑	
Healthdrive Dental Group, One Prestige Dr., Suite 107, Meriden, CT 06456	Dentist	☐	☑	
		☐	☐	
		☐	☐	
		☐	☐	
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* Use addtional sheets if necessary.
** Refer to Page 4 for definition of related.

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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/2034C**	**9/30/2017**	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation.....	$	716,924	590,885	126,039	
2. Disability Insurance.....	$				
3. Unemployment Insurance.....	$	116,091	95,682	20,409	
4. Social Security (F.I.C.A.).....	$	620,768	511,634	109,134	
5. Health Insurance.....	$	1,596,236	1,315,610	280,626	
6. Life Insurance (employees only) (not-owners and not-operators).....	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators).....	$	35,704	29,427	6,277	
8. Uniform Allowance.....	$				
9. Other (*Specify*)..... See Attached Schedule	$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*.....	$	64,565	64,565		
d. Accounting and Auditing.....	$	12,200	9,985	2,215	
e. Legal (*Services should be fully described on Page 7)*	$	13,544	11,085	2,459	
f. Insurance on Lives of Owners and Operators (*Specify*)*.....	$				
g. Office Supplies.....	$	85,333	69,837	15,496	
h. Telephone and Cellular Phones.....					
1. Telephone & Pagers.....	$	53,917	44,126	9,791	
2. Cellular Phones.....	$	1,560	1,277	283	
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	$	935,579	765,686	169,893	
Subtotal	$	4,252,421	3,509,799	742,622	

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

(Carry Subtotals forward to next page)

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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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/2034C**	**9/30/2017**	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		4,252,421	3,509,799	742,622	
l. Travel and Entertainment					
1. Resident Travel and Entertainment.....	$				
2. Holiday Parties for Staff.....	$	7,007	5,735	1,272	
3. Gifts to Staff and Residents.....	$	29,511	24,152	5,359	
4. Employee Travel.....	$	4,500	3,683	817	
5. Education Expenses Related to Seminars and Conventions	$	12,256	10,030	2,226	
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*).....	$	13,328	10,908	2,420	
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***..... See Attached Schedule	$	30,952	25,331	5,621	
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.....	$	10,328	8,453	1,875	
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	8,921	7,301	1,620	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	2,500	2,046	454	
9. Subscriptions.....	$	1,172	959	213	
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**.....	$	560,412	458,646	101,766	
13. Other (*Specify*) See Attached Schedule	$	117,368	96,056	21,312	
C-14 Total Administrative & General Expenditures	$	5,050,676	4,163,099	887,577	

* 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)
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	$ 25,331	$ 5,621	
Total Other Advertising	$ 25,331	$ 5,621	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM	$ 137	$ 33	
CAHCF	$ 6,938	$ 1,539	
Society for Human Resource Mgmt	$ 226	$ 48	
Total Dues	$ 7,301	$ 1,620	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Total Contributions	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	$ 12,320	$ 2,733	
Payroll Processing Fees	$ 18,556	$ 4,117	
Employee Physicals	$ 14,243	$ 3,160	
Data Processing	$ 42,281	$ 9,381	
Licenses	$ 2,084	$ 463	
CMS penalty Case No. 2017-01-LTC-225	$ 5,320	$ 1,180	
DPH penalty Citation No. 2017-33	$ 1,252	$ 278	
Total Other Administrative and General	$ 96,056	$ 21,312	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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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	$780,149	Contract Attached to a Prior Year	See Below
Allocation of the above	$514,898 $124,824 $140,427	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 18, Line 2C Pg 20, Line 5J
Athena Health Care Assoc., Inc. 135 South Road Farmington, CT 06032	$45,514	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.**

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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/2034C**	**9/30/2017**	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food.....	$	347,339	284,265	63,074	
2. Non-Food Supplies.....	$	51,590	42,222	9,368	
3. Other (*Specify*)_____	$	54	44	10	
Dishes = $54					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**.....	$	124,824	102,157	22,667	
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	523,807	428,688	95,119	

		Total	CCNH	RHNS	(Specify)
2F.	Dietary Questionnaire				
G.	Resident Meals: Total no. of meals served per day:*	456	373	83	

H.	Is cost of employee meals included in 2E?	☐ Yes	☑ No		
I.	Did you receive revenue from employees?	☐ Yes	☑ No	If yes, specify amount.	
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	☑ Yes	☐ No	If yes, specify cost. = $6563	
L.	Is any revenue collected from these people?	☑ Yes	☐ No	If yes, specify amount. = $36	
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			**Pg. 18, ln 2a1**	
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	☐ Yes	☑ No	If yes, specify cost.	
O.	Is any revenue collected from employees?	☐ Yes	☑ No	If yes, specify amount.	
P.	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.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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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/2034C**	**9/30/2017**	19 | 37

Item		Total	CCNH	RHNS	(Specify)
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. $	24,062	19,693	4,369	
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**.....	$				
d. Other (*Specify*) **Supplies = $7,838**	$	7,838	6,414	1,424	
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	31,900	26,107	5,793	

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	☐ Yes	☑ No	If yes, specify cost.
H.	Did you receive revenue from employees?	☐ Yes	☑ No	If yes, specify amount.
I.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)		
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	☐ Yes	☑ No	If yes, specify cost.
K.	Did you receive revenue from these people?	☐ Yes	☑ No	If yes, specify amount.
L.	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 3E.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

