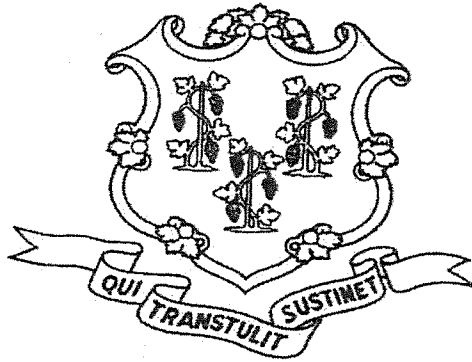


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as licensed) Sheriden Woods Health Care Center	
Address (No. & Street, City, State, Zip Code) 321 Stonecrest Drive, Bristol, CT 06010	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 2004C	RHNS	(Specify)	Medicare Provider 07-5350
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Medicaid Provider Numbers:	CCNH 2004C	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) Sheriden Woods	License No. 2004C	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 Sheriden Woods [facility name], for the cost report period beginning 10/1/18 and ending 9/30/19, 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) <i>Lizbeth Carmichael</i>		Date <i>9/17/2020</i>	Signed (Owner) <i>[Signature]</i>		Date <i>9/17/2020</i>
Printed Name (Administrator) <i>Lizbeth Carmichael</i>			Printed Name (Owner) <i>Lawrence Santilli</i>		
Subscribed and Sworn to before me:	State of <i>CT</i>	Date <i>9/17/2020</i>	Signed (Notary Public) <i>[Signature]</i>	Comm. Expires <i>8/1/2020</i>	
Address of Notary Public <i>38 Linda Dr. Plainville CT 06062</i>					

(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 Sheriden Woods Health Care Center		Period Covered:	From 10/1/2018	To 9/30/2019
Address of Facility 321 Stonecrest Drive, Bristol, CT 06010				
Report Prepared By Athena Health Care Associates, Inc		Phone Number (860) 751-3900	Date 2/14/2020	
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 860-583-1827	Report for Year Ended 9/30/2019	Page 2	of 37
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Name of Facility (as shown on license) Sheriden Woods Health Care Center	Address (No. & Street, City, State, Zip) 321 Stonecrest Drive, Bristol, CT 06010
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License Numbers:	CCNH 2004C	RHNS (Specify)	Medicare Provider No. 07-5350
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Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)	

Type of Ownership (Check appropriate box)			
<input type="checkbox"/> Proprietorship	<input type="checkbox"/> LLC	<input type="checkbox"/> Partnership	<input checked="" type="radio"/> Profit Corp.
<input type="checkbox"/> Non-Profit Corp.	<input type="checkbox"/> Government	<input type="checkbox"/> Trust	

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

Has there been any change in ownership or operation during this report year?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," explain fully.
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Administrator		
Name of Administrator Lizbeth Carmichael	Nursing Home Administrator's License No.:	936

Other Operators/Owners who are assistant administrators (full or part time) of this facility.	
Name	License No.:
Not Applicable	

General Information and Questionnaire
Corporate Owners

Name of Facility Sheriden Woods Health Care Center	License No. 2004C	Report for Year Ended 9/30/2019	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated	
Sheriden Woods Health Care Center, Inc.	321 Stonecrest Rd, Bristol, CT 06010	CT	

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G Santilli	321 Stonecrest Rd, Bristol, CT 06010	President	6445.27
Michael E Mosier	321 Stonecrest Rd, Bristol, CT 06010	Treasurer, Secretary	

Names of Stockholders Owning at Least 10% of Shares			
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Other than listed above:			
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Conservators for Lawrence E Santilli	321 Stonecrest Rd, Bristol, CT 06010		2054.73
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General Information and Questionnaire Related Parties*

Name of Facility Sheriden Woods Health Care Center	License No. 2004C	Report for Year Ended 9/30/2019	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No
 If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? Yes No
 If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No %**				
Misc Facilities	Various	<input checked="" type="radio"/>	>98%	Interfacility Loans	pg 33 A2		
Athena Health 401K plan	135 South Road, Farmington, CT	<input type="radio"/>		Facility participates in a common 401(K) plan			
Athena Health Care	135 South Road, Farmington, CT	<input checked="" type="radio"/>	<50%	See Attached			
Athena Health Care Insurance	135 South Road, Farmington, CT	<input type="radio"/>		Self Insured Employee Health and Dental Insurance	pg 15 1a5	1,185,453	1,185,453
Sheriden Woods Landlord	321 Stonecrest Drive, Bristol, CT 06010	<input checked="" type="radio"/>		Lease of Property	pg 22 9. 10b, pg 27 14	702,068	702,068
Procure LTC Pharmacy of CT LLC	1492 Highland Ave, Cheshire, CT 06410	<input checked="" type="radio"/>	>50%	Pharmacy	pg 20 5a2	339,047	339,047
Laurel Ridge Healthcare Center	642 Danbury Rd, Ridgefield, CT 06877	<input checked="" type="radio"/>	>98%	Bank Service Charges	pg 16, m13	7,917	7,917
		<input type="radio"/>					
		<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

