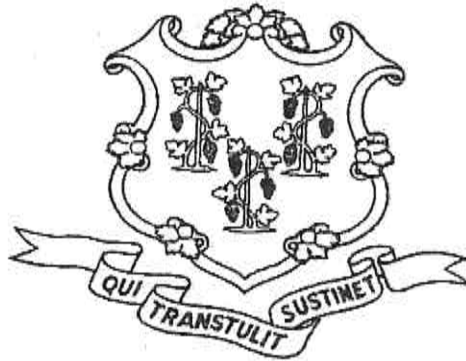
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2020

Name of Facility (as licensed) Sheriden Woods Health Care Center		
Address (No. & Street, City, State, Zip Code) 321 Stonecrest Drive, Bristol, CT 06010		
Type of Facility		
☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2004C			07-5350

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	2004C		

For Department Use Only

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	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 Sheriden Woods 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
Janet Shaken		2/12/2021		2/12/2021
Printed Name (Administrator) Lizbeth Carmichael			Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me: Karol Montagna	State of Connecticut	Date 2/12/2021	Signed (Notary Public) Karol Montagna	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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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 10/1/2019	To 9/30/2020
Address of Facility 321 Stonecrest Drive, Bristol, CT 06010				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900		Date 2/15/2021	

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
860-583-1827	9/30/2020	2	37

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

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

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

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

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.:
Lizbeth Carmichael	936

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

Name	License No.:
Not Applicable	

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2020	3	37

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

Name of Partners/Members	Business Address	Title	% Owned

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	2004C	9/30/2020	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
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	easurer, Secreta	
Names of Stockholders Owning at Least 10% of Shares			
Other than listed above:			
Conservators for Lawrence E Santilli	321 Stonecrest Rd, Bristol, CT 06010		2054.73

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2020	3B	37

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

Owner(s) of Facility

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2020	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	%**				
Misc Facilities	Various	⊙	○	>98%	Interfacility Loans	Pg 33 A2		
Athena Health 401K Plan	135 South Road, Farmington, CT	○	⊙		Facility participates in a common 401(K) pla			
Athena Health Care	135 South Road, Farmington, CT	⊙	○	<50%	See Attached			
Athena Health Care Insurance	135 South Road, Farmington, CT	○	⊙		Self Insured Employee Health and Dental In	pg 15 1a5	1,209,839	1,209,839
Sheriden Woods Landlord	321 Stonecrest Drive, Bristol, CT 06010	○	⊙		Lease of Property	pg 22 9. 10b, pg 27 14	698,496	698,496
Procare LTC Pharmacy of CT LLC	1492 Highland Ave, Cheshire, CT 06410	⊙	○	>50%	Pharmacy	pg 20 5a2	438,480	438,480
Laurel Ridge Healthcare Center	642 Danbury Rd, Ridgefield, CT 06877	⊙	○	>98%	Bank Service Charges	pg 16, m13	4,860	4,860
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

Sheriden Woods Healthcare Center
RELATED PARTIES
PAGE 4

FACILITY NAME	ADDRESS	Also Provided oods/Services n-Related Parti			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	X		<50%	Management Fees	Pg 28	$656,219	$310,470
	Farmington, CT 06032				Promotion	Pg 16, M3	$455	$455
					Postage	Pg 16, M7	$240	$240
					Data/Payroll Processing	Pg 16, M13	$7,156	$7,156
					Cyber Security insurance	Pg 27, 14a	$1,625	$1,625
					Painters/ Tablets	Pg 22, 6a	$9,499	$9,499
					Program nursing supplies	Pg 16, L3	$43,785	$43,785
Athena Captive LLC	135 South Rd Farmington, CT 06032		x		Workers Comp Captive	pg. 15 a1	$485,323	$485,323

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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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 6 of 37
Sheriden Woods Health Care Center		2004C	9/30/2020	

Name and Address of Lessor	Related * to Owners, Operators, Officers: Yes	Related * to Owners, Operators, Officers: No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	○	⊙	Postal Machines	Automatic Renewal	39 months	1,211	1,211
Leaf	○	⊙	Copier	Automatic Renewal	48 months	13,234	13,234
Hewlett-Packard	○	⊙	PCC Equipment	08/27/13	60 months	12,073	12,073
Wells Fargo Financials	○	⊙	Xerox Printer	04/06/20	48 months	6,840	6,840
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	33,358

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.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Cente	2004C	9/30/2020	7	37

