State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) Spectrum Healthcare Torrington		
Address (No. & Street, City, State, Zip Code) 225 Wyoming Ave 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 10/1/2015	Report for Year Ending 9/30/2016	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2333			07-5204

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	20024		

For Department Use Only

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

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General Information

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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 IMPRISIONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Spectrum Healthcare Torrington [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, 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
Robert Powers		2-3-17	Sean Murphy	2/3/17
Printed Name (Administrator) Robert Powers			Printed Name (Owner) Sean Murphy	
Subscribed and Sworn to before me:	State of Connecticut	Date 2-3-17	Signed (Notary Public) Andrea R Beetham	Comm. Expires 05/31/2021
Address of Notary Public 141 Vernon St West, Manchester, CT 06042				

(Notary Seal)

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Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Spectrum Healthcare Torrington	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 225 Wyoming Ave Torrington, CT 06790				
Report Prepared By Gennaro Evangelista	Phone Number 860-871-5454		Date 2/1/2017	

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
860 482-8563	9/30/2016	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Spectrum Healthcare Torrington	225 Wyoming Ave Torrington, CT 06790

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2333			07-5204

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.:
Robert Powers	2012

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Spectrum Healthcare Torrington LLC	27 Naek Road, Vernon, CT 06066	Torrington, CT

Name of Partners/Members	Business Address	Title	% Owned
Howard Dickstein	27 Naek Road, Vernon, CT 06066	President & CEO	65
Brian Dickstein	27 Naek Road, Vernon, CT 06066	VP, Operations	17.5
Sean Murphy	27 Naek Road, Vernon, CT 06066	CFO	17.5

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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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10% of Shares			

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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

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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	%**				
Spectrum Healthcare, LLC	27 Naek Rd., Vernon, CT 06066	○	⊙		Management Company	Page 16 Line 1m12		
Spectrum Healthcare, LLC	27 Naek Rd., Vernon, CT 06066	○	⊙		Admissions	Page 34 Line D7	27,789	27,789
Spectrum Healthcare Derby	211 Chatfield St Derby, CT 06418	○	⊙		Dietician	Page 34 Line 3	2,239	2,239
Spectrum Healthcare Manchester	565 Vernon St Manchester, CT 06040	○	⊙		Dietician	Page 34 Line 3	24,480	24,480
Spectrum Healthcare Derby	211 Chatfield St Derby, CT 06418	○	⊙		Social Services	Page 10 Line a12m	16,370	16,370
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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.

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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		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Accelerated Care Plus Corp 4850 Joule St Suite A-1 Reno, NV 89502	O	⊙	PT Equipment	06/01/12			9,021
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					

Is a Mileage Log Book Maintained for All Leased Vehicles ? O Yes O No **Total ***** 9,021

* 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

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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 Blum, Shapiro & Company	29 So. Main St., W Hartford, CT 06127
2 MidCap Funding	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Reviewed Financial Statements, Tax return preparation	$ 1,500
2	Due Diligence Exam	$ 14,858
3		$
4		$
		Charge for Services Provided $ 16,358

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

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Treasurer, State of CT	
2 Michalik, Bauer, Silva & Ciccarillo LLP	
3 Midcap Funding	
4 Donald W. Light	
5 American Arbitration Associates	

Address (*No. & Street, City, State, Zip Code*)
1 250 Constitution Plaza, Hartford, CT
2 35 Pearl St Suite 300 New Britain, CT
3
4 204 Goodhosue Road, Litchfield, CT
5 One Center Plaza, Third Floor, Boston, MA

Services Provided by This Firm (*describe fully*)

1	Conservator Fees	$ 1,375
2	Collections	$ 12,765
3	Loan Amendments	$ 1,889
4	Conservator Fees	$ 337
5	Arbitration	$ 275
		Charge for Services Provided $ 16,641

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

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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	126	126			126	126			126	126		
B. On last day of THIS report period	126	126			126	126			126	126		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	105	105			105	105			88	88		
B. As of midnight of THIS report period	99	99			88	88			99	99		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,297	4,297			3,347	3,347			950	950		
B. Medicaid (Conn.)	28,215	28,215			21,416	21,416			6,799	6,799		
C. Medicaid (other states)												
D. Private Pay	2,202	2,202			1,408	1,408			794	794		
E. State SSI for RCH												
F. Other (Specify)	1,241	1,241			992	992			249	249		
G. Total Care Days During Period (3A thru F)	35,955	35,955			27,163	27,163			8,792	8,792		
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												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	35,955	35,955			27,163	27,163			8,792	8,792		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ◉ No
If "YES", provide the following information:

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

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	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	11	74		14				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.		241.02		420-435				
c. Three or more bed rms.				380.00				

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	5,546	5,546		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	858	858		
2. Restorative Treatments				
C. Other	72	72		
D. ***Total Physical Therapy Treatments***	6,476	6,476		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	949	949		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	11	11		
2. Restorative Treatments				
C. Other	76	76		
D. ***Total Speech Therapy Treatments***	1,036	1,036		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	5,028	5,028		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	761	761		
2. Restorative Treatments				
C. Other	88	88		
D. ***Total Occupational Therapy Treatments***	5,877	5,877		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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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)	115,596	2,195				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	396,525	15,733				
5. Dietary Service						
a. Head Dietitian	41,569	1,248				
b. Food Service Supervisor	51,159	2,063				
c. Dietary Workers	413,387	21,019				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	51,235	2,118				
b. Other Maintenance Workers	33,646	2,286				
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	207,718	4,361				
b. RN						
1. Direct Care	417,571	10,173				
2. Administrative**	163,671	4,206				
c. LPN						
1. Direct Care	1,159,331	39,405				
2. Administrative**	56,835	1,782				
d. Aides and Attendants	1,412,694	79,512				
e. Physical Therapists	14,721	663				
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	124,043	6,191				
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	96,777	3,985				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	4,756,477	196,940				

* 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)

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

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Physician Services	$ 14,364	192				
Total	$ 14,364	192	$ -	-	$ -	-

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

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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										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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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* **										
Ilene Berkon-Cardello PTO Adjustment	-3,138					-64	A2			
Kimberly Coleman 10/01/2015-05/13/2016	89,039			Standard	Responsible for daily operations of facility.	1,705	A2			
Robert Powers 06/27/20116-09/30/2016	29,695			Standard	Responsible for daily operations of facility.	554	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016	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						
3. Pharmacist	28,157	376				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	417,999	6,968				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	107,900	1,440				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
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	115,878	1,544				
b. Other						
10. Occupational Therapist						
a. Resident Care	396,069	5,280				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	28,392	516				
2. Administrative***						
b. LPN						
1. Direct Care	5,523	122				
2. Administrative***						
c. Aides	10,450	418				
d. Other						
12. Other (Specify)						
See Attached Schedule	14,364	192				
B-13 Total Fees Paid in Lieu of Salaries	1,124,733	16,856				

* 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
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Prohealth Physicians, 52 Peck Rd., Torrington, CT 06790	Medical Director	○	◉	
The Nurse Network-5 Central Ave, E Hartford, CT 06150	Pool Nursing	○	◉	
Pharamerica, PO Box 409251, Atlanta, GA 30384	Pharmacy Consultant	○	◉	
Amor C. Lomibao, MD., 6 Frey Rd., Canton, CT 06019	Medical Director	○	◉	
Steven Yoelson, 161 Mansfield Rd., Harwinton, CT 06791	Medical Staff	○	◉	
Accuscript Consulting Services-276 Cedar Bridge Ave., Lakewild, NJ 08701	Pharmacy Consultant	○	◉	
Select Rehabilitation, Inc., 550 Frontage Rd., Suite 2415 Northfield, IL 60093	Contract Therapy	○	◉	
Dr. Joseph Brenes-The Hospitalist Company-PO Box 844929, Los Angles, CA 90084-4929	Medical Director	○	◉	
Dr. Richard Krinsky-1215 New Litchfield St., Torrington, CT 06790	Pulmonary Consultant	○	◉	
Favorite Healthcare Staffing-PO Box 803356, Kansas City, MI 64180-3356	Pool Nursing	○	◉	
Ready Nurse-2602 Highlands Blvd. N. Palm Harbor, FL 34684	Pool Nursing	○	◉	
HealthDrive Dental Group-888 Worchester St., Wellesley. MA 02482-3744	Dental Consultant	○	◉	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