Sheridan Woods Healthcare Center
 RELATED PARTIES
 PAGE 4

FACILITY NAME	ADDRESS	Also Provided Goods/Services Non-Related Party		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"/>	Management Fees	Pg 28	\$638,140	\$293,848
		<input type="checkbox"/>	<input type="checkbox"/>	Promotion	Pg 16, M3	\$1,567	\$1,567
		<input type="checkbox"/>	<input type="checkbox"/>	Postage	Pg 16, M7	\$58	\$58
		<input type="checkbox"/>	<input type="checkbox"/>	Data/Payroll Processing	Pg 16, M13	\$4,411	\$4,411
		<input type="checkbox"/>	<input type="checkbox"/>	Cyber Security Insurance	Pg 27, 14a	\$1,625	\$1,625
Athena Captive LLC	135 South Rd Farmington, CT 06032	<input type="checkbox"/>	<input type="checkbox"/>	Painters	Pg 22, 6a	\$10,125	\$10,125
		<input type="checkbox"/>	<input type="checkbox"/>	Employee relations	Pg 16, 13	\$1,529	\$1,529
				Workers Comp Captive	pg. 15 a1	\$513,285	\$513,285

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Sheriden Woods Health Care Center	License No. 2004C	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.

Not Applicable

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

Not Applicable

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

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

Not Applicable: No Non-Nursing Home Cost Centers

**General Information and Questionnaire
 Leases (Excluding Real Property)**

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

Name of Facility		License No.		Report for Year Ended			Page	of
Sheriden Woods Health Care Center		2004C		9/30/2019			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	<input type="radio"/>	<input checked="" type="radio"/>	Postal Machines	Automatic Renewal	39 months	1,211	1,211	
Leaf	<input type="radio"/>	<input checked="" type="radio"/>	Copier	Automatic Renewal	48 months	13,234	13,234	
Hewlett-Packard	<input type="radio"/>	<input checked="" type="radio"/>	PCC Equipment	08/27/13	60 months	21,149	21,149	
	<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"/>						
						Total ***	35,594	

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

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.

General Information and Questionnaire
Accounting Basis

Name of Facility Sheriden Woods Health Care Center	License No. 2004C	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 Dworkin, Hillman, Lamorte & Sterczala	Four Corporate Dr, Shelton, CT
2 Marcum LLP	555 Long Wharf Drive, New Haven, CT
3 HFG Line of Credit	
4	

Services Provided by This Firm (*describe fully*)

1 2019 Year-end Audit and tax return preparation	\$ 10,100
2 Medicare cost report preparation	\$ 2,700
3 Line of Credit Audit Fee: Disallow	\$ 3,253
4	\$
	Charge for Services Provided
	\$ 16,053

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 Goldman, Gruder & Woods LLC	203-899-8900
2 Murtha Cullina	860-240-6000
3 Jackson Lewis P.C	860-522-0404
4 Probate court	860-584-6230
5 Mcgann, Barlett, & Brown	860-282-4670

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

- 1 200 Connecticut Ave, Norwalk, CT
- 2 185 Asylum Street, Hartford, CT
- 3 133 Westchester Ave, West Harrison, NY
- 4 111 North Main Street, Bristol
- 5 111 Founders Plaza, E. Hartford, CT

Services Provided by This Firm (*describe fully*)

1 Collections: Disallowed	\$ 1,043
2 General/ Review Credit/ HFG: \$5,905.97: Disallow / Sec of State Filings \$170: Allow	\$ 6,295
3 Employee Claims : Disallowed	\$ 66,340
4 Medicaid Application: Disallowed	\$ 2,500
5	\$
	Charge for Services Provided
	\$ 76,178

