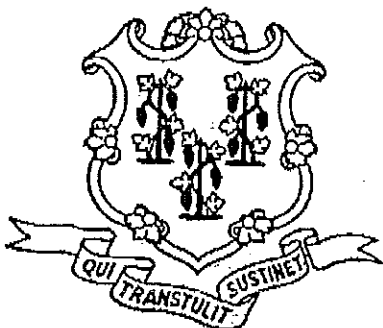


State of Connecticut



15-75

(4)

[Signature]

Annual Report of Long-Term Care Facility Cost Year 2015

RECEIVED

APR 17 2016

DEPT. OF SOCIAL SERVICES
OFFICE OF CON AND RATE SETTINGS

Name of Facility (as licensed) Shady Knoll Health Care Center	
Address (No. & Street, City, State, Zip Code) 44 Skokorat Street Seymour, CT 06483	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)
<input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 2107C	RHNS	(Specify)	Medicare Provider No. 07-5386
------------------	---------------	------	-----------	-------------------------------------

Medicaid Provider Numbers:	CCNH 2107C	RHNS	ICF-MR
----------------------------	---------------	------	--------

For Department Use Only

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



**MYERS AND
STAUFFER** I.L.C.
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, Administrative Assistant

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2015	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 Shady Knoll Health Care Center [facility name] for the cost report period beginning October 01, 2014 and ending September 30, 2015, 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 penalties 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
<i>Deborah S. Torrey</i>		2/10/16	<i>Lawrence Santilli</i>		2/10/16
Printed Name (Administrator)			Printed Name (Owner)		
Deborah S. Torrey			Lawrence Santilli		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires	
	Conn	2/10/16	<i>Sharm J. Okrusch</i>	03/31/20	
Address of Notary Public					
76 Christine Drive Southington CT 06489					

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 Shady Knoll Health Care Center	Period Covered:	From	To	
		10/1/2014	9/30/2015	
Address of Facility 44 Skokorat Street Seymour, CT 06483				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900	Date 2/10/2016		
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.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-881-2555		Report for Year Ended 09/30/15	Page 2	of 37
Name of Facility (as shown on license) Shady Knoll Health Care Center		Address (No. & Street, City, State, Zip) 44 Skokorat Street Seymour, CT 06483		
License Numbers:	CCNH 2107C	RHNS	(Specify)	Medicare Provider No. 07-5386
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="checkbox"/> PROPRIETORSHIP <input type="checkbox"/> LLC <input type="checkbox"/> PARTNERSHIP <input checked="" type="checkbox"/> PROFIT CORP. <input type="checkbox"/> NON-PROFIT CORP. <input type="checkbox"/> GOVERNMENT <input type="checkbox"/> TRUST				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Deborah S. Torrey		Nursing Home Administrator's License No.:	001800	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		
Not Applicable				

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2015	3A	37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
Shady Knoll Health Center, Inc.	41 Skokorat St, Seymour, CT 06483	CT		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Lawrence G. Santilli	41 Skokorat St, Seymour, CT 06483	President	5602.02	
Debra M Soucey	41 Skokorat St, Seymour, CT 06483	Secretary		
Michael E. Mosier	41 Skokorat St, Seymour, CT 06483	Treasurer		
Names of Stockholders Owning at Least 10% of Shares				
Custodians for Lawrence E. Santilli	41 Skokorat St, Seymour, CT 06483		2397.98	

State of Connecticut
 Annual Report of Long-Term Care Facility
 CSP-4 Rev. 10/2005

**General Information and Questionnaire
 Related Parties***

Name of Facility	License No.	Report for Year Ended	Page	of	
Shady Knoll Health Care Center	2107C	9/30/2015	4	37	
<p>Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p>If "Yes," provide the Name/Address and complete the information on Page 11 of the report.</p> <p>If "Yes," provide the following information:</p>					
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 in Page # / Line #	Actual Cost to the Related Party
Laurel Ridge Health Care Center	642 Danbury Road Ridgefield, CT 06877	<input checked="" type="checkbox"/> >98%	Bank Fees	Pg 16 ln m13	\$7,632
Associates Inc. 401 (K) Plan	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/> >50%	Facility Participates in a Multi Facility 401(K) Plan		
Athena Captive	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/> >98%	Workers Comp Captive	Pg 15 ln a1	\$375,730
Shady Knoll Landlord	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/> >98%	Lease of Facility	Pg 22, ln 9, 10b; Pg 27 ln 14	\$787,789
Countryside Manor	1660 Stafford Ave, Bristol, CT 06010	<input checked="" type="checkbox"/> >98%	Interfacility loans of \$30,000	Pg 33, Ln A2	
Litchfield Woods Health Care	235 Roberts St, Torrington, CT 06790	<input checked="" type="checkbox"/> >98%	Legal Fees	Pg 15 Ln 1e	\$5,077
The Summit at Plantsville	261 Summit St, Plantsville, CT 06479	<input checked="" type="checkbox"/> >98%	Repairs & Maintenance	Pg 22 Ln 6a	\$4,510
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/> >50%	See Attached		
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/> >50%	Self Insured Employee Health & Dental Insurance	Pg 15, Ln 1a5	\$1,103,470

* Use additional sheets if necessary.

