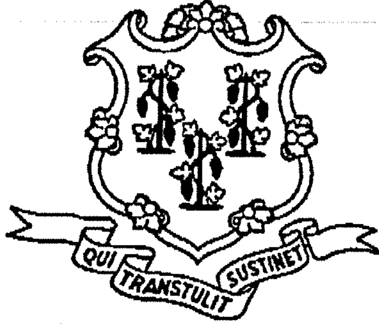
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed)		
Sheriden Woods Health Care Center		
Address (No. & Street, City, State, Zip Code) 321 Stonecrest Drive, Bristol, CT 06010		
Type of Facility		
☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2004C			07-5350

Medicaid Provider Numbers:	CCNH	RHNS	ICF-MR
	2004C		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**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 **Sheriden Woods 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
Donna C. Orefice		2/15/2017	[signature]	2/15/2017
Printed Name (Administrator) **Donna Orefice**			Printed Name (Owner) **Lawrence Santilli**	
Subscribed and Sworn to before me:	State of Conn	Date 2/15/17	Signed (Notary Public) [signature]	Comm. Expires 3/31/20
Address of Notary Public			41 Terrace Ln Bristol CT 06010	

(Notary Seal)

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 **Sheriden Woods Health Care Center**	Period Covered:		From **10/1/2015**	To **9/30/2016**
Address of Facility **321 Stonecrest Drive, Bristol, CT 06010**				
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.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-583-1827	09/30/16	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Sheriden Woods Health Care Center	**321 Stonecrest Drive, Bristol, CT 06010**

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2004C			**07-5350**

Type of Facility (Check appropriate box(es))

- [x] Chronic and Convalescent Nursing Home only (CCNH)
- [ ] Rest Home with Nursing Supervision only (RHNS)
- [ ] (Specify)

Type of Ownership (Check appropriate box)

- [ ] PROPRIETORSHIP
- [ ] LLC
- [ ] PARTNERSHIP
- [x] 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 [x] No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Donna Orefice	**1677**

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

Name	License No.:
Not Applicable	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned
Not Applicable			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**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
Sheriden Woods Health Care Center, Inc.	**321 Stonecrest Rd, Bristol, CT 06010**	**CT**

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G Santilli	**321 Stonecrest Rd, Bristol, CT 06010**	**President**	**5318.06**
Debra M Soucey	**321 Stonecrest Rd, Bristol, CT 06010**	**Secretary**	
Michael E Mosier	**321 Stonecrest Rd, Bristol, CT 06010**	**Treasurer**	
Names of Stockholders Owning at Least 10% of Shares			
Other than listed above:			
Conservators for Lawrence E Santilli	**321 Stonecrest Rd, Bristol, CT 06010**		**1748.73**

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**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			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Misc Facilities	**Various**	☑	☐	**>98%**	**Interfacility Loans**	**pg 33 A2**		
Athena Health 401K plan	**135 South Road, Farmington, CT**	☑	☐		**Facility participates in a common 401(K) plan**			
Athena Health Care	**135 South Road, Farmington, CT**	☑	☐	**<50%**	**Management Fees**	**pg 16 m12**	**$690,813**	**$338,347**
Athena Health Care Insurance	**135 South Road, Farmington, CT**	☑	☐		**Self Insured Employee Health and Dental Insurance**	**pg 15 1a5**	**$1,190,922**	**$1,190,922**
Sheriden Woods Landlord	**321 Stonecrest Drive, Bristol, CT 06010**	☑	☐	**>98%**	**Lease of Property**	**pg 22 9. 10b, pg 27 14**	**$721,880**	**$721,880**
Procare LTC Pharmacy of CT LLC	**1492 Highland Ave, Cheshire, CT 06410**	☑	☐		**Pharmacy**	**pg 20 5a2**	**$288,684**	**$288,684**
		☐	☐					
		☐	☐					
		☐	☐					

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	

Name and Address of Lessor	Related * to Owners, Operators, Officers: Yes	Related * to Owners, Operators, Officers: No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	☐	☑	**Postal Machines**	**12/09/10**	**39 months**	**$1,219**	**$1,219**
Leaf	☐	☑	**Copier**	**02/22/13**	**48 months**	**$11,894**	**$11,894**
Hewlett-Packard	☐	☑	**PCC Equipment**	**08/27/13**	**60 months**	**$7,534**	**$7,534**
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
						Total ***	$20,647

Is a Mileage Log Book Maintained for All Leased Vehicles ? **Not Applicable - No Vehicles** ☐ Yes ☐ No

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	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	**Dworkin, Hillman, Lamorte & Sterczala**	**Four Corporate Dr, Shelton, CT**
2	**Marcum LLP**	**555 Long Wharf Drive, New Haven, CT**
3	**Dopkins & Company, LLP**	**200 International Dr., Buffalo, NY**
4		

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	2015 Year-end Audit and tax return preparation	$ 14,000
2	Medicare cost report rpeparation	$ 2,650
3	KeyBank Loan refinance	$ 3,669
4		$ -
	Charge for Services Provided	$20,319

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	**Goldman, Gruder & Woods LLC**	**203-899-8900**
2	**Murtha Cullina/Schiff Hardin**	**860-240-6000**
3	**Shipman & Goodwin/Halloran & Sage**	**860-561-3100**
4	**probate court**	**860-584-6230**
5	**Schiff, Hardin LLP**	**312-258-5500**

