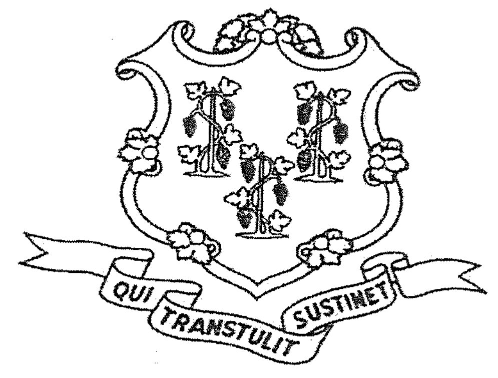
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2018

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 10/1/2017	Report for Year Ending 9/30/2018	

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

Table of Contents

General Information - Administrator's/Owner's Certification		1
General Information and Questionnaire - Data Required for Real Wage Adjustment		1A
General Information and Questionnaire - Type of Facility - Organization Structure		2
General Information and Questionnaire - Partners/Members		3
General Information and Questionnaire - Corporate Owners		3A
General Information and Questionnaire - Individual Proprietorship		3B
General Information and Questionnaire - Related Parties		4
General Information and Questionnaire - Basis for Allocation of Costs		5
General Information and Questionnaire - Leases		6
General Information and Questionnaire - Accounting Basis		7
Schedule of Resident Statistics		8
Schedule of Resident Statistics (Cont'd)		9
A.	Report of Expenditures - Salaries & Wages	10
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B.	Report of Expenditures - Professional Fees	13
	Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C.	Expenditures Other than Salaries - Administrative and General	15
C.	Expenditures Other than Salaries (Cont'd) - Administrative and General	16
	Schedule C-1 - Management Services	17
C.	Expenditures Other than Salaries (Cont'd) - Dietary	18
C.	Expenditures Other than Salaries (Cont'd) - Laundry	19
C.	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
	Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C.	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
	Depreciation Schedule	23
	Amortization Schedule	24
C.	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C.	Expenditures Other than Salaries (Cont'd) - Interest	26
C.	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D.	Adjustments to Statement of Expenditures	28
D.	Adjustments to Statement of Expenditures (Cont'd)	29
F.	Statement of Revenue	30
G.	Balance Sheet	31
G.	Balance Sheet (Cont'd)	32
G.	Balance Sheet (Cont'd)	33
G.	Balance Sheet (Cont'd)	34
G.	Balance Sheet (Cont'd) - Reserves and Net Worth	35
H.	Changes in Total Net Worth	36
I.	Preparer's/Reviewer's Certification	37

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	9/30/2018	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, 2017 and ending September 30, 2018, 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
[signature]		02/15/19	[signature]	2/15/19
Printed Name (Administrator) Jonah Kraus			Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	State of CT	Date 2/15/19	Signed (Notary Public) [signature] PAT HYJEK	Comm. Expires 1/1/2020
Address of Notary Public 484 Farmington Ave Hartford CT 06105			NOTARY PUBLIC MY COMMISSION EXPIRES_____	

(Notary Seal)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1A Rev. 6/95

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 10/1/2017	To 9/30/2018
Address of Facility 321 Stonecrest Drive, Bristol, CT 06010				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900		Date 2/22/2019	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-583-1827	9/30/2018	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.:
Robert Guastella	936

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

Name	License No.:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility Sheriden Woods Health Care Center	License No. 2004C	Report for Year Ended 9/30/2018	Page 3 of 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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2018	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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2018	3B	37

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

Owner(s) of Facility

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire

Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2018	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	pg 16 m12		
Athena Health Care Insurance	135 South Road, Farmington, CT	○	⊙		Self Insured Employee Health and Dental In	pg 15 1a5	1,377,257	1,377,257
Sheriden Woods Landlord	321 Stonecrest Drive, Bristol, CT 06010	○	⊙		Lease of Property	pg 22 9. 10b, pg 27	715,133	715,133
Procare LTC Pharmacy of CT LLC	1492 Highland Ave, Cheshire, CT 06410	⊙	○	>50%	Pharmacy	pg 20 5a2	422,887	422,887
Laurel Ridge Healthcare Center	642 Danbury Rd, Ridgefield, CT 06877	⊙	○	>98%	Bank Service Charges	pg 16, m13	7,456	7,178
		○	⊙					
		○	⊙					

