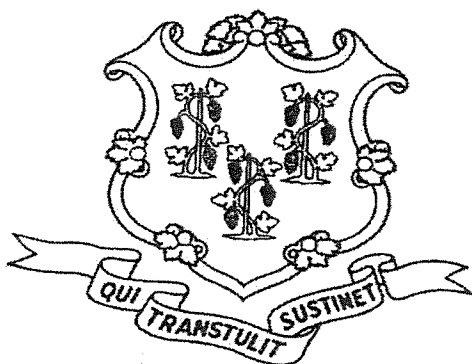


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

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 Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH) (RHNS)	
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 2382	RHNS	(Specify)	Medicare Provider 075379
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Medicaid Provider Numbers:	CCNH 2382	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Sharon SNF CT LLC, d/b/a Sharon Health Care Center	License No. 2382	Report for Year Ended 9/30/2019	Page 1	of 37
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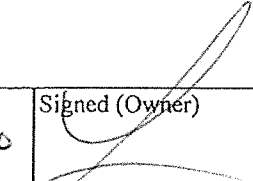
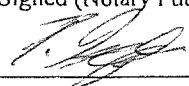
Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 1, 2018 and ending September 30, 2019, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator) 		Date 2/17/20	Signed (Owner) 		Date 2/17/20
Printed Name (Administrator) Sawyer Thornton			Printed Name (Owner) Lawrence Santilli		
Subscribed and Sworn to before me:	State of CT	Date 2/17/20	Signed (Notary Public) 	Comm. Expires 8/1/2020	
Address of Notary Public 38 Lillie Dr. Plainville CT 06062					

(Notary Seal)

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

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 10/1/2018	To 9/30/2019
Address of Facility 27 Hospital Hill Road, Sharon, CT 06069				
Report Prepared By Athena Health Care Associates, Inc.		Phone Number 860-751-3900	Date	
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 860-364-1002		Report for Year Ended 9/30/2019	Page 2	of 37
Name of Facility (as shown on license) Sharon SNF CT LLC, d/b/a Sharon Health Care Center		Address (No. & Street, City, State, Zip) 27 Hospital Hill Road, Sharon, CT 06069		
License Numbers:	CCNH 2382	RHNS (Specify)	Medicare Provider No. 075379	
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Sawyer Thornton		Nursing Home Administrator's License No.:	2111	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		
Not Applicable				

General Information and Questionnaire Related Parties*

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care Center	License No. 2382	Report for Year Ended 9/30/2019	Page 4	of 37			
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input checked="" type="radio"/> Yes <input type="radio"/> 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				
Sharon Landlord CT LLC	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>	Lease of Real Property	Pg 22, 19 and L10b; pg	232,500	232,500
Athena Captive	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>	Worker's Compensation Captive	Pg 15 1a1	245,061	245,061
Athena Health Care Assoc 401k Plan	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>	Facility participates in common 401k plan			
Athena Health Care Insurance	135 South Rd, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	Self Insured Employee Health & Dental	Pg 15 1a5	720,925	720,925
ProCare, LTC	111 Executive Blvd., Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	Pharmacy	Pg 13 b3, Pg 20 5a	273,460	273,460
Miscellaneous Facilities	Various	<input checked="" type="radio"/>	<input type="radio"/>	Interfacility loans	Pg 33, A2		
Athena Health Care	135 South Rd, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	See Attached			
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				

* Use additional sheets if necessary.

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

Sharon Health Care
RELATED PARTIES QUESTIONNAIRE
PAGE 4

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties %**		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No				
Athena Health Care	135 South Rd Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Employee Relations Data processing, Payroll processing, Advertising-help wanted Maintenance & Repairs Postage Cyber security insurance Office Supplies Management Fees Business Promotion Health Insurance Compliance	Pg 16, l5 Pg 16, m13 Pg 22, 6a Pg 16, m7 Pg 27, 14a Pg 15, 1g Pg 16, m12 Pg 16, m3 Pg 15, a5	8,554.00 4,942.00 7,459.00 34.00 1,625.00 505.00 295,298.00 761.00 7,434.00 326,612.00	8,554.00 4,942.00 7,459.00 34.00 1,625.00 505.00 162,595.00 761.00 7,434.00 193,909.00

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care	License No. 2382	Report for Year Ended 9/30/2019	Page 5	of 37
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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 (<i>See listing page 13</i>)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

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

Not Applicable

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

Yes No If "No," explain fully why such allocation was not made.