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

1 **200 Connecticut Ave, Norwalk, CT**
2 **185 Asylum Street, Hartford, CT**
3 **12 N.Main St., West Hartford, Ct 06107**
4 **111 North Main Street, Bristol**
5 **660 Sears Tower, Chicago, IL**

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	Collections:Disallowed	$ 2,905
2	Annual Reports$791,disallowed; Collections $416, disallowed	$ 1,207
3	Employee Claims : disallowed	$ 393
4	Probate Matters:Disallowed	$ 579
5	Loan Modification -KeyBank-disallowed	$ 2,685
	Charge for Services Provided	$7,769

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

☑ Yes ☐ No **Pg 15, Line1e**

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	09/30/16	8	37

					Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period.........	146	146			146	146			146	146		
B. On last day of THIS report period................	146	146			146	146			146	146		
2. Number of Residents												
A. As of midnight of PREVIOUS report period.....	134	134			129	129			134	134		
B. As of midnight of THIS report period............	136	136			130	130			136	136		
3. Total Number of Days Care Provided During Period												
A. Medicare..	6,368	6,368			4,943	4,943			1,425	1,425		
B. Medicaid (Conn.)..................................	40,721	40,721			30,425	30,425			10,296	10,296		
C. Medicaid (other states)...........................												
D. Private Pay...	4,066	4,066			3,199	3,199			867	867		
E. State SSI for RCH.................................												
F. Other (Specify) Managed Care	269	269			158	158			111	111		
G. Total Care Days During Period (3A thru F)......	51,424	51,424			38,725	38,725			12,699	12,699		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days....................	174	174			136	136			38	38		
B. Other Bed Reserve Days........................	16	16			14	14			2	2		
5. ***Total Resident Days*** **(3G + 4A + 4B).........**	51,614	51,614			38,875	38,875			12,739	12,739		

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Schedule of Resident Statistics (Cont'd)

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

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

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

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

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

Item	Medicare CCNH	Medicaid CCNH	Medicaid RHNS	Self-Pay CCNH	Self-Pay RHNS	Self-Pay (Specify)	Other State Assisted R.C.H.	Other State Assisted ICF-MR
No. of Residents	11	112		10		3		
Per Diem Rate								
a. One bed rm.	497.31	214.50		501.00		410.79		
b. Two bed rms.	497.31	214.50		487.00		410.79		
c. Three or more bed rms.				482.00		410.79		

Item	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	10,274	10,274		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	2,736	2,736		
2. Restorative Treatments				
C. Other	14,287	14,287		
D. ***Total Physical Therapy Treatments***	27,297	27,297		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	1,089	1,089		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	266	266		
2. Restorative Treatments				
C. Other	1,033	1,033		
D. ***Total Speech Therapy Treatments***	2,388	2,388		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	8,807	8,807		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	2,270	2,270		
2. Restorative Treatments				
C. Other	14,387	14,387		
D. ***Total Occupational Therapy Treatments***	25,464	25,464		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**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)	110,895	1,948				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	249,242	10,705				
5. Dietary Service						
a. Head Dietitian	64,591	1,697				
b. Food Service Supervisor	59,777	1,996				
c. Dietary Workers	422,105	29,738				
6. Housekeeping Service						
a. Head Housekeeper	67,245	2,165				
b. Other Housekeeping Workers	236,664	17,119				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	69,803	2,134				
b. Other Maintenance Workers	62,174	3,323				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	110,315	9,415				
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	223,357	4,169				
b. RN						
1. Direct Care	601,313	15,903				
2. Administrative**	517,848	18,032				
c. LPN						
1. Direct Care	1,256,650	51,286				
2. Administrative**						
d. Aides and Attendants	2,023,283	138,552				
e. Physical Therapists	337,018	11,264				
f. Speech Therapists	65,243	1,339				
g. Occupational Therapists	390,060	9,929				
h. Recreation Workers	208,115	9,955				
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	186,605	7,358				
n. Marketing						
o. Other (Specify)						
A-13. Total Salary Expenditures	7,262,303	348,027				

* 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)
Medical Staff Meetings	$ 850	6				
Total	$ 850	6	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**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.

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
Sheriden Woods Health Care Center	**2004C**	**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* **										
Robert F. Fritz (10/1/2015 - 7/26/2016)	84,956			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	1,521	A2			
Donna C. Orefice (7/27/2016- 9/30/2016)	25,939			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	427	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	13	37

Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
	Total Cost and 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	8,309	73				
3. Pharmacist	13,418	206				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	173,695	2,622				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	35,063	169				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**	1,549	14				
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	850	6				
9. Speech Therapist						
a. Resident Care	43,705	618				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	4,977	80				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	281,566	3,788				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Gerident Solutions LLC P.O.Box 290539, Wethersfield, CT	Dentist	☐	☑	
Dr. C. Licata,ProHealth Physicians, 625 Clark Ave., Bristol, CT 06010	Medical Director and Medical Staff	☐	☑	
Procare LTC Pharmacy of CT LLC, 1492 Highland Ave, Cheshire, CT 06410	Pharmacist	☑	☐	Common Owners
Athena Health Care Systems 135 South Road, Farmington, CT 06032	MDS Fill In, Nursing	☑	☐	Common Owners
Access Therapies, 5980 W 71st St, Suite 102, Indianapolis, IN 46278	Physical Therapy	☐	☑	
Dr. A. Scappaticci,ProHealth Physicians, 625 Clark Ave. Bristol, CT 06010	Medical Staff and Asst. Medical Director	☐	☑	
Marilyn L.Petitt, 50 Wood street, Torrington, CT	Social Services	☐	☑	
Swallowing Diagnostics, 21 Waterville RD, Avon, CT	Speech Therapy Services	☐	☑	
Dr. J. Adler, 621 Terryville Ave, Bristol, CT 06010	Medical Staff	☐	☑	
Advanced Medical Personnel Services, PO Box 392450, Philadelphia, PA 15251	Speech Therapy	☐	☑	
Omnicare of CT, 525 Knotter Drive, Cheshire, CT 06410	Pharmacist	☐	☑	
Fusion Medical Staffing, 11808 Grant St #100, Omaha, NE 68164	Physical Therapy	☐	☑	
		☐	☐	
		☐	☐	
		☐	☑	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation...............	$	542,388	542,388		
2. Disability Insurance.......................	$				
3. Unemployment Insurance.................	$	198,465	198,465		
4. Social Security (F.I.C.A.).................	$	534,664	534,664		
5. Health Insurance...........................	$	979,742	979,742		
6. Life Insurance (employees only) (not-owners and not-operators)...........	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)...........	$	37,734	37,734		
8. Uniform Allowance........................	$				
9. Other (*Specify*)........................... See Attached Schedule	$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*..	$	32,447	32,447		
d. Accounting and Auditing.....................	$	20,319	20,319		
e. Legal (*Services should be fully described on Page 7)*	$	7,769	7,769		
f. Insurance on Lives of Owners and Operators (*Specify*)*......................	$				
g. Office Supplies..................................	$	64,989	64,989		
h. Telephone and Cellular Phones..............					
1. Telephone & Pagers........................	$	33,681	33,681		
2. Cellular Phones.	$	3,526	3,526		
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	$	951,071	951,071		
Subtotal	$	3,407,045	3,407,045		

* 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	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,407,045	3,407,045		
l. Travel and Entertainment					
1. Resident Travel and Entertainment..........................	$				
2. Holiday Parties for Staff...............................	$	2,913	2,913		
3. Gifts to Staff and Residents................................	$	27,418	27,418		
4. Employee Travel...	$	2,331	2,331		
5. Education Expenses Related to Seminars and Conventions	$	6,369	6,369		
6. Automobile Expense (*not purchase or depreciation*).....	$				
7. Other (*Specify*)... See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)..........	$	8,921	8,921		
2. Advertising Telephone Directory (*all such expenses*)***	$	870	870		
3. Advertising Other (*Specify*)***............................... See Attached Schedule	$	23,069	23,069		
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)***.........	$	150	150		
7. Postage...	$	6,072	6,072		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	10,296	10,296		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions..	$	979	979		
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**................	$	425,400	425,400		
13. Other (*Specify*) See Attached Schedule	$	108,316	108,316		
C-14 Total Administrative & General Expenditures	$	4,030,149	4,030,149		

* 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	$ 23,069		
Total Other Advertising	$ 23,069	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 10,296		
Total Dues	$ 10,296	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Lobbying Fees	$ 4,074		
Licenses	$ 1,431		
Bank Charges	$ 11,588		
Payroll Processing Fees	$ 26,183		
Background Checks/Physicals	$ 29,342		
Data Processing	$ 21,335		
Compliance Consulting	$ 10,276		
CMS penalty #2015-01-LTC-185	$ 1,300		
IRS CP215#06-1184629 Dec 2012	$ 523		
ST of CT violation #2016-076	$ 1,740		
Energy Audit	$ 524		
Total Other Administrative and General	$ 108,316	$ -	$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	$581,128	Contract Attached to a Prior Year	See Below
Allocation of the above	$383,544 $92,980 $104,604	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	$41,856	Admin/General	Pg 16, Line 12

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food..........................	$	352,352	352,352		
2. Non-Food Supplies.....................	$	61,158	61,158		
3. Other (*Specify*)________________ **Dishes = $114**	$	114	114		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**......................	$	92,980	92,980		
d. Other (*Specify*)____________________	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	506,604	506,604		

2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*	422	422		

	Question	Yes	No	
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. = $165
L.	Is any revenue collected from these people?	☐ Yes	☑ No	If yes, specify amount.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	☐ Yes	☑ No	If yes, specify cost.
O.	Is any revenue collected from employees?	☐ Yes	☑ No	If yes, specify amount.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
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. $	26,611	26,611		
b. Purchased Services (*by contract other than through Management Services)* *(Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**......................	$				
d. Other (*Specify*) **Supplies = $7,481**	$	7,481	7,481		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	34,092	34,092		

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.

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
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	40,759	40,759		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*..................................		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)....		$	40,759	40,759		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy......................................		$				
2. Purchased from **Pro Care**		$	307,588	307,588		
b. Medicine Cabinet Drugs..............................		$	21,851	21,851		
c. Medical and Therapeutic Supplies......................		$	326,173	326,173		
d. Ambulance/Limousine***..............................		$	1,504	1,504		
e. Oxygen						
1. For Emergency Use................................		$				
2. Other***..		$	37,490	37,490		
f. X-rays and Related Radiological Procedures***..		$	41,223	41,223		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***...		$	19,929	19,929		
i. Recreation..		$	16,163	16,163		
j. Other (Specify)**** See Attached Schedule		$	271,892	271,892		
5K. ***Total Resident Care Expenditures*** (5a - 5j).............		$	1,043,813	1,043,813		

* 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.