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 Sheriden Woods Health Care Center	License No. 2004C	Report for Year Ended 9/30/2019						Page 8	of 37		
		Period 10/1 Thru 6/30		Period 7/1 Thru 9/30		Total	RHNS (Specify)			CCNH	RHNS (Specify)
		Total CCNH Level	Total RHNS Level	Total	RHNS						
1. Certified Bed Capacity											
A. On last day of PREVIOUS report period	146	146		146		146		146			
B. On last day of THIS report period	146	146		146		146		146			
2. Number of Residents											
A. As of midnight of PREVIOUS report period	137	137		137		137		142			
B. As of midnight of THIS report period	144	144		142		142		144			
3. Total Number of Days Care Provided During Period											
A. Medicare	6,023	6,023		4,532		4,532		1,491			
B. Medicaid (Conn.)	43,033	43,033		32,207		32,207		10,826			
C. Medicaid (other states)											
D. Private Pay	1,998	1,998		1,565		1,565		433			
E. State SSI for RCH											
F. Other (Specify) Managed Care	176	176		23		23		153			
G. Total Care Days During Period (3A thru F)	51,230	51,230		38,327		38,327		12,903			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds											
A. Medicaid Bed Reserve Days	361	361		320		320		41			
B. Other Bed Reserve Days	11	11		6		6		5			
5. Total Resident Days (3G + 4A + 4B)	51,602	51,602		38,653		38,653		12,949			

Schedule of Resident Statistics (Cont'd)

Name of Facility Sheriden Woods Health Care Center			License No. 2004C			Report for Year Ended 9/30/2019			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> 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	9		117		7		11						
Per Diem Rate													
a. One bed rm.	540.71		223.42		581.00		501.80						
b. Two bed rms.	540.71		223.42		567.00		501.80						
c. Three or more bed rms.							501.80						
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								5,693	5,693				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								2,006	2,006				
2. Restorative Treatments													
C. Other								12,508	12,508				
D. Total Physical Therapy Treatments								20,207	20,207				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								696	696				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								185	185				
2. Restorative Treatments													
C. Other								543	543				
D. Total Speech Therapy Treatments								1,424	1,424				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								6,698	6,698				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								1,763	1,763				
2. Restorative Treatments													
C. Other								13,459	13,459				
D. Total Occupational Therapy Treatments								21,920	21,920				

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Sheriden Woods Health Care Center	2004C	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)	122,544	1,920				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	244,625	10,628				
5. Dietary Service						
a. Head Dietitian	66,364	1,727				
b. Food Service Supervisor	57,520	2,074				
c. Dietary Workers	446,042	31,142				
6. Housekeeping Service						
a. Head Housekeeper	72,547	2,311				
b. Other Housekeeping Workers	248,684	17,191				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	68,947	2,101				
b. Other Maintenance Workers	65,152	3,304				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	117,927	9,621				
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	212,815	3,930				
b. RN						
1. Direct Care	548,114	13,324				
2. Administrative**	467,932	16,801				
c. LPN						
1. Direct Care	1,326,468	51,001				
2. Administrative**						
d. Aides and Attendants	2,242,914	132,205				
e. Physical Therapists	392,075	11,945				
f. Speech Therapists	5,506	118				
g. Occupational Therapists	290,001	7,862				
h. Recreation Workers	209,655	9,800				
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	209,862	8,005				
n. Marketing						
o. Other (Specify)						
See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	7,415,694	337,010				

* 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 Sheriden Woods Health Care Center	License No. 2004C	Report for Year Ended 9/30/2019		Page 11	of 37		
		Line Where Claimed on Page 10	Name and Address of All Other Employment**				
Name	CCNH	RHNS (Specify)	Salary Paid	Fringe Benefits and/or Other Payments (describe fully)	Total Hours Worked	Total Hours Worked	Compensation Received
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) Sheriden Woods Health Care Center		License No. 2004C	Report for Year Ended 9/30/2019		Page 12	of 37			
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS (Specify)							
Section III - Administrators***									
Robert S. Guastella (10/1/18-12/27/18)	28,020		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	344	A2			
Jonah Kraus (12/27/18-7/23/19)	67,658		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	1,176	A2			
Lizabeth Carmichael (7/2319-9/30/19)	26,866		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	400	A2	Countryside Manor of Bristol, 1660 Stafford Ave, Bristol, CT 06010	1,680	102,788
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.

Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Sheriden Woods Health Care Center	2004C	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	14,142	96				
3. Pharmacist	14,411	291				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	40,668	132				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	287	5				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
Medical Staff Meetings	300	3				
9. Speech Therapist						
a. Resident Care	3,600	10				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	118,367	1,600				
2. Administrative***	1,151	26				
b. LPN						
1. Direct Care	3,250	48				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	196,176	2,211				

* 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 Sheriden Woods Health Care Center		License No. 2004C	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		
HealthDrive Dental Group, 1 Prestige Drive, Suite 107, Meriden, CT, 06450	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. C. Licata, ProHealth Physicians, 625 Clark Ave., Bristol, CT 06010	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Procure LTC Pharmacy of CT LLC, 1492 Highland Ave, Cheshire, CT 06410	Pharmacist	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners; Minority Interest	
Athena Health Care Systems 135 South Road, Farmington, CT 06032	MDS Fill In	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners	
Vista Behavioral Health, 152 Simsbury Rd, Avon, CT 06001	Medical Staff	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. A. Scappaticci, ProHealth Physicians, 625 Clark Ave. Bristol, CT 06010	Asst. Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
HealthDrive Audiology Group, 1 Prestige Drive, Meriden, CT, 06450	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Swallowing Diagnostics, 21 Waterville RD, Avon, CT	Speech Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>		
Bristol Hospital, 41 Brewster Rd, Bristol, CT, 06010	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
The Nurse Network, 653 Main St, Plantsville, CT 06479	Nurse Pool	<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
Sheriden Woods Health Care Center	2004C	9/30/2019		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 513,285	513,285			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 98,536	98,536			
4. Social Security (F.I.C.A.)	\$ 480,569	480,569			
5. Health Insurance	\$ 1,039,884	1,039,884			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 29,236	29,236			
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*	\$ 77,144	77,144			
d. Accounting and Auditing	\$ 16,053	16,053			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 76,178	76,178			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 64,071	64,071			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 54,597	54,597			
2. Cellular Phones	\$ 1,680	1,680			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 958,071	958,071			
Subtotal	\$ 3,409,304	3,409,304			

* 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	\$ -	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended		Page	of
Sheriden Woods Health Care Center	2004C	9/30/2019		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	3,409,304	3,409,304			
i. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 6,816	6,816			
3. Gifts to Staff and Residents	\$ 40,105	40,105			
4. Employee Travel	\$ 1,085	1,085			
5. Education Expenses Related to Seminars and Conventions	\$ 8,080	8,080			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 4,270	4,270			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$ 285	285			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 21,559	21,559			
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	\$ 5,501	5,501			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 9,458	9,458			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 1,250	1,250			
9. Subscriptions	\$ 785	785			
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**	\$ 433,992	433,992			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 101,687	101,687			
C-14 Total Administrative & General Expenditures	\$ 4,044,177	4,044,177			

* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 21,559		
Total Other Advertising	\$ 21,559	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 9,458		
Total Dues	\$ 9,458	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
P/S Administration/Bookkeeping	\$ 3,010		
Licenses	\$ 2,451		
Bank Charges	\$ 18,865		
Payroll Processing Fees	\$ 21,420		
Background Checks/Physicals	\$ 19,306		
Data Processing	\$ 34,205		
Penalty- IRS Tax Year 2016	\$ 2,430		
Total Other Administrative and General	\$ 101,687	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	2004C	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 Assoc., Inc 135 South Road Farmington, CT 06032	600,436	Contract Attached to a Prior Year	See Below
Allocation of the above	\$108078	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	37,704	Admin/General	Pg 16, Line 12

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

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

Name of Facility Sheriden Woods Health Care Center		License No. 2004C	Report for Year Ended 9/30/2019	Page 18	of 37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$ 334,801	334,801			
2. Non-Food Supplies	\$ 64,197	64,197			
3. Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Other (Specify) _____ Management Services	\$ 96,070	96,070			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 495,068	495,068			
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)	
F. Resident Meals: Total no. of meals served per day:*	421	421			
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.	\$8,132
K. Is any revenue collected from these people?	<input checked="" type="radio"/> Yes	<input type="radio"/> No		If yes, specify amt.	\$235
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)					18, 2a1
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 Sheriden Woods Health Care Center		License No. 2004C	Report for Year Ended 9/30/2019	Page 19	of 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. \$	23,626	23,626		
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$				
c. Other (<i>Specify</i>) Supplies = \$7,468	\$	7,468	7,468		
3D. Total Laundry Expenditures (3a + b + c)	\$	31,094	31,094		
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
Sheriden Woods Health Care Center		2004C	9/30/2019		20	37
Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced		51,285	51,285		
a. In-House Care	by Personnel					
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$					
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)		\$				
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		\$				
2. Purchased from Procare LTC Pharmacy		\$	269,835	269,835		
b. Medicine Cabinet Drugs		\$	28,064	28,064		
c. Medical and Therapeutic Supplies		\$	327,336	327,336		
d. Ambulance/Limousine***		\$	4,689	4,689		
e. Oxygen						
1. For Emergency Use		\$				
2. Other***		\$	64,091	64,091		
f. X-rays and Related Radiological Procedures***		\$	25,169	25,169		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$				
h. Laboratory***		\$	44,685	44,685		
i. Recreation		\$	15,175	15,175		
j. Direct Management Services*		\$				
k. Indirect Management Services*		\$				
l. Other (Specify)*** See Attached Schedule		\$	213,684	213,684		
5M. Total Resident Care Expenditures (5a - 5j)		\$	992,728	992,728		

