State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) Sharon SNF CT LLC, d/b/a Sharon Health Care Center
Address (No. & Street, City, State, Zip Code) 27 Hospital Hill Road Sharon, CT 06069
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Report for Year Beginning	Report for Year Ending
10/1/2015	9/30/2016

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2382			075379

Medicaid Provider Numbers:	CCNH	RHNS	ICF-MR
	2382		

For Department Use Only

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

Table of Contents

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2016	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 Sharon SNF CT LLC, d/b/a Sharon Health Care Center [facility name] for the cost report period beginning October 01, 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 penalities of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)	Date
		2-15-17		2-15-17
Printed Name (Administrator) **John Hortsman**			Printed Name (Owner) **Lawrence Santilli**	
Subscribed and Sworn to before me:	State of Conn	Date 2/15/17	Signed (Notary Public)	Comm. Expires 3 31 20
Address of Notary Public			41 Terrace Ln Bristol CT 0600	

(Notary Seal)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1A Rev. 6/95

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 **Sharon SNF CT LLC, d/b/a Sharon Health Care Center**	Period Covered:		From **10/1/2015**	To **9/30/2016**
Address of Facility **27 Hospital Hill Road Sharon, CT 06069**				
Report Prepared By **Athena Health Care Associates, Inc**	Phone Number **(860) 751-3900**		Date **2/15/2017**	

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 10/2005

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-364-1002	**09/30/16**	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**27 Hospital Hill Road Sharon, CT 06069**

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2382			**075379**

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.:
John Hortsman	**359**

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

Name	License No.:
Not Applicable	

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Sharon SNF CT LLC	**27 Hospital Hill Road, Sharon, CT**	**CT**

Name of Partners/Members	Business Address	Title	% Owned
Lawrence G Santilli	**135 South Road, Farmington, CT 06032**	**Manager**	**67.6700%**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Not Applicable			
Names of Stockholders Owning at Least 10% of Shares			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	3B	37

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

Owner(s) of Facility
Not Applicable

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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	4	37

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: Yes	No	%**	Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
Sharon Landlord CT LLC	**135 South Road, Farmington, CT 06032**	☐	☑		**Lease of Real Property**	**Pg 22, l9 and L10b; pg 27, ln 14a**	**$355,088**	**$355,088**
Athena Health Care	**135 South Road, Farmington, CT 06032**	☑	☐	**>98%**	**General Liab Ins-AFCO**	**Pg. 27, 14a**	**$1,731**	**$1,731**
Athena Health Care	**135 South Road, Farmington, CT 06032**	☑	☐	**>50%**	**Management fees**	**Pg 17, Pg 15 le**	**$2,586**	**$146,421**
Athena Health Care	**135 South Road, Farmington, CT 06032**	☑	☐	**>98%**	**Health/Dental Insurance**		**$780,289**	**$780,289**
Athena Health Care	**135 South Road, Farmington, CT 06032**	☑	☐	**>98%**	**Data Processing fees, P/R Processing fees, lobbying and office supplies, Purch**	**Pg 16, m13, Pg 16, m12**	**$15,405**	**$15,405**
Procare, LTC	**111 Executive Blvd., Farmingdale, NY 11735**	☑	☐	**>98%**	**Pharmacy**		**$140,986**	**$140,986**
Athena Health Care	**135 South Road, Farmington, CT 06032**	☑	☐	**>98%**	**MDS Nurse Consultant, Maintenance & Repairs, Employee Relations**	**Pg 13, B11a2,;Pg 22, 6a ; Pg 16, l5**	**$6,789**	**$6,789**
Interfacility Loans	**Various**	☑	☐	**>98%**	**Interfacility payable of ($445,000) not included in expense**	**Pg 33 A2**		
Athena Captive	**135 South Road, Farmington, CT 06032**	☐	☑		**Worker's Compensation Captive**	**Pg 15 1a1**	**$247,410**	**$247,410**

* Use additional sheets if necessary.

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

Sharon 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 401 K Plan	135 South Rd Farmington, CT 06032		x		Facility participates in common 401K plan			
						TOTAL	$0	$0

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 9/2002

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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Leaf Capital Funding, LLC 1720A Crete St, Moberly, MO 65270	☐	☑	**Copier-Lease ended 08/16**	**05/10/12**	**48 months**	**$7,849**	**$7,459**
Pitney Bowes PO Box 371887, Pittsburgh, PA 15250	☐	☑	**Postage Meter**	**04/08/10**	**Expired**	**$2,254**	**$1,159**
Leaf Capital Funding, LLC 1720A Crete St, Moberly, MO 65270	☐	☑	**Copier-Lease ended 07/16**	**11/19/12**	**41 months**	**$563**	**$622**
Hewlett Packard, PO Box 402582, Atlanta, GA	☐	☑	**PCC Equipment**	**08/27/13**	**60 months**	**$7,290**	**$7,290**
Hewlett Packard, PO Box 402582, Atlanta, GA	☐	☑	**Fortinet Fortiphone system**	**04/29/16**	**60 months**	**$7,077**	**$2,961**
Leaf Capital Funding, LLC 1720A Crete St, Moberly, MO 65270	☐	☑	**Xerox 7970 Copier/Xerox 3655 Copier**	**06/08/16**	**50 months**	**$10,210**	**$2,679**
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Is a Mileage Log Book Maintained for All Leased Vehicles ? **Not Applicable - No Vehicles** ☐ Yes ☐ No **Total *** $22,170

* 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.

Hewlett-Packard Financial
Services
200 Connell Drive Suite 5000
Berkeley Heights, NJ 07922
888-277-0670

4/29/2016

SHARON HEALTH CARE CENTER
135 SOUTH RD
FARMINGTON, CT 06032
Attn: Michael Mosier

Subject: Business Lease Agreement Number: 522744596928549USA2

Dear *Michael Mosier*:

Thank you for selecting Hewlett-Packard Financial Services Company for your financial solutions.

We are in receipt of the Final invoice(s) for the above referenced Lease Number. The invoice(s) reflect an adjustment to the Total Cost originally indicated on the Schedule. The Total Cost has been adjusted from $28,620.23 to $27,699.18 which is a de*crease* of $921.15.

This change was due to:

☒ Upfront Taxes
☒ Shipping/Handling
☒ Decrease in Equipment
☐ Other as explained below

As a result of the above, your monthly payments will decrease from $554.56 to $536.71.

All terms used herein and not defined shall have the meanings set forth in the Business Lease Agreement. All other terms and conditions of the Business Lease Agreement remain unchanged and in full force and effect.

If you should have any questions or require additional information, please contact me at richard.b.roma@hpe.com.

Sincerely,

Rick Roma
Contract Administrator

New Lease

Hewlett-Packard Financial
Services
200 Connell Drive Suite 5000
Berkeley Heights, NJ 07922
888-277-0670

4/29/2016

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135 SOUTH RD
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Sincerely,

Rick Roma
Contract Administrator

Hewlett-Packard Financial Services Company
200 Connell Drive, Suite 5000
Berkeley Heights, NJ 07922

Lessee (Complete Legal Name): SHARON SNF CT, LLC

Lease Agreement Number: 522744596928549USA2

Business Lease Agreement

This lease (including the attached Schedules A and B, this "Lease") refers throughout to Lessee as "you" or "your" and to Lessor as "we", "us" or "our". In consideration of our purchase of the equipment described on Schedule A (the "Equipment"), you hereby lease the Equipment from us for your business purposes only (and not for personal, family or household purposes), subject to all terms and conditions of this Lease. You acknowledge that you selected the vendor as identified in Schedule A (the "Vendor") and all such Equipment without our assistance. **You agree that this Lease is a net lease so you will pay, by Lease payment increase or upon our demand, all costs, fees, taxes (e.g. property, sales and use taxes) or other charges connected with the Lease and the Equipment, as well as all costs for insurance, repairs, maintenance, shipping, and filing fees.** You authorize us to adjust your Lease payment by up to ten percent (10%) if the actual total cost of the Equipment at acceptance varies from the original estimate. Lease payments shall commence on the Acceptance Date, as defined below, and are due in advance or arrears each monthly or quarterly period ("Period") during the Lease term on the monthly or quarterly anniversary of the Acceptance Date, all as specified in Schedule A . You agree to pay a one-time documentation fee in the amount specified in Schedule A with the first Lease payment to cover account-setup costs. If you do not elect to either purchase the Equipment, renew the Lease or return the Equipment by the end of the Lease term in accordance with the terms of Schedule A hereto, or you fail to comply with your obligations arising from the election, you will continue to pay the original Lease payments for any full or partial Period that you keep the Equipment. If you have selected either a FMV or a 10% End of Term Purchase Option (as indicated on Schedule A), then we and you intend this Lease to be a "Finance Lease" as defined in Article 2A of the Uniform Commercial Code (as enacted and in effect in any applicable jurisdiction, the "UCC") and you authorize us to file a UCC financing statement to give public notice of our ownership of the Equipment. If you have selected a $1.00 End of Term Purchase Option or if this Lease is otherwise deemed to be a "lease intended for security", then to secure payment and performance of your obligations under this Lease, you hereby grant us a purchase money security interest in the Equipment and in all attachments, accessories, additions, products, replacements, and proceeds (including insurance proceeds) to and of the Equipment, as well as a security interest in any other equipment we have leased to or financed for you, and you authorize us to file a UCC financing statement to perfect such security interest. You hereby appoint us as your attorney-in-fact to: (i) sign any UCC financing statements in your name, (ii) modify Schedule A to reflect any Lease payment adjustment provided for above and to complete or modify any Equipment description in Schedule A or any related document to accurately describe the Equipment actually accepted by you, and (iii) correct all typographical, clerical or legal name errors discovered in any or all of the documentation required in connection with this Lease and execute or initial all such documentation corrections in your name.