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

Shady Knoll 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	<table border="1"> <tr> <td style="text-align: center;">X</td> <td style="text-align: center;">>50%</td> </tr> </table>	X	>50%	MDS Consulting, PT Consulting Legal, Office Supplies Employee Relations, Education/Training, Other Advertising, Lobbying Payroll Service Fees, Data Processing Fees, Repairs & Maintenance, Movable Equipment, Management Fees	Pg 13 5a, 11a2 Pg 15 in 1e, 1g Pg 16 in 13, 15 Pg 16 in m3, m13 Pg 22 in 6a, Pg 32 in C5, Pg 17	\$703,026	\$326,061
X	>50%							

**General Information and Questionnaire
 Basis for Allocation of Costs**

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2015	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary.....	Number of meals served to residents
Laundry.....	Number of pounds processed
Housekeeping.....	Number of square feet serviced
Nursing.....	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants.....	Number of hours of resident care provided by EACH specialist (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.

Not Applicable

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

Not Applicable

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

**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	
Shady Knoll Health Care Center		2107C	9/30/2015		6	37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Postal Equipment	04/01/14	Automatic Renewal	\$3,308	\$3,308
Leaf Capital Funding, 1720A Crete Street, Moherly, MO 65270	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Copier	06/19/13	33 Months	\$2,808	\$2,808
Graphic Savings group, 457 Castle Ave, Fairfield, CT 06825	<input type="checkbox"/>	<input checked="" type="checkbox"/>	copier	03/01/12	48 Months	\$8,244	\$8,244
Leaf Capital Funding, 1720A Crete Street, Moherly, MO 65270	<input type="checkbox"/>	<input checked="" type="checkbox"/>	copier	02/07/12	48 months	\$3,360	\$3,360
IHP Financial Services, 200 Connell Dr, Suite 5000, Berkeley Heights, NJ 07922	<input type="checkbox"/>	<input checked="" type="checkbox"/>	PCC Equipment	08/16/13	60 months	\$6,584	\$6,584
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
						Total ***	\$24,304

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

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
 ** Attach copies of newly acquired leases.
 *** Amount should agree to Page 22, Line 6e.

General Information and Questionnaire
Accounting Basis

Name of Facility Shady Knoll Health Care Center	License No. 2107C	Report for Year Ended 9/30/2015	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Cash <input type="checkbox"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "No," explain.				
Independent Accounting Firm				
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)		
1 Marcum LLP		555 Long Wharf Dr, 12th Floor, New Haven, CT 06511		
2 Dworken, Hillman, Lamorte & Sterczala		4 Corporate Drive, Suite 488, Shelton, CT 06484		
3 Dopkins & Company, LLP		200 International Dr, Buffalo, NY 14221		
4				
Services Provided by This Firm (<i>describe fully</i>)				
1	2014 Medicare Cost Report Prep (Disallow)			\$ 2,650
2	2015 Audit, Year End Financials & Tax Return \$14,000: Allowed; IRS Audit Work \$9,600: Disallow			\$ 23,600
3	KeyBank Audit: Disallowed			\$ 1,912
4				\$ -
				Charge for Services Provided \$28,162
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Pg 15, Line 1d				
Legal Services Information				
Name of Legal Firm or Independent Attorney			Telephone Number	
1 Schiff Hardin LLP			312-258-5500	
2 Murtha Cullina, LLP			860-240-6000	
3 Mancini, Provenzano & Futtner/Probate			860-861-5811	
4 Goldman Gruder & Woods			203-899-8900	
5 See Attached				
Address (No. & Street, City, State, Zip Code)				
1 6600 Sears Tower, Chicago, IL 60606-6473				
2 185 Asylum St, Hartford, CT 06103				
3 92 North Summit St, Southington, CT 06489				
4 200 Connecticut Ave, Norwalk, CT 06854				
5				
Services Provided by This Firm (<i>describe fully</i>)				
1	Revolving Credit Agreement: Disallow			\$ 5,077
2	Prep Secretary of State Annual Reports and Audit Letter \$790: Allowed; Loan Modification \$7,590 Disallow			\$ 8,380
3	Collections: Disallow			\$ 3,198
4	Collections: Disallow			\$ 47,523
5	OSHA Complaint, Visa Application & Conservatorship fee: Disallow			\$ 8,330
				Charge for Services Provided \$72,508
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Pg 15, Line 1e				

Shady Knoll Health Care
Attachment Page 7 - Additional Legal Fees
9/30/2015

<u>Name</u>	<u>Telephone Number</u>	<u>Address</u>	<u>Services Provided</u>	<u>Amount</u>
Shipman & Goodwin	860-251-5000	One Constitution Plaza Hartford, CT 06103	OSHA Complaint: Disallow	\$3,390.00
Goff Wilson	603-228-1277	Two Capital Plaza Concord, NH 03302	H-1B Visa for Employee: Disallow	\$4,725.00
Conservatorship Fee			Disallow	<u>\$215.00</u>
				\$8,330.00