Not Applicable: No Non-Nursing Home Cost Centers

General Information and Questionnaire
Accounting Basis

Name of Facility Sharon SNF CT LLC, d/b/a Sharon	License No. 2382	Report for Year Ended 9/30/2019	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual Cash Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1 2018 Audit Fees (22,500 allowed) 2018 Tax Return (4,125 allowed)	\$ 26,625
2 2018 Medicare Cost Report (allowed)	\$ 2,700
3 2017 & 2018 Partnership Tax Return (disallowed)	\$ 4,400
4 2018 Form 8752 (allowed)	\$ 500
	Charge for Services Provided
	\$ 34,225

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

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha Cullina, LLP	860-240-6000
2 Goldman, Gruder & Woods/Pilicy & Ryan PC	203-899-8900/860-274-0018
3 Jackson Lewis PC	914-872-6767
4 Litchfield Hills Probate	860-824-7012
5 Sanford Consult/Senior Planning	860-283-9730/855-775-2664

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

1 City Place, 185 Asylum St, Hartford, CT 06103
2 200 CT Ave, Norwalk, CT/365 Main St, Watertown, CT
3 1133 Westchester Ave St S125, West Harrison, NY 10604
4 100 Pease St, Canaan, CT 06018
5 33 Smith Rd, Thomaston, CT/100 Blvd of America, Lakewood, NJ

Services Provided by This Firm (*describe fully*)

1 Audit & Annual Filing \$359 (allowed), General \$417 (disallowed)	\$ 776
2 A/R Collections/General Matters (disallowed)	\$ 7,085
3 Medical Malpractice (disallowed)	\$ 5,101
4 Probate Hearings (disallowed)	\$ 240
5 Medicaid Applications (disallowed)	\$ 4,000
	Charge for Services Provided
	\$ 17,202

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

Schedule of Resident Statistics

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care Center	License No. 2382		Report for Year Ended 9/30/2019				Page 8	of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Period 10/1 Thru 6/30		Period 7/1 Thru 9/30			
				Total	CCNH	RHNS			(Specify)
1. Certified Bed Capacity									
A. On last day of PREVIOUS report period	88	88		88		88		88	
B. On last day of THIS report period	88	88		88		88		88	
2. Number of Residents									
A. As of midnight of PREVIOUS report period	76	76		76		79		79	
B. As of midnight of THIS report period	82	82		79		82		82	
3. Total Number of Days Care Provided During Period									
A. Medicare	4,596	4,596		3,248		1,348		1,348	
B. Medicaid (Conn.)	18,335	18,335		13,447		4,888		4,888	
C. Medicaid (other states)	1,102	1,102		883		219		219	
D. Private Pay	3,796	3,796		3,076		720		720	
E. State SSI for RCH									
F. Other (Specify) Managed Care	699	699		653		46		46	
G. Total Care Days During Period (3A thru F)	28,528	28,528		21,307		7,221		7,221	
Total Number of Days Not Included in Figures in 3G									
4. for Which Revenue Was Received for Reserved Beds									
A. Medicaid Bed Reserve Days	4	4				4		4	
B. Other Bed Reserve Days	21	21		14		7		7	
5. Total Resident Days (3G + 4A + 4B)	28,553	28,553		21,321		7,232		7,232	

Schedule of Resident Statistics (Cont'd)

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Ca	License No. 2382	Report for Year Ended 9/30/2019	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No
 If "YES", provide the following information:

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

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

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

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

Item	Medicare		Medicaid		Self-Pay			Other State Assisted	
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	13		58		8		3		
Per Diem Rate									
a. One bed rm.	585.65		258.30		570.00		464.22		
b. Two bed rms.	585.65		258.30		555.00		464.22		
c. Three or more bed rms.									