EXCEPT AS TO QUIET ENJOYMENT, WE MAKE ABSOLUTELY NO REPRESENTATIONS OR WARRANTIES, EXPRESSED OR IMPLIED, INCLUDING NO WARRANTY OF MERCHANTABILITY OR OF FITNESS FOR A PARTICULAR PURPOSE. You can only make any claim relating to the Equipment against the Vendor or manufacturer, and you waive any such claim against us. We hereby assign any Equipment warranties during the Lease term for your exercise at your expense. **WE WILL NOT BE LIABLE FOR INCIDENTAL, SPECIAL, INDIRECT, OR CONSEQUENTIAL DAMAGES. YOU AGREE TO MAKE PAYMENTS TO US WHEN DUE, UNCONDITIONALLY, WITHOUT ABATEMENT OR OFFSET FOR ANY CAUSE AND REGARDLESS OF ANY PROBLEMS WITH THE EQUIPMENT, VENDOR, OR US AND YOU WAIVE ANY CLAIM OR DEFENSE TO ANY LEASE PAYMENT.**

You agree to indemnify us against third party claims or other loss or damages, including attorneys' fees, arising directly or indirectly out of Equipment defects, use, or operation, and whether arising out of breach of contract, tort, or strict or product liability. You agree not to move the Equipment or to transfer, sell, sublease, or encumber either the Equipment or any rights under this Lease without our prior written consent. We may freely assign our rights and interests under this Lease without notice to you or your consent. You agree that our assignee will have the same rights and remedies as we do and that our assignee's rights will not be subject to any claims or defenses you may have against us. You and any guarantor hereby authorize us to share information about you and any guarantor (including personally identifiable information) with our assignees, potential assignees, the Vendor and other third parties providing services to us.

We own the Equipment and, unless you have selected a $1.00 End of Term Purchase Option, we retain all benefits of ownership and you agree not to take any position inconsistent with our ownership. We may inspect the Equipment and attach Equipment ownership labels. You are solely responsible for the installation, operation, and maintenance of the Equipment, will keep it in good condition, will use it in compliance with applicable law, and will not attach it to building fixtures. You bear all risk of loss or damage to or from the Equipment arising prior to its return to us and will have it duly insured against all risk of loss and damage up to the greater of its replacement value or the Stipulated Loss Value (as defined below) and against public liability for bodily injury or damage to property arising in connection with the Equipment. You will provide to us a certificate showing that you have such insurance coverages, naming us as loss payee. Upon the occurrence of any loss or irreparable damage to the Equipment ("Casualty Loss"), you agree to immediately (c) replace the affected Equipment with equipment of equivalent or better value and supplied by a manufacturer acceptable to us or (d) pay us an amount ("Stipulated Loss Value") which is the sum of (i) all arrears in Lease payments as of the date of payment of the Stipulated Loss Value, if any (ii) all Lease payments payable from the date of payment of the Stipulated Loss Value up until expiry of the term (discounted at a rate equal to the 3% per annum (the "Discount Rate"), compounded monthly) and (iii) an amount calculated by multiplying the Equipment Total Cost with the applicable percentage specified in the next sentence. The applicable percentage will be 40% for Equipment having an initial Term of less than 24 months; 35% for Equipment having an initial Term of 24 months or greater, but less than 36 months; and 30% for Equipment having an initial Term of 36 months or greater.

You do not and will not: 1) export, re-export, or transfer any Equipment, software, source code or any direct product thereof to a prohibited destination, or to nationals of proscribed countries wherever located, without prior authorization from the United States and other applicable governments; and 2) use any Equipment, software or technology, technical data, or technical assistance related thereto or the products thereof in the design, development, or production of nuclear, missile, chemical, or biological weapons or transfer the same to a prohibited destination, or to nationals of proscribed countries, without prior authorization from the United States and other applicable governments. You are not an entity or person designated by the United States government or any other applicable government with which transacting business without the prior consent of such government is prohibited.

You are familiar with the U.S. Foreign Corrupt Practices Act, the U.K. Bribery Act, and other analogous anti-corruption legislation in other jurisdictions in which you conduct business or which otherwise apply to you, and with related regulations (collectively the "Anti-Corruption Laws"). You shall not in connection with this Lease: (i) make any improper payment or transfer anything of value, offer, promise or give a financial or other advantage or request to, or agree to receive or accept a financial or other advantage from, either directly or indirectly, any government official or government employee (including employees of a government corporation or public international organization) or to any political party or candidate for public office or to any other person or entity with an intent to obtain or retain business or otherwise gain an improper business advantage; or (ii) take any action which would cause us to be in violation of any Anti-Corruption Laws. You shall promptly notify us if you become aware of any violation of the representations and covenants set forth in this paragraph.

If you do not pay or perform any obligation under this Lease within 10 days of when such payment or performance is due, or you or any guarantor die, become insolvent or unable to pay debts when due; stop doing business as a going concern; merge, consolidate, transfer all or substantially all of your assets; make an assignment for the benefit of creditors, file bankruptcy, appoint a trustee or receiver or undergo a material adverse change in your financial or operating condition, we can do any or all of the following: (1) accelerate without notice all payments provided for in this Lease (discounted at the Discount Rate), (2) immediately repossess the Equipment or (absent Equipment repossession or return) claim a further amount equal to Stipulated Loss Value from you, (3) collect all costs of collection, including any bad check charges and reasonable attorneys' fees, (4) collect lost tax benefits and all unpaid amounts due hereunder, (5) sell or relet the Equipment, and (6) exercise all other remedies at law or equity. If we do not receive any payment when due, you will pay a one-time late charge on any overdue payment equal to the greater of $.10 per dollar for each late payment, or $15 (to compensate for the cost and expense of collecting and processing the late payment), plus a charge of 1 1/2% of the late payment for every month after the first month in which the payment is late (for damages including our inability to reinvest the late amount), but in any case, never to exceed more than the maximum charge allowed by law. In addition, if you are delinquent in payment, you agree to pay the actual out-of-pocket expenses incurred by us in our collection efforts (including, but not limited to, any bad check charges). Your payments may be applied, as we elect, first to the oldest amount due. Our action or failure to act on any one remedy shall not constitute an election of such as our sole remedy. Any provision of this Lease is severable if unenforceable. Any action or claim by you against us shall be commenced within one year after the cause of action arises or be forever barred.

You agree to sign such other documents and take such other actions as we may require to accomplish the intent and purpose of this Lease. All of your representations, warranties and obligations hereunder shall survive the termination of this Lease. All notices, demands and other communications required to be given under this Lease shall be in writing and shall be deemed to have been given if delivered personally or mailed via certified mail or a nationally recognized overnight courier service.

Hewlett-Packard Financial Services Company
200 Connell Drive, Suite 5000
Berkeley Heights, NJ 07922

TIME IS OF THE ESSENCE. THIS LEASE SHALL BE DEEMED FULLY EXECUTED AND PERFORMED IN THE STATE OF NEW JERSEY AND SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS THEREOF. TO THE EXTENT NOT PROHIBITED BY APPLICABLE LAW, THE PARTIES HERETO EXPRESSLY WAIVE ALL RIGHTS TO A TRIAL BY JURY IN ANY JURISDICTION. YOU WAIVE ANY STATUTORY PROVISIONS WHICH CONFLICT WITH THE TERMS OF THIS LEASE, INCLUDING BUT NOT LIMITED TO UCC ARTICLE 2A SECTION 303 AND SECTIONS 508 THROUGH 522. You acknowledge that neither any Vendor nor any Equipment salesperson is an agent of ours nor are they authorized to waive or alter the terms of this Lease. Their representations in no way affect any of our rights and obligations as herein set forth. If an E-Signature Rider is executed and delivered to us in connection with this Lease ("E-Rider"), such E-Rider will apply in the event this Lease and the Delivery and Acceptance Certificate (if requested) are submitted to you for electronic execution. You agree that an executed copy of this Lease bearing our original manual signature and your signature (either an original manual signature or such signature reproduced by means of a reliable electronic form, such as a photocopy, facsimile or, if you have executed this Lease electronically pursuant to an executed E-Rider, a printout of this Lease from our systems bearing your electronic signature), shall be marked "Original" by us and shall constitute the only original document for all effective purposes; all other copies shall be duplicates. To the extent this Lease constitutes chattel paper (as defined in the UCC), no security interest in this Lease may be created except by possession or transfer of the executed copy marked "Original" by us.

You acknowledge that certain personal information may be communicated to us in the course of the performance of the Lease and will be used by us to administer our rights and obligations under the Lease and any other agreement entered into between you and us. You confirm that you have obtained any requisite consent to the disclosure and processing of such information by us for that purpose. All such personal data will be processed in accordance with the Hewlett-Packard privacy policy in force from time to time (available at www.hp.com). You authorize us to share information related to this Lease with our affiliates for any reason and any third party as necessary to fulfill our obligations under this Lease.

By signing and initialing a copy of this Lease where required below (either on paper or electronically) and providing the deposit account information required by Schedule B, you are agreeing to all of the terms and conditions of this Lease, including the terms and conditions contained in Schedules A and B and Annex 1, each of which is hereby incorporated by reference into this Business Lease Agreement. This Lease shall become effective upon our acceptance hereof but we will have no obligation to purchase the Equipment until you have accepted it as set forth below.

LESSEE SIGNATURE HERE AND BELOW*

BY: _____

Print Name and Title of Signatory:

Michael E Mosier, CFO/Member

Read Carefully Before Signing

This lease is non-cancellable and is our full and final agreement, merging all prior understandings, and cannot be modified or terminated except by a written agreement signed by you and by a corporate officer of our company. You warrant to us that you have received, reviewed and approved your vendor's written supply contract covering the equipment terms of sale and warranties. You hereby authorize us to purchase the equipment in reliance solely upon your statements herein. By your initials below, you shall be deemed to have irrevocably accepted the equipment 10 business days after shipment of the equipment to you unless we receive your written rejection prior to the end of the 10-day period. However, you agree to execute and deliver to us a delivery and acceptance certificate upon our request. "Acceptance date" means the first business day following the expiration of such 10-day period or such other date set forth in any delivery and acceptance certificate requested by us. The term of this lease shall begin on the acceptance date.

*LESSEE (INITIAL) X _____

DATE: 1/15/16

ACCEPTED BY: HEWLETT-PACKARD FINANCIAL SERVICES COMPANY[1]

BY: _____ DATE: 4/29/16

Guaranty

In consideration of this Lease of Equipment to Lessee, and to be legally bound, the undersigned ("Guarantor") personally, irrevocably and unconditionally guarantees payment and performance of, and as a primary debtor agrees to be jointly and severally liable for (without becoming entitled to the benefits of) all obligations under this Lease until such obligations are satisfied. WE MAY PROCEED AGAINST THE GUARANTOR IN THE FIRST INSTANCE WITHOUT RESORTING TO OTHER REMEDIES, AND THE GUARANTOR WAIVES ANY STATUTORY OR OTHER RIGHT TO REQUIRE OTHERWISE. Guarantor waives subrogation rights; waives defenses and rights relating to impairment, invalidity, modification, extension of the Lease, or relating to substitution, dishonor, release or compromise of Lessee; waives demand, protest, presentment; and waives all notices related to any of the foregoing. Guarantor shall pay all costs of enforcement and collection including attorneys' fees. THIS GUARANTY SHALL BE GOVERNED BY THE LAWS OF NEW JERSEY. GUARANTOR CONSENTS TO THE PERSONAL JURISDICTION AND VENUE OF FEDERAL AND STATE COURTS IN NEW JERSEY. THE PARTIES HERETO EXPRESSLY WAIVE ALL RIGHTS TO A TRIAL BY JURY.