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Management Fee Direct	\$ 108,078		
Oxygen Concentrator Rentals	\$ 16,838		
Medical Equip Rentals-Medicaid	\$ 25,957		
Physical Therapy Supplies	\$ 36,372		
Cable TV Services	\$ 15,641		
Occupational Therapy Supplies	\$ 166		
Medical Equip Rentals-other	\$ 10,632		
Total Other Resident Care	\$ 213,684	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended			Page	of
Sheriden Woods Health Care Center	2004C	9/30/2019			22	37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	87,720	87,720			
b. Heat	\$	59,756	59,756			
c. Light & Power	\$	100,193	100,193			
d. Water	\$	64,650	64,650			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	35,594	35,594			
f. Other <i>(itemize)</i>	\$	74,185	74,185			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	422,098	422,098			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$	2,095	2,095			
b. Building & Building Improvements	\$	56,437	56,437			
c. Non-Movable Equipment	\$	18,040	18,040			
d. Movable Equipment	\$	59,486	59,486			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	136,058	136,058			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$	17,399	17,399			
c. Leasehold Improvements	\$	69,108	69,108			
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$	86,507	86,507			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	500,984	500,984			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	127,746	127,746			
c. Personal property taxes	\$	29,313	29,313			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	880,608	880,608			

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	\$ 11,245		
Rubbish Removal	\$ 28,804		
Snow Removal	\$ 6,700		
Supplies	\$ 27,436		
Total Other Repairs and Maintenance	\$ 74,185	\$ -	\$ -

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:				
Various	Various	\$ 68,221	Various	\$ 3,708
Total additions for Movable Equipment		\$ 68,221		\$ 3,708 *
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:				
Various	Various	\$ 714,851	Various	\$ 35,676
Total additions for Leasehold Improvement		\$ 714,851		\$ 35,676 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended		Page	of			
		9/30/2019				24	37	
Item	Date of Acquisition	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. Organization Expense								
1.								
2.								
3.								
A-4. Subtotal								
B. Mortgage Expense								
1.								
2.								
3. Finance Fees - Midcap	2	2018	52,198	11,600	S/L	3 year	17,399	17,399
B-4. Subtotal								
C. Leasehold Improvements and Other								
1. Acquired prior to this report period	9	2018	1,548,565	301,993	S/L	Various	33,432	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	9	2019	714,851		S/L	Various	35,676	
C-4. Subtotal								
D. Total Amortization								
								69,108
								86,507

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

Part B - Owner and Related Parties

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	03/29/12			
c. Interest Rate for the Cost Year	3.22%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	10,969,330			
f. Principal balance outstanding as of	3,248,096			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Sheriden Woods Health Care Center		2004C	9/30/2019		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
Sheriden Woods Health Care Center		2004C		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)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify)				\$	246,769	246,769	
Vendor Interest = \$22,427; Line of Credit Interest = \$224,							
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	246,769	246,769	
14. Insurance							
a. Insurance on Property (buildings only)				\$	81,371	81,371	
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)				\$	81,371	81,371	
15. Total All Expenditures (A-13 thru C-14)				\$	14,805,783	14,805,783	