State of Connecticut
 Annual Report of Long-Term Care Facility
 CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility	License No.		Report for Year Ended				Page of
	2107C		09/30/15		Period 7/1 Thru 9/30		
	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.....	128	128			128	128	
B. On last day of THIS report period.....	128	128			128	128	
2. Number of Residents							
A. As of midnight of PREVIOUS report period.....	126	126			125	126	
B. As of midnight of THIS report period.....	120	120			124	120	
3. Total Number of Days Care Provided During Period							
A. Medicare.....	6,936	6,936			5,454	1,482	
B. Medicaid (Conn.).....	32,212	32,212			24,036	8,176	
C. Medicaid (other states).....							
D. Private Pay.....	4,940	4,940			3,446	1,494	
E. State SSI for RCH.....							
F. Other (Specify) Managed Care	473	473			405	68	
G. Total Care Days During Period (3A thru F).....	44,561	44,561			33,341	11,220	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds							
A. Medicaid Bed Reserve Days.....	170	170			146	24	
B. Other Bed Reserve Days.....	79	79			59	20	
5. Total Resident Days (3G + 4A + 4B).....	44,810	44,810			33,546	11,264	

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2015	9	37

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 (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH	RHNS	(Specify)	
				(1)	(2)	(3)	(1)	(2)	(3)				

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

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

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

Item	Medicare		Medicaid		Self-Pay		Other State Assisted		
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	9	89			17		5		
Per Diem Rate									
a. One bed rm.	518.08	227.14			481.00		417.04		
b. Two bed rms.	518.08	227.14			471.00		417.04		
c. Three or more bed rms.									

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	7,603	7,603		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	464	464		
2. Restorative Treatments				
C. Other	15,020	15,020		
D. Total Physical Therapy Treatments	23,087	23,087		

8. Total Number of Speech Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	891	891		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	49	49		
2. Restorative Treatments				
C. Other	1,670	1,670		
D. Total Speech Therapy Treatments	2,610	2,610		

9. Total Number of Occupational Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	5,272	5,272		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	302	302		
2. Restorative Treatments				
C. Other	13,935	13,935		
D. Total Occupational Therapy Treatments	19,509	19,509		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Shady Knoll Health Care Center	2107C	9/30/2015	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	106,172	2,098				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	236,206	10,576				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	66,241	2,077				
c. Dietary Workers	379,033	27,395				
6. Housekeeping Service						
a. Head Housekeeper	50,410	2,429				
b. Other Housekeeping Workers	192,324	15,114				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	67,366	2,300				
b. Other Maintenance Workers	50,981	2,621				
8. Laundry Service						
a. Supervisor	37,693	1,925				
b. Other Laundry Workers	101,703	6,895				
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	204,970	4,440				
b. RN						
1. Direct Care	494,456	13,689				
2. Administrative**	507,519	18,386				
c. LPN						
1. Direct Care	1,054,662	42,110				
2. Administrative**						
d. Aides and Attendants	1,643,740	116,803				
e. Physical Therapists	540,335	16,585				
f. Speech Therapists	202,097	3,842				
g. Occupational Therapists	325,065	8,966				
h. Recreation Workers	132,473	7,452				
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	196,824	8,270				
n. Marketing						
o. Other (Specify)						
<i>A-13. Total Salary Expenditures</i>	6,590,270	313,973				

* 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.

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 Annual Report of Long-Term Care Facility
 CSP-11 Rev. 10/2005

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

Name of Facility		License No.		Report for Year Ended		Page	of		
Shady Knoll Health Care Center		2107C		9/30/2015		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.

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		
Shady Knoll Health Care Center		2107C		9/30/2015		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***									
Deborah S. Toney	106,172		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,098	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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Shady Knoll Health Care Center	2107C	9/30/2015	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.....	11,274	309				
2. Dentist.....	13,901	59				
3. Pharmacist.....	9,454	159				
4. Podiatrist.....						
5. Physical Therapy						
a. Resident Care.....						
b. Other.....						
6. Social Worker.....						
7. Recreation Worker.....						
8. Physicians						
a. Medical Director (entire facility).....	60,000	175				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**.....	8,223					
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify) See Attached Schedule	120	2				
9. Speech Therapist						
a. Resident Care.....	1,800	5				
b. Other.....						
10. Occupational Therapist						
a. Resident Care.....						
b. Other.....						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	4,852	78				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides.....						
d. Other.....						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	109,624	787				