GUARANTOR SIGNATURE HERE:

Name	Address

BY: X _____

Soc. Sec #: _____

[1]Authorized to do business in the name of Hewlett-Packard Financial Services Company Inc. in Alabama and New York.

Hewlett-Packard Financial Services Company
200 Connell Drive, Suite 5000
Berkeley Heights, NJ 07922

Schedule A to Business Lease Agreement

Lease Agreement Number: 522744596928549USA2

Lessee (full legal name): SHARON SNF CT, LLC			
Billing Address: 135 SOUTH ROAD, FARMINGTON, CT 06032, UNITED STATES **Tax ID Number:**			
Telephone Number (including area code): **Fax Number (including area code):**			
Equipment Description: See Attached Annex 1 to this Schedule			
Equipment Location: (if different from Billing Address) 27 HOSPITAL HILL RD, SHARON, CONNECTICUT, 06069, UNITED STATES			
Vendor Information: CDW Government, Inc			
Term: 60 **Period:** Monthly **Payable:** Arrears	**End-of-Term Option:** DOLLAR OUT	**Periodic Lease Payment:** $554.56	**Tax on Periodic Lease Payment (if applicable):** $35.21 589.77
Advance Lease Payment:	**Tax on Advance Lease Payment (if applicable)**	**Documentation Fee:** $100.00	
The payment of any Advance Lease Payment reflected herein shall be a condition to Lessor's agreement to this Lease and may include either or both of the following: (a) applicable taxes, and/or (b) any other "Down Payment" (defined herein below). "Down Payment" shall mean such amount determined by Lessor required upon the execution of this Lease and shall be credited against the original cost of the Equipment leased under this Lease.		**Total First Payment:** $689.77 (The Total First Payment shall include any Advance Lease Payment, the first Periodic Lease Payment, any applicable taxes, and the Documentation Fee.)	

570.97
0.1462
34.267

Lessee's end of term options:
If you have on a timely basis fully complied with all the terms and conditions of this Lease, you may choose to exercise one of the following options upon the natural expiration of the term or any extension or renewal term on an "all or none" basis as to each option, provided however, you must give us written notice not less than ninety (90) days before expiration of the relevant term:

1. PURCHASE OPTIONS: You may purchase the Equipment for the Purchase Price (as defined below) on an "as-is, where-is" basis, without any representations or warranties, including no warranties of merchantability or fitness for a particular purpose. "Purchase Price" means (a) if you have selected a FMV End of Term Purchase Option (as indicated above), the then "Fair Market Value" (as defined below) of the Equipment (plus all applicable taxes), or (b) if you have selected a 10% End of Term Purchase Option (as indicated above), an amount equal to ten percent (10%) of the original Equipment cost (plus all applicable taxes), or (c) if you have selected a $1.00 End of Term Purchase Option (as indicated above), an amount equal to one dollar ($1.00) (plus all applicable taxes). "Fair Market Value" means the price that a willing buyer (who is neither a lessee in possession nor a used equipment dealer) would pay for the Equipment in an arm's-length transaction to a willing seller under no compulsion to sell; provided, however, that in such determination: (i) the Equipment will be assumed to be in the condition in which it is required to be maintained and returned under this Lease, (ii) in the case of any installed Equipment, that Equipment shall be valued on an installed basis, and (iii) costs of removal from the current location shall not be a deduction from such valuation. If you and we are unable to agree on the Fair Market Value of the Equipment at least thirty (30) days before Lease expiration, we will appoint an independent appraiser (reasonably acceptable to you and at your expense) to determine the Fair Market Value and such appraiser's determination will be final, binding and conclusive.

2. RENEWAL OPTION: You may renew the Lease at the then Fair Market Rental Value. "Fair Market Rental Value" means the amount of periodic rent that would be payable for the Equipment in an arm's length transaction between an informed and willing lessee and an informed and willing lessor, neither under compulsion to lease. Such amount will not be reduced by the costs of removing any Equipment from its current location or moving it to a new location. In the event of such an election, Lessee shall enter into a mutually agreeable renewal agreement with Lessor on or before the last day of the then applicable term confirming the period for which the Lease is to be renewed (the "Renewal Term"), and the amount of Rent and the times at which such Rent is to be payable during the Renewal Term.

3. EQUIPMENT RETURN OPTION: You may return the Equipment, at your expense, to a location designated by us on or before the last day of the Lease term. Upon return, the Equipment must be in the same condition as when you first received it (excepting only reasonable wear and tear) and include all original parts, attachments and accessories. For all Equipment to be returned to us, you agree to (a) remove any of your labels, tags or other identifying marks on the Equipment and wipe clean or permanently delete all data contained on the Equipment, including without limitation, any data contained on internal or external drives, discs, or accompanying media, and (b) pack the Equipment in accordance with the manufacturer's guidelines. You must also return to us all copies of any operating system software (including any certificate of authenticity) you received with the Equipment.

4. AUTOMATIC EXTENSION. IF THE LEASE DOES NOT CONTAIN A $1.00 END-OF-TERM PURCHASE OPTION, AND YOU FAIL TO DELIVER TO US THE END-OF-TERM NOTICE NOT LESS THAN NINETY (90) DAYS BEFORE THE EXPIRATION OF THE RELEVANT TERM, THEN, WITHOUT ANY ADDITIONAL NOTICE OR DOCUMENTATION, THE THEN RELEVANT TERM SHALL BE AUTOMATICALLY EXTENDED FOR SUCCESSIVE CALENDAR MONTHS WITH RESPECT TO ALL ITEMS OF EQUIPMENT SUBJECT TO THIS LEASE THROUGH THE END OF THE CALENDAR PERIOD FALLING AT LEAST 90 DAYS AFTER THE DATE YOU SHALL HAVE DELIVERED TO US AN END-OF-TERM NOTICE WITH RESPECT TO THIS LEASE AND ALL OTHER PROVISIONS OF THE LEASE SHALL CONTINUE TO APPLY. IF YOU DELIVER SUCH END-OF-TERM NOTICE, BUT SHALL HAVE SUBSEQUENTLY FAILED TO COMPLY WITH ITS OBLIGATIONS ARISING FROM THE ELECTIONS SPECIFIED THEREIN; THEN THE THEN APPLICABLE TERM OF THIS LEASE SHALL, WITHOUT ANY ADDITIONAL NOTICE OR DOCUMENTATION, BE AUTOMATICALLY EXTENDED. FOR EACH CALENDAR PERIOD THAT THE THEN APPLICABLE TERM OF THIS LEASE IS SO EXTENDED, YOU SHALL PAY TO US LEASE PAYMENTS IN AN AMOUNT EQUAL TO THE PERIODIC LEASE PAYMENT IN EFFECT IMMEDIATELY PRIOR TO SUCH EXTENSION AND ALL OTHER PROVISIONS OF THE LEASE SHALL CONTINUE TO APPLY.

Lessee (initial): ____________

Hewlett-Packard Financial Services Company
200 Connell Drive, Suite 5000
Berkeley Heights, NJ 07922

Annex 1 to the Schedule

Equipment Schedule Number 522744596928549USA2 Forming Part of Lease # 522744596928549USA2 between Lessor Hewlett-Packard Financial Services Company and Lessee SHARON SNF CT, LLC

QTY	ITEM NO.	DESCRIPTION	UNIT PRICE	EXTENDED PRICE
1	3881740	FORTINET 1YR 8X5 FC FORTIVOICEENT Mfg#: FVE-1000E-T-BDL-311-12 Contract: Premier - Yankee Alliance PP-IT-133 Electronic distribution - NO MEDIA	1,991.73	1,991.73
1	3881740	FORTINET 1YR 8X5 FC FORTIVOICEENT Mfg#: FVE-1000E-T-BDL-311-12 Contract: Premier - Yankee Alliance PP-IT-133 Electronic distribution - NO MEDIA	1,991.73	1,991.73
10	3123388	FORTINET FORTIFONE 260I W/4KEY Mfg#: FON-260I Contract: Premier - Yankee Alliance PP-IT-133	88.96	889.60
2	3697324	FORTINET IP PHONE DISP 8 Mfg#: FON-470I Contract: Premier - Yankee Alliance PP-IT-133	204.50	409.00
3	3254435	FORTINET FORTIFONE 870I HANDSET Mfg#: FON-870I-H Contract: Premier - Yankee Alliance PP-IT-133	131.00	393.00
2	3254432	FORTINET FORTIFONE FF-870I HNDSET Mfg#: FON-870I Contract: Premier - Yankee Alliance PP-IT-133	196.00	392.00
1	2993048	FORTINET FORTIFONE EXPANSION MODULE Mfg#: FF-50E Contract: MARKET	65.25	65.25
2	3946957	FORTINET 1YR 24X7 FC Mfg#: FC-10-FVE11-247-02-12 Contract: Premier - Yankee Alliance PP-IT-133 Electronic distribution - NO MEDIA	547.60	1,095.20
1	3944089	FORTINET FVC EXPANSION MOD W/PR BTN Mfg#: FF-70E Contract: Premier - Yankee Alliance PP-IT-133	170.51	170.51
2	3083341	FORTINET FORTIFONE 460I W/10 KEYS Mfg#: FON-460I Contract: Premier - Yankee Alliance PP-IT-133	266.72	533.44
26	3944128	FORTINET FORTIFONE 370I Mfg#: FON-370I Contract: Premier - Yankee Alliance PP-IT-133	159.97	4,159.22
24	2256590	FORTINET TRAVEL CREDIT Mfg#: FP-10-TE001-000-00-00 Contract: Premier - Yankee Alliance PP-IT-133	110.00	2,640.00
4	3483841	FORTINET ONSITE RESOURCE SVC Mfg#: FP-10-PS001-800-01-01 Contract: Premier - Yankee Alliance PP-IT-133	2,950.00	11,800.00
2	2964528	GRANDSTREAM 48-PORT FXS VOIP GTWY Mfg#: GS-GXW4248 Contract: Premier - Yankee Alliance PP-IT-133	1,016.70	2,033.40

Shipping **$58.75**

Total Amount **$28,620.23**

The described items constitute all the Equipment covered by the above referenced lease.