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	4,571	4,571		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	709	709		
2. Restorative Treatments				
C. Other	21,322	21,322		
D. Total Physical Therapy Treatments	26,602	26,602		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	539	539		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	74	74		
2. Restorative Treatments				
C. Other	832	832		
D. Total Speech Therapy Treatments	1,445	1,445		

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	3,503	3,503		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	814	814		
2. Restorative Treatments				
C. Other	12,226	12,226		
D. Total Occupational Therapy Treatments	16,543	16,543		

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	9/30/2019	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> 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)	120,485	2,066				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	215,242	9,486				
5. Dietary Service						
a. Head Dietitian	14,054	348				
b. Food Service Supervisor	67,572	2,087				
c. Dietary Workers	331,467	20,469				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	177,581	11,591				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	65,382	2,246				
b. Other Maintenance Workers	46,381	2,129				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	86,557	6,517				
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	121,757	2,102				
b. RN						
1. Direct Care	364,362	7,915				
2. Administrative**	362,355	12,289				
c. LPN						
1. Direct Care	627,803	20,865				
2. Administrative**						
d. Aides and Attendants	1,327,348	69,297				
e. Physical Therapists	404,496	12,035				
f. Speech Therapists	55,384	1,267				
g. Occupational Therapists	187,443	4,571				
h. Recreation Workers	158,331	7,529				
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	170,809	5,567				
n. Marketing						
o. Other (Specify)						
See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	4,904,809	200,376				

* 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 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		9/30/2019		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		
Sharon SNF CT LLC, d/b/a Sharon Health Care Center		2382		9/30/2019		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 (10/1/18-7/21/19)	97,352		Health & Life Insurances, Payroll Taxes	Day to Day Operations of the nursing home facility	1,669		Newtown Rehabilitation, 139 Toddy Hill Rd, Newtown, CT 06470	485	32,648
Sawyer Thornton (7/22/19-9/30/19)	23,133		Health & Life Insurances, Payroll Taxes	Day to Day Operations of the nursing home facility	397				
Section IV - Assistant Administrators									

*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
 ** Include all other employment worked during the cost year.
 *** If more than one Administrator is reported, include dates of employment for each.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Sharon SNF CT LLC, d/b/a Sharon Health Care Cer	2382	9/30/2019	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	10,624	25				
3. Pharmacist	8,741	48				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	81,000	280				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	521	6				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	6,387	22				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	492,794	5,020				
2. Administrative***						
b. LPN						
1. Direct Care	87,389	1,543				
2. Administrative***						
c. Aides	86,589	2,927				
d. Other						
12. Other (Specify) See Attached Schedule	49,200	480				
B-13 Total Fees Paid in Lieu of Salaries	823,245	10,351				

* 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 Sharon SNF CT LLC, d/b/a Sharon Health Care Center		License No. 2382	Report for Year Ended 9/30/2019	Page 14	of 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 Rd, Woodbridge, CT 06525	Psychiatrist	<input type="radio"/>	<input checked="" type="radio"/>		
Masstex Imaging, 3 Electronics Ave, Suite 201, Danvers, MA 01923	Dysphagia Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
ProCare Professional Healthcare, PO Box 823461, Philadelphia, PA 19182	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Nurse Network, 653 Main Street, Plantsville, CT 06479	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
ProCare, LTC, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners/Minority Interest	
Healthdrive, 85 Barnes Rd, Wallingford, CT 06492	Podiatrist, Ophthalmologist, Audiology, Eye & Dental	<input type="radio"/>	<input checked="" type="radio"/>		
Mark Marshall, DO, 32 Burton Rd, Salisbury, CT 06068	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Quotidian, 52 Seneff Rd, Washington, CT 06793	Assistant Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
SDX Dysphagia Experts, 21 Waterville Rd, Avon, CT 06001	Dysphagia Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Barbara Maltby, Sharon Hospital, 238 Indian Mountain Rd, Lakeville, CT 06039	Medical Ethics Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care	2382	9/30/2019	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 245,061	245,061		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 54,132	54,132		
4. Social Security (F.I.C.A.)	\$ 332,212	332,212		
5. Health Insurance	\$ 655,053	655,053		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 15,254	15,254		
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 98,371	98,371		
d. Accounting and Auditing	\$ 34,225	34,225		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 17,202	17,202		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 56,336	56,336		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 7,516	7,516		
2. Cellular Phones	\$ 2,803	2,803		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$ 29,660	29,660		
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 504,932	504,932		
Subtotal	\$ 2,052,757	2,052,757		