* Use additional 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
Spectrum Healthcare Torrington	2333	9/30/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	133,066	133,066		
2. Disability Insurance	$				
3. Unemployment Insurance	$	103,525	103,525		
4. Social Security (F.I.C.A.)	$	357,858	357,858		
5. Health Insurance	$	741,003	741,003		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	243,715	243,715		
8. Uniform Allowance	$	21,761	21,761		
9. Other (*Specify*) See Attached Schedule	$	30,459	30,459		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	360,000	360,000		
d. Accounting and Auditing	$	16,358	16,358		
e. Legal (*Services should be fully described on Page 7)*	$	16,641	16,641		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	17,494	17,494		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	26,948	26,948		
2. Cellular Phones	$				
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	$	645,818	645,818		
Subtotal	$	2,714,647	2,714,647		

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

(Carry Subtotals forward to next page)

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

Spectrum Healthcare Torrington
9/30/2016

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Union Training Fund	$ 30,459		
Total	$ 30,459	$ -	$ -

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,714,647	2,714,647		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	$	4,795	4,795		
2. Holiday Parties for Staff	$	852	852		
3. Gifts to Staff and Residents	$	470	470		
4. Employee Travel	$	2,791	2,791		
5. Education Expenses Related to Seminars and Conventions	$	1,728	1,728		
6. Automobile Expense (*not purchase or depreciation*)	$	1,000	1,000		
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	9,546	9,546		
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	$	10,223	10,223		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	9,721	9,721		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	47,076	47,076		
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	46,018	46,018		
C-14 Total Administrative & General Expenditures	$	2,848,868	2,848,868		

* 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)
Advertising-Promotional	$ 1,250		
Marketing Expenses	$ 8,296		
Total Other Advertising	$ 9,546	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Dues	$ 9,721		
Total Dues	$ 9,721	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Licenses	$ 1,960		
Employee Background Check	$ 3,690		
Bank Fees	$ 39,496		
Licenses	$ 450		
Miscellaneous	$ 60		
Equipment Rental	$ 362		
Total Other Administrative and General	$ 46,018	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Spectrum Healthcare Torrington	License No. 2333	Report for Year Ended 9/30/2016	Page 17 | of 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 #
Spectrum Health Care PO Box 2417 Vernon, CT 06066		Home Office, Human Resource, Treasury Management and Financial Oversight	Page 16 line 1m12

*** 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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CSP-18 Rev. 9/2002

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
Spectrum Healthcare Torrington	2333	9/30/2016	18 of 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	265,127	265,127		
2. Non-Food Supplies	$	30,006	30,006		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____	$	1,050	1,050		
Equipment Rental					
Small Equipment Purchase					
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	296,183	296,183		

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

H. Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I. Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
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.
L. Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)			
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 amt.
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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CSP-19 Rev. 9/2002

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
Spectrum Healthcare Torrington	2333	9/30/2016	19 | 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. $	57	57		
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. $	8,940	8,940		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	238,110	238,110		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	247,106	247,106		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	O Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	O Yes	⊙ No	If yes, specify amt.
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?	O Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	O Yes	⊙ No	If yes, specify amt.
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
Spectrum Healthcare Torrington	2333	9/30/2016	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.	$	664	664		
b. Purchased Services (*by contract other than through Management Services*) (*Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	253,229	253,229		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	253,893	253,893		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	291,939	291,939		
b. Medicine Cabinet Drugs		$	15,990	15,990		
c. Medical and Therapeutic Supplies		$	171,129	171,129		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	79,694	79,694		
f. X-rays and Related Radiological Procedures***		$	38,231	38,231		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	28,386	28,386		
i. Recreation		$	15,012	15,012		
j. Other (Specify)**** See Attached Schedule		$	245,556	245,556		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	885,937	885,937		

* 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)
IV Therapy	$ 86,864		
Outside Medical Services	$ 15,626		
Respiratory Therapy	$ 143,066		
Total Other Resident Care	$ 245,556	$ -	$ -