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center				2004C	9/30/2019	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	\$ 290,001	290,001		
4.			Other - See attached Schedule	\$ 2,479	2,479		
Page 13 - Professional Fees							
5.	13	B8C	Resident Care Physicians **	\$ 287	287		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1C	Bad Debts	\$ 77,144	77,144		
10.	15	1D&E	Accounting	\$ 79,261	79,261		
10a.			Legal	\$			
11.			Telephone	\$			
12.	15	1H2	Cellular Telephone	\$ 960	960		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	1, 3	Gifts, flowers and coffee shops	\$ 40,105	40,105		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	M2&3	Unallowable Advertising *	\$ 21,844	21,844		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$ 227,233	227,233		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 22,651	22,651		
Page 18 - Dietary Expenditures							
24.	18	2A1	Meals to employees, guests and others who are not residents	\$ 7,897	7,897		
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)				\$ 769,862	769,862		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12m	Marketing Salaries & Benefits	\$ 2,479		
Total Other Salaries Adjustment			\$ 2,479	\$ -	\$ -

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	\$ 1,250		
16	M13	Bank Charges	\$ 18,865		
16	M13	Penalty- IRS Tax Year 2016	\$ 2,430		
22	6F	Stericycle Settlement	\$ 106		
Total Other A&G Adjustments			\$ 22,651	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center				2004C	9/30/2019	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 769,862	769,862		
Page 20 - Resident Care Supplies***							
27.	20	5a1&	Prescription Drugs	\$ 269,835	269,835		
28.	20	5d	Ambulance/Limousine	\$ 4,689	4,689		
29.	20	5f	X-rays, etc	\$ 25,169	25,169		
30.	20	5h	Laboratory	\$ 44,685	44,685		
31.	20	5c	Medical Supplies	\$ 27,789	27,789		
32.	20	5e2	Oxygen (non emergency)	\$ 64,091	64,091		
33.	20	5j	Occupational Therapy	\$ 166	166		
34.			Other - See Attached Schedule	\$ 28,488	28,488		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 9,237	9,237		
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.	\$ 208	208		
44.			Other - Miscellaneous Administrative	\$ 12,041	12,041		
45.			Management Fees Direct	\$ 61,973	61,973		
46.			Management Fees Indirect	\$ 55,087	55,087		
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)				\$ 1,373,320	1,373,320		

*** 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			\$ -	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV5	Radio and Television Revenue	\$ 12,041		
Total Other Adjustments			\$ 12,041	\$ -	\$ -

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
Sheriden Woods Health Care Center	2004C	9/30/2019			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 24,500,066	24,500,066				
b. Medicaid Room and Board Contractual Allowance **	\$ (14,975,077)	(14,975,077)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,839,895	1,839,895				
b. Medicare Room and Board Contractual Allowance **	\$ 126,696	126,696				
4. a. Private-Pay Residents and Other	\$ 2,649,388	2,649,388				
b. Private-Pay Room and Board Contractual Allowance **	\$ (335,229)	(335,229)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 177,638	177,638				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (177,638)	(177,638)				
c. Prescription Drugs - Non-Medicare	\$ 155,985	155,985				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (155,985)	(155,985)				
2. a. Medical Supplies - Medicare	\$ 13,189	13,189				
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$ 26,358	26,358				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (26,358)	(26,358)				
3. a. Physical Therapy - Medicare	\$ 719,077	719,077				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (586,628)	(586,628)				
c. Physical Therapy - Non-Medicare	\$ 362,040	362,040				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (362,040)	(362,040)				
4. a. Speech Therapy - Medicare	\$ 104,270	104,270				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (69,327)	(69,327)				
c. Speech Therapy - Non-Medicare	\$ 69,810	69,810				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (69,810)	(69,810)				
5. a. Occupational Therapy - Medicare	\$ 809,795	809,795				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (650,032)	(650,032)				
c. Occupational Therapy - Non-Medicare	\$ 357,495	357,495				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (357,495)	(357,495)				
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 14,146,083	14,146,083				
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 (<i>Specify</i>)	\$ 208	208				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 207,880	207,880				
V. Total Other Revenue (1 thru 8)	\$ 208,088	208,088				
VI. Total All Revenue (III + V)	\$ 14,354,171	14,354,171				