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

⊙ Accrual O Cash O Modified Cash

Is the accounting basis for this period the same as for the previous period? ⊙ Yes O 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		
4		

Services Provided by This Firm (*describe fully*)

	Service		Amount
1	2020 Year-end Audit and tax return preparation	$	10,400
2	Medicare cost report preparation	$	2,700
3	Line of Credit Audit Fee: Disallow	$	3,990
4		$	
	Charge for Services Provided	$	17,090

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

⊙ Yes O No Pg 15, Line1d

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	Goldman, Gruder & Woods LLC	203-899-8900
2	Midcap	
3	Cicchiello & Cicchiello LLP	
4	Probate Court	860-584-6230
5		

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

1 200 Connecticut Ave, Norwalk, CT
2
3 364 Franklin Ave, Hartford, CT 06114
4 240 Stafford Ave, Bristol, CT 06010
5

Services Provided by This Firm (*describe fully*)

	Service		Amount
1	General Matters: Disallow	$	9,070
2	HFG: $3,171.40: Disallow	$	3,171
3	Employee Claims : Disallow	$	75,575
4	Conservatorship: Disallow	$	1,587
5		$	
	Charge for Services Provided	$	89,403

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

⊙ Yes O No Pg 15, Line 1e

Schedule of Resident Statistics

Name of Facility Sheriden Woods Health Care Center			License No. 2004C		Report for Year Ended 9/30/2020						Page 8 of 37	
					Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	146	146			146	146						
B. On last day of THIS report period	146	146							146	146		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	144	144			144	144						
B. As of midnight of THIS report period	108	108							108	108		
3. Total Number of Days Care Provided During Period												
A. Medicare	7,449	7,449			6,302	6,302			1,147	1,147		
B. Medicaid (Conn.)	34,474	34,474			26,839	26,839			7,635	7,635		
C. Medicaid (other states)												
D. Private Pay	1,841	1,841			1,587	1,587			254	254		
E. State SSI for RCH												
F. Other (Specify) Managed Care	555	555			343	343			212	212		
G. Total Care Days During Period (3A thru F)	44,319	44,319			35,071	35,071			9,248	9,248		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	71	71			71	71						
B. Other Bed Reserve Days	4	4			4	4						
5. ***Total Resident Days*** **(3G + 4A + 4B)**	44,394	44,394			35,146	35,146			9,248	9,248		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	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	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	8	87		4		9		
Per Diem Rate								
a. One bed rm.	512.53	223.42		597.00		390.98		
b. Two bed rms.	512.53	223.42		567.00		390.98		
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	5,327	5,327		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,564	1,564		
2. Restorative Treatments				
C. Other	11,473	11,473		
D. ***Total Physical Therapy Treatments***	18,364	18,364		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	919	919		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	80	80		
2. Restorative Treatments				
C. Other	920	920		
D. ***Total Speech Therapy Treatments***	1,919	1,919		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	4,972	4,972		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,218	1,218		
2. Restorative Treatments				
C. Other	11,202	11,202		
D. ***Total Occupational Therapy Treatments***	17,392	17,392		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2020	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
	Total Cost and 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)	137,883	1,968				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	285,502	10,939				
5. Dietary Service						
a. Head Dietitian	79,682	1,942				
b. Food Service Supervisor	59,815	2,193				
c. Dietary Workers	533,283	30,945				
6. Housekeeping Service						
a. Head Housekeeper	82,200	2,410				
b. Other Housekeeping Workers	305,998	17,611				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	73,867	2,135				
b. Other Maintenance Workers	67,942	3,184				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	153,269	9,671				
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	241,247	4,000				
b. RN						
1. Direct Care	694,502	15,842				
2. Administrative**	494,546	16,204				
c. LPN						
1. Direct Care	1,383,108	47,699				
2. Administrative**						
d. Aides and Attendants	2,350,601	118,239				
e. Physical Therapists	528,459	14,030				
f. Speech Therapists	92,415	1,879				
g. Occupational Therapists	369,646	9,253				
h. Recreation Workers	236,150	10,188				
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	275,317	9,668				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	8,445,432	330,000				

* 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	$ -	-	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2020	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										
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.

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CSP-12 Rev. 10/2005

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 9/30/2020			Page 12	of 37
	Salary Paid									
Name	CCNH	RHNS	(Specify)	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
Section III - Administrators* **										
Lizbeth Carmichael (10/1/19-9/30/20)	137,883			Health & Life Insurances, Payroll Taxes	Day to day operations of the nursing home facility.	1,968	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.