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2019	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	2,052,757	2,052,757		
l. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$ 6,665	6,665		
3. Gifts to Staff and Residents	\$ 23,513	23,513		
4. Employee Travel	\$ 3,457	3,457		
5. Education Expenses Related to Seminars and Conventions	\$ 14,284	14,284		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 5,918	5,918		
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 11,992	11,992		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 19,431	19,431		
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	\$ 6,078	6,078		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 9,125	9,125		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 335	335		
9. Subscriptions	\$ 1,545	1,545		
10. Contributions*** See Attached Schedule	\$			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$			
12. Administrative Management Services**	\$ 194,897	194,897		
13. Other (<i>Specify</i>) See Attached Schedule	\$ 108,436	108,436		
C-14 Total Administrative & General Expenditures	\$ 2,458,433	2,458,433		

* 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	\$ 19,431		
Total Other Advertising	\$ 19,431	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF Dues	\$ 8,610		
ACHCA Dues	\$ 515		
Total Dues	\$ 9,125	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Data Processing Fees	\$ 36,189		
Bank Charges	\$ 17,262		
Payroll Processing Fees	\$ 16,688		
Compliance Consulting	\$ 6,591		
Licenses	\$ 1,026		
Penalties CMS 2019-01-LTC, State of CT 2019-018	\$ 20,839		
Employee Physicals and Background Checks	\$ 9,841		
Total Other Administrative and General	\$ 108,436	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Health	2382	9/30/2019	17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Associates, Inc, 135 South Rd, Farmington, CT 06032	295,298	Full Management Services	See below
Amounts added back on Page 28	194,897	Admin/Gen 66%	Pg 16 Line 12
	47,248	Indirect 16%	Pg 18 Line 2C
	53,154	Direct 18%	Pg 20, Line 5J
Athena Health Care Associates, Inc, 135 South Rd, Farmington, CT 06032		Admin/Gen-Other Expenses	Pg 16, Line 12

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center		2382	9/30/2019		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 259,041	259,041			
2.	Non-Food Supplies	\$ 26,804	26,804			
3.	Other (Specify) _____ Dishes & Utensils	\$ 1,796	1,796			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Other (Specify) _____ Indirect Portion of Management Fee		\$ 47,248	47,248			
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 334,889	334,889			
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)	
F.	Resident Meals: Total no. of meals served per day:*	234	234			
G.	Is cost of employee meals included in 2D?	<input checked="" type="radio"/> Yes	<input type="radio"/> No			
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)					
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input checked="" type="radio"/> Yes	<input type="radio"/> No	If yes, specify cost.		\$2,679
K.	Is any revenue collected from these people?	<input checked="" type="radio"/> Yes	<input type="radio"/> No	If yes, specify amt.		\$1,803
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)					
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
N.	Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
O.	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.

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	9/30/2019	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. \$	8,561	8,561		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Other (Specify) Laundry Supplies	\$	4,063	4,063		
3D. Total Laundry Expenditures (3a + b + c)	\$	12,624	12,624		
3E. Laundry Questionnaire					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. 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 3D.
 *** 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
Sharon SNF CT LLC, d/b/a Sharon Health Car		2382	9/30/2019		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 (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	29,291	29,291		
	b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$				
	C. Other (<i>Specify</i>)	\$				
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	29,291	29,291		
5.	Resident Care (Supplies)**					
	a. Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from ProCare	\$	297,609	297,609		
	b. Medicine Cabinet Drugs	\$	8,071	8,071		
	c. Medical and Therapeutic Supplies	\$	240,107	240,107		
	d. Ambulance/Limousine***	\$	9,096	9,096		
	e. Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	18,625	18,625		
	f. X-rays and Related Radiological Procedures***	\$	22,221	22,221		
	g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
	h. Laboratory***	\$	22,983	22,983		
	i. Recreation	\$	29,376	29,376		
	j. Direct Management Services*	\$	53,154	53,154		
	k. Indirect Management Services*	\$				
	l. Other (Specify)**** See Attached Schedule	\$	75,956	75,956		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	777,198	777,198		

* 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	\$ 6,852		
Medical Equipment Rental Medicaid	\$ 23,011		
Cable TV Services	\$ 19,125		
Oxygen Equipment Rental	\$ 14,950		
Medical Equipment Rental Other	\$ 12,018		
Total Other Resident Care	\$ 75,956	\$ -	\$ -