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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/2034C**	**9/30/2017**	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	44,187	36,163	8,024	
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*.....		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)....		$	44,187	36,163	8,024	
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy.....		$				
2. Purchased from **Procare LTC**		$	419,067	419,067		
b. Medicine Cabinet Drugs.....		$	112,525	92,091	20,434	
c. Medical and Therapeutic Supplies.....		$	261,351	213,893	47,458	
d. Ambulance/Limousine***.....		$	19,048	19,048		
e. Oxygen						
1. For Emergency Use.....		$				
2. Other***.....		$	65,737	53,800	11,937	
f. X-rays and Related Radiological Procedures***.....		$	90,548	90,548		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***.....		$	101,412	101,412		
i. Recreation.....		$	29,698	24,305	5,393	
j. Other (Specify)**** See Attached Schedule		$	295,734	249,511	46,223	
5K. ***Total Resident Care Expenditures*** (5a - 5j).....		$	1,395,120	1,263,675	131,445	

* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Management Fee Direct	$ 114,927	$ 25,500	
Medical Equip Rentals-Medicaid	$ 28,581	$ 6,342	
Physical Therapy Supplies	$ 50,873	$ 3,307	
OT Supplies	$ 6,709	$ 330	
Oxygen Concentrator Rentals	$ 8,993	$ 1,995	
Cable TV Fees	$ 12,375	$ 2,746	
Medical Equip Rentals-Other	$ 27,053	$ 6,003	
Total Other Resident Care	$ 249,511	$ 46,223	$ -

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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/2034C**	**9/30/2017**	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	☐	☑		Payroll Processing	18,592	4,081		16	m13
USA Hauling	PO Box 808, East Windsor, CT 06088	☐	☑		Rubbish Removal	30,707	6,747		22	6f
S&T Landscaping	147 Cirlce Dr., Torrington, CT 06790	☐	☑		Snow Removal	19,752	4,336		22	6f
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	☑	☐	Common Owners: Minority Interest	Pharmacy	466,994			20	5a2
		☐	☐							
		☐	☐							
		☐	☐							
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		☐	☐							
		☐	☐							

* 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/2034C**	**9/30/2017**			22 | 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	111,967	91,635	20,332	
b. Heat	$	159,655	130,663	28,992	
c. Light & Power	$	144,283	118,082	26,201	
d. Water	$	53,157	43,504	9,653	
e. Equipment Lease (*Provide detail on page 6*)	$	21,825	17,862	3,963	
f. Other (*itemize*)	$	139,224	113,942	25,282	
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	630,111	515,688	114,423	
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	13,003	10,565	2,438	
d. Movable Equipment	$	84,874	68,960	15,914	
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	97,877	79,525	18,352	
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	190,008	154,382	35,626	
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	190,008	154,382	35,626	
9. Rental payments on leased real property less real estate taxes included in item 10b	$	960,925	780,752	180,173	
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	197,585	160,538	37,047	
c. Personal property taxes	$	29,436	23,917	5,519	
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,475,831	1,199,114	276,717	

* 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**	**(Specify)**
Groundskeeping	$ 11,054	$ 2,453	
Rubbish Removal	$ 31,218	$ 6,927	
Snow Removal	$ 20,466	$ 4,541	
Supplies	$ 51,204	$ 11,361	
Total Other Repairs and Maintenance	$ 113,942	$ 25,282	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	**2034C/2034C**	**9/30/2017**	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								
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		484,414	448,268	SL	Various	13,003	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								13,003

	Is a mileage logbook maintained?		Date of Acquisition									
	Yes	No	Month	Year	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
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	2016	1,817,746		1,817,746	1,482,698	S/L	Various	73,698	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2017	113,134		113,134		S/L	Various	11,176	
D-3. Subtotal												84,874
E. ***Total Depreciation***												97,877

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	Cost	Useful Life	Depreciation	
Additions:					
Oct-16	fortinet 2yr Fortigate	$ 545	3	$ 91	
Oct-16	new lobby furniture	$ 5,048	15	$ 168	
Oct-16	wheelchair	$ 625	5	$ 63	
Oct-16	boost autoscrubber	$ 7,096	5	$ 710	
Oct-16	pcc conversion	$ 20,257	3	$ 3,376	
Dec-16	folding table	$ 509	10	$ 25	
Feb-17	4 tv's	$ 1,303	5	$ 130	
Feb-17	replace 5 tables	$ 1,154	15	$ 38	
Feb-17	4 wood doors	$ 1,175	15	$ 39	
Mar-17	architectural designs	$ 5,000	5	$ 500	
Mar-17	10 shelving units	$ 1,914	20	$ 48	
Mar-17	5 wood doors	$ 1,063	15	$ 35	
Mar-17	folding table	$ 532	10	$ 27	
Apr-17	4 tv's	$ 1,303	5	$ 130	
Apr-17	4 tables	$ 1,447	10	$ 72	
May-17	2 dryers	$ 2,199	10	$ 110	
Jun-17	149 tv's	$ 48,528	5	$ 4,853	
Aug-17	tables 7 chairs	$ 2,861	10	$ 143	
Sep-17	snow thrower	$ 1,779	5	$ 178	
Sep-17	2 dryers	$ 8,796	10	$ 440	
Total additions for Movable Equipment		$ 113,134		$ 11,176	*
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:					
Oct-16	replaced fire panel & front annuciator	$ 4,771	10	$ 239	
Oct-16	replaced burner tube, motor, temp sensor	$ 1,631	10	$ 82	
Oct-16	service secure care system	$ 1,127	5	$ 113	
Nov-16	replaced 1st floor annuciator	$ 778	5	$ 78	
Nov-16	dual jack callcord patient station	$ 1,218	5	$ 122	
Dec-16	repair wall in freezer	$ 681	5	$ 68	
Dec-16	washing machine repair	$ 617	5	$ 62	
Mar-17	replace motor and blower	$ 1,803	5	$ 180	
Jul-17	3 heat pumps	$ 3,693	10	$ 185	
Jul-17	repair leaks in heating loop	$ 2,739	5	$ 274	
Aug-17	new exhaust fan	$ 2,100	10	$ 105	
Aug-17	new relay module	$ 766	5	$ 77	
Aug-17	new pump, vent pipe, duct	$ 3,839	5	$ 384	
Sep-17	gland plate	$ 3,508	5	$ 351	
Sep-17	motor	$ 1,592	5	$ 159	
Total additions for Leasehold Improvements		$ 30,863		$ 2,479	*
Deletions:					
Total deletions for Leasehold Improvements		$ -		$ -	**

