State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2020

Name of Facility (as licensed) Sharon SNF CT LLC, d/b/a Sharon Health Care Center		
Address (No. & Street, City, State, Zip Code) 27 Hospital Hill Road Sharon, CT 06069		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2382			075379

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	2382		

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
Sharon SNF CT LLC, d/b/a Sharon Health Care Cente	2382	9/30/2020	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 IMPRISIONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Sharon SNF CT LLC, d/b/a Sharon Health Care Center [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)	Date	Signed (Owner)	Date
	2/12/2021		2/12/2021
Printed Name (Administrator) Sawyer Thornton Sawyer Thornton		Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me: Karol Montagna / State of Connecticut	Date: 2/12/2021	Signed (Notary Public)	Comm. Expires: 4/30/2022
Address of Notary Public: 74 Ruela Drive, Naugatuck CT 06770			

(Notary Seal)

KAROL MONTAGNA
NOTARY PUBLIC
MY COMMISSION EXPIRES APR. 30, 2022

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care Center	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 27 Hospital Hill Road Sharon, CT 06069				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900		Date 2/15/2021	

Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid $				
2. Laundry wages paid $				
3. Housekeeping wages paid $				
4. Nursing wages paid $				
5. All other wages paid $				
6. ***Total Wages Paid*** $				
7. Total salaries paid $				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report) $				

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-364-1002	9/30/2020	2	37

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

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

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

○ Proprietorship ⊙ LLC ○ Partnership ○ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ⊙ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Sawyer Thornton	2111

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
Sharon SNF CT LLC, d/b/a Sharon Health Care Cente	2382	9/30/2020	3	37

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

Name of Partners/Members	Business Address	Title	% Owned
Lawrence G Santilli	135 South Road, Farmington, CT 06032	Manager	0.7134

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health C	2382	9/30/2020	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated

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

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Ce	2382	9/30/2020	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2020	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	%**				
Sharon Landlord CT LLC	135 South Road, Farmington, CT 06032	○	⊙		Lease of Real Property	Pg 22, l9 and L10b; pg	226,542	226,542
Athena Captive	135 South Road, Farmington, CT 06032	○	⊙		Worker's Compensation Captive	Pg 15 1a1	230,585	230,585
Athena Health Care Assoc. 401 K Plan	135 South Road, Farmington, CT 06032	○	⊙		Facility participates in common 401k plan			
Athena Health Care Insurance	135 South Road, Farmington, CT 06032	⊙	○	<50%	Self Insured Employee Health & Dental	Pg 15 1a5	818,365	818,365
Procare, LTC	111 Executive Blvd., Farmingdale, NY 11735	⊙	○	>50%	Pharmacy	Pg 13 B3, Pg20 5a	319,640	319,640
Miscellaneous Facilities	Various	⊙	○	>98%	Interfacility loans	Pg 33, A2		
Athena Health Care	135 South Rd, Farmington, CT 06032	⊙	○	<50%	See attached			
		○	⊙					
		○	⊙					

* 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	x		>50%				
					Data processing, Payroll processing	Pg 16, m13	7,157.00	7,157.00
					Maintenance & Repairs	Pg 22, 6a	2,812.00	2,812.00
					Nusring Supplies	Pg 20, 5c	16,942.00	16,942.00
					Management Fees	Pg 16, m12	276,000.00	155,403.00
					Business Promotion	Pg 16, m3	455.00	455.00
					Health Insurance Compliance	Pg 15, a5	5,629.00	5,629.00
							308,995.00	188,398.00

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care	2382	9/30/2020	5	37

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

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

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

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

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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2020	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Leaf Capital Funding, LLC 1720A Crete St, Moberly, MO 65270	O	⊙	Xerox 7970 Copier/Xerox 3655 Copier	06/08/16	50 months	10,210	10,210
Pitney Bowes PO Box 371887, Pittsburgh, PA 15250	O	⊙	Postage Meter	01/10/16	51 months	820	820
Leaf Capital Funding, LLC 1720A Crete St, Moberly, MO 65270	O	⊙	Xerox 3655i Copier System	03/25/18	29 months	1,081	1,081
Hewlett Packard, PO Box 402582, Atlanta, GA	O	⊙	Fortinet Fortiphone system	04/29/16	60 months	14,142	14,142
	O	⊙					
	O	⊙					
	O	⊙					
	O	⊙					
	O	⊙					
	O	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? O Yes ⊙ No **Total** *** 26,253