B. Report of Expenditures - Professional Fees

Name of Facility Sheriden Woods Health Care Center	License No. 2004C		Report for Year Ended 9/30/2020		Page 13	of 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	15,257	104				
3. Pharmacist	7,934	160				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	40,268	43				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**						
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	150	2				
9. Speech Therapist						
a. Resident Care	2,160	6				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	10,286	139				
2. Administrative***	6,258	141				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	82,313	595				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2020	14	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	○	⊙	
Dr. C. Licata, ProHealth Physicians, 625 Clark Ave., Bristol, CT 06010	Medical Director	○	⊙	
Procare LTC Pharmacy of CT LLC, 1492 Highland Ave, Cheshire, CT 06410	Pharmacist	⊙	○	Common Owners; Minority Interest
Dr. A. Scappaticci, ProHealth Physicians, 625 Clark Ave. Bristol, CT 06010	Asst. Medical Director	○	⊙	
Swallowing Diagnostics, 21 Waterville RD, Avon, CT	Speech Therapy Services	○	⊙	
The Nurse Network, 653 Main St, Plantsville, CT 06479	Nurse Pool	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* 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	9/30/2020	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	485,323	485,323		
2. Disability Insurance	$				
3. Unemployment Insurance	$	92,161	92,161		
4. Social Security (F.I.C.A.)	$	565,672	565,672		
5. Health Insurance	$	1,101,841	1,101,841		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	34,111	34,111		
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	132,449	132,449		
d. Accounting and Auditing	$	17,090	17,090		
e. Legal (*Services should be fully described on Page 7)*	$	89,403	89,403		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	55,161	55,161		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	70,928	70,928		
2. Cellular Phones	$	2,880	2,880		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$	250	250		
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	781,160	781,160		
Subtotal	$	3,428,429	3,428,429		

* 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	9/30/2020		16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,428,429	3,428,429		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	3,180	3,180		
3. Gifts to Staff and Residents	$	28,797	28,797		
4. Employee Travel	$	462	462		
5. Education Expenses Related to Seminars and Conventions	$	4,842	4,842		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	8,989	8,989		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	15,064	15,064		
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	$	3,413	3,413		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	11,719	11,719		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	800	800		
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**	$	445,924	445,924		
13. Other (*Specify*) See Attached Schedule	$	101,475	101,475		
C-14 Total Administrative & General Expenditures	$	4,053,094	4,053,094		

* 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	$ 15,064		
Total Other Advertising	$ 15,064	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 11,719		
Total Dues	$ 11,719	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Energy Audit	$ 126		
Licenses	$ 655		
Bank Charges	$ 17,018		
Payroll Processing Fees	$ 26,653		
Employee Physicals	$ 48,611		
	$ 8,412		
Total Other Administrative and General	$ 101,475	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Sheriden Woods Health Care Center	License No. 2004C	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	618,515	Contract Attached to a Prior Year	See Below
Allocation of the above	408,220	Admin/Gen 66%	Pg 16, Line 12
	98,962	Indirect 16%	Pg 18, Line 2C
	111,333	Direct 18%	Pg 20, Line 5J
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	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	2004C	9/30/2020	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	381,519	381,519		
2. Non-Food Supplies	$	60,940	60,940		
3. Other (*Specify*) Dishes	$	719	719		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Management Services	$	98,962	98,962		
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	542,140	542,140		

2E. Dietary Questionnaire			Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*						
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.			$7,253
K. Is any revenue collected from these people?	⊙ Yes	○ No	If yes, specify amt.			$719
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?	○ 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.

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 9/30/2020	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. $	27,141	27,141		
b. Purchased Services (*by contract other than through Management Services*) (*Complete Schedule C-2 att. Page 21*)	$				
c. Other (*Specify*) Supplies	$	10,389	10,389		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	37,530	37,530		

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.