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Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Management Fee Direct	$ 104,604		
Oxygen Concentrator Rentals	$ 19,044		
Speech Therapy Supplies	$ 360		
Medical Equip Rentals-Medicaid	$ 50,641		
Physical Therapy Supplies	$ 75,091		
Cable TV Services	$ 9,740		
Occupational Therapy Supplies	$ 528		
Medical Equip Rentals-other	$ 11,884		
Total Other Resident Care	$ 271,892	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name of Individual or Company	Address	Related ** to Owners, Operators, Officers: Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***: CCNH	RHNS	(Specify)	Pg	Line
ADP	PO Box 7247, Philadelphia, PA	☐	☑		Payroll Processing	26,183			16	m13
Procare LTC Pharmacy of CT LLC	1492 Highland Ave, Cheshire, CT 06410	☑	☐		Pharmacy	307,588			20	5a2
CWPM, Inc.	25 Norton Place, Plainville, CT	☐	☑		Rubbish Removal	26,793			22	6f
Landscaping/Winterberry Landscaping & Garden Center	Burlington, CT/2070 West St., Southington, CT	☐	☑		Landscaping and Snow Removal	20,864			22	6f
Harmony Healthcare	430 Boston Street, Suite 104, Topsfield, MA 01983	☐	☑		Compliance Consulting	10,800			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).

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

Name of Facility	License No.	Report for Year Ended			Page of
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Item	Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance................................ $	89,852	89,852		
b. Heat.. $	75,639	75,639		
c. Light & Power.. $	114,767	114,767		
d. Water.. $	37,323	37,323		
e. Equipment Lease (*Provide detail on page 6*)........ $	20,647	20,647		
f. Other (*itemize*)...................................... $	87,711	87,711		
See Attached Schedule				
6g. ***Total Maint. & Operating Expense*** (6a - 6f)........... $	425,939	425,939		
7. Depreciation (*complete schedule page 23**)				
a. Land Improvements..................................... $	5,813	5,813		
b. Building & Building Improvements..................... $	96,163	96,163		
c. Non-Movable Equipment................................ $	29,456	29,456		
d. Movable Equipment.................................... $	98,526	98,526		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)............... $	229,958	229,958		
8. Amortization (*Complete att. Schedule Page 24**)				
a. Organization Expense.................................. $				
b. Mortgage Expense...................................... $				
c. Leasehold Improvements................................ $	16,056	16,056		
d. Other (*Specify*)...................................... $				
*8e. ***Total Amortization Costs*** (8a + b + c + d)............... $	16,056	16,056		
9. Rental payments on leased real property less real estate taxes included in item 10b...................... $	494,620	494,620		
10. Property Taxes				
a. Real estate taxes paid by owner........................ $				
b. Real estate taxes paid by lessor........................ $	133,593	133,593		
c. Personal property taxes................................ $	16,913	16,913		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)............ $	891,140	891,140		

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

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Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	$ 18,349		
Rubbish Removal	$ 26,793		
Snow Removal	$ 2,515		
Supplies	$ 40,054		
Total Other Repairs and Maintenance	$ 87,711	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**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	151,416		151,416	130,943	S/L	Var	5,813	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Var		
A-4. Subtotal								5,813
B. **Building and Building Improvements**								
1. Acquired prior to this report period	2,318,266		2,318,266	1,582,495	S/L	Various	96,163	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								96,163
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	559,159		559,159	386,783	S/L	Various	29,456	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					SL	Various		
C-4. Subtotal								29,456

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	2015	1,407,725		1,407,725	1,074,677	S/L	Various	94,356	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2016	57,954		57,954		S/L	Various	4,170	
D-3. Subtotal												98,526
E. ***Total Depreciation***												229,958

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Land Improvements		$ -		$ - *
Deletions:				
Total deletions for Land Improvements		$ -		$ - **

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Building Improvements		$ -		$ - *
Deletions:				
Total deletions for Building Improvements		$ -		$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Non-Movable Equipment		$ -		$ - *
Deletions:				
Total deletions for Non-Movable Equipment		$ -		$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

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Attachment Page 23
Page 2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/1/2015-9/30/2016	see attached schedule	$ 4,380	3	$ 730
10/1/2015-9/30/2016	see attached schedule	$ 19,244	5	$ 1,924
10/1/2015-9/30/2016	see attached schedule	$ 22,278	10	$ 1,114
10/1/2015-9/30/2016	see attached schedule	$ 12,052	15	$ 402
Total additions for Movable Equipment		$ 57,954		$ 4,170 *
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:				
10/1/2015-9/30/2016	see attached schedule	$ 9,160	10	
10/1/2015-9/30/2016	see attached schedule	$ 4,533	15	
10/1/2015-9/30/2016	see attached schedule	$ 385,251	20	
10/1/2015-9/30/2016	see attached schedule	$ 2,768	25	
Total additions for Leasehold Improvements		$ 401,712		$ - *
Deletions:				
Total deletions for Leasehold Improvements		$ -		$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	24	37

Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. **Organization Expense** 1.									
2.									
3.									
A-4. Subtotal..................................									
B. **Mortgage Expense** 1.									
2.									
3. **Finance Fees - Key Bank**	6	2007	5 yrs	285,130	285,130	s/l	5 year		
B-4. Subtotal..................................									
C. **Leasehold Improvements and Other** (Specify) 1. Acquired prior to this report period	9	2015	Various	571,750	120,456		Var	16,056	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2016	Various	401,712		s/l	Var		
C-4. Subtotal..................................									16,056
D. ***Total Amortization***									16,056