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 Ca	2382	9/30/2019		22	37
Item	Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 90,812	90,812			
b. Heat	\$ 70,026	70,026			
c. Light & Power	\$ 85,803	85,803			
d. Water	\$ 57,220	57,220			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 18,985	18,985			
f. Other (<i>itemize</i>)	\$ 75,551	75,551			
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 398,397	398,397			
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$				
b. Building & Building Improvements	\$				
c. Non-Movable Equipment	\$ 14,139	14,139			
d. Movable Equipment	\$ 39,867	39,867			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 54,006	54,006			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$ 49,526	49,526			
d. Other (<i>Specify</i>)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$ 49,526	49,526			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$				
10. Property Taxes					
a. Real estate taxes paid by owner	\$ 232,500	232,500			
b. Real estate taxes paid by lessor	\$ 45,792	45,792			
c. Personal property taxes	\$ 2,986	2,986			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 384,810	384,810			

* 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)
Maintenance Supplies	\$ 17,988		
Groundskeeping	\$ 11,480		
Rubbish Removal	\$ 34,427		
Snow Removal	\$ 11,656		
Total Other Repairs and Maintenance	\$ 75,551	\$ -	\$ -

Depreciation Schedule

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care Center		License No. 2382		Report for Year Ended 9/30/2019				Page 23	of 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	209,766		209,766	101,501	SL	Various	14,139		
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal								14,139	
D. Movable Equipment									
1. Motor Vehicles (Specify name, model and year of each vehicle)									
a. Ford, E35YCUTA, 2003	10,000		10,000	10,000	SL	10			
b. Bus Graphics	4,668		4,668	4,668	SL	5			
c.									
d.									
2. Movable Equipment									
a. Acquired prior to this report period									
b. Disposals (attach schedule)	450,002		450,002	266,417	SL	Var	38,021		
c. Acquired during this report period (attach schedule)									
D-3. Subtotal			32,725		SL	Var	1,846		
E. Total Depreciation								39,867	
								54,006	

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
11/1/2018	Beds with Rails/Bumpers	\$ 4,249	10	\$ 212
5/1/2019	Ice Machine	\$ 6,142	10	\$ 307
5/1/2019	4 Mattresses	\$ 1,800	5	\$ 180
6/1/2019	Wheelchair	\$ 1,577	5	\$ 158
6/1/2019	Laptop	\$ 665	3	\$ 111
7/1/2019	Electrotherapy Machine	\$ 3,877	7	\$ 277
9/1/2019	11 Electric Beds	\$ 14,415	12	\$ 601
Total additions for Movable Equipment		\$ 32,725		\$ 1,846 *
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:				
10/1/2018	AC Blower Motor and Wheel	\$ 950	5	\$ 95
10/1/2018	AC Conveyor Housing and Slide	\$ 950	5	\$ 95
10/1/2018	Fire Pump Improvements	2962	10	148
1/1/2019	Water Heater	15748	10	787
1/1/2019	Fire Alarm Annunciator	1402	10	70
1/1/2019	Fire Alarm Annunciator	2235	10	112
5/1/2019	Plumbing Improvements	2162	15	72
5/1/2019	HVAC Improvements	2406	15	80
6/1/2019	Tank Level Switch	1850	10	93
6/1/2019	HVAC Improvements	8145	15	272
9/1/2019	Recirculation Pump	1606	10	80
Total additions for Leasehold Improvement		\$ 40,416		\$ 1,904 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care Center		Date of Acquisition		License No. 2382	Report for Year Ended 9/30/2019		Page 24	of 37
					Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**		
Item		Month	Year	Length of Amortization	Cost to Be Amortized			Totals
A. Organization Expense								
1.								
2.								
3.								
A-4. Subtotal								
B. Mortgage Expense								
1.								
2.								
3.								
B-4. Subtotal								
C. Leasehold Improvements and Other								
1. Acquired prior to this report period					607,709	241,030	SL	47,622
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal		9	2019	various	40,416		SL	1,904
D. Total Amortization								49,526
								49,526

* 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.

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

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Hd	License No. 2382	Report for Year Ended 9/30/2019	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* Yes No If "Yes," complete Part B. If "No," complete Part C.