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	9/30/2020	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	67,151	67,151		
b. Purchased Services (*by contract other than through Management Services*) (*Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	67,151	67,151		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Procare, LTC		$	409,200	409,200		
b. Medicine Cabinet Drugs		$	13,217	13,217		
c. Medical and Therapeutic Supplies		$	446,782	446,782		
d. Ambulance/Limousine***		$	6,677	6,677		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	42,321	42,321		
f. X-rays and Related Radiological Procedures***		$	34,500	34,500		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	57,672	57,672		
i. Recreation		$	7,330	7,330		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	245,014	245,014		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,262,713	1,262,713		

* 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	$ 111,333		
Oxygen Concentrator Rentals	$ 21,437		
Medical Equip Rentals-Medicaid	$ 41,607		
Physical Therapy Supplies	$ 39,105		
Cable TV Services	$ 16,480		
Medical Equip Rentals-Other	$ 15,052		
Total Other Resident Care	$ 245,014	$ -	$ -

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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
Sheriden Woods Health Care Center	2004C	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	PO Box 7247, Philadelphia, PA	○	⊙		Payroll Processing	13,796			16	m13
Procare LTC Pharmacy of CT LLC	1492 Highland Ave, Cheshire, CT 06410	⊙	○	Common owners/Minority share	Pharmacy	438,480			20	5a2
CWPM, Inc.	25 Norton Place, Plainville, CT	○	⊙		Rubbish Removal	28,944			22	6f
Winterberry Landscaping & Garden Center	2070 West St., Southington, CT	○	⊙		Landscaping	15,173			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	$ 15,795		
Rubbish Removal	$ 30,900		
Snow Removal	$ 6,216		
Supplies	$ 18,767		
Total Other Repairs and Maintenance	$ 71,678	$ -	$ -

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	9/30/2020	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	69,378	69,378		
b. Heat	$	63,451	63,451		
c. Light & Power	$	101,835	101,835		
d. Water	$	51,560	51,560		
e. Equipment Lease (*Provide detail on page 6*)	$	33,358	33,358		
f. Other (*itemize*)	$	71,678	71,678		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	391,260	391,260		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	1,623	1,623		
b. Building & Building Improvements	$	50,297	50,297		
c. Non-Movable Equipment	$	14,638	14,638		
d. Movable Equipment	$	61,849	61,849		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	128,407	128,407		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	17,399	17,399		
c. Leasehold Improvements	$	82,269	82,269		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	99,668	99,668		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	458,409	458,409		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	128,755	128,755		
c. Personal property taxes	$	25,319	25,319		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	840,558	840,558		

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

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	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	151,417		151,417	146,643	S/L	Various	1,623	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								1,623
B. **Building and Building Improvements**								
1. Acquired prior to this report period	2,318,266		2,318,266	1,893,894	S/L	Various	50,297	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								50,297
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	559,159		559,159	485,487	S/L	Various	14,638	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								14,638

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	2019	1,649,924		1,649,924	1,369,312	S/L	Various	59,093	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2020	34,231		34,231		S/L	Various	2,756	
D-3. Subtotal												61,849
E. ***Total Depreciation***												128,407

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3
**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3
**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3
**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/1/2019	Dining Tables and chairs	2,972	15	99	
4/1/2020	Mattresses	3,755	5	376	
4/1/2020	Recliners	1,348	10	67	
4/1/2020	Recliners	1,307	10	65	
6/1/2020	TV's	1,929	5	193	
6/1/2020	Mattresses	3,634	5	363	
6/1/2020	Tablets	1,064	5	106	
7/1/2020	Tablets	2,726	5	273	
7/1/2020	Mattresses	3,635	5	364	
7/1/2020	Mattresses	3,635	5	364	
7/1/2020	Wheelchair	1,500	5	150	
8/1/2020	Ice and Water Dispenser	6,726	10	336	
Total additions for Movable Equipment		$ 34,231		$ 2,756	*
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:					
4/1/2020	HVAC Improvements	3,003	15	100	
4/1/2020	HVAC Improvements	2,711	15	90	
6/1/2020	Control Panel for Alarm System	1,690	10	85	
Total additions for Leasehold Improvement		$ 7,404		$ 275	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

Amortization Schedule*

Name of Facility Sheriden Woods Health Care Center			License No. 2004C		Report for Year Ended 9/30/2020			Page 24	of 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. Finance Fees - Midcap	2	2020	3	56,972	28,999	S/L	3 year	17,399	
B-4. Subtotal									17,399
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2019	Various	1,775,416	265,301	S/L	Variou	81,994	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2020	Various	7,404		S/L	Variou	275	
C-4. Subtotal									82,269
D. ***Total Amortization***									99,668

* 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	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	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	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	3,070,689			
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	9/30/2020	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)

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 Cente	2004C	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*)			$				
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*) Vendor Interest= $23,189; LOC Interest= $193,563			$	216,752	216,752		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	216,752	216,752		
14. Insurance a. Insurance on Property (buildings only)			$	111,332	111,332		
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)***			$	111,332	111,332		
15. ***Total All Expenditures (A-13 thru C-14)***			$	16,050,275	16,050,275		