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

Amortization Schedule - Detail of Leasehold Improvements & Other

Name of Facility **Sheriden Woods Health Care Center**			License No. **2004C**		Report for Year Ended **9/30/2016**			Page 24A	of 37
C. **Leasehold Improvements** (Specify) 1. Acquired prior to this report period	9	2015	Various	83,750	14,656			16,056	
2. Disposals (attach schedule)									
3. Acquired during this report period	9	2016	Various	401,712		s/l	variou		
C-4. Subtotal..............................									16,056
C. **Other** (Specify) 1. Bed License	9	1997	None	488,000	105,800	S/L	None		
2.									
C-4. Subtotal..............................									
Total Acquired prior to this report period	9	2015	Various	571,750	120,456		Var	16,056	
Total Disposals									
Total Acquired during this report period	9	2016	Various	401,712		s/l	Var		

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	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	11/18/86
4. Date of Initial Licensure	11/06/86
5. Total Licensed Bed Capacity	146
6. Square Footage	
7. Acquisition Cost	
a. Land	143,268
b. Building	3,443,098

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD/Key Bank			
b. Date Mortgage Obtained	03/29/12			
c. Interest Rate for the Cost Year	3.22%/6.92%			
d. Term of Mortgage (number of years)	22/8			
e. Amount of Principal Borrowed	10,969,330			
f. Principal balance outstanding as of 9/30/2016	9,968,390			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage..............................	$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage............................	$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage..............................	$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage.............................	$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount........................	$				
2. Loan Origination Date........................					
3. Interest Rate %................................					
4. Term..					
5. CHEFA Interest Expense.......................					
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)	$				

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	**2004C**	**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*)............................... $	8,510	8,510		
A. Item: **Generator** / Rate / Amount: -				
Lender: **Webster Capital**				
Address of Lender: **P.O Box 330, Hartford, CT 06141**				
B. Item / Rate / Amount: -				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)........................... $	8,510	8,510		
12. D. Other Interest Expense (*Specify*)............... $	128,878	128,878		
Vender Interest = $3,014; Key Bank Term Loan Int & Fees = $9,554; Line of Credit Interest = $116,310				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)......$	137,388	137,388		
14. Insurance a. Insurance on Property (buildings only)....... $	96,214	96,214		
b. Insurance on Automobiles..................... $				
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*)............. $				
2. Fire and Extended Coverage............... $				
3. Other (*Specify*).............................. $				
14d. ***Total Insurance Expenditures*** (14a + b + c)... $	96,214	96,214		
15. ***Total All Expenditures (A-13 thru C-14)*** .... $	14,749,967	14,749,967		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	**2004C**	**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....................	$	390,060	390,060		
4.	**Var**	**Var**	Other - See attached Schedule...........	$	88,530	88,530		
Page 13 - Professional Fees								
5.	**13**	**B8c**	Resident Care Physicians **..............	$	1,549	1,549		
6.			Occupational Therapy...................	$				
7.			Other - See attached Schedule...........	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits...................	$				
9.	**15**	**1c**	Bad Debts..............................	$	32,447	32,447		
10.	**15**	**1d&e**	Accounting & Legal......................	$	10,647	10,647		
11.	**30**	**IV3**	Telephone..................................	$				
12.	**15**	**1h2**	Cellular Telephone.........................	$	3,166	3,166		
13.			Life insurance premiums on the life of Owners, Partners, Operators..........	$				
14.	**16**	**1 3**	Gifts, flowers and coffee shops...........	$	27,418	27,418		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees...............	$				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative....	$				
17.			Automobile Expense (e.g. personal use).	$				
18.	**16**	**m2&3**	Unallowable Advertising *...............	$	23,939	23,939		
19.	**15**	**1j&k1 &2**	Income Tax / Corporate Business Tax...	$	250	250		
20.			Fund Raising / Contributions.............	$				
21.	**16**	**m12**	Unallowable Management Fees...........	$	232,628	232,628		
	18	**2c**		$	56,395	56,395		
	20	**5j**		$	63,444	63,444		
22.	**16**	**6**	Barber and Beauty.........................	$				
23.	**Var**	**Var**	Other - See attached Schedule............	$	29,501	29,501		
Page 18 - Dietary Expenditures								
24.	**18**	**2a1**	Meals to employees, guests and others who are not residents......................	$	165	165		
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)	$	960,139	960,139		

* 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	A12b2	Clinical Coordinator Salary & Benefits	85,983		
10	12m	Marketing Salaries & Benefits	2,547		
Total Other Salaries Adjustment			$ 88,530	$ -	$ -

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	11,588		
16	M13	Lobbying Fees	4,074		
16	M13	Compliance Consulting	10,276		
16	M13	State of CT Penalty	1,740		
16	M13	IRS Penalty	523		
16	M13	CMS Penalty	1,300		
Total Other A&G Adjustments			$ 29,501	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	960,139	960,139		
Page 20 - Resident Care Supplies*								
27.	20	5a1&2	Prescription Drugs......................	$	307,588	307,588		
28.	20	5d	Ambulance/Limousine.................	$	1,504	1,504		
29.	20	5f	X-rays, etc............................	$	41,223	41,223		
30.	20	5h	Laboratory.............................	$	19,929	19,929		
31.	20	5c	Medical Supplies........................	$	29,888	29,888		
32.	20	5e2	Oxygen (non emergency)...............	$	37,490	37,490		
33.	20	5j	Occupational Therapy..................	$	528	528		
34.	Var	Var	Other - See Attached Schedule........	$	11,884	11,884		
Page 22 - Maintenance and Property								
35.	Var	Var	Excess Movable Equipment Depreciation See Attached Schedule....................	$	8,139	8,139		
36.			Depreciation on Unallowable Motor Vehicles............................	$				
37.			Unallowable Property and Real Estate Taxes................................	$				
38.			Rental of Building Space or Rooms.....	$				
39.			Other - See Attached Schedule...........	$				
Page 27 - Insurance								
40.			Mortgage Insurance.......................	$				
41.			Property Insurance........................	$				
Other - Miscellaneous								
42.			Research or Experimental Activities.....	$				
43.	20	5j	Radio and Television Revenue...........	$	6,140	6,140		
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........	$	71	71		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule.........................	$				
Not For Profit Providers Only								
50.	Var	Var	Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule....................	$				
51.			***Total Amount of Decrease (Items 1 - 50)***	$	1,424,523	1,424,523		