Lessee (initial): X_____

LEAF

LEASE AGREEMENT

1720A Crete Street, Moberly, MO 65270
Phone: 800-662-3759, Fax: 800-426-2626

LESSEE LEGAL NAME:	Tax ID#:	Telephone No:
Sharon Health Care	452207854	8603641002
Billing Address:	**Equipment Location (if other than Billing Address):**	
27 Hospital Hill Rd, Sharon, CT 06069	27 Hospital Hill Rd, Sharon, CT 06069	

EQUIPMENT DESCRIPTION: (indicate quantity, new or used and include make, model, serial # and all attachments—see below and/or attached Schedule A)

Unit Quantity	Description of Equipment Leased	Make and Type	Model Number	Serial Number
	* PLEASE REFER TO SCHEDULE A			

BASE TERM IN MONTHS	TOTAL NUMBER OF LEASE PAYMENTS	END OF LEASE PURCHASE OPTION		
50	2 @ $0.00 followed by 48 @ $800.00 (plus taxes)	X Fair market value, plus taxes ___ 10% of Equipment cost, plus taxes ___ $1.00, plus taxes (FMV unless another option is selected. You may not exercise a purchase option if you are in default. If you exercise a purchase option we will convey all of our right, title and interest in such Equipment to you on an AS-IS WHERE IS without warranty.)	(a) Advance Payment:	$0.00
			(b) Security Deposit:	$0.00
			(c) Documentation Fee:	$95.00
			Total due a+b+c=:	$95.00

If more than one lease payment is required as an Advance Payment, the balance will be applied to lease payments in inverse order, starting with the last lease payment. Your obligation to pay all amounts and perform all other obligations is non-cancellable, absolute, unconditional and not subject to abatement, set-off or defense.

TERMS AND CONDITIONS

In this agreement ("Lease"), "we," "our," and "us" refers to LEAF Capital Funding, LLC as Lessor and "you" and "your" refer to the Lessee. You agree to lease the Equipment upon the following terms and conditions:

1. LEASE PAYMENTS AND TERM: The Lease is enforceable on you upon your execution. The term of the Lease shall commence on the date the Equipment is delivered to you ("Lease Commencement Date"). The first Lease Payment shall be due on the date we specify in the month following the Lease Commencement Date as set forth in our invoice, and the remaining Lease Payments will be due on the same day of each subsequent month (each, a "Payment Date") until paid in full. The Base Term shall commence on the date one month prior to the first Payment Date. We may charge you a portion of one Lease Payment for the period from the Lease Commencement Date until the first day of the Base Term ("Interim Rent"). The Interim Rent shall be due as invoiced. We may adjust the Lease Payments up to 15% if the actual costs are different than the estimate used to calculate the Lease Payments.

2. DELIVERY, ACCEPTANCE, USE AND REPAIR: You are responsible for Equipment delivery and installation. You unconditionally accept the Equipment upon the earlier of (a) your oral or written acceptance of the Equipment, or (b) 10 days after delivery of the Equipment. You authorize us to fill in the Lease Commencement Date, serial numbers and other information. You will not move the Equipment from the above location without our written consent and are responsible for maintaining the Equipment in good repair. We are not responsible for Equipment or vendor failures.

3. INDEMNIFICATION: You agree to indemnify, defend and hold us harmless from and against any losses, damages, penalties, claims and suits, including attorneys' fees and expenses related to the ordering, manufacture, installation, ownership, condition, use, lease, possession, delivery or return of Equipment.

4. LEASE EXPIRATION, RENEWAL: Unless you notify us at least 90 days prior to the expiration of the Lease of your election to return or purchase the Equipment, this Lease will renew on a month-to-month basis at the same monthly Lease Payment until you either exercise the purchase option or provide us with at least 90 days notice and return the Equipment. If you return the Equipment, (i) it must be to the location we designate and you are responsible for all return costs and we may charge a Restocking Fee equal to one Lease Payment, and (ii) you must securely remove all data from any and all disk drives or magnetic media prior to returning the Equipment (and you are solely responsible for selecting an appropriate removal standard that meets your business needs and complies with applicable laws). You will pay us for any loss in value resulting from failure to maintain the Equipment in accordance with this Lease or for damages incurred in shipping and handling. If you exercise a purchase option we will convey all of our interest in such Equipment to you on an AS-IS WHERE IS basis without representation or warranty.

5. LATE FEES AND CHARGES: If any amount is not paid within five (5) days of when due, you agree to pay us a late charge equal to the lesser of 10% of the amount past due or the maximum legal amount. Amounts which are not paid within 30 days of when due shall accrue interest at 1.5% per month (or if less, the maximum legal rate) until paid. You agree to pay $25 for each pay by phone and $35 for each returned payment.

6. NO WARRANTY: We do not manufacture the Equipment and you have selected the Equipment and the supplier. **WE MAKE NO EXPRESS OR IMPLIED WARRANTIES, INCLUDING THOSE OF MERCHANTABILITY OR FITNESS FOR A PURPOSE AND ARE NOT RESPONSIBLE FOR CONSEQUENTIAL OR INCIDENTAL DAMAGES.**

7. INSURANCE, RISK OF LOSS: You bear all risk of loss or damage to the Equipment from its order until it is returned in the required condition or purchased by you ("Risk Period"). During the Risk Period you will maintain property and liability insurance on the Equipment acceptable to us, naming us loss payee and additional insured. If you do not provide us with proof of such insurance, we may secure insurance on the Equipment to cover our interests (and only our interests). If we obtain such insurance, you will pay us an additional amount for the cost of such insurance and an administrative fee, the cost of which may be more than the cost to obtain your own insurance and on which we may make a profit.

8. OWNERSHIP AND TAXES: We own the Equipment (excluding licensed software). If you are deemed to own it, you grant us a security interest in the Equipment. You authorize us to file UCC financing statements to confirm our interest. You will pay, when due, all taxes, fines and penalties relating to the purchase, use, leasing and/or ownership of the Equipment. If we pay any taxes, (including property tax), fees or penalties on your behalf, you will pay us the amount we paid plus an administrative fee. You agree to pay us the documentation fee specified above or if not so specified, the greater of either $125 or 0.5% of the Equipment cost. If we require an Equipment site inspection, or you request administrative services, you agree to reimburse our costs.

9. DEFAULT: If you or any guarantor do not pay us any amount within ten (10) days of its due date, or breach any terms of this Lease, any guaranty or any license relating to the Equipment, you will be in default. If you default, we may require you to do any combination of the following: (a) immediately pay all amounts then due, plus the present value of the remaining Lease Payments, Interim Rent and residual value of the Equipment, as determined by us, discounted at an annual rate of 3%; (b) return all of the Equipment; (c) allow us to repossess the Equipment; or (d) use any and all remedies available to us under applicable law. If you default, you agree to pay the cost of repossession and our attorney's fees and costs. In addition to all other charges and as reimbursement for expenses incurred and not as a penalty, we may require you to reimburse us for the phone calls, letters, and any additional expense incurred in the collection or servicing of this Lease for you. If we take possession of the Equipment, we may sell or otherwise dispose of it with or without notice, at a public or private sale, and apply the net proceeds (after we have deducted all costs related to the sale or disposition of the Equipment) to the amounts that you owe us. You agree that if notice of sale is required by law, 10 days' notice shall constitute reasonable notice. You remain responsible for any amounts that are due after we have applied such net proceeds. We may apply any security deposits to your obligations and if you do not default, the balance will be refunded without interest.

10. ASSIGNMENT: You have no right to sell or assign the Equipment or Lease. We may sell or assign our rights in the Lease and/or Equipment and the new owner will have all our rights but will not be subject to any claim or defense you have against us.

11. ARTICLE 2A: You agree this Lease is a "finance lease" as defined in Article 2A of the Uniform Commercial Code. You waive all rights and remedies conferred upon a lessee by Article 2A (508-522) of the UCC. You have received a copy of the Supply Contract or been informed of the identity of the Supplier and you may have rights under the Supply Contract and may contact the Supplier for a description of those rights.

12. CREDIT INFORMATION: You authorize us or any of our affiliates to obtain credit bureau reports, and make other credit inquiries that we deem necessary.

13. CHOICE OF LAW: THIS LEASE WILL BE GOVERNED BY PENNSYLVANIA LAW. YOU CONSENT TO JURISDICTION IN THE STATE OR FEDERAL COURTS IN PENNSYLVANIA AND WAIVE ANY RIGHT TO A TRIAL BY JURY.

14. MISCELLANEOUS: This Lease is the parties' entire agreement and can be amended only in writing signed by both parties. This Lease may be executed in counterparts (manually or by electronic means) and, when transmitted to us shall be binding upon you for all purposes. This Lease is not binding on us until we sign it. You agree not to raise as a defense to the enforcement of this Lease that it was executed or transmitted to us by electronic means. You will use the Equipment only for business purposes and not for personal, family or household use.

ACCEPTED BY LESSEE: Sharon Health Care

Print Name: Todd Pavlicks Title: IT Manager

Lessee Authorized Signature E-Mail Address: Date: 6/8/16

PERSONAL GUARANTY: Undersigned guarantees that Lessee will make all payments and perform all other obligations under the Lease when due. Undersigned agrees that this is a guaranty of payment and not of collection, and that we can proceed directly against undersigned without first proceeding against Lessee or the Equipment. Undersigned also waives all suretyship defenses and notification if the Lessee is in default and consents to any extensions or modifications granted to Lessee. Undersigned will pay us all expenses (including attorneys' fees) we incur in enforcing our rights against undersigned or Lessee. If more than one person signs this guaranty, each agrees that his/her liability is joint and several. Undersigned authorizes us and our affiliates to obtain credit bureau reports and make inquiries regarding undersigned's personal credit. You consent to jurisdiction in the State or Federal courts in Pennsylvania and expressly waive any right to a trial by jury.