* 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
Sharon SNF CT LLC, d/b/a Sharon	2382	9/30/2020	7	37

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1	2019 Audit fees(22,500-allowed), 2019 Tax Return (6,825-allowed)	$ 24,700
2	2018 Medicare Cost report-(allowed)	$ 2,700
3	2018 & 2019 Partnership Tax Return (disallowed)	$ 4,625
4	2019 Form 8752 (allowed)	$ 1,000
		Charge for Services Provided $ 33,025

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

⊙ Yes ○ No | Pg 15, Line1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha, Cullina, LLP	860-240-6000
2 Goldman, Gruder, & Woods/Pilicy & Ryan PC	203-899-8900/860-274-0018
3 Jackson Lewis PC	914-872-6767
4	
5	

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

1 City Place, 185 Asylum St., Hartford, CT 06103
2 200 Connecticut Ave, Norwalk, CT/365 Main St, Watertown, CT
3 1133 Westchester Ave Suite S125, West Harrison, NY 10604
4
5

Services Provided by This Firm (*describe fully*)

1	Audit & Ann. Filing $234 (Allowed), General 990 (disallowed)	$ 1,224
2	A/R Collections/General Matters (disallowed)	$ 12,259
3	Medical Malpractice (disallowed)	$ 858
4		$
5		$
		Charge for Services Provided $ 14,341

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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2020	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	88	88			88	88						
B. On last day of THIS report period	88	88							88	88		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	82	82			82	82						
B. As of midnight of THIS report period	50	50							50	50		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,822	5,822			5,251	5,251			571	571		
B. Medicaid (Conn.)	13,959	13,959			11,379	11,379			2,580	2,580		
C. Medicaid (other states)	395	395			395	395						
D. Private Pay	1,779	1,779			1,348	1,348			431	431		
E. State SSI for RCH												
F. Other (Specify) Managed Care	245	245			207	207			38	38		
G. Total Care Days During Period (3A thru F)	22,200	22,200			18,580	18,580			3,620	3,620		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	5	5			5	5						
B. Other Bed Reserve Days	16	16			16	16						
5. ***Total Resident Days*** **(3G + 4A + 4B)**	22,221	22,221			18,601	18,601			3,620	3,620		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Ca	2382	9/30/2020	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	6	34		6		4		
Per Diem Rate								
a. One bed rm.	598.70	258.30		600.00		437.46		
b. Two bed rms.	437.46	258.30		585.00		437.46		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	4,954	4,954		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	712	712		
2. Restorative Treatments				
C. Other	10,942	10,942		
D. ***Total Physical Therapy Treatments***	16,608	16,608		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	675	675		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	95	95		
2. Restorative Treatments				
C. Other	1,223	1,223		
D. ***Total Speech Therapy Treatments***	1,993	1,993		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	4,213	4,213		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	819	819		
2. Restorative Treatments				
C. Other	11,390	11,390		
D. ***Total Occupational Therapy Treatments***	16,422	16,422		