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.
 ** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
31, A2	Interest on A/R	777,115	\$ 208		
Total Interest Income			\$ 208	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30, 4a	Rehab Settlement	\$ 140		
30, 4a	Stericycle Settlement	\$ 106		
30, 8	Bad Debt Recoveries	\$ 207,634		
Total Other Revenue		\$ 207,880	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2019	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	55,190
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,853,969
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4 Inventories			\$	24,566
5. Prepaid Expenses			\$	391,774
a. Prepaid Insurance	351,154			
b. Prepaid Expenses	13,414			
c. Deposit Taxes	27,206			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	37,571
A/R Related Assets	37,571			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,363,070
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	151,417	\$	4,774
	Accum. Depreciation	146,643		
	Net			
3. Buildings	*Historical Cost	2,318,266	\$	424,371
	Accum. Depreciation	1,893,895		
	Net			
4. Leasehold Improvements	*Historical Cost	1,287,416	\$	1,127,915
	Accum. Depreciation	159,501		
	Net			
5. Non-Movable Equipment	*Historical Cost	559,160	\$	73,672
	Accum. Depreciation	485,488		
	Net			
6. Movable Equipment	*Historical Cost	1,633,611	\$	264,298
	Accum. Depreciation	1,369,313		
	Net			
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation			
	Net			
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	1,442
Moveable Equipment Carryforward	16,313			
See Schedule	(14,871)			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,896,472

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

(Carry Total forward to next page)

SHERIDEN WOODS HEALTH CARE CENTER
PREPAID EXPENSE 1580
FYE 9/30/19

<u>Description</u>	<u>Sep-19</u>
FMLA License	455.00
Data Processing	4,161.15
Copier Lease	3,403.44
Email Hosting	1,672.80
Scheduling	1,924.26
Medicare Services	1,796.85
Balance	<u><u>\$ 13,413.50</u></u>

Cost Year	Amount					Totals
	TV's 2013 Cost Report	TV's 2014 Cost Report	TV's 2015 Cost Report	TV's 2016 Cost Report	TV's 2017 Cost Report	
1998						
1998	Cost	\$ 625	\$ 2,426	\$ 8,187	\$ 14,424	\$ 180,944
1998	Term	\$ 5	\$ 5	\$ 5	\$ 5	\$ 5
1998	Deprec					
1998	Book Value					\$ 31
1999	Deprec					\$ 401
1999	Book Value					\$ 11,670
2000	Deprec					\$ 105,065
2000	Book Value					\$ 11,679
2001	Deprec					\$ 93,435
2001	Book Value					\$ 11,685
2002	Deprec					\$ 81,820
2002	Book Value					\$ 11,914
2003	Deprec					\$ 73,263
2003	Book Value					\$ 11,918
2004	Deprec					\$ 61,409
2004	Book Value					\$ 4,299
2005	Deprec					\$ 19,097
2005	Book Value					\$ 4,292
2006	Deprec					\$ 14,805
2006	Book Value					\$ 4,315
2007	Deprec					\$ 10,616
2007	Book Value					\$ 8,906
2008	Deprec					\$ 46,012
2008	Book Value					\$ 9,526
2009	Deprec					\$ 42,767
2009	Book Value					\$ 6,146
2010	Deprec					\$ 36,642
2010	Book Value					\$ 6,147
2011	Deprec					\$ 30,495
2011	Book Value					\$ 6,115
2012	Deprec					\$ 24,381
2012	Book Value					\$ 5,795
2013	Deprec					\$ 18,584
2013	Book Value					\$ 5,197
2014	Deprec					\$ 14,013
2014	Book Value					\$ 4,823
2015	Deprec					\$ 11,616
2015	Book Value					\$ 5,881
2016	Deprec					\$ 13,923
2016	Book Value					\$ 8,139
2017	Deprec					\$ 20,208
2017	Book Value					\$ 7,381
2018	Deprec					\$ 35,090
2018	Book Value					\$ 9,541
2019	Deprec					\$ 25,549
2019	Book Value					\$ 9,237
2020	Deprec					\$ 16,313
2020	Book Value					\$ 8,177
2021	Deprec					\$ 8,136
2021	Book Value					\$ 5,912
2022	Deprec					\$ 2,224
2022	Book Value					\$ 2,224

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			\$ -

Schedule of Other Current Assets (Itemize) 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	
		Misc Diff Fixed Assets to books	\$ (14,871)
Total Other Other Fixed Assets (Itemize)			\$ (14,871)

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)			\$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2019	32	37
Account			Amount	
Total Brought Forward:			\$	4,259,542
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	6,764,604		
	Accum. Depreciation	6,744,270	Net	\$ 20,334
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)			\$	20,334
D. Investment and Other Assets				
1. Deferred Deposits				\$
2. Escrow Deposits				\$
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)				\$ 382,200
5. Investments Related to Resident Care (<i>itemize</i>)				\$