* 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 Systems	135 South Road Farmington, CT 06032	X		<50%	Management, Legal, Marketing, Bank Fees, A/R, MIS, mortgage fees, Insurance, Health Insurance Payroll processing fees Computer conversion, data processing employee relations maintenance & repairs Nursing consulting/ Supplies Office Supplies Postage	Pg 15, 1e & 1g, 1a5 Pg 16, m3, m13, Pg 17 Pg 27, 12D & 14a Pg 16, m13 pg 23 D2c, pg 16 m13 pg 16 L3 pg 22, 6a pg 13, B5 & B11, p20 L5c pg 15 L1g p16 Lm7	$690,120	$279,765

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page 5 of 37
Sheriden Woods Health Care Center	2004C	9/30/2018	5 of 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:No Non-Nursing Home Cost Centers

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 9/2002

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	9/30/2018	6 | 37

Name and Address of Lessor	Related * to Owners, Operators, Officers: Yes	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	1,219	1,219
Leaf	○	⊙	Copier	Automatic Renewal	48 months	13,234	13,234
Hewlett-Packard	○	⊙	PCC Equipment	08/27/13	60 months	21,148	21,148
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 35,601

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Cente	2004C	9/30/2018	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	2018 Year-end Audit and tax return preparation	$	9,800
2	Medicare cost report preparation	$	2,700
3	Line of Credit Audit Fee: Disallow	$	3,474
4		$	
	Charge for Services Provided	$	15,974

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	Murtha Cullina/Schiff Hardin	860-240-6000
3	Shipman & Goodwin/Halloran & Sage	860-561-3100
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 12 N.Main St., West Hartford, Ct 06107
4 111 North Main Street, Bristol
5 111 Founders Plaza, E. Hartford, CT

Services Provided by This Firm (*describe fully*)

	Service		Amount
1	Collections:Disallowed	$	7,175
2	General/ Review Credit/ HFG: $5,771: Disallow / Sec of State Filings $92: Allow	$	5,863
3	Employee Claims : Disallowed	$	10,882
4	Probate Matters: Disallowed	$	23,185
5		$	
	Charge for Services Provided	$	47,105

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

⊙ Yes O No Pg 15, Line1e

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2018	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	146	146			146	146			146	146		
B. On last day of THIS report period	146	146			146	146			146	146		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	132	132			132	132			137	137		
B. As of midnight of THIS report period	143	143			137	137			143	143		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,501	5,501			3,868	3,868			1,633	1,633		
B. Medicaid (Conn.)	41,335	41,335			31,236	31,236			10,099	10,099		
C. Medicaid (other states)												
D. Private Pay	2,719	2,719			1,815	1,815			904	904		
E. State SSI for RCH												
F. Other (Specify) Managed Medicare	988	988			782	782			206	206		
G. Total Care Days During Period (3A thru F)	50,543	50,543			37,701	37,701			12,842	12,842		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	291	291			190	190			101	101		
B. Other Bed Reserve Days	35	35			23	23			12	12		
5. *Total Resident Days* (3G + 4A + 4B)	50,869	50,869			37,914	37,914			12,955	12,955		

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

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2018	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

	Medicare	Medicaid		Self-Pay			Other State Assisted	
Item	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	10	117		4		12		
Per Diem Rate								
a. One bed rm.	553.97	214.64		551.00		420.38		
b. Two bed rms.	553.97	214.64		537.00		420.38		
c. Three or more bed rms.						420.38		