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

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Shady Knoll Health Care Center		2107C	9/30/2015		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Athena Health Care Systems, 135 South Road, Farmington, CT 06062	Physical Therapy, MDS Fill-In	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Ownership		
Healthdrive Podiatry, 888 Worcester St, Wellesley, MA 02482	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Eye Care Group, 1201 West Main St, Suite 100, Waterbury, CT 06708	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Omnicare of Connecticut, 525 Knotter Drive, Cheshire, CT 06410	Pharmacist	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Margaret Holden, 255 Cooper Pl. New Haven, CT 06511	Dietician	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Norwalk Hospital, 24 Stevens Street, Norwalk, CT 06850	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Spfinting Solutions, 800 Silver Lane, Suite 210, East Hartford, CT 06118	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Healthdrive Medical & Dental Practices, 1 Prestige Dr, Meriden, CT 06450	Dentist	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Healthdrive Eye Care Group, 888 Worcester St, Wellesley, MA 02482	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Valley Orthopaedic, 2 Trap Falls Rd, Suite 404, Shelton, CT 06484	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Dr. Hafsa Nawaz, West Haven Medical Group, 387 Campell Ave, Suite 2, West Haven, CT	Asst. Medical Director	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Griffin Hospital, 130 Division St, Derby, CT 06418	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Samuel Streit, 330 Bridgeport Ave, Shelton, CT 06484	Medical Staff	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Garumuni Desilva, MD, West Haven Medical Group, 387 Campell Ave, Suite 2, West Haven,	Medical Director	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
SDX Swallowing Diagnostics, 21 Waterville Rd, Avon, CT 06001	Speech Therapy	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Shady Knoll Health Care Center	2107C	9/30/2015		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation.....	\$ 375,730	375,730			
2. Disability Insurance.....	\$				
3. Unemployment Insurance.....	\$ 161,942	161,942			
4. Social Security (F.I.C.A.).....	\$ 488,503	488,503			
5. Health Insurance.....	\$ 908,000	908,000			
6. Life Insurance (employees only) (not-owners and not-operators).....	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators).....	\$ 28,353	28,353			
8. Uniform Allowance.....	\$				
9. Other (<i>Specify</i>)..... See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*.....	\$ 98,366	98,366			
d. Accounting and Auditing.....	\$ 28,162	28,162			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 72,508	72,508			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*.....	\$				
g. Office Supplies.....	\$ 51,814	51,814			
h. Telephone and Cellular Phones.....					
1. Telephone & Pagers.....	\$ 34,153	34,153			
2. Cellular Phones.....	\$ 2,545	2,545			
i. Appraisal (<i>Specify purpose and attach copy</i>)*.....	\$				
j. Corporation Business Taxes (<i>franchise tax</i>).	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*.....	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 796,111	796,111			
Subtotal	\$ 3,046,187	3,046,187			

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
Shady Knoll Health Care Center	2107C	9/30/2015		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	3,046,187	3,046,187			
l. Travel and Entertainment					
1. Resident Travel and Entertainment.....	\$				
2. Holiday Parties for Staff.....	\$ 7,551	7,551			
3. Gifts to Staff and Residents.....	\$ 15,513	15,513			
4. Employee Travel.....	\$ 16,192	16,192			
5. Education Expenses Related to Seminars and Conventions	\$ 4,624	4,624			
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).....	\$ 4,376	4,376			
2. Advertising Telephone Directory (all such expenses)***	\$ 1,085	1,085			
3. Advertising Other (Specify)***.....	\$ 35,817	35,817			
See Attached Schedule					
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.....	\$ 9,954	9,954			
* 8. Dues and Membership Fees to Professional Associations (Specify)	\$ 8,718	8,718			
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions.....	\$ 359	359			
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**.....	\$ 430,388	430,388			
13. Other (Specify)	\$ 132,965	132,965			
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$ 3,713,729	3,713,729			

* 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	\$ 35,817		
Total Other Advertising	\$ 35,817	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 8,718		
Total Dues	\$ 8,718	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Lobbying Fees	\$ 4,287		
Data Processing Fees	\$ 16,215		
Bank Charges	\$ 17,543		
Payroll Processing Fees	\$ 24,108		
Employee Physicals	\$ 15,151		
Compliance Consulting	\$ 50,761		
Penalty-State of CT Citation #2015-005	\$ 1,020		
Penalty-DOL OSHA Inspection #1016348	\$ 2,800		
Licenses	\$ 1,080		
Total Other Administrative and General	\$ 132,965	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Shady Knoll Health Care Center	2107C	9/30/2015	17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	\$590,354	Contract Attached to a Prior Year	See Below
Allocation of the above	\$389,634 \$94,457 \$106,264	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	\$40,754	Admin/Gen - Other Exp	Pg 16, Line 12

*** In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.**

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

Name of Facility	License No.	Report for Year Ended		Page	of
Shady Knoll Health Care Center	2107C	9/30/2015		18	37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food.....	\$ 269,638	269,638			
2. Non-Food Supplies.....	\$ 34,060	34,060			
3. Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Management Services**.....	\$ 94,457	94,457			
d. Other (Specify) _____	\$				
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 398,155	398,155			
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)	
G. Resident Meals: Total no. of meals served per day:*	366	366			
H. Is cost of employee meals included in 2E?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No			
I. Did you receive revenue from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> 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?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, specify cost. = \$395		
L. Is any revenue collected from these people?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, specify amount. = \$198		
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?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.		
O. Is any revenue collected from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> 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.

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
Shady Knoll Health Care Center	2107C	9/30/2015	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. \$			
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. \$	13,378	13,378	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$			
c. Management Services**	\$			
d. Other (Specify) Supplies = \$5,959	\$	5,959	5,959	
3E. Total Laundry Expenditures (3a + b + c + d)	\$	19,337	19,337	
3F. Laundry Questionnaire				
G. Is cost of employee laundry included in 3E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.	
H. Did you receive revenue from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.	
K. Did you receive revenue from these people?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> 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.