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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	9/30/2020	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)	120,384	2,226				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	294,038	9,598				
5. Dietary Service						
a. Head Dietitian	30	1				
b. Food Service Supervisor	85,175	2,177				
c. Dietary Workers	488,200	20,727				
6. Housekeeping Service						
a. Head Housekeeper	44,284	1,209				
b. Other Housekeeping Workers	229,154	10,444				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	80,455	2,165				
b. Other Maintenance Workers	61,786	2,132				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	161,422	7,763				
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	150,566	2,382				
b. RN						
1. Direct Care	634,119	12,034				
2. Administrative**	475,087	11,772				
c. LPN						
1. Direct Care	740,568	19,194				
2. Administrative**						
d. Aides and Attendants	1,583,429	62,162				
e. Physical Therapists	523,520	12,138				
f. Speech Therapists	92,008	1,967				
g. Occupational Therapists	271,562	5,888				
h. Recreation Workers	224,873	7,769				
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	247,550	6,278				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	6,508,210	200,026				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	$	Hours	$	Hours	$	Hours
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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2020	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										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2020	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* **										
Sawyer Thornton (10/1/19-9/30/20)	120,384			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,226	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
Sharon SNF CT LLC, d/b/a Sharon Health Care Cer	2382	9/30/2020	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	9,557	25				
3. Pharmacist	8,852	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	194				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	354	4				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
Psych Consulting Services	49,200	524				
9. Speech Therapist						
a. Resident Care	3,743	13				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	324,125	2,992				
2. Administrative***						
b. LPN						
1. Direct Care	38,004	671				
2. Administrative***						
c. Aides	3,760	127				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	518,595	4,598				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2020	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Dr. Sabooh Mubbashar, 123 Peck Hill Road, Woodbridge, CT 06525	Psychiatrist	○	⊙	
Masstex Imaging, 3 Electronics Ave, Suite 201, Danvers, MA 01923	Dysphagia Consultant	○	⊙	
Procare Professional Healthcare, P.O. Box 823461, Philadelphia, PA 19182	Nurse Pool	○	⊙	
Nurse Network, 653 Main Street, Plantsville, CT 06479	Nurse Pool	○	⊙	
Procare, LTC, 111 Executive Blvd., Farmingdale, NY 11735	Pharmacist	⊙	○	Common Owners/Minority Interest
Healthdrive, 85 Barnes Rd, Wallingford, CT 06492	Podiatrist, Ophthalmologist, Audiology, Eye & Dental	○	⊙	
Mark Marshall, DO, 32 Burton Road, Salisbury, CT 06068	Medical director	○	⊙	
Quotidian, 52 Seneff Road, Washington, CT 06793	Assistant Medical Director	○	⊙	
SDX Dysphagia Experts, 21 Waterville Rd, Avon, CT 06001	Dysphagia Consultant	○	⊙	
Norton and Associates, Inc., 34 Elm Street, Cohasset, MA, 02025	Nurse Pool	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care	2382	9/30/2020	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	230,585	230,585		
2. Disability Insurance	$				
3. Unemployment Insurance	$	60,521	60,521		
4. Social Security (F.I.C.A.)	$	454,596	454,596		
5. Health Insurance	$	741,239	741,239		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	20,610	20,610		
8. Uniform Allowance	$	862	862		
9. Other (*Specify*) See Attached Schedule	$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	135,695	135,695		
d. Accounting and Auditing	$	33,025	33,025		
e. Legal (*Services should be fully described on Page 7)*	$	14,341	14,341		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	44,043	44,043		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	10,207	10,207		
2. Cellular Phones	$	1,560	1,560		
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*	$	18,421	18,421		
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	344,707	344,707		
Subtotal	$	2,110,412	2,110,412		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Cente	2382	9/30/2020	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,110,412	2,110,412		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	1,900	1,900		
3. Gifts to Staff and Residents	$	24,215	24,215		
4. Employee Travel	$	2,415	2,415		
5. Education Expenses Related to Seminars and Conventions	$	3,842	3,842		
6. Automobile Expense (*not purchase or depreciation*)	$	3,963	3,963		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	12,046	12,046		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	12,662	12,662		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	7,252	7,252		
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	7,655	7,655		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	2,475	2,475		
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**	$	182,160	182,160		
13. Other (*Specify*)	$	91,559	91,559		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,462,556	2,462,556		

* 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	$ 12,662		
Total Other Advertising	$ 12,662	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF DUES	$ 7,345		
ACHCA Dues	$ 310		
Total Dues	$ 7,655	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Data Processing Fees	$ 44,938		
Bank Charges	$ 14,381		
Payroll Processing Fees	$ 17,667		
Employee Physicals and bavkground checks	$ 8,651		
Compliance Consulting	$ 4,447		
Licenses	$ 1,475		
Total Other Administrative and General	$ 91,559	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Healtl	License No. 2382	Report for Year Ended 9/30/2020	Page 17 of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	276,000	Full Management Services	See Below
Amounts added back on Page 28	182,160	Admin/Gen 66%	Pg 16, Line 12
	44,160	Indirect 16%	Pg 20, Line 5k
	49,680	Direct 18%	Pg 20, Line 5J
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032		Admin/Gen-Other Expense	Pg 16, Line 12