***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
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Item	Date of Acquisition Month	Date of Acquisition Year	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
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2. **Finance Fees-Refinance 2007**	6	2007	5 yrs	12,500	12,500	SL	0		
3. **Finance Fees-**	9	2012		16,429	3,929				
B-4. Subtotal									
C. **Leasehold Improvements and Other** (Specify)									
1. Acquired prior to this report period	9	2016	Various	5,228,937	3,180,463	SL	Var	187,529	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2017	Various	30,863		SL	Var	2,479	
C-4. Subtotal									190,008
D. ***Total Amortization***									190,008

* 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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Supplemental Page

Amortization Schedule - Detail of Leasehold Improvements & Other

Name of Facility			License No.		Report for Year Ended			Page	of
Litchfield Woods Health Care Center			**2034C/2034C**		**9/30/2017**			24A	37
C. **Leasehold Improvements** (Specify)									
1. Acquired prior to this report period	9	2016	Various	3,889,170	2,382,870	SL	Var	187,529	
2. Disposals (attach schedule)									
3. Acquired during this report period	9	2017	Various	30,863		SL	Var	2,479	
C-4. Subtotal									190,008
C. **Other** (Specify)									
1. Bed License Purchase	12	1997	15 yrs	1,140,000	741,000	SL	0		
2. Bed License Purchase	10	1993	None	199,767	56,593	None			
C-4. Subtotal									
Total Acquired prior to this report period	9	2016	Various	5,228,937	3,180,463	SL	Var	187,529	
Total Disposals									
Total Acquired during this report period	9	2017	Various	30,863		SL	Var	2,479	

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

Name of Facility	License No.	Report for Year Ended	Page	of
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11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	1988
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	05/11/88
5. Total Licensed Bed Capacity	160
6. Square Footage	
7. Acquisition Cost	
a. Land	29,039
b. Building	7,151,576

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	03/29/12			
c. Interest Rate for the Cost Year	3.22%			
d. Term of Mortgage (number of years)	35			
e. Amount of Principal Borrowed	8,985,315			
f. Principal balance outstanding as of 9/30/2017	7,445,742			
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.

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

Name of Facility	License No.	Report for Year Ended			Page of
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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. ***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 Center	**2034C/2034C**	**9/30/2017**	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*)..... $ **Vendor Interest = $13,161; Key Bank Note Interest & Fees = $18,233**	31,394	25,507	5,887	
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D).....$	31,394	25,507	5,887	
14. Insurance a. Insurance on Property (buildings only)..... $	101,253	82,268	18,985	
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)... $	101,253	82,268	18,985	
15. ***Total All Expenditures (A-13 thru C-14)*****.....** $	17,955,898	14,908,954	3,046,944	

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Litchfield Woods Health Care Center	**2034C/2034C**	**9/30/2017**	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs..... $				
2.			Salaries not related to Resident Care.... $				
3.	10	A12g	Occupational Therapy..... $	533,355	508,339	25,016	
4.	Var	Var	Other - See attached Schedule..... $	52,800	43,212	9,588	
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **..... $	1,786	1,786		
6.			Occupational Therapy..... $				
7.			Other - See attached Schedule..... $				
Pages 15 & 16 - Administrative and General							
8.	15	1a9	Discriminatory Benefits..... $				
9.	15	1c	Bad Debts..... $	64,565	64,565		
10.	15	1d&e	Accounting & Legal..... $	12,841	10,509	2,332	
11.	30	IV3	Telephone..... $				
12.	15	1h2	Cellular Telephone..... $	360	295	65	
13.			Life insurance premiums on the life of Owners, Partners, Operators..... $				
14.	16	l3	Gifts, flowers and coffee shops..... $	29,511	24,152	5,359	
15.	16	L5	Education expenditures to colleges or universities for tuition and related costs for owners and employees..... $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative.... $				
17.			Automobile Expense (e.g. personal use). $				
18.	16	m2&3	Unallowable Advertising *..... $	30,952	25,331	5,621	
19.			Income Tax / Corporate Business Tax... $				
20.			Fund Raising / Contributions..... $				
21.	16	m12	Unallowable Management Fees..... $	369,120	302,091	67,029	
	18	2c	$	89,484	73,234	16,250	
	20	5j	$	100,669	82,388	18,281	
22.	16	m6	Barber and Beauty..... $				
23.	Var	Var	Other - See attached Schedule..... $	25,583	20,938	4,645	
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents..... $	9,646	7,894	1,752	
Page 19 - Laundry Expenditures							
25.	19	3d	Laundry services to employees, guests and others who are not residents..... $				
Page 20 - Housekeeping Expenditures							
26.	20	4d	Housekeeping services to employees and others who are not residents..... $				
			Subtotal (Items 1 - 26) $	1,320,672	1,164,734	155,938	