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,602	3,602		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,119	1,119		
2. Restorative Treatments				
C. Other	4,960	4,960		
D. ***Total Physical Therapy Treatments***	9,681	9,681		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	945	945		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	68	68		
2. Restorative Treatments				
C. Other	1,407	1,407		
D. ***Total Speech Therapy Treatments***	2,420	2,420		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,104	3,104		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	688	688		
2. Restorative Treatments				
C. Other	5,796	5,796		
D. ***Total Occupational Therapy Treatments***	9,588	9,588		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2018	10	37

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

Item	Total Cost and Hours					
	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)	144,352	2,142				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	237,562	11,129				
5. Dietary Service						
a. Head Dietitian	64,034	1,694				
b. Food Service Supervisor	56,300	1,935				
c. Dietary Workers	437,869	32,098				
6. Housekeeping Service						
a. Head Housekeeper	69,651	2,265				
b. Other Housekeeping Workers	236,196	17,082				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	68,123	2,112				
b. Other Maintenance Workers	60,788	3,193				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	110,313	9,606				
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	194,978	3,869				
b. RN						
1. Direct Care	583,521	15,746				
2. Administrative**	448,472	16,299				
c. LPN						
1. Direct Care	1,287,010	51,288				
2. Administrative**						
d. Aides and Attendants	2,118,018	126,830				
e. Physical Therapists	434,724	13,530				
f. Speech Therapists	86,381	1,897				
g. Occupational Therapists	325,016	8,737				
h. Recreation Workers	202,716	9,749				
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	202,810	8,545				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	7,368,834	339,746				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	$	Hours	$	Hours	$	Hours
0	$ -	-	$ -	-	$ -	-
Medical Staff Meetings	$ 500	4	$ -	-	$ -	-
0	$ -	-	$ -	-	$ -	-
0	$ -	-	$ -	-	$ -	-
0	$ -	-	$ -	-	$ -	-
0	$ -	-	$ -	-	$ -	-
0	$ -	-	$ -	-	$ -	-
0	$ -	-	$ -	-	$ -	-
0	$ -	-	$ -	-	$ -	-
0	$ -	-	$ -	-	$ -	-
0	$ -	-	$ -	-	$ -	-
0	$ -	-	$ -	-	$ -	-
0	$ -	-	$ -	-	$ -	-
0	$ -	-	$ -	-	$ -	-
0						
Total	$ 500	4	$ -	-	$ -	-

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-11 Rev. 10/2005

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	9/30/2018	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Sheriden Woods Health Care Center				2004C		9/30/2018			12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Robert S. Guastella (10/1/17-9/30/18)	144,352			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,142	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.

State of Connecticut
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		9/30/2018		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	11,258	57				
3. Pharmacist	13,197	267				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	40,168	85				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	57	1				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	1,080	3				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	107,146	1,648				
2. Administrative***	15,243	343				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	500	4				
B-13 Total Fees Paid in Lieu of Salaries	188,649	2,408				

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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	9/30/2018	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Gerident Solutions LLC P.O.Box 290539, Wethersfield, CT	Dentist	○	⊙	
Dr. C. Licata,ProHealth Physicians, 625 Clark Ave., Bristol, CT 06010	Medical Director and Medical Staff	○	⊙	
Procare LTC Pharmacy of CT LLC, 1492 Highland Ave, Cheshire, CT 06410	Pharmacist	⊙	○	Common Owners; Minority Interest
Athena Health Care Systems 135 South Road, Farmington, CT 06032	MDS Fill In, Nursing, Admin	⊙	○	Common Owners
Vista Behavioral Health, 152 Simsbury Rd, Avon, CT 06001	Medical Staff	○	⊙	
Dr. A. Scappaticci,ProHealth Physicians, 625 Clark Ave. Bristol, CT 06010	Medical Staff and Asst. Medical Director	○	⊙	
HealthDrive Medical & Dental Practice, 1 Prestige Drive,Suite 107, Meriden, CT, 06450	Dental, Physician Services	○	⊙	
Swallowing Diagnostics, 21 Waterville RD, Avon, CT	Speech Therapy Services	○	⊙	
Procare Professional Healthcare Services, PO BOX 646, Oxford, CT, 06478	Nursing	○	⊙	
The Nurse Network, 653 Main St, Plantsville, CT 06479	Nurse Pool	○	⊙	
HealthDrive Audiology Group, 1 Prestige Drive, Meriden, CT, 06450	Physician Services	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 10/2005