SIGNED X Print Name: E-Mail Address:

Accepted by:
LEAF Capital Funding, LLC By: Title: Operations Manager Date: 6/15/2016

LEAF

SCHEDULE A TO LEASE AGREEMENT
(EQUIPMENT DESCRIPTION)

Lease Application No.: 360441

QNT	Equipment Description	New/Used	Make	Model	Serial Number
	Location: 27 Hospital Hill Rd, Sharon, CT 06069				
1	Xerox 7970 Copier System	New			B0W593593
8	Xerox 3655 Copier Systems	New			C7X369015 C7X369005 C7X369007 C7X369271 C7X369274 C7X370848 C7X370932

LESSEE: Sharon Health Care

BY: _____

PRINT NAME: Todd Panilaitis

TITLE: IT Manager

DATE: 6/8/16

LEAF CAPITAL FUNDING, LLC

BY: _____

PRINT NAME: John Corderman

TITLE: Operations Manager

DATE: 6/15/2016

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	7	37

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

☑ Accrual ☐ Cash ☐ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 **Marcum LLP**	**185 Asylum Street, Hartford, CT 06103**
2 **Marcum LLP**	**185 Asylum Street, Hartford, CT 06103**
3 "	
4 "	

Services Provided by This Firm (*describe fully*)

1	**2016 Audit fees(22,000-allowed), 2016Tax Return (4,125-allowed)**	**$ 26,125**
2	**2015 Medicare Cost report-allowed**	**$ 2,650**
3	**2015 affiliate tax return -disallowed**	**$ 2,155**
4	**2015 Form 8752-disallowed**	**$ 500**

Charge for Services Provided **$31,430**

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

☑ Yes ☐ No **Pg 15, Line1d**

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 **Murtha, Cullina, LLP**	**860-240-6000**
2 **Goldman, Gruder, & Woods**	**203-899-8900**
3 **Goldman, Gruder, & Woods**	**203-899-8900**
4 **Litchfield Hills Probate**	**860-824-7012**
5	

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

1 **City Place, 185 Asylum St., Hartford, CT 06103**
2 **200 Connecticut Ave, Norwalk, CT 06854**
3 **200 Connecticut Ave, Norwalk, CT 06854**
4 **100 Pease St., Canaan, CT 06018**
5

Services Provided by This Firm (*describe fully*)

1	**Title servies/resident discharge issue (disallowed)**	**$ 466**
2	**A/R Collections (disallowed)**	**$ 22,767**
3	**Audit letter -allowed**	**$ 660**
4	**Probate Hearings-disallowed**	**$ 225**
5		$ -

Charge for Services Provided **$24,118**

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

☑ Yes ☐ No **Pg 15, Line 1e**

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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**09/30/16**	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period.....	**88**	**88**			**88**	**88**			**88**	**88**		
B. On last day of THIS report period.....	**88**	**88**			**88**	**88**			**88**	**88**		
2. Number of Residents												
A. As of midnight of PREVIOUS report period.....	**75**	**75**			**75**	**75**			**75**	**75**		
B. As of midnight of THIS report period.....	**81**	**81**			**75**	**75**			**81**	**81**		
3. Total Number of Days Care Provided During Period												
A. Medicare.....	**4,373**	**4,373**			**3,183**	**3,183**			**1,190**	**1,190**		
B. Medicaid (Conn.).....	**17,046**	**17,046**			**13,067**	**13,067**			**3,979**	**3,979**		
C. Medicaid (other states).....	**3,734**	**3,734**			**2,797**	**2,797**			**937**	**937**		
D. Private Pay.....	**2,789**	**2,789**			**2,038**	**2,038**			**751**	**751**		
E. State SSI for RCH.....												
F. Other (Specify) Managed Care	**477**	**477**			**245**	**245**			**232**	**232**		
G. Total Care Days During Period (3A thru F).....	**28,419**	**28,419**			**21,330**	**21,330**			**7,089**	**7,089**		
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.....	**11**	**11**			**11**	**11**						
5. ***Total Resident Days*** **(3G + 4A + 4B).....**	**28,430**	**28,430**			**21,341**	**21,341**			**7,089**	**7,089**		

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

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	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
				Lost			Gained						
	CCNH (1)	RHNS (2)	(Specify) (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	15	58		6		2		
Per Diem Rate								
a. One bed rm.	579.69	247.89		490.00		529.55		
b. Two bed rms.	579.69	247.89		475.00		529.55		
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	5,084	5,084		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	468	468		
2. Restorative Treatments				
C. Other	12,582	12,582		
D. ***Total Physical Therapy Treatments***	18,134	18,134		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	1,687	1,687		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	8	8		
2. Restorative Treatments				
C. Other	863	863		
D. ***Total Speech Therapy Treatments***	2,558	2,558		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,998	3,998		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	448	448		
2. Restorative Treatments				
C. Other	11,985	11,985		
D. ***Total Occupational Therapy Treatments***	16,431	16,431		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	10	37

Are time records maintained by all individuals receiving compensation? ☑ Yes ☐ 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)	131,388	2,048				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	213,842	9,411				
5. Dietary Service						
a. Head Dietitian	131					
b. Food Service Supervisor	68,000	2,132				
c. Dietary Workers	325,715	21,046				
6. Housekeeping Service						
a. Head Housekeeper	49,744	2,042				
b. Other Housekeeping Workers	172,019	11,825				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	60,368	2,214				
b. Other Maintenance Workers	40,105	1,902				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	72,566	5,554				
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	124,953	2,079				
b. RN						
1. Direct Care	415,565	11,275				
2. Administrative**	382,511	13,464				
c. LPN						
1. Direct Care	665,201	22,471				
2. Administrative**						
d. Aides and Attendants	1,096,538	63,110				
e. Physical Therapists	455,251	12,621				
f. Speech Therapists	73,473	1,892				
g. Occupational Therapists	202,320	5,139				
h. Recreation Workers	150,419	7,326				
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	147,862	5,680				
n. Marketing						
o. Other (Specify)						
A-13. Total Salary Expenditures	4,847,971	203,231				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Physician: Other Fees (Page 13)

Service	$ CCNH	Hours CCNH	$ RHNS	Hours RHNS	$ (Specify)	Hours (Specify)
Psych Consulting Services	$ 32,800	52				
Total	$ 32,800	52	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

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

State of Connecticut
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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	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* **										
John Hortsman (10/01/15-09/30/16)	131,388			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,048	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**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	7,490	96				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	47,961	740				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	59,500	704				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	22,870	92				
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	32,800	52				
9. Speech Therapist						
a. Resident Care	9,510	27				
b. Other						
10. Occupational Therapist						
a. Resident Care	124,453	1,980				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	162,253	2,843				
2. Administrative***	1,295	22				
b. LPN						
1. Direct Care	101,155	1,984				
2. Administrative***						
c. Aides	109,729	3,929				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	679,016	12,469				

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Dr. Sabooh Mubbashar, 123 Peck Hill Road, Woodbridge, CT 06525	Psychiatrist	☐	☑	
Douglas Finch, PO Box 1009, Kent, CT 06757	Physician	☐	☑	
N M Orthopedic Associates, 131 Kent Rd, New Milford, CT 06776	Physician	☐	☑	
Evan Rashkoff, MD, 269 Indian Mountain Road, Lakeville, CT 06039	Assistant Medical Director	☐	☑	
Omnicare of Connecticut, 525 Knotter Drive, Cheshire, CT 06410	Pharmacist	☐	☑	
Healthdrive, 85 Barnes Rd, Wallingford, CT 06492	Podiatrist, Ophthalmologist, & Dental	☐	☑	
Mark Marshall, DO, 32 Burton Road, Salisbury, CT 06068	Medical director	☐	☑	
Quotidian, 52 Seneff Road, Washington, CT 06793	Assistant Medical Director	☐	☑	
Procare Professional Healthcare, P.O. Box 823461, Philadelphia, PA 19182	Nurse Pool	☐	☑	
Access Therapies, Inc., P.O. Box 823461, Philadelphia, PA 19182	Physical Therapist	☐	☑	
Ready Nurse Staffing Services, PO Box 200528, Houston, TX 77216	Nurse Pool	☐	☑	
Nurse Network, 653 Main Street, Plantsville, CT 06479	Nurse Pool	☐	☑	
Procare, LTC, 111 Executive Blvd., Farmingdale, NY 11735	Pharmacist	☑	☐	Common Owners
Athena Health Care, 135 South Road, Farmington, CT 06032	MDS Nurse - Fill-in	☑	☐	Common Owners
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* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	14A	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
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* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	14B	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
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* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2016	14C	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
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* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	14D	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
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* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation.....	$	247,410	247,410		
2. Disability Insurance.....	$				
3. Unemployment Insurance.....	$	104,469	104,469		
4. Social Security (F.I.C.A.).....	$	359,309	359,309		
5. Health Insurance.....	$	681,568	681,568		
6. Life Insurance (employees only)					
(not-owners and not-operators).....	$				
7. Pensions (Non-Discriminatory)	$	17,011	17,011		
(not-owners and not-operators).....					
8. Uniform Allowance.....	$	169	169		
9. Other (*Specify*).....	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*.....	$	114,449	114,449		
d. Accounting and Auditing.....	$	31,430	31,430		
e. Legal (*Services should be fully described on Page 7)*	$	24,118	24,118		
f. Insurance on Lives of Owners and Operators (*Specify*)*.....	$				
g. Office Supplies.....	$	57,144	57,144		
h. Telephone and Cellular Phones.....					
1. Telephone & Pagers.....	$	11,133	11,133		
2. Cellular Phones.....	$	1,579	1,579		
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*.....	$	250	250		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	505,704	505,704		
Subtotal	$	2,155,743	2,155,743		

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

(Carry Subtotals forward to next page)

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

State of Connecticut
Annual Report of Long-Term Care Facility
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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,155,743	2,155,743		
l. Travel and Entertainment					
1. Resident Travel and Entertainment.....	$				
2. Holiday Parties for Staff.....	$	2,850	2,850		
3. Gifts to Staff and Residents.....	$	13,977	13,977		
4. Employee Travel.....	$	1,865	1,865		
5. Education Expenses Related to Seminars and Conventions	$	12,805	12,805		
6. Automobile Expense (*not purchase or depreciation*).....	$	7,590	7,590		
7. Other (*Specify*).....	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*).....	$	27,335	27,335		
2. Advertising Telephone Directory (*all such expenses*)***	$	1,633	1,633		
3. Advertising Other (*Specify*)***.....	$	21,512	21,512		
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.....	$	9,894	9,894		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	7,155	7,155		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions.....	$	530	530		
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**.....	$	2,586	2,586		
13. Other (*Specify*) See Attached Schedule	$	95,584	95,584		
C-14 Total Administrative & General Expenditures	$	2,361,059	2,361,059		