D. Adjustments to Statement of Expenditures

Name of Facility Sheriden Woods Health Care Center					License No. 2004C	Report for Year Ended 9/30/2020		Page 28 of 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	$	369,646	369,646		
4.			Other - See attached Schedule	$	115,111	115,111		
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	1c	Bad Debts	$	132,449	132,449		
10.	15	1d	Accounting	$	3,990	3,990		
10a.			Legal	$	89,403	89,403		
11.			Telephone	$				
12.	15	1h2	Cellular Telephone	$	2,160	2,160		
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.	16	1,3	Gifts, flowers and coffee shops	$	28,797	28,797		
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 *	$	15,064	15,064		
19.	15	1j&k	Income Tax / Corporate Business Tax	$	250	250		
20.			Fund Raising / Contributions	$				
21.			Unallowable Management Fees	$	228,194	228,194		
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	17,018	17,018		
Page 18 - Dietary Expenditures								
24.	18	2a1	Meals to employees, guests and others who are not residents	$	6,534	6,534		
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)	$	1,008,616	1,008,616		

* 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	$ 3,111		
10	12d	Payroll Settlement	$ 12,000		
10	12a	Payroll Settlement	$ 100,000		
Total Other Salaries Adjustment			$ 115,111	$ -	$ -

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	$ 17,018		
Total Other A&G Adjustments			$ 17,018	$ -	$ -

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CSP-29 Rev. 9/2018

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	9/30/2020		29	37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	1,008,616	1,008,616		
Page 20 - Resident Care Supplies*								
27.	20	5a1&	Prescription Drugs	$	409,200	409,200		
28.	20	5d	Ambulance/Limousine	$	6,677	6,677		
29.	20	5f	X-rays, etc	$	34,500	34,500		
30.	20	5h	Laboratory	$	57,672	57,672		
31.	20	5c	Medical Supplies	$	35,387	35,387		
32.	20	500	Oxygen (non emergency)	$	42,321	42,321		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	20,398	20,398		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$	8,370	8,370		
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.			Interest Income on Account Rec.	$	390	390		
44.			Other - Miscellaneous Administrative	$	12,880	12,880		
45.			Management Fees Direct	$	62,235	62,235		
46.			Management Fees Indirect	$	55,320	55,320		
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)***				$	1,753,966	1,753,966		

*** 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.

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental	$ 15,052		
20	5b	Ebox	$ 997		
30	IV8	Nursing Supplies Rebate	$ 4,349		
Total Other Ancillary Costs			$ 20,398	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Moveable Equip Deprec Carryforwards	$ 8,370		
Total Excess Movable Equipment Depreciation			$ 8,370	$ -	$ -

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 and Television Revenue	$ 12,880		
Total Other Adjustments			$ 12,880	$ -	$ -

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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CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	2004C	9/30/2020	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	20,461,385	20,461,385		
b. Medicaid Room and Board Contractual Allowance **	$	(12,608,482)	(12,608,482)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,216,781	2,216,781		
b. Medicare Room and Board Contractual Allowance **	$	4,316	4,316		
4. a. Private-Pay Residents and Other	$	3,547,788	3,547,788		
b. Private-Pay Room and Board Contractual Allowance **	$	(819,922)	(819,922)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	160,513	160,513		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(160,513)	(160,513)		
c. Prescription Drugs - Non-Medicare	$	238,762	238,762		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(238,762)	(238,762)		
2. a. Medical Supplies - Medicare	$	20,787	20,787		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	58,463	58,463		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(58,463)	(58,463)		
3. a. Physical Therapy - Medicare	$	677,449	677,449		
b. Physical Therapy - Medicare Contractual Allowance **	$	(534,420)	(534,420)		
c. Physical Therapy - Non-Medicare	$	379,826	379,826		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(379,826)	(379,826)		
4. a. Speech Therapy - Medicare	$	164,135	164,135		
b. Speech Therapy - Medicare Contractual Allowance **	$	(114,392)	(114,392)		
c. Speech Therapy - Non-Medicare	$	83,075	83,075		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(83,075)	(83,075)		
5. a. Occupational Therapy - Medicare	$	679,360	679,360		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(540,739)	(540,739)		
c. Occupational Therapy - Non-Medicare	$	365,125	365,125		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(365,125)	(365,125)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	481,422	481,422		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	13,635,468	13,635,468		
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)*	$	390	390		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other *(Specify)*	$	224,386	224,386		
V. Total Other Revenue (1 thru 8)	$	224,776	224,776		
VI. Total All Revenue (III +V)	$	13,860,244	13,860,244		