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

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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
Sharon SNF CT LLC, d/b/a Sharon Health Care Cente	2382	9/30/2020	18	37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	218,711	218,711		
2. Non-Food Supplies	$	20,452	20,452		
3. Other (*Specify*) Dishes	$	655	655		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	239,818	239,818		

2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*		182	182		

G.	Is cost of employee meals included in 2D?	⊙ Yes	○ No		
H.	Did you receive revenue from employees?	○ Yes	⊙ 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?	⊙ Yes	○ No	If yes, specify cost.	$2,293
K.	Is any revenue collected from these people?	⊙ Yes	○ No	If yes, specify amt.	$1,093
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg 18, Line 2a1
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⊙ No	If yes, specify cost.	
N.	Is any revenue collected from employees?	○ Yes	⊙ 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.

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CSP-19 Rev. 9/2018

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

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care Center	License No. 2382	Report for Year Ended 9/30/2020	Page 19 of 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	15,692	15,692		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Supplies	$	6,193	6,193		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	21,885	21,885		

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	O Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	O Yes	⊙ 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?	O Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	O Yes	⊙ 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care	2382	9/30/2020	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel		40,000	40,000		
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	24,146	24,146		
b. Purchased Services (*by contract other than through Management Services*) (*Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel		40,000	40,000		
	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	24,146	24,146		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Procare, LTC		$	299,188	299,188		
b. Medicine Cabinet Drugs		$	11,886	11,886		
c. Medical and Therapeutic Supplies		$	238,432	238,432		
d. Ambulance/Limousine***		$	22,283	22,283		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	7,590	7,590		
f. X-rays and Related Radiological Procedures***		$	23,825	23,825		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	18,370	18,370		
i. Recreation		$	20,178	20,178		
j. Direct Management Services*		$	49,680	49,680		
k. Indirect Management Services*		$	44,160	44,160		
l. Other (Specify)**** See Attached Schedule		$	57,964	57,964		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	793,556	793,556		

* 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	$ 8,556		
Medical Equipment Rental-Medicaid	$ 1,252		
Cable TV Services	$ 22,800		
Oxygen Equipment Rental	$ 17,779		
Medical Equipment Rental-Other	$ 7,577		
Total Other Resident Care	$ 57,964	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2020	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADP	100 Corporate Drive, Windsor, CT 06095	○	⊙		Payroll Processing	12,491			16	m13
Welsh Sanitation	PO Box 1209, Hopewell Junction, NY 12533	○	⊙		Rubbish Removal	31,751			22	6f
Procare	111 Executive Blvd., Farmingdale, NY 11735	⊙	○	Common Owners/Minority Interest	Pharmacy	319,640			16	m13
Haab Landscaping	66 Skunks Misery Rd, Millerton, NY 12546	○	⊙		Snow Removal/Landscaping	10,566			22	6f
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* List all contracted services over $10,000. Use additional sheets if necessary.
** Refer to Page 4 for definition of related.
*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	$ 12,840		
Rubbish Removal	$ 32,877		
Snow Removal	$ 7,604		
Supplies	$ 14,860		
Total Other Repairs and Maintenance	$ 68,181	$ -	$ -

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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
Sharon SNF CT LLC, d/b/a Sharon Health Ca	2382	9/30/2020			22 | 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	78,468	78,468		
b. Heat	$	55,884	55,884		
c. Light & Power	$	82,152	82,152		
d. Water	$	51,697	51,697		
e. Equipment Lease (*Provide detail on page 6*)	$	26,253	26,253		
f. Other (*itemize*)	$	68,181	68,181		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	362,635	362,635		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	13,799	13,799		
d. Movable Equipment	$	37,884	37,884		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	51,683	51,683		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	52,010	52,010		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	52,010	52,010		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	226,542	226,542		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	46,472	46,472		
c. Personal property taxes	$	2,889	2,889		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	379,596	379,596		