* 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	43,212	9,588	
Total Other Salaries Adjustment			$ 43,212	$ 9,588	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	8n	Disallowed Dues	2,046	454	
16	M13	Bank Charges	12,320	2,733	
16	M13	CMS Penalty Case No. 2017-01-LTC 225	5,320	1,180	
16	M13	DPH Penalty Citation No. 2017-33	1,252	278	
Total Other A&G Adjustments			$ 20,938	$ 4,645	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Litchfield Woods Health Care Center	**2034C/2034C**	**9/30/2017**	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	1,320,672	1,164,734	155,938	
Page 20 - Resident Care Supplies***							
27.	20	5a1&2	Prescription Drugs..... $	419,067	419,067		
28.	20	5d	Ambulance/Limousine..... $	19,048	19,048		
29.	20	5f	X-rays, etc..... $	90,548	90,548		
30.	20	5h	Laboratory..... $	101,412	101,412		
31.	20	5c	Medical Supplies..... $	35,299	28,889	6,410	
32.	20	5e2	Oxygen (non emergency)..... $	65,737	53,800	11,937	
33.	20	5j	Occupational Therapy..... $	7,039	6,709	330	
34.	Var	Var	Other - See Attached Schedule..... $	48,989	42,013	6,976	
Page 22 - Maintenance and Property							
35.	Var	Var	Excess Movable Equipment Depreciation See Attached Schedule..... $	10,612	8,622	1,990	
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..... $				
Page 27 - Insurance							
40.			Mortgage Insurance..... $				
41.			Property Insurance..... $				
Other - Miscellaneous							
42.			Research or Experimental Activities..... $				
43.	20	5j	Radio and Television Revenue..... $	11,521	9,429	2,092	
44.			Vending Machine Revenue..... $				
45.			Purchase Discounts and Allowances..... $				
46.			Duplications of functions or services.... $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest..... $				
48.	30	IV5	Interest Income on Accounts Rec..... $	277	227	50	
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule..... $				
Not For Profit Providers Only							
50.	Var	Var	Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule..... $				
51.	***Total Amount of Decrease (Items 1 - 50)*** ..... $			2,130,221	1,944,498	185,723	

*** 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	27,053	6,003	
20	5b	Ebox	14,960	973	
Total Other Ancillary Costs			$ 42,013	$ 6,976	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7f	Movable Equip Depr Carryforward AJE	8,622	1,990	
Total Excess Movable Equipment Depreciation			8,622	1,990	

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Property Adjustments					

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Adjustments			$ -	$ -	$ -

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Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

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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/2034C**	**9/30/2017**	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	21,569,815	21,073,068	496,747	
b. Medicaid Room and Board Contractual Allowance **	$	(12,080,189)	(11,751,207)	(328,982)	
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents (*all inclusive*)	$	5,006,005	1,583,607	3,422,398	
b. Medicare Room and Board Contractual Allowance **	$	952,273	115,514	836,759	
4. a. Private-Pay Residents and Other	$	2,550,476	1,388,937	1,161,539	
b. Private-Pay Room and Board Contractual Allowance **	$	(147,250)	(36,531)	(110,719)	
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	652,479	652,479		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(652,479)	(652,479)		
c. Prescription Drugs - Non-Medicare	$	219,288	215,999	3,289	
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(219,288)	(215,999)	(3,289)	
2. a. Medical Supplies - Medicare	$	19,299	19,299		
b. Medical Supplies - Medicare Contractual Allowance **	$	(691)	(691)		
c. Medical Supplies - Non-Medicare	$	41,965	40,504	1,461	
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(41,718)	(40,504)	(1,214)	
3. a. Physical Therapy - Medicare	$	1,773,410	1,748,243	25,167	
b. Physical Therapy - Medicare Contractual Allowance **	$	(1,548,061)	(1,536,649)	(11,412)	
c. Physical Therapy - Non-Medicare	$	319,000	306,000	13,000	
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(319,000)	(306,000)	(13,000)	
4. a. Speech Therapy - Medicare	$	414,545	414,545		
b. Speech Therapy - Medicare Contractual Allowance **	$	(360,699)	(360,699)		
c. Speech Therapy - Non-Medicare	$	78,795	78,795		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(78,795)	(78,795)		
5. a. Occupational Therapy - Medicare	$	1,672,228	1,655,230	16,998	
b. Occupational Therapy - Medicare Contractual Allowance **	$	(1,474,142)	(1,466,434)	(7,708)	
c. Occupational Therapy - Non-Medicare	$	249,700	241,100	8,600	
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(249,700)	(241,100)	(8,600)	
6. a. Other (*Specify*) - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III *Total Resident Revenue* (Section I.thru Section II.)	$	18,347,266	12,846,232	5,501,034	
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)*	$	126,553	103,572	22,981	
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	30,512	24,971	5,541	
V. Total Other Revenue (1 thru 8)	$	157,065	128,543	28,522	
VI. Total All Revenue (III + V)	$	18,504,331	12,974,775	5,529,556	