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

Description	Total				
1. Date Land Purchased					
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 9/30/19	2,951,175			
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
Sharon SNF CT LLC, d/b/a Sharon H		2382	9/30/2019		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Sharon SNF CT LLC, d/b/a Sharon		2382		9/30/2019		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)				\$	2,393	2,393	
A. Item		Rate	Amount				
Energy Efficient Lighting Proj		3.99%	134,398				
Lender							
GPE Financial							
Address of Lender							
82 Wolcott Rd, Wethersfield, CT							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$	2,393	2,393	
12. D. Other Interest Expense (Specify)				\$	4,687	4,687	
Vender Interest							
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	7,080	7,080	
14. Insurance							
a. Insurance on Property (buildings only)				\$	57,072	57,072	
b. Insurance on Automobiles				\$	869	869	
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)				\$	57,941	57,941	
15. Total All Expenditures (A-13 thru C-14)				\$	10,188,717	10,188,717	

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	9/30/2019	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	\$ 187,443	187,443		
4.			Other - See attached Schedule	\$ 4,485	4,485		
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **	\$ 521	521		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 98,371	98,371		
10.	15	1d	Accounting	\$ 4,400	4,400		
10a.			Legal	\$ 16,843	16,843		
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 2,083	2,083		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	13	Gifts, flowers and coffee shops	\$ 23,513	23,513		
15.	16	15	Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$ 300	300		
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 *	\$ 19,431	19,431		
19.	15	1j&k	Income Tax / Corporate Business Tax	\$ 29,660	29,660		
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$ 87,584	87,584		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 24,188	24,188		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$ 2,679	2,679		
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 501,501	501,501		

* 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	\$ 4,485		
Total Other Salaries Adjustment			\$ 4,485	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	8n	Disallowed Dues	\$ 335		
16	M13	Bank Charges	\$ 17,262		
16	M13	Compliance Consulting	\$ 6,591		
Total Other A&G Adjustments			\$ 24,188	\$ -	\$ -

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	9/30/2019	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 501,501	501,501		
Page 20 - Resident Care Supplies***							
27.	20	5a1&	Prescription Drugs	\$ 297,609	297,609		
28.	20	5d	Ambulance/Limousine	\$ 9,096	9,096		
29.	20	5f	X-rays, etc	\$ 22,221	22,221		
30.	20	5h	Laboratory	\$ 22,983	22,983		
31.	20	5c	Medical Supplies	\$ 8,800	8,800		
32.	20	500	Oxygen (non emergency)	\$ 18,625	18,625		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 20,033	20,033		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 2,019	2,019		
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.			Other - Indirect	\$ 15,525	15,525		
43.	30	IV5	Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$ 23,887	23,887		
46.			Management Fees Indirect	\$ 21,232	21,232		
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 963,531	963,531		

*** 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.

Total Other Adjustments			\$ 15,525	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Sharon SNF CT LLC, d/b/a Sharon Healt	2382	9/30/2019		30	37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (CT only)	\$ 10,076,474	10,076,474			
b. Medicaid Room and Board Contractual Allowance **	\$ (5,429,365)	(5,429,365)			
2. a. Medicaid (All other states)	\$ 630,584	630,584			
b. Other States Room and Board Contractual Allowance **	\$ (366,787)	(366,787)			
3. a. Medicare Residents (all inclusive)	\$ 2,209,863	2,209,863			
b. Medicare Room and Board Contractual Allowance **	\$ 240,728	240,728			
4. a. Private-Pay Residents and Other	\$ 2,726,557	2,726,557			
b. Private-Pay Room and Board Contractual Allowance **	\$ (109,341)	(109,341)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 223,065	223,065			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (223,065)	(223,065)			
c. Prescription Drugs - Non-Medicare	\$ 73,431	73,431			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (73,431)	(73,431)			
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 807,472	807,472			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (667,165)	(667,165)			
c. Physical Therapy - Non-Medicare	\$ 154,600	154,600			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (154,600)	(154,600)			
4. a. Speech Therapy - Medicare	\$ 158,810	158,810			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (118,881)	(118,881)			
c. Speech Therapy - Non-Medicare	\$ 25,650	25,650			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (25,650)	(25,650)			
5. a. Occupational Therapy - Medicare	\$ 723,698	723,698			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (610,386)	(610,386)			
c. Occupational Therapy - Non-Medicare	\$ 145,060	145,060			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (145,060)	(145,060)			
6. a. Other (Specify) - Medicare	\$ 11,674	11,674			
b. Other (Specify) - Non-Medicare	\$				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 10,283,935	10,283,935			
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)	\$ 103,630	103,630			
V. Total Other Revenue (1 thru 8)	\$ 103,630	103,630			
VI. Total All Revenue (III + V)	\$ 10,387,565	10,387,565			