* *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 Revenue from CRF Funds	$ 481,422		
Total Other Resident Revenue		$ 481,422	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
31,A2	Interest on A/R	390	$ 390		
Total Interest Income			$ 390	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Payroll Settlement	$ 112,000		
30, 4a	Nursing Supplies Rebate	$ 4,349		
30, 8	Bad Debt Recoveries	$ 108,037		
Total Other Revenue		$ 224,386	$ -	$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 241,686
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,849,391
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (924,946)
4 Inventories				$ 25,858
5. Prepaid Expenses				$ 195,776
a. Prepaid Insurance		144,061		
b. Prepaid Expenses		3,608		
c.				
d. See Schedule		48,107		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$ (350,000)
8. Other Current Assets (*itemize*)				$ 37,571
A/R Related Facilities		37,571		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,075,336
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	151,417		$ 3,151
	Accum. Depreciation	148,266	Net	
3. Buildings	*Historical Cost	2,318,266		$ 374,075
	Accum. Depreciation	1,944,191	Net	
4. Leasehold Improvements	*Historical Cost	1,294,820		$ 1,053,050
	Accum. Depreciation	241,770	Net	
5. Non-Movable Equipment	*Historical Cost	559,160		$ 59,034
	Accum. Depreciation	500,126	Net	
6. Movable Equipment	*Historical Cost	1,674,283		$ 243,122
	Accum. Depreciation	1,431,161	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (4,999)
Moveable Equipment Carryforward		9,872		
See Schedule		(14,871)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,727,433

* 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
September 30, 2020

Description	
Software Agreements	35.00
Software Agreements	1,260.00
Software Agreements	296.10
Software Agreements	2,016.76
Balance	**$ 3,607.86**

Cost Year Amount Totals

Sheriden Woods 2020

		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	TV's 2020 cost report	Totals
	Cost	$ 625	$ 2,426	$ 8,187	$ 14,424	$ 22,263	$ 1,929	$ 182,873
	Term	$ 5	$ 5	$ 5	$ 5	$ 5	$ 5	
1998	Deprec							$ 31
1998	Book Value							$ 401
1999	Deprec							$ 11,670
1999	Book Value							$ 105,065
2000	Deprec							$ 11,679
2000	Book Value							$ 93,435
2001	Deprec							$ 11,685
2001	Book Value							$ 81,820
2002	Deprec							$ 11,914
2002	Book Value							$ 73,263
2003	Deprec							$ 11,918
2003	Book Value							$ 61,409
2004	Deprec							$ 4,299
2004	Book Value							$ 19,097
2005	Deprec							$ 4,292
2005	Book Value							$ 14,805
2006	Deprec							$ 4,315
2006	Book Value							$ 10,616
2007	Deprec							$ 8,906
2007	Book Value							$ 46,012
2008	Deprec							$ 9,526
2008	Book Value							$ 42,767
2009	Deprec							$ 6,146
2009	Book Value							$ 36,642
2010	Deprec							$ 6,147
2010	Book Value							$ 30,495
2011	Deprec							$ 6,115
2011	Book Value							$ 24,381
2012	Deprec							$ 5,795
2012	Book Value							$ 18,584
2013	Deprec	$ 63						$ 5,197
2013	Book Value	$ 563						$ 14,013
2014	Deprec	$ 125	$ 243					$ 4,823
2014	Book Value	$ 438	$ 2,184					$ 11,616
2015	Deprec	$ 125	$ 485	$ 819				$ 5,881
2015	Book Value	$ 313	$ 1,699	$ 7,369				$ 13,923
2016	Deprec	$ 125	$ 485	$ 1,637	$ 1,443			$ 8,139
2016	Book Value	$ 188	$ 1,214	$ 5,732	$ 12,981			$ 20,208
2017	Deprec	$ 125	$ 485	$ 1,637	$ 2,885	$ 2,227		$ 7,381
2017	Book Value	$ 63	$ 729	$ 4,095	$ 10,096	$ 20,036		$ 35,090
2018	Deprec	$ 63	$ 485	$ 1,637	$ 2,885	$ 4,453		$ 9,541
2018	Book Value	$ -	$ 244	$ 2,458	$ 7,211	$ 15,583		$ 25,549
2019	Deprec		$ 244	$ 1,637	$ 2,885	$ 4,453		$ 9,237
2019	Book Value		$ -	$ 821	$ 4,326	$ 11,130		$ 16,313
2020	Deprec			$ 821	$ 2,885	$ 4,453	$ 193	$ 8,370 *
2020	Book Value			$ -	$ 1,441	$ 6,677	$ 1,736	$ 9,872 -
2021	Deprec				$ 1,441	$ 4,453	$ 386	$ 6,298
2021	Book Value				$ 0	$ 2,224	$ 1,350	$ 3,574