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue		$ -	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
pg 31, L A2	Interest on A/R		$ 227	$ 50	
pg 34, Ln B3	Interest Income on Related Party Note		$ 103,345	$ 22,931	
Total Interest Income			$ 103,572	$ 22,981	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
NA	Bad Debt Recoveries	$ 24,971	$ 5,541	
Total Other Revenue		$ 24,971	$ 5,541	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	**2034C/2034C**	**9/30/2017**	31	37

Account			Amount
Assets			
A. Current Assets			
1. Cash (*on hand and in banks*)			$ 356,902
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			$ 1,851,025
3. Other Accounts Receivable (Excluding Owners or Related Parties)			$
4 Inventories			$ 23,074
5. Prepaid Expenses			$ 303,794
a. Prepaid Insurance		279,808	
b. Prepaid Health Insurance		9,297	
c. Other Prepaid Expenses		14,689	
d.			
6. Interest Receivable			$ 62,780
7. Medicare Final Settlement Receivable			$
8. Other Current Assets (*itemize*)			$ 227,412
A/R Non-Related Facilities		66	
A/R Related Party Facilities		227,346	
A-9. ***Total Current Assets*** (Lines A1 thru 8)			$ 2,824,987
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	3,920,036	$ 1,347,155
	Accum. Depreciation	(2,572,881) Net	
5. Non-Movable Equipment	*Historical Cost	484,412	$ 23,143
	Accum. Depreciation	(461,269) Net	
6. Movable Equipment	*Historical Cost	1,870,831	$ 303,260
	Accum. Depreciation	(1,567,571) Net	
7. Motor Vehicles	*Historical Cost		$
	Accum. Depreciation	Net	
8. Minor Equipment-Not Depreciable			$
9. Other Fixed Assets (*itemize*)			$ 60,049
Excluded Movable Equipment		60,049	
		-	
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)			$ 1,733,607

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

(Carry Total forward to next page)

Litchfield Woods
Other Prepaid Expenses #1580
9/30/17

Schiff Hardin legal fees	13,426.79
FMLA online license 12/1/17-12/1/20	1,262.50
	14,689.29

Litchfield Woods Moveable Equipment Carryforward Schedule

Cost Year		Amount	Amount	Amount	Amount	Amount	Amount		Totals
		2009 Cost Report-Heritage Furn	2009 Cost Report-Heritage Furn	2009 Cost Report-TV's	2010 Cost Report-Heritage Furn	2013 Cost Report-TV's	2016 Cost Report-TV's	2017 vCost report-TV's	
	Cost	$ 361	$ 219	$ 5,315	$ 160	$ 8,406	$ 7,470	$ 51,134	$ 277,740
	Term	5.00	10.00	5.00	5.00	5.00	5.00	5.00	
1997	Deprec								$ 128
1997	Book Value								$ 1,567
1998	Deprec								$ 223
1998	Book Value								$ 2,461
1999	Deprec								$ 14,806
1999	Book Value								$ 130,351
2000	Deprec								$ 15,315
2000	Book Value								$ 117,671
2001	Deprec								$ 15,315
2001	Book Value								$ 102,359
2002	Deprec								$ 15,295
2002	Book Value								$ 87,063
2003	Deprec								$ 17,121
2003	Book Value								$ 80,777
2004	Deprec								$ 17,759
2004	Book Value								$ 69,349
2005	Deprec								$ 17,536
2005	Book Value								$ 54,801
2006	Deprec								$ 17,538
2006	Book Value								$ 37,262
2007	Deprec								$ 18,995
2007	Book Value								$ 53,335
2008	Deprec								$ 18,986
2008	Book Value								$ 35,662
2009	Deprec	$ 36	$ 11	$ 532					$ 4,421
2009	Book Value	$ 325	$ 208	$ 4,783					$ 37,136
2010	Deprec	$ 72	$ 22	$ 1,063	$ 16				$ 4,900
2010	Book Value	$ 253	$ 186	$ 3,720	$ 144				$ 32,395
2011	Deprec	$ 72	$ 22	$ 1,063	$ 32				$ 4,916
2011	Book Value	$ 181	$ 164	$ 2,657	$ 112				$ 27,478
2012	Deprec	$ 72	$ 22	$ 1,063	$ 32				$ 4,553
2012	Book Value	$ 109	$ 142	$ 1,594	$ 80				$ 22,925
2013	Deprec	$ 72	$ 22	$ 1,063	$ 32	$ 841			$ 4,756
2013	Book Value	$ 37	$ 120	$ 531	$ 48	$ 7,565			$ 26,575
2014	Deprec	$ 37	$ 22	$ 531	$ 32	$ 1,681			$ 4,996
2014	Book Value	$ -	$ 98	$ -	$ 16	$ 5,884			$ 21,579
2015			$ 22		$ 16	$ 1,681			$ 4,396
2015			$ 76		$ -	$ 4,203			$ 17,183
2016			$ 22			$ 1,681	$ 747		$ 5,127
2016			$ 54			$ 2,522	$ 6,723		$ 19,526
2017			$ 22			$ 1,681	$ 1,494	$ 5,113	$ 10,612
2017			$ 32			$ 841	$ 5,229	$ 46,021	$ 60,049
2018			$ 22			$ 842	$ 1,494	$ 10,227	$ 14,460
2018			$ 10			$ 841	$ 3,735	$ 35,794	$ 46,431
2019			$ 10				$ 1,494	$ 10,227	$ 13,565
2019			$ -				$ 2,241	$ 25,567	$ 32,025
2020							$ 1,494	$ 10,227	$ 13,402
2020							$ 747	$ 15,340	$ 18,623
2021							$ 747	$ 10,227	$ 12,655
2021							$ -	$ 5,113	$ 5,968
2022								$ 5,113	$ 5,965
2022								$ -	$ 3