* 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	$ 21,512		
Total Other Advertising	$ 21,512	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF/ACHCA DUES	$ 7,155		
Total Dues	$ 7,155	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Lobbying Fees	$ 2,947		
Data Processing Fees	$ 18,264		
Bank Charges	$ 12,523		
Payroll Processing Fees	$ 18,435		
Employee Physicals and bavkground checks	$ 16,559		
Medicaid 4 U	$ 2,000		
Compliance Consulting	$ 9,306		
DHP Case #	$ 2,320		
Licenses	$ 2,730		
CMS Case #2016-01-LTC-142	$ 10,500		
Total Other Administrative and General	$ 95,584	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility **Sharon SNF CT LLC, d/b/a Sharon Health Care Center**	License No. **2382**	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 #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032		Full Management Services	See Below
Amounts added back on Page 28		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	$2,586	Admin/Gen-Other Expense	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.**

State of Connecticut
Annual Report of Long-Term Care Facility
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 of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food.....	$	193,638	193,638		
2. Non-Food Supplies.....	$	20,438	20,438		
3. Other (*Specify*)_____	$	1,537	1,537		
Dishes = $1,537					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**.....	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	215,613	215,613		
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*		233	233		
H. Is cost of employee meals included in 2E?		☑ Yes	☐ No		
I. Did you receive revenue from employees?		☐ Yes	☑ No	If yes, specify amount.	
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?		☑ Yes	☐ No	If yes, specify cost. = $3563	
L. Is any revenue collected from these people?		☑ Yes	☐ No	If yes, specify amount. = $3148	
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				**Pg 18, Line 2a1**	
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?		☐ Yes	☑ No	If yes, specify cost.	
O. Is any revenue collected from employees?		☐ Yes	☑ No	If yes, specify amount.	
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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

State of Connecticut
Annual Report of Long-Term Care Facility
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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	10,350	10,350		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**.....	$				
d. Other (*Specify*) **Supplies = $4,900**	$	4,900	4,900		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	15,250	15,250		

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

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 9/2002

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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel		40,000	40,000		
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	24,381	24,381		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel		40,000	40,000		
	Amt.	$				
c. Management Services*.....		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)....		$	24,381	24,381		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy.....		$				
2. Purchased from **Omni Care**		$	238,942	238,942		
b. Medicine Cabinet Drugs.....		$	12,932	12,932		
c. Medical and Therapeutic Supplies.....		$	176,805	176,805		
d. Ambulance/Limousine***.....		$	2,285	2,285		
e. Oxygen						
1. For Emergency Use.....		$				
2. Other***.....		$	38,309	38,309		
f. X-rays and Related Radiological Procedures***.....		$	20,887	20,887		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***.....		$	29,569	29,569		
i. Recreation.....		$	32,502	32,502		
j. Other (Specify)**** See Attached Schedule		$	124,016	124,016		
5K. ***Total Resident Care Expenditures*** (5a - 5j).....		$	676,247	676,247		

* 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)**
Physical Therapy Supplies	$ 48,344		
Medical Equipment Rental-Medicaid	$ 15,574		
Cable TV Services	$ 19,722		
Oxygen Equipment Rental	$ 3,753		
Medical Equipment Rental-Other	$ 35,917		
Speech Therapy Supplies	$ 706		
Total Other Resident Care	$ 124,016	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**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	100 Corporate Drive, Windsor, CT 06095	☐	☑		Payroll Processing	18,435			16	m13
Ct Waste Processing	PO Box 99, Plainville, CT 06062	☐	☑		Rubbish Removal	29,015			22	6f
Procare	111 Executive Blvd., Farmingdale, NY 11735	☑	☐	Common Owners	Pharmacy	139,500			16	m13
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							

* 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).

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	22 | 37

Item	Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance..... $	82,289	82,289		
b. Heat..... $	53,893	53,893		
c. Light & Power..... $	95,434	95,434		
d. Water..... $	57,968	57,968		
e. Equipment Lease (*Provide detail on page 6*)..... $	22,170	22,170		
f. Other (*itemize*)..... $	76,513	76,513		
See Attached Schedule				
6g. ***Total Maint. & Operating Expense*** (6a - 6f)..... $	388,267	388,267		
7. Depreciation (*complete schedule page 23**)				
a. Land Improvements..... $				
b. Building & Building Improvements..... $				
c. Non-Movable Equipment..... $	17,550	17,550		
d. Movable Equipment..... $	51,677	51,677		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)..... $	69,227	69,227		
8. Amortization (*Complete att. Schedule Page 24**)				
a. Organization Expense..... $				
b. Mortgage Expense..... $				
c. Leasehold Improvements..... $	44,498	44,498		
d. Other (*Specify*)..... $				
*8e. ***Total Amortization Costs*** (8a + b + c + d)..... $	44,498	44,498		
9. Rental payments on leased real property less real estate taxes included in item 10b..... $	355,088	355,088		
10. Property Taxes				
a. Real estate taxes paid by owner..... $				
b. Real estate taxes paid by lessor..... $	52,055	52,055		
c. Personal property taxes..... $	2,530	2,530		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)..... $	523,398	523,398		

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

Schedule of Other Repairs and Maintenance

Description	**CCNH**	**RHNS**	**(Specify)**
Groundskeeping	$ 12,876		
Rubbish Removal	$ 29,015		
Snow Removal	$ 6,115		
Supplies	$ 28,507		
Total Other Repairs and Maintenance	$ 76,513	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal.....								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	208,608		208,608	50,657			17,434	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	1,157		1,157		SL	Various	116	
C-4. Subtotal.....								17,550

	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. **Ford, E35YCUTA, 2003**	x		4	2013	10,000		10,000	7,000	SL	10	2,000	
b. **Bus Graphics**			9	2014	4,668		4,668	2,334	SL	5	934	
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	2013	324,739		324,739	127,144	S/L	Var	45,882	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2014	40,981		40,981		S/L	Var	2,861	
D-3. Subtotal.....												51,677
E. ***Total Depreciation***												69,227

*

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:					
Mar-16	Inverter for Washer/Memory Chip	$ 1,157	5	$ 116	
		$ -			
Total additions for Non-Movable Equipment		$ 1,157		$ 116	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Oct-15	Ultracare Beds (2) with Panels/rails/controls	$ 4,052	10	$ 203	
Oct-15	Quick Move transfer aid	$ 2,080	10	$ 104	
Dec-15	HP SB 250 computer with mouse/keyboard	$ 550	3	$ 92	
Dec-15	R C A 32" TV's with tilt mounts	$ 1,638	5	$ 164	
Jan-16	Mitsubishi Inverter with memory chip	$ 1,119	10	$ 56	
Jan-16	Ultracare Beds (2) with Panels/rails/controls	$ 4,052	10	$ 203	
Jan-16	Wireless Cards for Kiosks (20)	$ 546	5	$ 55	
Feb-16	HVAC Inverter FR-D720 with memory chip	$ 1,120	10	$ 56	
Mar-16	Fortinet fortifone 371i (3) Inv CGP5195	$ 627	5	$ 63	
Mar-16	Fortinet fortifone 371i (3) Inv CGR7662	$ 627	5	$ 63	
Mar-16	HP SB 450 laptop with stand/tag	$ 570	3	$ 95	
Apr-16	Ultracare Beds (2) with Panels/rails/controls	$ 4,052	10	$ 203	
Apr-16	HP SB 280 G1 Desktops (2)	$ 816	3	$ 136	
Apr-16	HP SB 450-G2 Laptops (2)	$ 1,128	3	$ 188	
May-16	Tumbler for dryer	$ 1,835	5	$ 184	
May-16	Tumbler for dryer	$ 1,672	5	$ 167	
May-16	1 HP Motor for dryer	$ 1,048	5	$ 105	
Jun-16	Conveyer drive for dishwasher	$ 1,102	5	$ 110	
Aug-16	Ultracare Beds (2) with Panels/rails/controls	$ 4,052	10	$ 203	
Sep-16	Distributor for Air Conditioning unit	$ 8,295	10	$ 415	
Total additions for Movable Equipment		$ 40,981		$ 2,861	*
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:					
Jan-16	3/4 " PVC Sign-	$ 2,972	10	$ 149	
Feb-16	Kohler radiator, Fuel gauge, cabling and coolar	$ 12,110	25	$ 242	
Feb-16	24 VDC power supply for mag-lock system	$ 1,281	10	$ 64	
Feb-16	Hot water coil, ductwork and piping	$ 11,699	15	$ 390	
Apr-16	Entrance sign 36" x 60" Logo Blue w metallic	$ 1,835	10	$ 92	
May-16	7.5 HP pump motor for heating system	$ 1,744	5	$ 174	
Jun-16	Sprinkler heads in kitchen (14)	$ 2,396	25	$ 48	
Aug-16	Door sounders	$ 1,355	10	$ 68	
Total additions for Leasehold Improvements		$ 35,392		$ 1,227	*
Deletions:					
Total deletions for Leasehold Improvements		$ -		$ -	**

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**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. **Finance Fees**									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other** (Specify)									
1. Acquired prior to this report period				352,211	88,913	SL		43,271	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2016	Various	35,391		SL	Var	1,227	
C-4. Subtotal									44,498
D. *Total Amortization*									44,498

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility

Supplemental Page

Amortization Schedule - Detail of Leasehold Improvements & Other

Name of Facility			License No.		Report for Year Ended			Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center			**2382**		**9/30/2016**			24A	37
C. **Leasehold Improvements** (Specify)									
1. Acquired prior to this report period				352,211	88,913	SL		43,271	
2. Disposals (attach schedule)									
3. Acquired during this report period	9	2016	5 YEARS	35,391		SL	0	1,227	
C-4. Subtotal									44,498
C. **Other** (Specify)									
1. Goodwill									
2.									
C-4. Subtotal									
Total Acquired prior to this report period				352,211	88,913	SL		43,271	
Total Disposals									
Total Acquired during this report period	9	2016	Various	35,391		SL	Var	1,227	

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	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	04/10/12
4. Date of Initial Licensure	04/10/12
5. Total Licensed Bed Capacity	88
6. Square Footage	40,000
7. Acquisition Cost	
a. Land	430,400
b. Building	6,024,600

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	04/10/12			
c. Interest Rate for the Cost Year	5.05%			
d. Term of Mortgage (number of years)	7			
e. Amount of Principal Borrowed	5,100,000			
f. Principal balance outstanding as of 9/30/2016	4,586,798			
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**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)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**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*)..... $	56,334	56,334		
Vender Interest = ($5,015); Interest Seller Note = $61,349				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D).....$	56,334	56,334		
14. Insurance				
a. Insurance on Property (buildings only)..... $	60,594	60,594		
b. Insurance on Automobiles..... $	1,336	1,336		
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)... $	61,930	61,930		
15. ***Total All Expenditures (A-13 thru C-14)*****.....** $	9,849,466	9,849,466		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2002