* 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)
N/A	Medicare Retroactive	\$ 4,803		
N/A	Medicaid Retroactive	\$ 6,871		
Total Other Resident Revenue - Medicare		\$ 11,674	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Dividend - Rehab Care	\$ 600		
	Bad Debt Recoveries	\$ 103,030		
Total Other Revenue		\$ 103,630	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Hea	2382	9/30/2019	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	358,694
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	921,657
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4 Inventories			\$	17,743
5. Prepaid Expenses			\$	308,847
a. Prepaid Insurance	225,793			
b. Prepaid Expenses Other	73,395			
c. Prepaid Insurance	9,659			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	136,037
Related Party	136,037			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,742,978
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 <u>648,125</u>		\$	357,569
	Accum. Depreciation <u>290,556</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>209,766</u>		\$	94,126
	Accum. Depreciation <u>115,640</u>	Net		
6. Movable Equipment	*Historical Cost <u>476,318</u>		\$	170,034
	Accum. Depreciation <u>306,284</u>	Net		
7. Motor Vehicles	*Historical Cost <u>14,668</u>		\$	
	Accum. Depreciation <u>14,668</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	6,484
Excluded Movable Equip/Move Equip Depr Var	6,484			
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	628,213

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

(Carry Total forward to next page)

SHARON HEALTH CARE
PREPAID EXPENSE
September 30, 2019

ACCT. # 1580

	Beginning Balance:	\$16,436.98
5148	OnShift 10/01/19-12/31/19	\$2,046.46
5364	October 2019 Insurance	\$55,000.00
5141	Pitney Bowes overpayment- pending refund	\$3,427.86
5141	Pitney Bowes double payment on INV 3306325675- pending refund	\$495.98
5138	Iron Mountain Storage \$746/mo. 7/1/19-6/30/2020	\$6,714.00
5148	A&A Cloudsmart 348.45/mo 8/1-1/2020	\$1,393.80
5148	HP Financial October 2019	\$570.97
5148	NaviHealth \$306.22 mo 7/19-6/30/2020	\$2,755.98
5135	Northwest CT Commerce Yearly Membership \$110/month	\$990.00
	Balance, 9/30/19	<u><u>\$73,395.05</u></u>

Sharon Moveable Equipment Carryforward Schedule

Cost Year	Amount	Amount	Amount	Amount	Total
	Excess on Change in Ownership	TV's 2013 cost report	2015 audit adjmt - lease expense	TV's 2016 cost report	TV's 2018 cost report
Cost Term	\$ 19,023 (1)	\$ 2,080 5.00	\$ 7,290 3.00	\$ 1,638 5.00	\$ 8,455 5.00
2012 Deprec	\$ 1,902				\$ 1,902
2012 Book Value	\$ 17,121				\$ 17,121
2013 Deprec	\$ 3,805	\$ 208			\$ 4,013
2013 Book Value	\$ 13,316	\$ 1,872			\$ 15,188
2014 Deprec	\$ 3,805	\$ 416			\$ 4,221
2014 Book Value	\$ 9,511	\$ 1,456			\$ 10,967
2015 Deprec	\$ 3,805	\$ 416	\$ 1,215		\$ 5,436
2015 Book Value	\$ 5,706	\$ 1,040	\$ 6,075		\$ 12,821
2016 Deprec	\$ 3,805	\$ 416	\$ 2,430	\$ 164	\$ 6,815
2016 Book Value	\$ 1,901	\$ 624	\$ 3,645	\$ 1,474	\$ 7,644
2017 Deprec	\$ 1,901	\$ 416	\$ 2,430	\$ 328	\$ 5,075
2017 Book Value	\$ -	\$ 208	\$ 1,215	\$ 1,146	\$ 2,569
2018 Deprec		\$ 208	\$ 1,215	\$ 328	\$ 846
2018 Book Value		\$ -	\$ -	\$ 818	\$ 7,610
2019				\$ 328	\$ 1,691
2019				\$ 490	\$ 5,919
				\$ 328	\$ 1,691
				\$ 162	\$ 4,228
				\$ 162	\$ 1,691
(1) Calculation of Excess				\$ 0	\$ 2,537
Cost Additions Prior to 2011	\$ 1,021,759				\$ 2,537
Acc'd Deprec Additions Prior to 2011	\$ (1,021,759)				\$ 1,691
Cost 2011 Additions	\$ 30,397				\$ 846
Acc'd Deprec 2011 Additions	\$ (2,210)				\$ (846)
Prior Owner Book Value 9/2010	\$ 28,187				\$ -
Additional Deprec for 10/2011-3/2	\$ (2,210)				\$ -
Carryforward Book Value	\$ 25,977				
Amount Booked by Buyer	\$ 45,000				
Excess Amount	\$ 19,023				