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	9/30/2018	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	554,622	554,622		
2. Disability Insurance	$				
3. Unemployment Insurance	$	100,731	100,731		
4. Social Security (F.I.C.A.)	$	432,470	432,470		
5. Health Insurance	$	1,075,483	1,075,483		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	27,393	27,393		
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*	$	4,979	4,979		
d. Accounting and Auditing	$	15,974	15,974		
e. Legal (*Services should be fully described on Page 7)*	$	47,105	47,105		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	69,029	69,029		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	59,594	59,594		
2. Cellular Phones	$	1,708	1,708		
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*	$	(100)	(100)		
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	953,425	953,425		
Subtotal	$	3,342,413	3,342,413		

* 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	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2018	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,342,413	3,342,413		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	7,372	7,372		
3. Gifts to Staff and Residents	$	19,671	19,671		
4. Employee Travel	$	1,136	1,136		
5. Education Expenses Related to Seminars and Conventions	$	3,478	3,478		
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*)	$	4,336	4,336		
2. Advertising Telephone Directory (*all such expenses*)***	$	682	682		
3. Advertising Other (*Specify*)*** See Attached Schedule	$	25,916	25,916		
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	$	5,860	5,860		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	9,173	9,173		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	202	202		
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**	$	430,215	430,215		
13. Other (*Specify*) See Attached Schedule	$	112,149	112,149		
C-14 Total Administrative & General Expenditures	$	3,962,603	3,962,603		

* 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	$ 25,916	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
Total Other Advertising	$ 25,916	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
CAHCF	$ 9,088	$ -	$ -
ALTCFM	$ 85	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
Total Dues	$ 9,173	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Lobbying Fees	$ 225	$ -	$ -
Licenses	$ 700	$ -	$ -
Bank Charges	$ 22,588	$ -	$ -
Payroll Processing Fees	$ 25,269	$ -	$ -
Background Checks/Physicals	$ 29,094	$ -	$ -
Data Processing	$ 34,112	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
Energy Audit	$ 161	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
Total Other Administrative and General	$ 112,149	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Sheriden Woods Health Care Center	License No. 2004C	Report for Year Ended 9/30/2018	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	594,714	Contract Attached to a Prior Year	See Below
Allocation of the above	$392511 $95154 $107049	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 20, Line 5K 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.**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 9/2002

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	9/30/2018	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	339,060	339,060		
2. Non-Food Supplies	$	67,601	67,601		
3. Other (*Specify*) Dishes=$46	$	46	46		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	406,707	406,707		

2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*	415	415		

	Question	Yes	No	If yes	Amount
H.	Is cost of employee meals included in 2E?	⊙ Yes	O No		
I.	Did you receive revenue from employees?	O Yes	⊙ No	If yes, specify amt.	
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	⊙ Yes	O No	If yes, specify cost.	$430
L.	Is any revenue collected from these people?	⊙ Yes	O No	If yes, specify amt.	$215
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			18,2al	
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	O Yes	⊙ No	If yes, specify cost.	
O.	Is any revenue collected from employees?	O Yes	⊙ No	If yes, specify amt.	
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	2004C	9/30/2018	19 | 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. $	25,166	25,166		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other *(Specify)* Supplies=$10,714	$	10,714	10,714		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	35,880	35,880		

3F. Laundry Questionnaire			
G. Is cost of employee laundry included in 3E?	O Yes	⊙ No	If yes, specify cost.
H. Did you receive revenue from employees?	O Yes	⊙ No	If yes, specify amt.
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	O Yes	⊙ No	If yes, specify cost.
K. Did you receive revenue from these people?	O Yes	⊙ No	If yes, specify amt.
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3E.