**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
Shady Knoll Health Care Center	2107C	9/30/2015		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	29,999	29,999		
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
	Amt. \$				
c. Management Services*	\$				
d. Other (<i>Specify</i>)	\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)....	\$	29,999	29,999		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy.....	\$				
2. Purchased from Omni Care	\$	327,989	327,989		
b. Medicine Cabinet Drugs.....	\$	9,467	9,467		
c. Medical and Therapeutic Supplies.....	\$	270,924	270,924		
d. Ambulance/Limousine***	\$	4,309	4,309		
e. Oxygen					
1. For Emergency Use.....	\$				
2. Other***	\$	41,598	41,598		
f. X-rays and Related Radiological Procedures***	\$	22,703	22,703		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	27,436	27,436		
i. Recreation.....	\$	24,544	24,544		
j. Other (<i>Specify</i>)**** See Attached Schedule	\$	176,930	176,930		
5K. Total Resident Care Expenditures (5a - 5j).....	\$	905,900	905,900		

* 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	\$ 106,264		
Physical Therapy Supplies	\$ 29,915		
Medical Equipment Rental-Other	\$ 15,521		
Cable TV Services	\$ 10,362		
Oxygen equipment rentals	\$ 6,563		
Medical Equipment Rental-Medicaid	\$ 8,305		
Total Other Resident Care	\$ 176,930	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended			Page	of
Shady Knoll Health Care Center	2107C	9/30/2015			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance..... \$	105,124	105,124				
b. Heat..... \$	51,948	51,948				
c. Light & Power..... \$	121,666	121,666				
d. Water..... \$	52,014	52,014				
e. Equipment Lease (Provide detail on page 6)..... \$	24,304	24,304				
f. Other (itemize)..... \$	86,869	86,869				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)..... \$	441,925	441,925				
7. Depreciation (complete schedule page 23*)						
a. Land Improvements..... \$	6,583	6,583				
b. Building & Building Improvements..... \$	101,320	101,320				
c. Non-Movable Equipment..... \$	38,550	38,550				
d. Movable Equipment..... \$	69,832	69,832				
*7e. Total Depreciation Costs (7a + b + c + d)..... \$	216,285	216,285				
8. Amortization (Complete att. Schedule Page 24*)						
a. Organization Expense..... \$						
b. Mortgage Expense..... \$						
c. Leasehold Improvements..... \$	3,141	3,141				
d. Other (Specify)..... \$						
*8e. Total Amortization Costs (8a + b + c + d)..... \$	3,141	3,141				
9. Rental payments on leased real property less real estate taxes included in item 10b..... \$	557,582	557,582				
10. Property Taxes						
a. Real estate taxes paid by owner..... \$						
b. Real estate taxes paid by lessor..... \$	142,320	142,320				
c. Personal property taxes..... \$	12,935	12,935				
11. Total Property Expenses (7e + 8e + 9 + 10)..... \$	932,263	932,263				

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

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

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended		Page	of	
		9/30/2015	24			37
Shady Knoll Health Care Center	2107C	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
Item	Date of Acquisition	Length of Amortization	Cost to Be Amortized			
	Month	Year				
A. Organization Expense						
1.						
2.						
3.						
A-4. Subtotal.....						
B. Mortgage Expense						
1. Finance Fees-Key Bank	6	2007	305,597	SL	0	
2. Finance Fees						
3. Finance Fees						
B-4. Subtotal.....						
C. Leasehold Improvements and Other (Specify)						
1. Acquired prior to this report period		2014	1,122,354	Various	42,354 Var	2,591
2. Disposals (attach schedule)						
3. Acquired during this report period (attach schedule)						
	9	2015	10,994	Various	10,994 Var	550
C-4. Subtotal.....						
D. Total Amortization						3,141
						3,141

* 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.

Amortization Schedule - Detail of Leasehold Improvements & Other

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2015	24A	37
C. Leasehold Improvements (Specify)				
1. Acquired prior to this report period		2,206	42,354	2,591
2. Disposals (attach schedule)	2014			
3. Acquired during this report period	9 2015		10,994	550
C-4. Subtotal.....				3,141
C. Other (Specify)				
1. Bed License Purchase	9 1997	368,811	1,080,000	0
2.				
C-4. Subtotal.....				
Total Acquired prior to this report period		371,017	42,354	2,591
Total Disposals	2014			
Total Acquired during this report period	9 2015		10,994	550

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

Name of Facility Shady Knoll Health Care Center	License No. 2107C	Report for Year Ended 9/30/2015	Page 25	of 37
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11. Property Questionnaire

Part A

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

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

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

Description	Total				
1. Date Land Purchased	1991				
2. Date Structure Completed	5/21/1993				
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure	05/21/93				
5. Total Licensed Bed Capacity	128				
6. Square Footage					
7. Acquisition Cost					
a. Land	652,528				
b. Building	5,696,463				
Part B - Owner and Related Parties					1st 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)	31				
e. Amount of Principal Borrowed	10,237,067				
f. Principal balance outstanding as of 9/30/2015	7,999,715				
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
Shady Knoll Health Care Center		2107C	9/30/2015			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)