*** 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	11,884		
Total Other Ancillary Costs			$ 11,884	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Moveable Equip Deprec Carryforwards	8,139		
Total Excess Movable Equipment Depreciation			8,139		

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			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	20,311,542	20,311,542		
b. Medicaid Room and Board Contractual Allowance **	$	(11,471,487)	(11,471,487)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents (*all inclusive*)	$	1,605,401	1,605,401		
b. Medicare Room and Board Contractual Allowance **	$	399,691	399,691		
4. a. Private-Pay Residents and Other	$	3,444,004	3,444,004		
b. Private-Pay Room and Board Contractual Allowance **	$	(284,816)	(284,816)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	223,978	223,978		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(223,737)	(223,737)		
c. Prescription Drugs - Non-Medicare	$	247,979	247,979		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(247,979)	(247,979)		
2. a. Medical Supplies - Medicare	$	69,686	69,686		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	80,435	80,435		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(80,435)	(80,435)		
3. a. Physical Therapy - Medicare	$	978,163	978,163		
b. Physical Therapy - Medicare Contractual Allowance **	$	(678,521)	(678,521)		
c. Physical Therapy - Non-Medicare	$	356,010	356,010		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(350,459)	(350,459)		
4. a. Speech Therapy - Medicare	$	158,545	158,545		
b. Speech Therapy - Medicare Contractual Allowance **	$	(107,852)	(107,852)		
c. Speech Therapy - Non-Medicare	$	75,821	75,821		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(75,821)	(75,821)		
5. a. Occupational Therapy - Medicare	$	952,335	952,335		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(693,453)	(693,453)		
c. Occupational Therapy - Non-Medicare	$	326,437	326,437		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(320,068)	(320,068)		
6. a. Other (*Specify*) - Medicare	$				
b. Other (*Specify*) - Non-Medicare	$				
III *Total Resident Revenue* (Section I.thru Section II.)	$	14,695,399	14,695,399		
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*)	$	71	71		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$				
V. Total Other Revenue (1 thru 8)	$	71	71		
VI. Total All Revenue (III + V)	$	14,695,470	14,695,470		

* *Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.*

** *Facility should report all contractual allowances and/or payer discounts..*

Schedule of Other Resident Revenue - Medicare

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

Schedule of Other Non-Medicare Resident Revenue

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

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
31, A2	Interest on A/R	$ 777,115	$ 71		
Total Interest Income			$ 71	$ -	$ -

Schedule of Other Revenue

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

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	31	37

Account			Amount
Assets			
A. Current Assets			
1. Cash (*on hand and in banks*)			$ 178,503
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			$ 777,115
3. Other Accounts Receivable (Excluding Owners or Related Parties)			$
4 Inventories			$ 29,182
5. Prepaid Expenses			$ 247,667
a. Prepaid Insurance		246,272	
b. Prepaid Expenses		1,395	
c.			
d.			
6. Interest Receivable			$
7. Medicare Final Settlement Receivable			$
8. Other Current Assets (*itemize*)			$ 88,599
Medicaid Cost Settlement		49,279	
A/R Related Facilities		39,320	
A-9. ***Total Current Assets*** (Lines A1 thru 8)			$ 1,321,066
B. Fixed Assets			
1. Land			$
2. Land Improvements	*Historical Cost	151,417	$ 14,661
	Accum. Depreciation	(136,756) Net	
3. Buildings	*Historical Cost	2,318,266	$ 639,608
	Accum. Depreciation	(1,678,658) Net	
4. Leasehold Improvements	*Historical Cost	485,461	$ 454,749
	Accum. Depreciation	(30,712) Net	
5. Non-Movable Equipment	*Historical Cost	559,160	$ 142,920
	Accum. Depreciation	(416,240) Net	
6. Movable Equipment	*Historical Cost	1,445,470	$ 272,266
	Accum. Depreciation	(1,173,204) Net	
7. Motor Vehicles	*Historical Cost		$
	Accum. Depreciation	Net	
8. Minor Equipment-Not Depreciable			$
9. Other Fixed Assets (*itemize*)			$ 5,326
Misc Diff Fixed assets to books		(14,882)	
Moveable Equipment Carryforward		20,208	
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)			$ 1,529,530

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

(*Carry Total forward to next page*)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	32	37

Account				Amount
			Total Brought Forward:	$ 2,850,596
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$ 143,268
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost	6,764,604		
	Accum. Depreciation	(6,740,718)	Net	$ 23,886
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)				$ 167,154
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$ 382,200
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$ (10,242,810)
Name and Address	Amount	Loan Date		
Due from Related Facilities	(10,242,810)			
7. Other Assets (*itemize*)				$ 32,043
Warranties		7,976		
Project Development		24,067		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (9,828,567)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ (6,810,817)

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 1,140,095
2. Notes Payable (*itemize*)				$ 1,877,845
Related Party		(88,000)		
Line of Credit		1,965,845		
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*)				$ 383,517
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 16,581
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*)				$ 4,806
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 267,288
Acc'd Operating Expenses		29,291		
Acc'd Expense - CT Sales Tax		1,206		
Provider Tax Due		236,791		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 3,690,132

* 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.