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			\$ -

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			\$ -

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref	Line Ref	Description	
Total Other Fixed Assets (Itemize)			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			\$ -

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

Page Ref	Line Ref	Description	
Total Other Long-Term Liabilities (Itemize)			\$ -

G. Balance Sheet (cont'd)

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Hea	License No. 2382	Report for Year Ended 9/30/2019	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 2,371,191	
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)			\$ 2,666,291	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$ 345,344	
Project Development		332,534		
Deferred Finance Fees		12,810		
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 3,011,635	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 5,382,826	

* 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
Sharon SNF CT LLC, d/b/a Sharon Health Ca		2382	9/30/2019	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	1,996,206
2. Notes Payable (<i>itemize</i>)				\$	659,000
Loans Related Parties					659,000

See Schedule					
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	135,848
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	5,574
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	886,280
Accrued Health Insurance		10,208	Provider Tax Due	123,682	
Due to Affiliates		693,158			
Accrued Operating Expenses		59,153			
Accrued Expenses - CT Sales & Use		79	See Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	3,682,908

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

(Carry Total forward to next page)

SHARON HEALTH CARE
ACCRUED EXPENSES - OPERATING
September 30, 2019

ACCT. # 2170

IBNR Health/Dental FY2018	27,699.13
Marcum Accounting Fee 9/30/18	22,500.00
Tripoint WC 2018	5,586.00
September NOA	1,034.80
October Comcast	(1,753.63)
Navihealth	3,674.63
Legal Invoice	412.50

BALANCE PER GENERAL LEDGER

\$59,153.43

G. Balance Sheet (cont'd)

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health		License No. 2382	Report for Year Ended 9/30/2019	Page 34	of 37
Account				Amount	
Total Brought Forward:				3,682,908	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
				\$	41,434
Name of Lender	Purpose	Amount	Date Due		
Energy Efficient Project		41,434			
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$	1,845,816
Notes Payable - Related Landlord		1,814,473			
Notes Payable - Mckesson		31,343			
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$	1,887,250
C. Total All Liabilities (Lines A-13 + B-5)				\$	5,570,158

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 Ho	2382	9/30/2019	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 (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(386,180)
6. Gain or Loss for Period			\$	198,848
				10/1/2018 thru 9/30/2019
7. Total Net Worth			\$	(187,332)
C. Total Reserves and Net Worth			\$	(187,332)
D. Total Liabilities, Reserves, and Net Worth			\$	5,382,826

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 Heal	2382	9/30/2019	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2018			\$	346,294
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	10,387,565
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	10,188,717
D. Net Income or Deficit			\$	198,848
E. Balance			\$	(147,446)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
Health Insurance Adjustment		30,325		
Amortize Start Up Cost		(70,214)		
Rounding		3		
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	(39,886)
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period	09/30/19		\$	(187,332)

I. Preparer's/Reviewer's Certification

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health	License No. 2382	Report for Year Ended 9/30/2019	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer 	Title CFO	Date Signed 2/17/2020		
Printed Name of Preparer Athena Health Care Associates, Inc.				
Address Address 135 South Rd, Farmington, CT 06032		Phone Number 860-751-3900		
Contacted Person Regarding Additional Information Needed Regarding This Report Michael Mosier		Phone Number 860-751-3900		
Contact Email Address mmosier@athenahealthcare.com				