*** 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	9/30/2018	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.	$	46,067	46,067		
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)		$	46,067	46,067		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from ProCare		$	359,570	359,570		
b. Medicine Cabinet Drugs		$	24,329	24,329		
c. Medical and Therapeutic Supplies		$	369,498	369,498		
d. Ambulance/Limousine***		$	2,294	2,294		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	52,200	52,200		
f. X-rays and Related Radiological Procedures***		$	28,142	28,142		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	25,520	25,520		
i. Recreation		$	17,006	17,006		
j. Direct Management Services*		$	107,049	107,049		
k. Indirect Management Services*		$	95,154	95,154		
l. Other (Specify)**** See Attached Schedule		$	143,455	143,455		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,224,217	1,224,217		

* 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)
0	$ -	$ -	$ -
		$ -	$ -
Oxygen Concentrator Rentals	$ 24,486	$ -	$ -
	$ -	$ -	$ -
Medical Equip Rentals-Medicaid	$ 29,269	$ -	$ -
Physical Therapy Supplies	$ 52,689	$ -	$ -
Cable TV Services	$ 18,023	$ -	$ -
	$ -	$ -	$ -
Medical Equip Rentals-other	$ 18,988	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
Total Other Resident Care	$ 143,455	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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	9/30/2018	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	18,610			16	m13
Procare LTC Pharmacy of CT LLC	1492 Highland Ave, Cheshire, CT 06410	⊙	○	Common owners/Minority share	Pharmacy	389,160			20	5a2
CWPM, Inc.	25 Norton Place, Plainville, CT	○	⊙		Rubbish Removal	29,055			22	6f
Diversified Sweeping and Landscaping/Winterberry	Burlington, CT/2070 West St., Southington,	○	⊙		Landscaping and Snow Removal	10,964			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).

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 6/95

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	9/30/2018	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	83,758	83,758		
b. Heat	$	59,426	59,426		
c. Light & Power	$	104,765	104,765		
d. Water	$	79,143	79,143		
e. Equipment Lease (*Provide detail on page 6*)	$	35,601	35,601		
f. Other (*itemize*)	$	94,524	94,524		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	457,217	457,217		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	3,012	3,012		
b. Building & Building Improvements	$	71,250	71,250		
c. Non-Movable Equipment	$	23,197	23,197		
d. Movable Equipment	$	58,231	58,231		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	155,690	155,690		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	11,600	11,600		
c. Leasehold Improvements	$	31,401	31,401		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	43,001	43,001		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	511,074	511,074		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	123,818	123,818		
c. Personal property taxes	$	27,141	27,141		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	860,724	860,724		

* 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)
0	$ -	$ -	$ -
Groundskeeping	$ 16,741	$ -	$ -
Rubbish Removal	$ 29,055	$ -	$ -
Snow Removal	$ 10,044	$ -	$ -
Supplies	$ 38,684	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
Total Other Repairs and Maintenance	$ 94,524	$ -	$ -

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2018	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. Land Improvements								
1. Acquired prior to this report period	151,416		151,416	141,536	S/L	Var	3,012	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								3,012
B. Building and Building Improvements								
1. Acquired prior to this report period	2,318,266		2,318,266	1,766,207	S/L	Various	71,250	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								71,250
C. Non-Movable Equipment								
1. Acquired prior to this report period	559,159		559,159	444,250	S/L	Various	23,197	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								23,197

	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	2017	1,527,556		1,527,556	1,251,595	S/L	Various	52,693	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2018	54,147		54,147		S/L	Various	5,538	
D-3. Subtotal												58,231
E. *Total Depreciation*												155,690

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	See Attached	$ 54,147	Various	$ 5,538	
Total additions for Movable Equipment		$ 54,147		$ 5,538	*
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	See Attached	$ 58,610	Various	$ 2,031	
Total additions for Leasehold Improvement		$ 58,610		$ 2,031	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