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	34	37

Account				Amount
			Total Brought Forward:	3,690,132
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$ 101,950
Name of Lender	Purpose	Amount	Date Due	
	Boiler Upgrade	**101,950**		
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*)				$ (566,413)
Due From Related Landlord		**(2,686,305)**		
Due to Related Landlord		**2,119,892**		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ (464,463)
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 3,225,669

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2016	35	37

Account		Amount
A. **Reserves**		
1. Reserve for value of leased land	$	143,268
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$	23,886
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	$	167,154
B. **Net Worth**		
1. Owner's Capital	$	
2. Capital Stock	$	1,000
3. Paid-in Surplus	$	
4. Treasury Stock	$	
5. Cumulated Earnings	$	(10,150,143)
6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$	(54,497)
7. Total Net Worth	$	(10,203,640)
C. ***Total Reserves and Net Worth***	$	(10,036,486)
D. ***Total Liabilities, Reserves, and Net Worth***	$	(6,810,817)

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**9/30/2016**	36	37

	Account			Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ (10,183,920)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 14,695,470
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 14,749,967
D.	Net Income or Deficit			$ (54,497)
E.	Balance			$ (10,238,417)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
		37,225		
	2015 reclass of expense to project developmen	**(2,452)**		
	rounding	**4**		
	2. Other (*itemize*)			
F-3.	Total Additions			$ 34,777
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			$ (10,203,640)

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

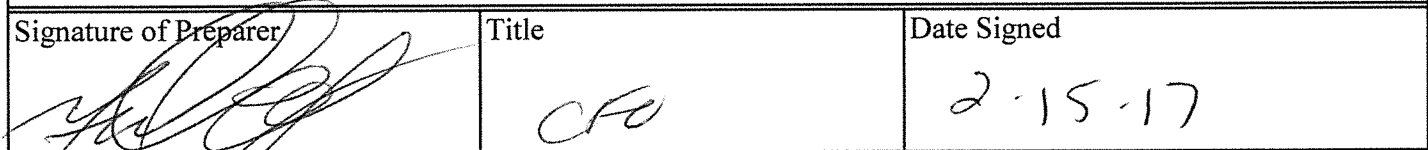
I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	**2004C**	**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
Sheriden Woods 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		7,262,303	7,262,303		
PG 10 PER COST REPORT		7,262,303	7,262,303		
DIFFERENCE					
PG 1A PER COST REPORT	N/A				
PG 10 PER COST REPORT	N/A				
DIFFERENCE					
PG 13 PER INTERFACE		281,566	281,566		
PG 13 PER COST REPORT		281,566	281,566		
DIFFERENCE					
PG 15 & 16 PER INTERFACE		4,030,149	4,030,149		
PG 15 & 16 PER COST REPORT		4,030,149	4,030,149		
DIFFERENCE					
PG 18 PER INTERFACE		506,604	506,604		
PG 18 PER COST REPORT		506,604	506,604		
DIFFERENCE					
PG 19 PER INTERFACE		34,092	34,092		
PG 19 PER COST REPORT		34,092	34,092		
DIFFERENCE					
PG 20 PER INTERFACE		1,084,572	1,084,572		
PG 20 PER COST REPORT		1,084,572	1,084,572		
DIFFERENCE					
PG 22 PER INTERFACE		1,317,079	1,317,079		
PG 22 PER COST REPORT		1,317,079	1,317,079		
DIFFERENCE					
PG 26 & 27 PER INTERFACE		233,602	233,602		
PG 26 & 27 PER COST REPORT		233,602	233,602		
DIFFERENCE					
TOTAL EXPENSES PER INTERFACE		14,749,967	14,749,967		
TOTAL EXPENSES PER COST REPORT		14,749,967	14,749,967		
DIFFERENCE					
TOTAL REVENUES PER INTERFACE		14,695,470	14,695,470		
TOTAL REVENUES PER COST REPORT		14,695,470	14,695,470		
DIFFERENCE					
EQUIPMENT LEASES PER PAGE 6		20,647			
EQUIPMENT LEASES PER PAGE 22,LINE 6e		20,647			
DIFFERENCE					