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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
Spectrum Healthcare Torrington	2333	9/30/2016	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		○	⊙		Payroll Processing	26,320			16	m11
MDI Achieve		○	⊙		Data Processing	18,853			16	m11
Tool 4 Data		○	⊙		Computer Maintenance	25,947			22	6f
Lafferty Enterprises		○	⊙		Ground Maintenance	16,750			22	6f
Healthcare Services Group		○	⊙		Laundry Services	238,110			19	3b
Healthcare Services Group		○	⊙		Housekeeping Services	253,229			20	4b
USA Hauling & Recycling		○	⊙		Trash Removal	12,785			22	6f
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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
Spectrum Healthcare Torrington	2333	9/30/2016	22	37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	25,637	25,637		
b. Heat	$	69,183	69,183		
c. Light & Power	$	135,592	135,592		
d. Water	$	42,086	42,086		
e. Equipment Lease (*Provide detail on page 6*)	$	9,021	9,021		
f. Other (*itemize*)	$	85,588	85,588		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	367,108	367,108		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	128,824	128,824		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	53,763	53,763		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	182,587	182,587		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	7,665	7,665		
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	7,665	7,665		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	483,174	483,174		
10. Property Taxes					
a. Real estate taxes paid by owner	$	100,652	100,652		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	11,881	11,881		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	785,959	785,959		

* 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)
Trash Removal	$ 12,785		
Hazardous Waste Removal	$ 5,629		
Service Contracts	$ 19,569		
Grounds Maintenance	$ 16,750		
Grounds Landscaping	$ 2,763		
Purchase Services	$ 1,872		
Software Maintenance	$ 272		
Computer Maintenance	$ 25,947		
Total Other Repairs and Maintenance	$ 85,588	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016	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	1,259,340		1,259,340	582,040	SL	Var	128,824	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								128,824
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					611,181		611,181	344,779			53,333	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					7,846		7,846				430	
D-3. Subtotal												53,763
E. ***Total Depreciation***												182,587

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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:					
10/27/2015	Computer	$ 1,031	5	$ 206	
04/26/2016	Slicer	$ 1,510	5	$ 151	
09/14/2016	Computers	$ 3,391	5	$ 57	
09/19/2016	2 Pressure Mattresses	$ 1,914	10	$ 16	
Total additions for Movable Equipment		$ 7,846		$ 430	*
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:					
Total additions for Leasehold Improvement		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016	24	37

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. Deferred Finance Line of Credit	7	2013	3	30,666	23,001	SL		7,665	
2.									
3.									
B-4. Subtotal									7,665
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									7,665

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

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	126
6. Square Footage	30,961
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of ____				
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
Care Capital Properties	225 Wyoming Ave Torrington	12/05/10	7	483,174

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
Spectrum Healthcare Torrington	2333	9/30/2016	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. ***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
Spectrum Healthcare Torrington	2333	9/30/2016	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*) $ Working Capital and Vendor Interest	344,862	344,862		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	344,862	344,862		
14. Insurance				
a. Insurance on Property (buildings only) $	74,868	74,868		
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)*** $	74,868	74,868		
15. ***Total All Expenditures (A-13 thru C-14)*** $	11,985,992	11,985,992		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Spectrum Healthcare Torrington	2333	9/30/2016	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.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	360,000	360,000		
10.			Accounting & Legal $				
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
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	m3	Unallowable Advertising * $	9,546	9,546		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	60	60		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	369,606	369,606		

* 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)
Total Other Salaries Adjustment			$ -	$ -	$ -

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	m13	Miscellaneous	$ 60		
Total Other A&G Adjustments			$ 60	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016	29	37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	369,606	369,606		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $				
28.			Ambulance/Limousine $				
29.			X-rays, etc $				
30.			Laboratory $				
31.			Medical Supplies $				
32.			Oxygen (non emergency) $				
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $				
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
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.			Radio and Television Revenue $				
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.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $	89,033	89,033		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			***Total Amount of Decrease (Items 1 - 50)*** $	458,639	458,639		

*** 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.

Spectrum Healthcare Torrington
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Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

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)
27	12d	Vendor Interest	$ 89,033		
Total Other Adjustments			$ 89,033	$ -	$ -