Sheriden Woods Health Care Center

9/30/2018

Attachment Page 23
Page 2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Oct-17	Ice/Water Dispenser	$ 4,571	10	$ 229
Oct-17	PC Board/bumpers	$ 1,109	10	$ 55
Oct-17	Motor and Wheel Blower	$ 1,104	5	$ 110
Nov-17	PC Board/ Control Boxes	$ 803	5	$ 80
Dec-17	Actuator/ Linak	$ 604	5	$ 60
Dec-17	Chair Lift	$ 642	10	$ 32
Dec-17	3 Mattresses	$ 853	5	$ 85
Dec-17	6 HP Laptops	$ 3,188	3	$ 531
Jan-18	Motor and Wheel Blower	$ 1,084	5	$ 108
Feb-18	3 Control Boxes/ PC Board	$ 804	5	$ 80
Mar-18	6 Ignition 2 task low back Office Chairs	$ 3,273	10	$ 164
Mar-18	3 Back Slings	$ 599	5	$ 60
Mar-18	6 Overbed Tables	$ 1,032	15	$ 34
Mar-18	2 Ice carts	$ 749	10	$ 37
Apr-18	Tablet PC	$ 569	5	$ 57
Apr-18	6 Mattresses	$ 1,566	5	$ 157
Apr-18	Chair Lift	$ 642	10	$ 32
May-18	MegaPulse, Omnisound, Omnicycle	$ 7,019	10	$ 351
May-18	6 Mattresses	$ 1,566	5	$ 157
May-18	Device Measurement Bed System	$ 1,224	5	$ 122
Jul-18	Control Box/ PC Board/ Linak	$ 1,659	5	$ 166
Jul-18	Control Box/ PC Board/ Linak	$ 1,659	5	$ 166
Jul-18	Chair Lift	$ 642	10	$ 32
Sep-18	2 Therm Heated Plate Bases	$ 824	10	$ 41
Sep-18	2 Therm Heated Plate Bases	$ 824	10	$ 41
Sep-18	Tablet PC	$ 630	5	$ 63
Sep-18	Point Click Care Conversion	$ 14,908	3	$ 2,485
Total additions for Movable Equipment		$ 54,147		$ 5,538
Deletions:				
Total deletions for Movable Equipment		$ -		$ -

	Diff to 23	
*	$ -	$ (0)
**	$ -	$ -

***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:				
Oct-17	Condensing Unit	$ 4,200	5	$ 420.00
Oct-17	Rewiring / Moving rooms	$ 1,425	5	$ 142.50
May-18	Valve/ Piping	$ 16,258	20	$ 406.45
Jun-18	Valve/ Piping	$ 28,278	20	$ 706.95
Jul-18	Roof Piping	$ 5,763	10	$ 288.15
Sep-18	Tile Flooring	$ 2,686	20	$ 67.15
Total additions for Leasehold Improvements		$ 58,610		$ 2,031 *
Deletions:				
Total deletions for Leasehold Improvements		$ -		$ - **

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2018	24	37

Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. **Organization Expense**									
1. Bed License	9	1999	None	488,000	105,800	S/L	None		
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3. Finance Fees - Midcap	2	2018	3	52,198		s/l	3 year	11,600	
B-4. Subtotal									11,600
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2017	Various	513,955	58,992			29,370	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2018	Various	58,610		s/l	variou	2,031	
C-4. Subtotal									31,401
D. ***Total Amortization***									43,001

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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	9/30/2018	25 | 37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ⦿ Yes O 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 ______	3,419,888			
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 6/95

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	9/30/2018	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)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 6/95