6. Loans to Owners or Related Parties (<i>itemize</i>)				\$ (10,242,810)
Name and Address	Amount	Loan Date		
Due from Related Facilities	(10,242,810)			
7. Other Assets (<i>itemize</i>)				\$ (540,515)
	IRS Deposits/ Finance Fees	23,199		
	Goodwill	(563,714)		
	See Schedule			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	(10,401,125)
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	(6,121,249)

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center		2004C	9/30/2019	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	1,417,068
2. Notes Payable (<i>itemize</i>)				\$	3,738,630
Related Party					100,000
Line of Credit					3,638,630
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>)				\$	209,999
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	9,954
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>)				\$	293,498
Provider Tax Due					240,847
Acc'd Health Insurance					21,593
Acc'd Operating Expenses					30,960
Acc'd Expense - CT Sales Tax					98 See Schedule
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	5,669,149

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

(Carry Total forward to next page)

Sheriden Woods
 Accrued Operating Expense - 2170
 September 30, 2019

DESCRIPTION	DEBIT	CREDIT	BALANCE
Health Insurance IBNR 9/30/18		\$42,007.47	\$42,007.47
Accounting SJE			\$0.00
			\$0.00
Payroll		\$145,103.83	\$145,103.83
Electric		\$1,926.96	\$1,926.96
Water & Sewer		\$19,822.80	\$19,822.80
Gas		\$1,426.78	\$1,426.78
Electric		\$5,671.17	\$5,671.17
Television	\$940.32		(\$940.32)
			\$0.00
			\$0.00
			\$0.00
Maintenance	\$3,744.34		(\$3,744.34)
Health Insurance		\$7,233.87	\$7,233.87
Patient Refund		\$724.05	\$724.05
Dental		\$3,368.58	\$3,368.58
Insurance		\$1,625.00	\$1,625.00
Insurance		\$11,740.00	\$11,740.00
Patient Refund Voids	\$25,618.30		(\$25,618.30)
Legal Voids	\$10,868.00		(\$10,868.00)
Unemployment Fees	\$840.00		(\$840.00)
Solar Credit	\$177,780.00		(\$177,780.00)
			\$0.00
Engagement Letter		\$10,100.00	\$10,100.00
			\$0.00
			\$30,959.55

G. Balance Sheet (cont'd)

Name of Facility Sheriden Woods Health Care Center	License No. 2004C	Report for Year Ended 9/30/2019	Page 34	of 37
Account				Amount
Total Brought Forward:				5,669,149
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
Name of Lender	Purpose	Amount	Date Due	\$
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>)				\$ (138,498)
		Due From Related Landlord	(2,301,923)	
		Due to Related Landlord	2,119,892	
		McKesson Note	43,533	
		See Schedule		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ (138,498)
C. Total All Liabilities (Lines A-13 + B-5)				\$ 5,530,651

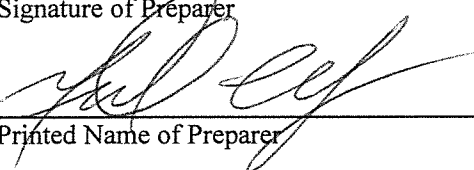
G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2019	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>)			\$	20,334
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			\$	20,334
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(11,170,337)
6. Gain or Loss for Period	10/1/2018	thru 9/30/2019	\$	(502,897)
7. Total Net Worth			\$	(11,672,234)
C. Total Reserves and Net Worth			\$	(11,651,900)
D. Total Liabilities, Reserves, and Net Worth			\$	(6,121,249)

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2019	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2018			\$	(11,207,114)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	14,354,171
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	14,857,068
D. Net Income or Deficit			\$	(502,897)
E. Balance			\$	(11,710,011)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2018 AJE Health Insurance		39,830		
Prior Year Management Fee Adj		(1,748)		
Prior Year Recreation Expense Adj		(300)		
2. Other <i>(itemize)</i>				
Rounding		(5)		
F-3. Total Additions			\$	37,777
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			\$	(11,672,234)
	09/30/19			

I. Preparer's/Reviewer's Certification

Name of Facility Sheriden Woods Health Care Center		License No. 2004C	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 CEO		Date Signed 2/17/2020	
Printed Name of Preparer Athena Health Care Associates, Inc					
Address Address 135 South Road Farmington, CT 06032				Phone Number (860) 751-3900	
Contacted Person Regarding Additional Information Needed Regarding This Report Paulina Myslinski				Phone Number (860) 751-3979	
Contact Email Address Pmyslinski@Athenahealthcare.com					