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
Spectrum Healthcare Torrington	2333	9/30/2016	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	11,297,303	11,297,303		
b. Medicaid Room and Board Contractual Allowance **	$	(4,461,470)	(4,461,470)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,815,620	1,815,620		
b. Medicare Room and Board Contractual Allowance **	$	647,929	647,929		
4. a. Private-Pay Residents and Other	$	1,351,911	1,351,911		
b. Private-Pay Room and Board Contractual Allowance **	$	(6,531)	(6,531)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	296,261	296,261		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(296,261)	(296,261)		
c. Prescription Drugs - Non-Medicare	$	133,099	133,099		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(133,099)	(133,099)		
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	867,314	867,314		
b. Physical Therapy - Medicare Contractual Allowance **	$	(695,085)	(695,085)		
c. Physical Therapy - Non-Medicare	$	204,896	204,896		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(204,896)	(204,896)		
4. a. Speech Therapy - Medicare	$	211,094	211,094		
b. Speech Therapy - Medicare Contractual Allowance **	$	(131,725)	(131,725)		
c. Speech Therapy - Non-Medicare	$	39,426	39,426		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(39,426)	(39,426)		
5. a. Occupational Therapy - Medicare	$	817,350	817,350		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(660,250)	(660,250)		
c. Occupational Therapy - Non-Medicare	$	182,931	182,931		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(182,931)	(182,931)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	11,053,458	11,053,458		
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)*	$	47	47		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	46	46		
V. Total Other Revenue (1 thru 8)	$	93	93		
VI. Total All Revenue (III +V)	$	11,053,551	11,053,551		

* *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

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
			$ 47		
Total Interest Income			$ 47	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Medical Records	$ 46		
Total Other Revenue		$ 46	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ (139,274)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,819,221
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 4,685
4 Inventories				$
5. Prepaid Expenses				$ 366,793
a. Prepaid-Expenses			7,600	
b. Prepaid - Insurance			359,193	
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 36,580
Deposits - Other			36,580	
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 3,088,004
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	1,259,340		$ 548,476
	Accum. Depreciation	710,864	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	619,027		$ 220,485
	Accum. Depreciation	398,542	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 768,961

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 3,856,965
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	30,666		
	Accum. Depreciation	30,666	Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$ 3,009,092
Name and Address	Amount	Loan Date		
Winsted/Spectrum	3,009,092			
7. Other Assets (*itemize*)				$
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 3,009,092
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 6,866,058

* 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
Spectrum Healthcare Torrington	2333	9/30/2016	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 1,218,667
2. Notes Payable (*itemize*)					$
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*)					$ 411,570
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 6,440
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*)					$ 1,121,810
Accrued Property Taxes	242,766	Accrue State Provider Ta	202,023		
Accrued Interest	17,524	Property Liability Insurar	197,197		
Accrued Other Expenses	291,471	Accrued Rent	193,830		
Resident Refunds	(27,465)	Prepaid-Other Expenses	4,465		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 2,758,487

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016	34	37

Account	Amount
Total Brought Forward:	2,758,487
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*)	$ 2,877,036

Name and Address of Lender	Amount	Loan Date
Hartford	2,827,303	
Derby/Manchester/Ansonia	49,733	

4. Other Long-Term Liabilities (*itemize*)		$ 2,212,508
Working Capital Line of Credit	2,225,387	
Due Prior Owner	(12,879)	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 5,089,545
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 7,848,032

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

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016	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					$	1,205,140
3. Reserve for depreciation value of leased personal property *(Equity)*					$	207,904
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					$	1,413,044
B. **Net Worth**						
1. Owner's Capital					$	
2. Capital Stock					$	
3. Paid-in Surplus					$	
4. Treasury Stock					$	
5. Cumulated Earnings					$	(1,462,577)
6. Gain or Loss for Period	10/1/2015	thru	9/30/2016		$	(932,441)
7. Total Net Worth					$	(2,395,018)
C. ***Total Reserves and Net Worth***					$	(981,974)
D. ***Total Liabilities, Reserves, and Net Worth***					$	6,866,058

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ (1,477,123)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 11,053,551
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 11,985,992
D.	Net Income or Deficit			$ (932,441)
E.	Balance			$ (2,409,564)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
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*** 09/30/16			$ (2,409,564)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Spectrum Healthcare Torrington	2333	9/30/2016	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Gennaro Evangelista	Accounting Manager	2/1/17

Printed Name of Preparer	
Gennaro Evangelista	
Addres Address	Phone Number
27 Naek Rd., Vernon, CT 06066	860-871-5454