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

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2020	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	209,765		209,765	115,639	SL	Various	13,799	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								13,799

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. Ford, E35YCUTA, 2003	x		4	2013	10,000		10,000	10,000	SL	10		
b. Bus Graphics			9	2014	4,668		4,668	4,668	SL	5		
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	2019	482,727		482,727	306,285	S/L	Var	36,778	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2020	10,911		10,911		S/L	Var	1,106	
D-3. Subtotal												37,884
E. ***Total Depreciation***												51,683

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:					
12/1/2019	Computers	$ 1,010	3	168	
3/1/2020	Floor Scrubber	$ 7,125	5	713	
3/1/2020	Chairs	1040	10	52	
3/1/2020	Computer	672	5	67	
6/1/2020	Tablets	1064	5	106	
Total additions for Movable Equipment		$ 10,911		$ 1,106	*
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:					
12/1/2019	Dryer Parts	$ 1,528	10	76	
12/1/2019	New Roof and Decking	$ 254,135	10	12,707	
2/1/2020	Actuator	1135	10	57	
Total additions for Leasehold Improvement		$ 256,798		$ 12,840	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2020	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				648,125	290,556	SL		39,170	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)	9	2020	Various	256,798		SL	Var	12,840	
C-4. Subtotal									52,010
D. ***Total Amortization***									52,010

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon He	2382	9/30/2020	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	04/10/12
4. Date of Initial Licensure	04/10/12
5. Total Licensed Bed Capacity	88
6. Square Footage	
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	2,907,233			
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.

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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	9/30/2020			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
Sharon SNF CT LLC, d/b/a Sharon	2382	9/30/2020	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*) $	980	980		
A. Item: Energy efficient lighting proj / Rate: 3.99% / Amount: 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) $	980	980		
12. D. Other Interest Expense (*Specify*) $ Vendor Interest = $7,439	7,439	7,439		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	8,419	8,419		
14. Insurance				
a. Insurance on Property (buildings only) $	67,771	67,771		
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)*** $	67,771	67,771		
15. ***Total All Expenditures (A-13 thru C-14)*** $	11,387,187	11,387,187		

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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	9/30/2020	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	$	271,562	271,562		
4.			Other - See attached Schedule	$	5,626	5,626		
Page 13 - Professional Fees								
5.	13	B8c	Resident Care Physicians **	$	354	354		
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	1c	Bad Debts	$	135,695	135,695		
10.	15	1d&e	Accounting	$	4,625	4,625		
10a.			Legal	$	14,107	14,107		
11.			Telephone	$				
12.	15	1h2	Cellular Telephone	$	840	840		
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.	16	13	Gifts, flowers and coffee shops	$	24,215	24,215		
15.	16	15	Education expenditures to colleges or universities for tuition and related costs for owners and employees	$	1,500	1,500		
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&1	Unallowable Advertising *	$	12,662	12,662		
19.	15	1j&k	Income Tax / Corporate Business Tax	$	18,421	18,421		
20.			Fund Raising / Contributions	$				
21.			Unallowable Management Fees	$	79,594	79,594		
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	18,828	18,828		
Page 18 - Dietary Expenditures								
24.	18	2a1	Meals to employees, guests and others who are not residents	$	1,199	1,199		
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)	$	589,228	589,228		

* 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	$ 5,626		
Total Other Salaries Adjustment			$ 5,626	$ -	$ -

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	$ 14,381		
16	M13	Compliance Consulting	$ 4,447		
Total Other A&G Adjustments			$ 18,828	$ -	$ -