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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/2034C**	**9/30/2017**	32	37

Account			Amount
		Total Brought Forward:	$ 4,558,594
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*)			$ 2,500
Name and Address	Amount	Loan Date	
Deferred Finance fees	2,500		
7. Other Assets (*itemize*)			$ 37,504
Deposits IRS		33,500	
Project Development		10,030	
A/R related party		(6,026)	
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$ 591,004
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ 5,149,598

* 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/2034C**	**9/30/2017**	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 1,950,047
2. Notes Payable (*itemize*)				$ (1,595,000)
Due from Related Party			(1,665,000)	
Line of Credit			70,000	
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*)				$ 170,830
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 1,576
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*				$
12. Other Current Liabilities (*itemize*)				$ 585,768
Acc'd Operating Expenses			330,841	
Acc'd Expense - CT Sales Tax			502	
Due to Medicaid-Provider Tax			244,631	
Accd Health Insurance			9,794	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 1,113,221

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

(Carry Total forward to next page)

** Interest Bearing - Do Not Include in Return on Equity Calculation.

LITCHFIELD WOODS
ACCRUED EXPENSES
9/30/2017

VENDOR	AMOUNT	
HEALTH INS.	$	75,169.24
w/e 9/30 payroll	$	158,106.73
Management Fee	$	276.41
Rubbish Removal	$	2,952.37
Pharmacy	$	32,350.62
Oxygen	$	8,568.63
Keybank final payment	$	7,077.22
Xray	$	2,168.39
Telephone	$	60.00
Insurance	$	3,442.99
Payroll processing	$	388.98
Data processing	$	123.46
Employee Physicals	$	3,247.00
Maintenance supplies	$	52.00
Food	$	(19.75)
Lab	$	77.78
Medical supplies	$	77.66
Office Supplies	$	4,683.98
Patient Refunds	$	9,864.31
Torrington Water	$	5,946.01
Medical Director	$	7,700.00
Equipment rental	$	3,822.66
Bank fee	$	3,316.43
Nursing rebate	$	(5,765.58)
Ambulance	$	7,153.70
TOTAL	$	330,841.24

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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/2034C**	**9/30/2017**	34	37

Account	Amount
Total Brought Forward:	1,113,221
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 670,400

Name and Address of Lender	Amount	Loan Date
Due to Related Party	**670,400**	**None**

4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 670,400
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 1,783,621

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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/2034C**	**9/30/2017**	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		$ 2,816,544
6. Gain or Loss for Period	10/1/2016 thru 9/30/2017	$ 548,433
7. Total Net Worth		$ 3,365,977
C. ***Total Reserves and Net Worth***		$ 3,365,977
D. ***Total Liabilities, Reserves, and Net Worth***		$ 5,149,598

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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/2034C**	**9/30/2017**	36	37

Account			Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016		$ 2,879,709
B.	Total Revenue (*From Statement of Revenue Page 30*)		$ 18,504,331
C.	Total Expenditures (*From Statement of Expenditures Page 27*)		$ 17,955,898
D.	Net Income or Deficit		$ 548,433
E.	Balance		$ 3,428,142
F.	Additions		
	1. Additional Capital Contributed (*itemize*)		
	2016 Health Insurance	**24,074**	
	SWAP Adjustment	**2,761**	
		(100,000)	
	2016 wage enhancement	**11,000**	
	2. Other (*itemize*)		
F-3.	Total Additions		$ (62,165)
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*** 09/30/17		$ 3,365,977

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Litchfield Woods Health Care Center	**2034C/2034C**	**9/30/2017**	37	37

Check appropriate category

CCNH	RHNS	Other (*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 appplicable 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
[signature]	CFO	2/9/18

Printed Name of Preparer

Athena Health Care Associates, Inc

Address	Phone Number
135 South Road Farmington, CT 06032	(860) 751-3900

Cost report forms generated by Athena Health Care Associates, Inc as approved in letter dated 12/11/2013.