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		Prepaid Insurance	$ 20,901
		Deposit Taxes	$ 27,206
Total Prepaid Expenses			$ 48,107

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	
		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	9/30/2020	32	37

	Account				Amount
				Total Brought Forward:	$ 2,802,769
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	6,748,166	Net	$ 16,438
	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)				$ 16,438
D.	Investment and Other Assets				
	1. Deferred Deposits				$
	2. Escrow Deposits				$
	3. Organization Expense	*Historical Cost			
		Accum. Depreciation		Net	$
	4. Goodwill (Purchased Only)				$ 382,200
	5. Investments Related to Resident Care (*itemize*)				$
	6. Loans to Owners or Related Parties (*itemize*)				$ (10,242,810)
	Name and Address	Amount	Loan Date		
	Due from Related Parties	(10,242,810)			
	7. Other Assets (*itemize*)				$ (553,140)
	IRS Deposits/Finance Fees		10,574		
	Goodwill		(563,714)		
	See Schedule				
D-8.	*Total Investments and Other Assets* (Lines D1 thru 7)				$ (10,413,750)
D-9.	*Total All Assets* (Lines A9 + B10 + C8 + D8)				$ (7,594,543)

* 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	9/30/2020	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 968,556
2. Notes Payable (*itemize*)				$ 4,469,454
Related Party		(133,799)		
Line of Credit		4,603,253		
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*)				$ 277,994
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 265,177
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*)				$ 618,193
Provider Tax Due	538,385			
Acc'd Health Insurance	22,780			
Acc'd Operating Expenses	57,028			
		See Schedule		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 6,599,374

* 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, 2020

DESCRIPTION	BALANCE
Health Insurance IBNR	$13,791.68
Nursing	$3,252.20
Food	$3,463.75
Electricity	$647.53
Gas	$1,542.92
Dental	$3,372.54
Advertising	($3,000.00)
Processing	$345.80
Internet	($1,320.55)
Maintenance Credits	($3,071.64)
Wellness	($14,450.82)
Sales Tax	$665.00
Legal	($250.00)
Legal	($250.00)
Legal	($60.00)
Lease	$1,140.07
Accounting	$10,400.00
Management Fee	$28,554.69
Water	$12,254.33
	$57,027.50

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2020	34	37

Account				Amount
			Total Brought Forward:	6,599,374
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
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*)				$ (159,894)
Due From Related Landlord		(2,279,786)		
Due to Related Landlord		2,119,892		
See Schedule				
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ (159,894)
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 6,439,480

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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	9/30/2020	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)*				$	16,438
	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				$	16,438
B.	**Net Worth**					
	1. Owner's Capital				$	
	2. Capital Stock				$	1,000
	3. Paid-in Surplus				$	
	4. Treasury Stock				$	
	5. Cumulated Earnings				$	(11,861,522)
	6. Gain or Loss for Period	10/1/2019	thru	9/30/2020	$	(2,189,939)
	7. Total Net Worth				$	(14,050,461)
C.	***Total Reserves and Net Worth***				$	(14,034,023)
D.	***Total Liabilities, Reserves, and Net Worth***				$	(7,594,543)

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page 36 of 37
Sheriden Woods Health Care Center	2004C	9/30/2020	

	Account		Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2019		$ (11,672,234)
B.	Total Revenue (*From Statement of Revenue Page 30*)		$ 13,860,336
C.	Total Expenditures (*From Statement of Expenditures Page 27*)		$ 16,050,275
D.	Net Income or Deficit		$ (2,189,939)
E.	Balance		$ (13,862,173)
F.	Additions		
	1. Additional Capital Contributed (*itemize*)		
	2019 Acc'd Payroll Expense change	(73,490)	
	2019 Health Insurance	(137,909)	
	Prior Year Depreciation	19,188	
	Prior Year Electricity	2,177	
	2. Other (*itemize*)		
	Prior Year Management fee	1,748	
	Rounding	(2)	
F-3.	Total Additions		$ (188,288)
G.	Deductions		
	1. Drawings of Owners/Operators/Partners (*Specify*)		$