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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	9/30/2020	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	589,228	589,228		
Page 20 - Resident Care Supplies***							
27.	20	5a1&	Prescription Drugs $	299,188	299,188		
28.	20	5d	Ambulance/Limousine $	22,283	22,283		
29.	20	5f	X-rays, etc $	23,825	23,825		
30.	20	5h	Laboratory $	18,370	18,370		
31.	20	5c	Medical Supplies $	8,800	8,800		
32.	20	5e2	Oxygen (non emergency) $	7,590	7,590		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	10,130	10,130		
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 $				
43.	30	IV5	Interest Income on Account Rec. $	39	39		
44.			Other - Miscellaneous Administrative $	19,200	19,200		
45.			Management Fees Direct $	21,707	21,707		
46.			Management Fees Indirect $	19,296	19,296		
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)*** $	1,041,675	1,041,675		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental-Other	$ 7,577		
20	5b	Ebox	$ 394		
30	IV8	Nursing Supply Rebate	$ 2,159		
Total Other Ancillary Costs			$ 10,130	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Movable Equipment (See Attached)	$ 2,019		
Total Excess Movable Equipment Depreciation			$ 2,019	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Radio & Televisionn Revenue	$ 19,200		
Total Other Adjustments			$ 19,200	$ -	$ -

Schedule of Other - Direct 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
Sharon SNF CT LLC, d/b/a Sharon Healt 2382	9/30/2020	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	7,972,037	7,972,037		
b. Medicaid Room and Board Contractual Allowance **	$	(4,324,160)	(4,324,160)		
2. a. Medicaid (*All other states*)	$	225,555	225,555		
b. Other States Room and Board Contractual Allowance **	$	(131,000)	(131,000)		
3. a. Medicare Residents *(all inclusive)*	$	2,623,877	2,623,877		
b. Medicare Room and Board Contractual Allowance **	$	95,424	95,424		
4. a. Private-Pay Residents and Other	$	1,896,396	1,896,396		
b. Private-Pay Room and Board Contractual Allowance **	$	(226,643)	(226,643)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	218,262	218,262		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(218,262)	(218,262)		
c. Prescription Drugs - Non-Medicare	$	107,845	107,845		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(107,845)	(107,845)		
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	$	708,684	708,684		
b. Physical Therapy - Medicare Contractual Allowance **	$	(549,931)	(549,931)		
c. Physical Therapy - Non-Medicare	$	156,100	156,100		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(156,100)	(156,100)		
4. a. Speech Therapy - Medicare	$	190,354	190,354		
b. Speech Therapy - Medicare Contractual Allowance **	$	(140,213)	(140,213)		
c. Speech Therapy - Non-Medicare	$	49,815	49,815		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(49,815)	(49,815)		
5. a. Occupational Therapy - Medicare	$	682,410	682,410		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(545,890)	(545,890)		
c. Occupational Therapy - Non-Medicare	$	157,030	157,030		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(157,030)	(157,030)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	1,450,737	1,450,737		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	9,927,637	9,927,637		
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)*	$	39	39		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	28,761	28,761		
V. Total Other Revenue (1 thru 8)	$	28,800	28,800		
VI. Total All Revenue (III +V)	$	9,956,437	9,956,437		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Misc CRF Covid Relief Funds	$ 1,450,737		
Total Other Resident Revenue		$ 1,450,737	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest on A/R	39	$ 39		
Total Interest Income			$ 39	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Nursing Supplies Rebate	$ 2,159		
	Bad Debt Recoveries	$ 26,602		
Total Other Revenue		$ 28,761	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Hea	2382	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 115,484
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,031,472
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (613,283)
4 Inventories				$ 14,570
5. Prepaid Expenses				$ 142,216
a. Prepaid Insurance		116,817		
b. Prepaid Expenses-Other		16,444		
c. Prepaid Insurance		8,955		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$ (150,000)
8. Other Current Assets (*itemize*)				$ 136,037
Related Party		136,037		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 676,496
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	904,923		$ 562,357
	Accum. Depreciation	342,566	Net	
5. Non-Movable Equipment	*Historical Cost	209,766		$ 80,327
	Accum. Depreciation	129,439	Net	
6. Movable Equipment	*Historical Cost	489,249		$ 145,081
	Accum. Depreciation	344,168	Net	
7. Motor Vehicles	*Historical Cost	14,668		$
	Accum. Depreciation	14,668	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 4,390
Excluded Movable Equipment/move equip accun		4,390		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 792,155

* 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, 2020

ACCT. # 1580

Software	$2,141
Overpayment	***$3,924***
Software	$2,902
Storage	$7,478
Balance, 9/30/20	**$16,444**