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**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.	10	A12g	Occupational Therapy..... $	202,320	202,320		
4.	Var	Var	Other - See attached Schedule..... $	10,922	10,922		
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **..... $	22,870	22,870		
6.	13	B10a	Occupational Therapy..... $	124,453	124,453		
7.			Other - See attached Schedule..... $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits..... $				
9.	15	1c	Bad Debts..... $	114,449	114,449		
10.	15	1d&e	Accounting & Legal..... $	26,113	26,113		
11.			Telephone..... $				
12.	15	1h2	Cellular Telephone..... $	499	499		
13.			Life insurance premiums on the life of Owners, Partners, Operators..... $				
14.	16	l3	Gifts, flowers and coffee shops..... $	13,977	13,977		
15.	16	l5	Education expenditures to colleges or universities for tuition and related costs for owners and employees..... $	2,449	2,449		
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 *..... $	23,145	23,145		
19.	15	1j&k1 &2	Income Tax / Corporate Business Tax... $	250	250		
20.			Fund Raising / Contributions..... $				
21.	16	m12	Unallowable Management Fees..... $	(96,638)	(96,638)		
	18	2c	$	(23,427)	(23,427)		
	20	5j	$	(26,356)	(26,356)		
22.	16	m6	Barber and Beauty..... $				
23.	Var	Var	Other - See attached Schedule..... $	39,596	39,596		
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents..... $	415	415		
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) $	435,037	435,037		

* 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	10,922		
Total Other Salaries Adjustment			$ 10,922	$ -	$ -

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	12,523		
16	M13	Lobbying Fees	2,947		
16	M13	Compliance Consulting	9,306		
16	M13	Penalties	12,820		
16	M13	Medicaid 4 U	2,000		
Total Other A&G Adjustments			$ 39,596	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 10/2006

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

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	435,037	435,037		
Page 20 - Resident Care Supplies***							
27.	20	5a1&2	Prescription Drugs..... $	238,942	238,942		
28.	20	5d	Ambulance/Limousine..... $	2,285	2,285		
29.	20	5f	X-rays, etc..... $	20,887	20,887		
30.	20	5h	Laboratory..... $	29,569	29,569		
31.	20	5c	Medical Supplies..... $	8,800	8,800		
32.	20	5e2	Oxygen (non emergency)..... $	38,309	38,309		
33.			Occupational Therapy..... $				
34.	Var	Var	Other - See Attached Schedule..... $	35,917	35,917		
Page 22 - Maintenance and Property							
35.	Var	Var	Excess Movable Equipment Depreciation See Attached Schedule..... $	4,549	4,549		
36.	22	7d	Depreciation on Unallowable Motor Vehicles..... $	2,934	2,934		
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..... $	16,122	16,122		
44.			Vending Machine Revenue..... $				
45.			Purchase Discounts and Allowances..... $				
46.			Duplications of functions or services.... $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest..... $				
48.	30	IV5	Interest Income on Accounts Rec..... $				
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)*** ..... $	833,351	833,351		

*** 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-Other	35,917		
Total Other Ancillary Costs			$ 35,917	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Movable Equipment (See Attached)	4,549		
Total Excess Movable Equipment Depreciation			4,549		

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			$ -	$ -	$ -

Schedule of Unallowable Building Interest

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	8,300,961	8,300,961		
b. Medicaid Room and Board Contractual Allowance **	$	(4,067,209)	(4,067,209)		
2. a. Medicaid (*All other states*)	$	1,759,235	1,759,235		
b. Other States Room and Board Contractual Allowance **	$	(864,427)	(864,427)		
3. a. Medicare Residents (*all inclusive*)	$	1,881,880	1,881,880		
b. Medicare Room and Board Contractual Allowance **	$	485,626	485,626		
4. a. Private-Pay Residents and Other	$	1,602,414	1,602,414		
b. Private-Pay Room and Board Contractual Allowance **	$	42,860	42,860		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	226,439	226,439		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(226,439)	(226,439)		
c. Prescription Drugs - Non-Medicare	$	109,907	109,907		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(109,907)	(109,907)		
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	86	86		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(86)	(86)		
3. a. Physical Therapy - Medicare	$	690,936	690,936		
b. Physical Therapy - Medicare Contractual Allowance **	$	(556,429)	(556,429)		
c. Physical Therapy - Non-Medicare	$	117,824	117,824		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(116,384)	(116,384)		
4. a. Speech Therapy - Medicare	$	233,652	233,652		
b. Speech Therapy - Medicare Contractual Allowance **	$	(141,455)	(141,455)		
c. Speech Therapy - Non-Medicare	$	14,329	14,329		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(14,329)	(14,329)		
5. a. Occupational Therapy - Medicare	$	646,951	646,951		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(547,623)	(547,623)		
c. Occupational Therapy - Non-Medicare	$	109,028	109,028		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(108,938)	(108,938)		
6. a. Other (*Specify*) - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	(1,199)	(1,199)		
III *Total Resident Revenue* (Section I.thru Section II.)	$	9,467,703	9,467,703		
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)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	3,600	3,600		
V. Total Other Revenue (1 thru 8)	$	3,600	3,600		
VI. Total All Revenue (III + V)	$	9,471,303	9,471,303		

* *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	Medicare Retroactive	$ (1,199)		
Total Other Resident Revenue		$ (1,199)	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
		N/A			
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Bad Debt Recoveries	$ 3,600		
Total Other Revenue		$ 3,600	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	8,300,961	8,300,961		
b. Medicaid Room and Board Contractual Allowance **	$	(4,067,209)	(4,067,209)		
2. a. Medicaid (*All other states*)	$	1,759,235	1,759,235		
b. Other States Room and Board Contractual Allowance **	$	(864,427)	(864,427)		
3. a. Medicare Residents (*all inclusive*)	$	1,881,880	1,881,880		
b. Medicare Room and Board Contractual Allowance **	$	485,626	485,626		
4. a. Private-Pay Residents and Other	$	1,602,414	1,602,414		
b. Private-Pay Room and Board Contractual Allowance **	$	42,860	42,860		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	226,439	226,439		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(226,439)	(226,439)		
c. Prescription Drugs - Non-Medicare	$	109,907	109,907		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(109,907)	(109,907)		
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	86	86		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(86)	(86)		
3. a. Physical Therapy - Medicare	$	690,936	690,936		
b. Physical Therapy - Medicare Contractual Allowance **	$	(556,429)	(556,429)		
c. Physical Therapy - Non-Medicare	$	117,824	117,824		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(116,384)	(116,384)		
4. a. Speech Therapy - Medicare	$	233,652	233,652		
b. Speech Therapy - Medicare Contractual Allowance **	$	(141,455)	(141,455)		
c. Speech Therapy - Non-Medicare	$	14,329	14,329		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(14,329)	(14,329)		
5. a. Occupational Therapy - Medicare	$	646,951	646,951		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(547,623)	(547,623)		
c. Occupational Therapy - Non-Medicare	$	109,028	109,028		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(108,938)	(108,938)		
6. a. Other (*Specify*) - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	(1,199)	(1,199)		
III *Total Resident Revenue* (Section I.thru Section II.)	$	9,467,703	9,467,703		
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)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	3,600	3,600		
V. Total Other Revenue (1 thru 8)	$	3,600	3,600		
VI. Total All Revenue (III + V)	$	9,471,303	9,471,303		

* *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..*

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	31	37

Account			Amount
Assets			
A. Current Assets			
1. Cash (*on hand and in banks*)			$ 77,452
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			$ 1,051,064
3. Other Accounts Receivable (Excluding Owners or Related Parties)			$
4 Inventories			$ 19,263
5. Prepaid Expenses			$ 192,387
a. Prepaid Insurance		178,052	
b. Prepaid Expenses-Other		14,335	
c.			
d.			
6. Interest Receivable			$
7. Medicare Final Settlement Receivable			$
8. Other Current Assets (*itemize*)			$ 136,538
Related Party		136,037	
A/R Other-food rebate		501	
A-9. ***Total Current Assets*** (Lines A1 thru 8)			$ 1,476,704
B. Fixed Assets			
1. Land			$
2. Land Improvements	*Historical Cost		$
	Accum. Depreciation	Net	
3. Buildings	*Historical Cost		$
	Accum. Depreciation	Net	
4. Leasehold Improvements	*Historical Cost	387,603	$ 254,191
	Accum. Depreciation	(133,412) Net	
5. Non-Movable Equipment	*Historical Cost	209,765	$ 141,558
	Accum. Depreciation	(68,207) Net	
6. Movable Equipment	*Historical Cost	350,706	$ 174,895
	Accum. Depreciation	(175,811) Net	
7. Motor Vehicles	*Historical Cost	14,668	$ 2,400
	Accum. Depreciation	(12,268) Net	
8. Minor Equipment-Not Depreciable			$
9. Other Fixed Assets (*itemize*)			$ 15,014
Excluded Movable Equipment		6,746	
Excluded Vehicles		8,268	
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)			$ 588,058

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	32	37

Account				Amount
			Total Brought Forward:	$ 2,064,762
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost.....			
	Accum. Depreciation		Net.....	$
3. Buildings	*Historical Cost.....			
	Accum. Depreciation		Net.....	$
4. Non-Movable Equipment	*Historical Cost.....			
	Accum. Depreciation		Net.....	$
5. Movable Equipment	*Historical Cost.....			
	Accum. Depreciation		Net.....	$
6. Motor Vehicles	*Historical Cost.....			
	Accum. Depreciation		Net.....	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost.....			
	Accum. Depreciation		Net.....	$
4. Goodwill (Purchased Only)				$ 2,724,133
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 167,537
Project Development		166,751		
Deposits-Taxes		786		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 2,891,670
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 4,956,432

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 1,346,292
2. Notes Payable (*itemize*)					$ 445,000
Loans - Related Parties				445,000	
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 228,237
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 10,821
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*)					$ 207,812
Acc'd Operating Expenses				83,084	
Acc'd Expense - CT Sales & Use Tax				730	
Provider Taxes Due				123,998	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 2,238,162

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	34	37

Account	Amount
Total Brought Forward:	2,238,162
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$ 134,398

Name of Lender	Purpose	Amount	Date Due
Energy Efficiency Project		**134,398**	

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$ 2,737,595
N/P United Methodist **1,798,803**	
N/P Related Landlord **938,792**	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 2,871,993
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 5,110,155

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**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	$
	3. Reserve for depreciation value of leased personal property (*Equity*) ..	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 224,444
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ (378,167)
	7. Total Net Worth	$ (153,723)
C.	***Total Reserves and Net Worth***	$ (153,723)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 4,956,432

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	36	37

	Account	Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015	$ 224,444
B.	Total Revenue (*From Statement of Revenue Page 30*)	$ 9,471,303
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$ 9,849,466
D.	Net Income or Deficit	$ (378,163)
E.	Balance	$ (153,719)
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	$ (153,719)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	**2382**	**9/30/2016**	37	37

Check appropriate category		
CCNH	RHNS	Other (*Specify*)
☑	☐	☐

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
	CFO	2-15-17

Printed Name of Preparer

Athena Health Care Associates, Inc

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

Cost report forms generated by Athena Health Care Associates, Inc as approved in letter dated 12/11/13.