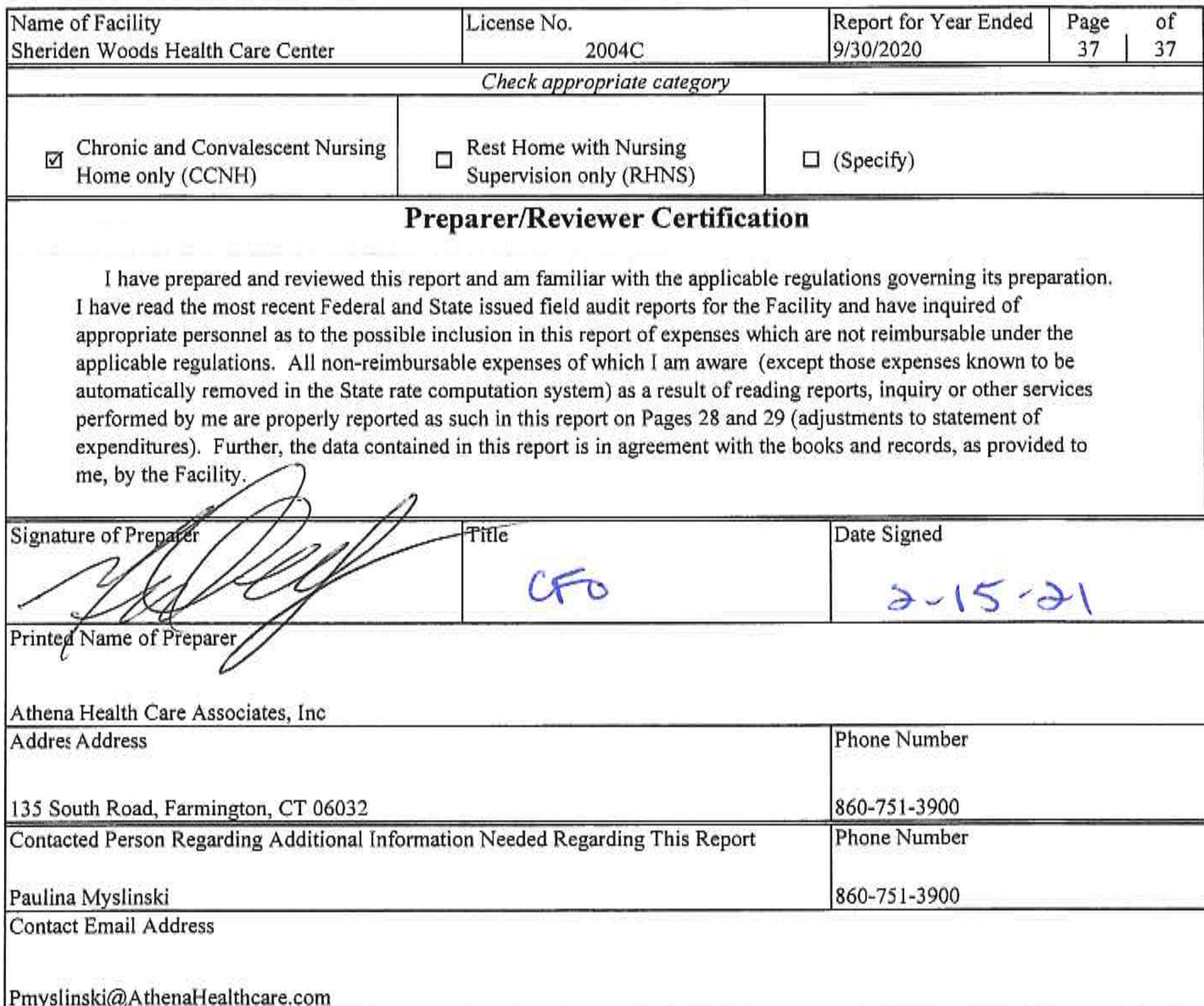
Name and Address (*No., City, State, Zip*)	Title	Amount

	2. Other Withdrawings (*Specify*)	$

Purpose	Amount

	3. Total Deductions		$
H.	***Balance at End of Period***	09/30/20	$ (14,050,461)

I. Preparer's/Reviewer's Certification



Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2020	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
[signature]	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