Name of Facility	License No.	Report for Year Ended	Page
Sheriden Woods 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	1,321,066
PG 31 CURRENT ASSETS PER COST REPORT	1,321,066
DIFFERENCE	
PG 31 FIXED ASSETS PER INTERFACE	1,529,530
PG 31 FIXED ASSETS PER COST REPORT	1,529,530
DIFFERENCE	
PG 32 LEASED ASSETS PER INTERFACE	167,154
PG 32 LEASED ASSETS PER COST REPORT	167,154
DIFFERENCE	
PG 32 OTHER ASSETS PER INTERFACE	(9,828,567)
PG 32 OTHER ASSETS PER COST REPORT	(9,828,567)
DIFFERENCE	
PG 32 TOTAL ASSETS PER INTERFACE	(6,810,817)
PG 32 TOTAL ASSETS PER COST REPORT	(6,810,817)
DIFFERENCE	
PG 33 CURRENT LIABS PER INTERFACE	3,690,132
PG 33 CURRENT LIABS PER COST REPORT	3,690,132
DIFFERENCE	
PG 34 LONG TERM LIABS PER INTERFACE	(464,463)
PG 34 LONG TERM LIABS PER COST REPORT	(464,463)
DIFFERENCE	
PG 34 TOTAL LIABS PER INTERFACE	3,225,669
PG 34 TOTAL LIABS PER COST REPORT	3,225,669
DIFFERENCE	
PG 35 RESERVES PER INTERFACE	167,154
PG 35 RESERVES PER COST REPORT	167,154
DIFFERENCE	
PG 35 NET WORTH PER INTERFACE	(10,203,640)
PG 35 NET WORTH PER COST REPORT	(10,203,640)
DIFFERENCE	
PG 35 TOTAL LIAB & WORTH PER INTERFACE	(6,810,817)
PG 35 TOTAL LIAB & WORTH PER COST REPORT	(6,810,817)
DIFFERENCE	
PG 32 TOTAL ASSETS PER COST REPORT	(6,810,817)
PG 35 TOTAL LIAB & WORTH PER COST REPORT	(6,810,817)
DIFFERENCE	
NET INCOME PER BALANCE SHEET	(54,497)
NET INCOME PER INCOME STATEMENT	(54,497)
DIFFERENCE	
PG 35 NET WORTH PER COST REPORT	(10,203,640)
TOTAL NET WORTH PER PG 36	(10,203,640)
DIFFERENCE	

Name of Facility	License No.	Report for Year Ended	Page
Sheriden Woods 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	7,769	NOT APPLICABLE		
PG 15, LINE 1e LEGAL FEES PER COST REPORT	7,769	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
PG 7 TOTAL ACCOUNTING FEES DETAIL	20,319	NOT APPLICABLE		
PG 15, LINE 1d ACCOUNTING FEES PER C/RPT	20,319	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	110,895	110,895		
PG 10 ADMINISTRATOR'S SALARY PER C/RPT	110,895	110,895		
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	27,297	NOT APPLICABLE		
HORIZONTAL TOTALS	27,297	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
ST TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	2,388	NOT APPLICABLE		
HORIZONTAL TOTALS	2,388	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
OT TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	25,464	NOT APPLICABLE		
HORIZONTAL TOTALS	25,464	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
NO. OF CERTIFIED BEDS RECONCILATION:				
NUMBER OF BEDS-BEG OF REPORT PERIOD(PG 8	146	146		
ADDITIONS/DELETIONS DURING PERIOD(PG 9)	-			
CALCULATED CERT. BEDS AT END OF PERIOD	146	146		
ACTUAL CERT. BEDS END OF PERIOD(PG 8)	146	146		
DIFFERENCE				

COMPARISON OF ACTUAL PATIENT DAYS TO MAXIMUM POSSIBLE PATIENT DAYS:

	TOTAL	CCNH	RHNS	OTHER
AVERAGE CERTIFIED BEDS	146.00000	146.00000		
MAXIMUM PATIENT DAYS	53,436	53,436		
ACTUAL PATIENT DAYS	51,614	51,614		
PERCENT OCCUPIED(NOT TO EXCEED 100%)	96.5903%	96.5903%		

Name of Facility	License No.	Report for Year Ended	Page
Sheriden Woods 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	14,660	14,661	(1)
BUILDING AND BUILDING IMPROVEMENTS	639,608	639,608	-
LEASEHOLD IMPROVEMENTS	454,750	454,749	1
NON-MOVEABLE EQUIPMENT	142,920	142,920	-
MOTOR VEHICLES	-	-	-
MOVEABLE EQUIPMNT(NET OF LEASED EQUIP)	292,476	272,266	20,210
LEASED MOVEABLE EQUIPMENT	-	-	-
ORGANIZATION/START-UP	-	-	-
OTHER-PG 24	382,200	N/A **	

FIXED ASSET CATEGORY	EXPENSE PG 23 OR 24	EXPENSE PG 22	Difference
LAND IMPROVEMENTS	5,813	5,813	-
BUILDING AND BUILDING IMPROVEMENTS	96,163	96,163	-
NON-MOVEABLE EQUIPMENT	29,456	29,456	-
MOVEABLE EQUIPMENT(NET OF LEASED EQUIP) & MOTOR VEHICLES	98,526	98,526	-
LEASED MOVEABLE EQUIPMENT	-	N/A *	
ORGANIZATION/START-UP	-	-	-
FINANCE FEES	-	-	-
LEASEHOLD IMPROVES	16,056	16,056	-
OTHER AMORTIZATION	-	-	-

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

FIXED ASSET CATEGORY		PG 23a/24a	PG 23/24	Difference
COMPARE DETAIL ADDITIONS TO PAGES 23 & 24				
LAND IMPROVEMENTS	ADDITIONS	-	-	-
	DEPREC	-	-	-
BUILDING IMPROVEMENTS	ADDITIONS	-	-	-
	DEPREC	-	-	-
NON-MOVEABLE EQUIPMENT	ADDITIONS	-	-	-
	DEPREC	-	-	-
MOVE EQUIP(NET OF LEASED EQUIP&VEHICLES	ADDITIONS	57,954	57,954	-
	DEPREC	4,170	4,170	0
LEASEHOLD IMPROVES	ADDITIONS	401,712	401,712	-
	DEPREC	-	-	-