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

Name of Facility	License No.	Report for Year Ended			Page	of
Shady Knoll Health Care Center	2107C	9/30/2015			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)..... \$		21,416	21,416			
A. Item	Rate	Amount				
Boiler Capital Lease		6.04%	390,250			
Lender						
Graybar Financial Services						
Address of Lender						
PO Box 644006, Cincinnati, OH 45264						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)..... \$		21,416	21,416			
12. D. Other Interest Expense (Specify)..... \$		241,976	241,976			
Vendor Interest = \$910; Key Bank Line of Credit Interest = \$102,539; Key Bank Term Loan Int & Fees = \$138,527						
13. Total All Interest Expense (12B7 + 12C3 + 12D)..... \$		263,392	263,392			
14. Insurance						
a. Insurance on Property (buildings only)..... \$		92,189	92,189			
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)... \$		92,189	92,189			
15. Total All Expenditures (A-13 thru C-14)..... \$		13,496,783	13,496,783			

D. Adjustments to Statement of Expenditures

Name of Facility:			License No.	Report for Year Ended	Page	of	
Shady Knoll Health Care Center			2107C	9/30/2015	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.....	\$ 325,065	325,065		
4.	Var	Var	Other - See attached Schedule.....	\$ 49,689	49,689		
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **	\$ 8,223	8,223		
6.			Occupational Therapy.....	\$			
7.			Other - See attached Schedule.....	\$			
Pages 15 & 16 - Administrative and General							
8.	15	1a9	Discriminatory Benefits.....	\$			
9.	15	1c	Bad Debts.....	\$ 98,366	98,366		
10.	15	1d&e	Accounting & Legal.....	\$ 85,880	85,880		
11.	30	IV3	Telephone.....	\$			
12.	15	1h2	Cellular Telephone.....	\$ 1,105	1,105		
13.			Life insurance premiums on the life of Owners, Partners, Operators.....	\$			
14.	16	13	Gifts, flowers and coffee shops.....	\$ 15,513	15,513		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees.....	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative....	\$			
17.			Automobile Expense (e.g. personal use).	\$			
18.	16	m2&3	Unallowable Advertising *.....	\$ 36,902	36,902		
19.			Income Tax / Corporate Business Tax...	\$			
20.			Fund Raising / Contributions.....	\$			
21.	16	m12	Unallowable Management Fees.....	\$ 248,797	248,797		
	18	2c		\$ 60,314	60,314		
	20	5j		\$ 67,854	67,854		
22.	16	m6	Barber and Beauty.....	\$			
23.	Var	Var	Other - See attached Schedule.....	\$ 76,411	76,411		
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents.....	\$ 395	395		
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)				\$ 1,074,514	1,074,514		

* 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	Marketing Salaries & Benefits	2,718		
10	12m	Community Liason Salary & Benefits	46,971		
Total Other Salaries Adjustment			\$ 49,689	\$ -	\$ -

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	Bank Charges	17,543		
16	M13	Lobbying Fees	4,287		
16	M13	Compliance Consulting	50,761		
16	M13	Penalty Citation	1,020		
16	M13	Penalty OSHA	2,800		
Total Other A&G Adjustments			\$ 76,411	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Shady Knoll Health Care Center			2107C	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,074,514	1,074,514		
Page 20 - Resident Care Supplies***							
27.	20	5a1&2	Prescription Drugs.....	\$ 327,989	327,989		
28.	20	5d	Ambulance/Limousine.....	\$ 4,309	4,309		
29.	20	5f	X-rays, etc.....	\$ 22,703	22,703		
30.	20	5h	Laboratory.....	\$ 27,436	27,436		
31.	20	5c	Medical Supplies.....	\$ 18,960	18,960		
32.	20	5e2	Oxygen (non emergency).....	\$ 41,598	41,598		
33.			Occupational Therapy.....	\$			
34.	Var	Var	Other - See Attached Schedule.....	\$ 15,521	15,521		
Page 22 - Maintenance and Property							
35.	Var	Var	Excess Movable Equipment Depreciation See Attached Schedule.....	\$ 12,874	12,874		
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.....	\$ 6,762	6,762		
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	rv5	Interest Income on Accounts Rec.....	\$ 188	188		
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)			\$ 1,552,854	1,552,854		

*** 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	15,521		
Total Other Ancillary Costs			\$ 15,521	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Movable Equipment (See Attached)	12,874		
Total Excess Movable Equipment Depreciation			12,874		