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	$ 19,023	(1) $ 2,080	$ 7,290	$ 1,638	$ 8,455	
	Term	5.00	5.00	3.00	5.00	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	$ 2,597
2018	Book Value		$ -	$ -	$ 818	$ 7,610	$ 8,428
2019					$ 328	$ 1,691	$ 2,019
2019					$ 490	$ 5,919	$ 6,409
					$ 328	$ 1,691	$ 2,019
					$ 162	$ 4,228	$ 4,390
					$ 162	$ 1,691	$ 1,853
					$ 0	$ 2,537	$ 2,537
						$ 1,691	$ 1,691
						$ 846	$ 846
						$ (846)	$ (846)
						$ -	$ -

(1) Calculation of Excess

Cost	Additions Prior to 2(	$ 1,021,759
Acc'd Deprec	Additions Prior to 2(	$ (1,021,759)
Cost	2011 Additions	$ 30,397
Acc'd Deprec	2011 Additions	$ (2,210)
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 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 Current Liabilities (Itemize)			$ -

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Hea	2382	9/30/2020	32	37

	Account			Amount
			Total Brought Forward:	$ 1,468,651
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 (*itemize*)			$
	6. Loans to Owners or Related Parties (*itemize*)			$
	Name and Address	Amount	Loan Date	
	7. Other Assets (*itemize*)			$ 158,257
	Project Development		113,737	
	Deferred Finance Fees		44,520	
	See Schedule			
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)			$ 2,824,548
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ 4,293,199

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Ca	2382	9/30/2020	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 906,353
2. Notes Payable (*itemize*)					$ 1,883,733
Loans - Related Parties			1,883,733		
See Schedule					
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*)					$ 170,931
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 217,441
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 960,700
Accrued Health Insurance		9,719	Provider Taxes Due	221,950	
Due to Affiliates		693,158			
Acc'd Operating Expenses		34,936			
Acc'd Expense - CT Sales & Use Tax		937	See Schedule		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 4,139,158

* 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 OPERATING EXP - 2170
September 30, 2020

DESCRIPTION	BALANCE
IBNR Healthcare	$8,586
X-Ray	$609
Lab	$1,013
Pharmacy	$18,873
Ambulance	($3,523)
Doctor	$3,000
Interest	($1,844)
Supplies	$704
Dental	$796
Lease	($205)
Lease	($2,283)
Insurance	($11,136)
Wellness	($2,156)
Engagement Letter	$22,500
	$34,936

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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	2382	9/30/2020	34	37

Account				Amount
			Total Brought Forward:	4,139,158
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$ 9,041
Name of Lender	Purpose	Amount	Date Due	
Energy Efficiency Project		9,041		
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*)				$ 1,814,473
Notes Payable: Related Landlord		1,814,473		
See Schedule				
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 1,823,514
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 5,962,672

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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 He	2382	9/30/2020	35	37

	Account	Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (238,723)
	6. Gain or Loss for Period 10/1/2019 thru 9/30/2020	$ (1,430,750)
	7. Total Net Worth	$ (1,669,473)
C.	***Total Reserves and Net Worth***	$ (1,669,473)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 4,293,199

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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	9/30/2020	36	37

Account			Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2019			$ (187,332)
B. Total Revenue (*From Statement of Revenue Page 30*)			$ 9,956,437
C. Total Expenditures (*From Statement of Expenditures Page 27*)			$ 11,387,187
D. Net Income or Deficit			$ (1,430,750)
E. Balance			$ (1,618,082)
F. Additions			
1. Additional Capital Contributed (*itemize*)			
Health Insurance	(80,803)		
2019 Greystone Refiancing	29,410		
Rounding	2		
2. Other (*itemize*)			
F-3. Total Additions			$ (51,391)
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*** 09/30/20			$ (1,669,473)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health	2382	9/30/2020	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
	CFO	2-15-21

Printed Name of Preparer

Athena Health Care Associates, Inc

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

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Paulina Myslinski	860-751-3900

Contact Email Address

Pmyslinski@athenahealthcare.com