Name of Facility	License No.	Report for Year Ended	Page
Litchfield Woods Health Care Center	2198-C/2198-C	9/30/2017	ERROR REPORT

INCOME/EXPENSE STATEMENT
ERROR CHECK LIST ***RED CELLS INDICATE POSSIBLE ERROR***
***** REVIEW THE FOLLOWING FOR POSSIBLE ERRORS *****
RECONCILIATION OF COST REPORT PAGES TO INTERFACE:
(NUMBERS FROM INTERFACE MUST EQUAL COST REPORT PAGES)

		TOTAL	CCNH	RHNS	OTHER: (Specify)
PG 1A PER INTERFACE	N/A				
PG 1A PER COST REPORT	N/A				
DIFFERENCE					
PG 10 PER INTERFACE		8,374,061	6,901,861	1,472,200	
PG 10 PER COST REPORT		8,374,061	6,901,861	1,472,200	
DIFFERENCE					
PG 1A PER COST REPORT	N/A				
PG 10 PER COST REPORT	N/A				
DIFFERENCE					
PG 13 PER INTERFACE		297,558	266,784	30,774	
PG 13 PER COST REPORT		297,558	266,784	30,774	
DIFFERENCE					
PG 15 & 16 PER INTERFACE		5,050,676	4,163,099	887,577	
PG 15 & 16 PER COST REPORT		5,050,676	4,163,099	887,577	
DIFFERENCE					
PG 18 PER INTERFACE		523,807	428,688	95,119	
PG 18 PER COST REPORT		523,807	428,688	95,119	
DIFFERENCE					
PG 19 PER INTERFACE		31,900	26,107	5,793	
PG 19 PER COST REPORT		31,900	26,107	5,793	
DIFFERENCE					
PG 20 PER INTERFACE		1,439,307	1,299,838	139,469	
PG 20 PER COST REPORT		1,439,307	1,299,838	139,469	
DIFFERENCE					
PG 22 PER INTERFACE		2,105,942	1,714,802	391,140	
PG 22 PER COST REPORT		2,105,942	1,714,802	391,140	
DIFFERENCE					
PG 26 & 27 PER INTERFACE		132,647	107,775	24,872	
PG 26 & 27 PER COST REPORT		132,647	107,775	24,872	
DIFFERENCE					
TOTAL EXPENSES PER INTERFACE		17,955,898	14,908,954	3,046,944	
TOTAL EXPENSES PER COST REPORT		17,955,898	14,908,954	3,046,944	
DIFFERENCE					
TOTAL REVENUES PER INTERFACE		18,504,331	12,974,775	5,529,556	
TOTAL REVENUES PER COST REPORT		18,504,331	12,974,775	5,529,556	
DIFFERENCE					
EQUIPMENT LEASES PER PAGE 6		21,825			
EQUIPMENT LEASES PER PAGE 22,LINE 6e		21,825			
DIFFERENCE					

Name of Facility	License No.	Report for Year Ended	Page
Litchfield Woods Health Care Center	2198-C/2198-C	9/30/2017	ERROR REPORT

BALANCE SHEET ERROR CHECK LIST
***** REVIEW THE FOLLOWING FOR POSSIBLE ERRORS *****
RECONCILIATION OF COST REPORT PAGES TO INTERFACE:
(NUMBERS FROM INTERFACE MUST EQUAL COST REPORT PAGES)
RED CELLS INDICATE POSSIBLE ERROR

	TOTAL
PG 31 CURRENT ASSETS PER INTERFACE	2,824,987
PG 31 CURRENT ASSETS PER COST REPORT	2,824,987
DIFFERENCE	
PG 31 FIXED ASSETS PER INTERFACE	1,733,607
PG 31 FIXED ASSETS PER COST REPORT	1,733,607
DIFFERENCE	
PG 32 LEASED ASSETS PER INTERFACE	
PG 32 LEASED ASSETS PER COST REPORT	
DIFFERENCE	
PG 32 OTHER ASSETS PER INTERFACE	591,004
PG 32 OTHER ASSETS PER COST REPORT	591,004
DIFFERENCE	
PG 32 TOTAL ASSETS PER INTERFACE	5,149,598
PG 32 TOTAL ASSETS PER COST REPORT	5,149,598
DIFFERENCE	
PG 33 CURRENT LIABS PER INTERFACE	1,113,221
PG 33 CURRENT LIABS PER COST REPORT	1,113,221
DIFFERENCE	
PG 34 LONG TERM LIABS PER INTERFACE	670,400
PG 34 LONG TERM LIABS PER COST REPORT	670,400
DIFFERENCE	
PG 34 TOTAL LIABS PER INTERFACE	1,783,621
PG 34 TOTAL LIABS PER COST REPORT	1,783,621
DIFFERENCE	
PG 35 RESERVES PER INTERFACE	
PG 35 RESERVES PER COST REPORT	
DIFFERENCE	
PG 35 NET WORTH PER INTERFACE	3,365,977
PG 35 NET WORTH PER COST REPORT	3,365,977
DIFFERENCE	
PG 35 TOTAL LIAB & WORTH PER INTERFACE	5,149,598
PG 35 TOTAL LIAB & WORTH PER COST REPORT	5,149,598
DIFFERENCE	
PG 32 TOTAL ASSETS PER COST REPORT	5,149,598
PG 35 TOTAL LIAB & WORTH PER COST REPORT	5,149,598
DIFFERENCE	
NET INCOME PER BALANCE SHEET	548,433
NET INCOME PER INCOME STATEMENT	548,433
DIFFERENCE	
PG 35 NET WORTH PER COST REPORT	3,365,977
TOTAL NET WORTH PER PG 36	3,365,977
DIFFERENCE	

Name of Facility	License No.	Report for Year Ended	Page
Litchfield Woods Health Care Center	2198-C/2198-C	9/30/2017	ERROR REPORT

INFORMATIONAL PAGES
ERROR CHECK LIST

RED CELLS INDICATE POSSIBLE ERROR

***** REVIEW THE FOLLOWING FOR POSSIBLE ERRORS *****

RECONCILIATION OF COST REPORT PAGES TO INTERFACE INPUT:
(NUMBERS FROM INTERFACE MUST EQUAL COST REPORT PAGES)