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			\$	\$	\$

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page of
Shady Knoll Health Care Center	2107C	9/30/2015			30 37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (CT only).....	\$ 15,221,460	15,221,460			
b. Medicaid Room and Board Contractual Allowance **.....	\$ (7,886,806)	(7,886,806)			
2. a. Medicaid (All other states).....	\$				
b. Other States Room and Board Contractual Allowance **.....	\$				
3. a. Medicare Residents (all inclusive).....	\$ 1,905,422	1,905,422			
b. Medicare Room and Board Contractual Allowance **.....	\$ 550,211	550,211			
4. a. Private-Pay Residents and Other.....	\$ 3,841,891	3,841,891			
b. Private-Pay Room and Board Contractual Allowance **.....	\$ (187,099)	(187,099)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare.....	\$ 191,603	191,603			
b. Prescription Drugs - Medicare Contractual Allowance **.....	\$ (191,603)	(191,603)			
c. Prescription Drugs - Non-Medicare.....	\$ 176,076	176,076			
d. Prescription Drugs - Non-Medicare Contractual Allowance **.....	\$ (176,076)	(176,076)			
2. a. Medical Supplies - Medicare.....	\$ 6,160	6,160			
b. Medical Supplies - Medicare Contractual Allowance **.....	\$ (2,817)	(2,817)			
c. Medical Supplies - Non-Medicare.....	\$ 1,271	1,271			
d. Medical Supplies - Non-Medicare Contractual Allowance **.....	\$ (1,271)	(1,271)			
3. a. Physical Therapy - Medicare.....	\$ 823,399	823,399			
b. Physical Therapy - Medicare Contractual Allowance **.....	\$ (595,459)	(595,459)			
c. Physical Therapy - Non-Medicare.....	\$ 291,571	291,571			
d. Physical Therapy - Non-Medicare Contractual Allowance **.....	\$ (291,431)	(291,431)			
4. a. Speech Therapy - Medicare.....	\$ 164,025	164,025			
b. Speech Therapy - Medicare Contractual Allowance **.....	\$ (123,635)	(123,635)			
c. Speech Therapy - Non-Medicare.....	\$ 86,404	86,404			
d. Speech Therapy - Non-Medicare Contractual Allowance **.....	\$ (86,404)	(86,404)			
5. a. Occupational Therapy - Medicare.....	\$ 683,153	683,153			
b. Occupational Therapy - Medicare Contractual Allowance **.....	\$ (529,817)	(529,817)			
c. Occupational Therapy - Non-Medicare.....	\$ 284,983	284,983			
d. Occupational Therapy - Non-Medicare Contractual Allowance **.....	\$ (284,983)	(284,983)			
6. a. Other (Specify) - Medicare.....	\$				
b. Other (Specify) - Non-Medicare.....	\$ 7,387	7,387			
III Total Resident Revenue (Section I.thru Section II.).....	\$ 13,877,615	13,877,615			
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).....	\$ 188	188			
6. Private Duty Nurses' Fees.....	\$				
7. Barber, Coffee, Beauty and Gift shops.....	\$				
8. Other (Specify).....	\$				
V. Total Other Revenue (1 thru 8).....	\$ 188	188			
VI. Total All Revenue (III + V).....	\$ 13,877,803	13,877,803			

* 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)
N/A	Retroactives	\$ 7,387		
Total Other Resident Revenue		\$ 7,387	\$ -	\$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
pg 31, L A2	Interest on A/R	N/A	\$ 188		
Total Interest Income			\$ 188	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Revenue		\$ -	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>).....			\$	403,410
2. Resident Accounts Receivable (Less Allowance for Bad Debts).....			\$	810,154
3. Other Accounts Receivable (Excluding Owners or Related Parties).....			\$	
4. Inventories.....			\$	31,220
5. Prepaid Expenses.....			\$	223,814
a. Prepaid Insurance	140,568			
b. Health Insurance Premium-October, 2015	82,381			
c. Pitney Bowes Lease Payment 10/10/15-1/10/16	865			
d.				
6. Interest Receivable.....			\$	
7. Medicare Final Settlement Receivable.....			\$	
8. Other Current Assets (<i>itemize</i>).....			\$	200,546
Due From Related Parties	198,473			
Due From Non-Related Parties	2,073			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,669,144
B. Fixed Assets				
1. Land.....			\$	
2. Land Improvements	*Historical Cost.....	70,380	\$	17,310
	Accum. Depreciation	(53,070) Net.....		
3. Buildings	*Historical Cost.....	2,747,856	\$	1,023,654
	Accum. Depreciation	(1,724,202) Net.....		
4. Leasehold Improvements	*Historical Cost.....	53,348	\$	48,001
	Accum. Depreciation	(5,347) Net.....		
5. Non-Movable Equipment	*Historical Cost.....	630,911	\$	432,574
	Accum. Depreciation	(198,337) Net.....		
6. Movable Equipment	*Historical Cost.....	839,070	\$	172,204
	Accum. Depreciation	(666,866) Net.....		
7. Motor Vehicles	*Historical Cost.....		\$	
	Accum. Depreciation	Net.....		
8. Minor Equipment-Not Depreciable.....			\$	
9. Other Fixed Assets (<i>itemize</i>).....			\$	28,280
Excluded Movable Equipment	28,280			
B-10. Total Fixed Assets (Lines B1 thru 9).....			\$	1,722,023

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2015	32	37
Account			Amount	
Total Brought Forward:			\$	3,391,167
C. Leasehold or like property recorded for Equity Purposes.				
1. Land.....			\$	649,355
2. Land Improvements	*Historical Cost.....			
	Accum. Depreciation	Net.....	\$	
3. Buildings	*Historical Cost.....	5,602,448		
	Accum. Depreciation	(4,154,857) Net.....	\$	1,447,591
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)			\$	2,096,946
D. Investment and Other Assets				
1. Deferred Deposits.....			\$	
2. Escrow Deposits.....			\$	
3. Organization Expense	*Historical Cost.....			
	Accum. Depreciation	Net.....	\$	
4. Goodwill (Purchased Only).....			\$	711,189
5. Investments Related to Resident Care (<i>itemize</i>).....			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	(18,180,047)
Name and Address		Amount	Loan Date	
Related Party Facilities		(18,180,047)	3/29/2012	
7. Other Assets (<i>itemize</i>).....			\$	34,424
Deposits-Lease		14,192		
Project Development		20,232		
D-8. Total Investments and Other Assets (Lines D1 thru 7).....			\$	(17,434,434)
D-9. Total All Assets (Lines A9 + B10 + C8 + D8).....			\$	(11,946,321)