Name of Facility	License No.	Report for Year Ended	Page
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2198-C/2198-C	9/30/2016	ERROR REPORT

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

		TOTAL	CCNH	RHNS	OTHER: (Specify)
PG 1A PER INTERFACE	N/A				
PG 1A PER COST REPORT	N/A				
DIFFERENCE					
PG 10 PER INTERFACE		4,847,971	4,847,971		
PG 10 PER COST REPORT		4,847,971	4,847,971		
DIFFERENCE					
PG 1A PER COST REPORT	N/A				
PG 10 PER COST REPORT	N/A				
DIFFERENCE					
PG 13 PER INTERFACE		679,016	679,016		
PG 13 PER COST REPORT		679,016	679,016		
DIFFERENCE					
PG 15 & 16 PER INTERFACE		2,361,059	2,361,059		
PG 15 & 16 PER COST REPORT		2,361,059	2,361,059		
DIFFERENCE					
PG 18 PER INTERFACE		215,613	215,613		
PG 18 PER COST REPORT		215,613	215,613		
DIFFERENCE					
PG 19 PER INTERFACE		15,250	15,250		
PG 19 PER COST REPORT		15,250	15,250		
DIFFERENCE					
PG 20 PER INTERFACE		700,628	700,628		
PG 20 PER COST REPORT		700,628	700,628		
DIFFERENCE					
PG 22 PER INTERFACE		911,665	911,665		
PG 22 PER COST REPORT		911,665	911,665		
DIFFERENCE					
PG 26 & 27 PER INTERFACE		118,264	118,264		
PG 26 & 27 PER COST REPORT		118,264	118,264		
DIFFERENCE					
TOTAL EXPENSES PER INTERFACE		9,849,466	9,849,466		
TOTAL EXPENSES PER COST REPORT		9,849,466	9,849,466		
DIFFERENCE					
TOTAL REVENUES PER INTERFACE		9,471,303	9,471,303		
TOTAL REVENUES PER COST REPORT		9,471,303	9,471,303		
DIFFERENCE					
EQUIPMENT LEASES PER PAGE 6		22,170			
EQUIPMENT LEASES PER PAGE 22,LINE 6e		22,170			
DIFFERENCE					

Name of Facility	License No.	Report for Year Ended	Page
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2198-C/2198-C	9/30/2016	ERROR REPORT

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

	TOTAL
PG 31 CURRENT ASSETS PER INTERFACE	1,476,704
PG 31 CURRENT ASSETS PER COST REPORT	1,476,704
DIFFERENCE	
PG 31 FIXED ASSETS PER INTERFACE	588,058
PG 31 FIXED ASSETS PER COST REPORT	588,058
DIFFERENCE	
PG 32 LEASED ASSETS PER INTERFACE	
PG 32 LEASED ASSETS PER COST REPORT	
DIFFERENCE	
PG 32 OTHER ASSETS PER INTERFACE	2,891,670
PG 32 OTHER ASSETS PER COST REPORT	2,891,670
DIFFERENCE	
PG 32 TOTAL ASSETS PER INTERFACE	4,956,432
PG 32 TOTAL ASSETS PER COST REPORT	4,956,432
DIFFERENCE	
PG 33 CURRENT LIABS PER INTERFACE	2,238,162
PG 33 CURRENT LIABS PER COST REPORT	2,238,162
DIFFERENCE	
PG 34 LONG TERM LIABS PER INTERFACE	2,871,993
PG 34 LONG TERM LIABS PER COST REPORT	2,871,993
DIFFERENCE	
PG 34 TOTAL LIABS PER INTERFACE	5,110,155
PG 34 TOTAL LIABS PER COST REPORT	5,110,155
DIFFERENCE	
PG 35 RESERVES PER INTERFACE	
PG 35 RESERVES PER COST REPORT	
DIFFERENCE	
PG 35 NET WORTH PER INTERFACE	(153,723)
PG 35 NET WORTH PER COST REPORT	(153,723)
DIFFERENCE	
PG 35 TOTAL LIAB & WORTH PER INTERFACE	4,956,432
PG 35 TOTAL LIAB & WORTH PER COST REPORT	4,956,432
DIFFERENCE	
PG 32 TOTAL ASSETS PER COST REPORT	4,956,432
PG 35 TOTAL LIAB & WORTH PER COST REPORT	4,956,432
DIFFERENCE	
NET INCOME PER BALANCE SHEET	(378,167)
NET INCOME PER INCOME STATEMENT	(378,163)
DIFFERENCE	(4)
PG 35 NET WORTH PER COST REPORT	(153,723)
TOTAL NET WORTH PER PG 36	(153,719)
DIFFERENCE	(4)

Name of Facility	License No.	Report for Year Ended	Page
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2198-C/2198-C	9/30/2016	ERROR REPORT

INFORMATIONAL PAGES
ERROR CHECK LIST

RED CELLS INDICATE POSSIBLE ERROR

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

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

	TOTAL	CCNH	RHNS	OTHER: (Specify)
PG 7 TOTAL LEGAL FEES DETAIL	24,118	NOT APPLICABLE		
PG 15, LINE 1e LEGAL FEES PER COST REPORT	24,118	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
PG 7 TOTAL ACCOUNTING FEES DETAIL	31,430	NOT APPLICABLE		
PG 15, LINE 1d ACCOUNTING FEES PER C/RPT	31,430	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
PG 11 OWNER'S SALARY PER COST REPORT	-			
PG 10 OWNER'S SALARY PER COST REPORT	-			
DIFFERENCE				
PG 12 ADMINISTRATOR'S SALARY PER C/RPT	131,388	131,388		
PG 10 ADMINISTRATOR'S SALARY PER C/RPT	131,388	131,388		
DIFFERENCE				
PG 12 ASST ADMIN'S SALARY PER COST REPORT	-			
PG 10 ASST ADMIN'S SALARY PER COST REPORT	-			
DIFFERENCE				
PT TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	18,134	NOT APPLICABLE		
HORIZONTAL TOTALS	18,134	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
ST TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	2,558	NOT APPLICABLE		
HORIZONTAL TOTALS	2,558	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
OT TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	16,431	NOT APPLICABLE		
HORIZONTAL TOTALS	16,431	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		

NO. OF CERTIFIED BEDS RECONCILATION:

NUMBER OF BEDS-BEG OF REPORT PERIOD(PG 8	88	88		
ADDITIONS/DELETIONS DURING PERIOD(PG 9)	-			
CALCULATED CERT. BEDS AT END OF PERIOD	88	88		
ACTUAL CERT. BEDS END OF PERIOD(PG 8)	88	88		
DIFFERENCE				

COMPARISON OF ACTUAL PATIENT DAYS TO MAXIMUM POSSIBLE PATIENT DAYS:

AVERAGE CERTIFIED BEDS	88.00000	88.00000		
MAXIMUM PATIENT DAYS	32,208	32,208		
ACTUAL PATIENT DAYS	28,430	28,430		
PERCENT OCCUPIED(NOT TO EXCEED 100%)	88.2700%	88.2700%		

Name of Facility	License No.	Report for Year Ended	Page
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2198-C/2198-C	9/30/2016	ERROR REPORT

DEPRECIATION TIE-IN ERROR CHECK LIST

RED CELLS INDICATE POSSIBLE ERROR

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

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

FIXED ASSET CATEGORY	BOOK VALUE PG 23 OR 24	BOOK VALUE PG 31 OR 32	Difference
LAND IMPROVEMENTS	-	-	-
BUILDING AND BUILDING IMPROVEMENTS	-	-	-
LEASEHOLD IMPROVEMENTS	254,191	254,191	-
NON-MOVEABLE EQUIPMENT	141,558	141,558	-
MOTOR VEHICLES	2,400	2,400	-
MOVEABLE EQUIPMNT(NET OF LEASED EQUIP)	189,833	174,895	14,938
LEASED MOVEABLE EQUIPMENT	-	-	-
ORGANIZATION/START-UP	-	-	-
OTHER-PG 24	-	N/A **	

FIXED ASSET CATEGORY	EXPENSE PG 23 OR 24	EXPENSE PG 22	Difference
LAND IMPROVEMENTS	-	-	-
BUILDING AND BUILDING IMPROVEMENTS	-	-	-
NON-MOVEABLE EQUIPMENT	17,550	17,550	-
MOVEABLE EQUIPMENT(NET OF LEASED EQUIP) & MOTOR VEHICLES	51,677	51,677	-
LEASED MOVEABLE EQUIPMENT	-	N/A *	
ORGANIZATION/START-UP	-	-	-
FINANCE FEES	-	-	-
LEASEHOLD IMPROVES	44,498	44,498	-
OTHER AMORTIZATION	-	-	-

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

FIXED ASSET CATEGORY		PG 23a/24a	PG 23/24	Difference
COMPARE DETAIL ADDITIONS TO PAGES 23 & 24				
LAND IMPROVEMENTS	ADDITIONS	-	-	-
	DEPREC	-	-	-
BUILDING IMPROVEMENTS	ADDITIONS	-	-	-
	DEPREC	-	-	-
NON-MOVEABLE EQUIPMENT	ADDITIONS	1,157	1,157	-
	DEPREC	116	116	(0)
MOVE EQUIP(NET OF LEASED EQUIP&VEHICLES	ADDITIONS	40,981	40,981	-
	DEPREC	2,861	2,861	0
LEASEHOLD IMPROVES	ADDITIONS	35,392	35,391	1
	DEPREC	1,227	1,227	(0)