	TOTAL	CCNH	RHNS	OTHER: (Specify)
PG 7 TOTAL LEGAL FEES DETAIL	13,544	NOT APPLICABLE		
PG 15, LINE 1e LEGAL FEES PER COST REPORT	13,544	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
PG 7 TOTAL ACCOUNTING FEES DETAIL	12,200	NOT APPLICABLE		
PG 15, LINE 1d ACCOUNTING FEES PER C/RPT	12,200	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
PG 11 OWNER'S SALARY PER COST REPORT	-			
PG 10 OWNER'S SALARY PER COST REPORT	-			
DIFFERENCE				
PG 12 ADMINISTRATOR'S SALARY PER C/RPT	153,927	125,975	27,952	
PG 10 ADMINISTRATOR'S SALARY PER C/RPT	153,927	125,975	27,952	
DIFFERENCE				
PG 12 ASST ADMIN'S SALARY PER COST REPORT	-			
PG 10 ASST ADMIN'S SALARY PER COST REPORT	-			
DIFFERENCE				
PT TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	4,751	NOT APPLICABLE		
HORIZONTAL TOTALS	4,751	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
ST TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	622	NOT APPLICABLE		
HORIZONTAL TOTALS	622	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
OT TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	4,712	NOT APPLICABLE		
HORIZONTAL TOTALS	4,712	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
NO. OF CERTIFIED BEDS RECONCILATION:				
NUMBER OF BEDS-BEG OF REPORT PERIOD(PG 8	160	130	30	
ADDITIONS/DELETIONS DURING PERIOD(PG 9)	-			
CALCULATED CERT. BEDS AT END OF PERIOD	160	130	30	
ACTUAL CERT. BEDS END OF PERIOD(PG 8)	160	130	30	
DIFFERENCE				

COMPARISON OF ACTUAL PATIENT DAYS TO MAXIMUM POSSIBLE PATIENT DAYS:

AVERAGE CERTIFIED BEDS	160.00000	130.00000	30.00000
MAXIMUM PATIENT DAYS	58,400	47,450	10,950
ACTUAL PATIENT DAYS	55,702	45,587	10,115
PERCENT OCCUPIED(NOT TO EXCEED 100%)	95.3801%	96.0738%	92.3744%

Name of Facility	License No.	Report for Year Ended	Page
Litchfield Woods Health Care Center	2198-C/2198-C	9/30/2017	ERROR REPORT

DEPRECIATION TIE-IN ERROR CHECK LIST

RED CELLS INDICATE POSSIBLE ERROR

*** REVIEW THE FOLLOWING FOR POSSIBLE ERRORS ***

RECONCILIATION OF COST REPORT BALANCE SHEET TO DEPRECIATION PAGES:
(BOOK VALUE NUMBERS FROM EACH COLUMN BELOW MUST EQUAL)

FIXED ASSET CATEGORY	BOOK VALUE PG 23 OR 24	BOOK VALUE PG 31 OR 32	Difference
LAND IMPROVEMENTS	-	-	-
BUILDING AND BUILDING IMPROVEMENTS	-	-	-
LEASEHOLD IMPROVEMENTS	1,347,155	1,347,155	-
NON-MOVEABLE EQUIPMENT	23,143	23,143	-
MOTOR VEHICLES	-	-	-
MOVEABLE EQUIPMNT(NET OF LEASED EQUIP)	363,308	303,260	60,048
LEASED MOVEABLE EQUIPMENT	-	-	-
ORGANIZATION/START-UP	-	-	-
OTHER-PG 24	542,174	N/A **	

FIXED ASSET CATEGORY	EXPENSE PG 23 OR 24	EXPENSE PG 22	Difference
LAND IMPROVEMENTS	-	-	-
BUILDING AND BUILDING IMPROVEMENTS	-	-	-
NON-MOVEABLE EQUIPMENT	13,003	13,003	-
MOVEABLE EQUIPMENT(NET OF LEASED EQUIP) & MOTOR VEHICLES	84,874	84,874	-
LEASED MOVEABLE EQUIPMENT	-	N/A *	
ORGANIZATION/START-UP	-	-	-
FINANCE FEES	-	-	-
LEASEHOLD IMPROVES	190,008	190,008	-
OTHER AMORTIZATION	-	-	-

* NOT APPLICABLE BECAUSE THERE IS NO CORRESPONDING LINE ON PAGE 22.
**NOT APPLICABLE BECAUSE THERE IS NO CORRESPONDING LINE ON PAGES 31 OR 32.

FIXED ASSET CATEGORY		PG 23a/24a	PG 23/24	Difference
COMPARE DETAIL ADDITIONS TO PAGES 23 & 24				
LAND IMPROVEMENTS	ADDITIONS	-	-	-
	DEPREC	-	-	-
BUILDING IMPROVEMENTS	ADDITIONS	-	-	-
	DEPREC	-	-	-
NON-MOVEABLE EQUIPMENT	ADDITIONS	-	-	-
	DEPREC	-	-	-
MOVE EQUIP(NET OF LEASED EQUIP&VEHICLES	ADDITIONS	113,134	113,134	-
	DEPREC	11,176	11,176	-
LEASEHOLD IMPROVES	ADDITIONS	30,863	30,863	-
	DEPREC	2,479	2,479	-