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2015	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable.....			\$	683,882
2. Notes Payable (<i>itemize</i>).....			\$	1,895,845
Loans - Related Parties	(30,000)			
Loan - Line of Credit	1,925,845			
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>).....			\$	
	Name of Lender	Purpose	Amount	Date Due
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>).....			\$	290,053
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>).....			\$	
6. Accrued Payroll Taxes Payable.....			\$	6,311
7. Medicare Final Settlement Payable.....			\$	
8. Medicare Current Financing Payable.....			\$	
9. Mortgage Payable (<i>Current Portion</i>).....			\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>).....			\$	12,116
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities (<i>itemize</i>).....			\$	384,967
	Acc'd Operating Expenses	181,567		
	Acc'd Expense - CT Sales & Use Tax	729		
	Provider Taxes Due	205,618		
	Acc'd Expense-Personal Property Tax	(2,947)		
A-13. Total Current Liabilities (Lines A1 thru 12).....			\$	3,273,174

* 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.

SHADY KNOLL HEALTH CENTER
ACCRUED EXPENSES - OPERATING
September 30, 2015

ACCT. # 2170

9/30/15 Audit Fee	\$14,000.00	5126
Athena-AAPC (ICD Code Book)	\$97.09	5138
Athena-Infrascale	\$339.60	5148
Athena-Shifthound	\$615.39	5148
Athena-Reverse Credit Memo	\$4,510.09	5539
Health Insurance IBNR AJE 9/30/14	\$36,463.94	5364
Payroll P/E 9/26/15	\$124,127.06	various
Accrued 401K	\$4,278.18	5366
Food Rebate received 10/15	(\$2,617.28)	6334
Management Fee True Up	(\$176.17)	5120
Direct Energy	\$1,810.22	5572
Eversource - Credit	<u>(\$1,881.11)</u>	5572
	\$181,567.01	

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center		2107C	9/30/2015	34	37
Account				Amount	
Total Brought Forward:				3,273,174	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>).....					
				\$	285,246
Name of Lender	Purpose	Amount	Date Due		
Graybar Financial Services	Boiler/Solar Panel	285,246	05/31/19		
2. Mortgages Payable.....				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>).....				\$	(9,320,123)
Name and Address of Lender	Amount	Loan Date			
Related Party	(9,320,123)	03/29/12			
4. Other Long-Term Liabilities (<i>itemize</i>).....				\$	(1,252,206)
N/P L/T Related Party Landlord		(2,551,616)			
Key Bank Term Loan		1,276,928			
Deferred Energy Credit		22,482			
B-5. Total Long-Term Liabilities (Lines B1 thru 4).....				\$	(10,287,083)
C. Total All Liabilities (Lines A-13 + B-5).....				\$	(7,013,909)

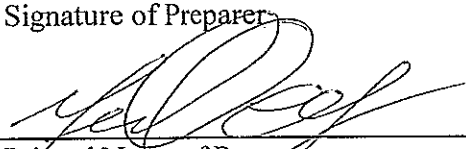
**G. Balance Sheet (cont'd)
 Reserves and Net Worth**

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2015	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land.....			\$	649,355
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized.....			\$	1,447,591
3. Reserve for depreciation value of leased personal property (<i>Equity</i>) ..			\$	
4. Reserve for leasehold real properties on which fair rental value is based.....			\$	
5. Reserve for funds set aside as donor restricted.....			\$	
6. Total Reserves.....			\$	2,096,946
B. Net Worth				
1. Owner's Capital.....			\$	
2. Capital Stock.....			\$	1,000
3. Paid-in Surplus.....			\$	
4. Treasury Stock.....			\$	
5. Cumulated Earnings.....			\$	(7,411,378)
6. Gain or Loss for Period				
	10/1/2014	thru	9/30/2015	\$ 381,020
7. Total Net Worth.....			\$	(7,029,358)
C. Total Reserves and Net Worth			\$	(4,932,412)
D. Total Liabilities, Reserves, and Net Worth			\$	(11,946,321)

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2015	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	(7,262,027)
B. Total Revenue (From Statement of Revenue Page 30)			\$	13,877,803
C. Total Expenditures (From Statement of Expenditures Page 27)			\$	13,496,783
D. Net Income or Deficit.....			\$	381,020
E. Balance.....			\$	(6,881,007)
F. Additions				
1. Additional Capital Contributed (itemize)				
SWAP Change			(154,504)	
			6,153	
2. Other (itemize)				
F-3. Total Additions.....			\$	(148,351)
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			\$	(7,029,358)

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2015	37	37
<i>Check appropriate category</i>				
CCNH	RHNS	Other (<i>Specify</i>)		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
	CFO	2/12/16		
Printed Name of Preparer				
Athena Health Care Associates, Inc				
Address		Phone Number		
135 South Road Farmington, CT 06032		(860) 751-3900		