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 Cent	2004C	9/30/2018	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment 1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $	2,499	2,499		
A. Item / Rate / Amount				
Lender Webster Capital				
Address of Lender P.O Box 330, Hartford, CT 06141				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $	2,499	2,499		
12. D. Other Interest Expense (*Specify*) $ Vendor Interest = $9,433; Key Bank Term Loan Int & Fee	178,792	178,792		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	181,291	181,291		
14. Insurance a. Insurance on Property (buildings only) $	84,212	84,212		
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)*** $	84,212	84,212		
15. ***Total All Expenditures (A-13 thru C-14)*** $	14,816,401	14,816,401		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2002

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	2004C	9/30/2018	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	$	325,016	325,016		
4.			Other - See attached Schedule	$	4,449	4,449		
Page 13 - Professional Fees								
5.	13	B8c	Resident Care Physicians **	$	57	57		
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	1c	Bad Debts	$	4,979	4,979		
10.	15	1d&e	Accounting	$	50,487	50,487		
10a.			Legal	$				
11.	30	IV3	Telephone	$				
12.	15	1h2	Cellular Telephone	$	628	628		
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.	16	1 3	Gifts, flowers and coffee shops	$	19,671	19,671		
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 *	$	26,598	26,598		
19.	15	1j&k	Income Tax / Corporate Business Tax	$	(100)	(100)		
20.			Fund Raising / Contributions	$				
21.	16	m12	Unallowable Management Fees	$	270,835	270,835		
22.	16	6	Barber and Beauty	$				
23.			Other - See attached Schedule	$	22,813	22,813		
Page 18 - Dietary Expenditures								
24.	18	2a1	Meals to employees, guests and others who are not residents	$	215	215		
Page 19 - Laundry Expenditures								
25.	19	3d	Laundry services to employees, guests and others who are not residents	$				
Page 20 - Housekeeping Expenditures								
26.	20	4d	Housekeeping services to employees, guests and others who are not residents	$				
			Subtotal (Items 1 - 26)	$	725,648	725,648		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12m	Marketing Salaries & Benefits	$ 4,449	$ -	$ -
Total Other Salaries Adjustment			$ 4,449	$ -	$ -

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	$ 22,588	$ -	$ -
16	M13	Lobbying Fees	$ 225	$ -	$ -
Total Other A&G Adjustments			$ 22,813	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 10/2006

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	9/30/2018	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	725,648	725,648		
Page 20 - Resident Care Supplies*								
27.	20	5a1&	Prescription Drugs	$	359,570	359,570		
28.	20	5d	Ambulance/Limousine	$	2,294	2,294		
29.	20	5f	X-rays, etc	$	28,142	28,142		
30.	20	5h	Laboratory	$	25,520	25,520		
31.	20	5c	Medical Supplies	$	27,824	27,824		
32.	20	5e2	Oxygen (non emergency)	$	52,200	52,200		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	191,918	191,918		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$	9,541	9,541		
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.	$	249	249		
44.			Other - Miscellaneous Administrative	$				
45.			Management Fees Direct	$				
46.			Management Fees Indirect	$				
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)***	$	1,422,906	1,422,906		

*** 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	$ 18,988	$ -	$ -
20	5b	Ebox	$ 18,986	$ -	$ -
20	5j	Cable TV Fees	$ 14,423		
18	2c	Unallowable Management Fees..........Indirect Care	$ 65,657	$ -	$ -
20	5j	Unallowable Management Fees..........Direct Care	$ 73,864	$ -	$ -
Total Other Ancillary Costs			$ 191,918	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Moveable Equip Deprec Carryforwards	$ 9,541	$ -	$ -
Total Excess Movable Equipment Depreciation			$ 9,541	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
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	9/30/2018	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	22,340,468	22,340,468		
b. Medicaid Room and Board Contractual Allowance **	$	(13,419,588)	(13,419,588)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,693,474	1,693,474		
b. Medicare Room and Board Contractual Allowance **	$	203,289	203,289		
4. a. Private-Pay Residents and Other	$	3,238,446	3,238,446		
b. Private-Pay Room and Board Contractual Allowance **	$	(445,134)	(445,134)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	216,017	216,017		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(216,017)	(216,017)		
c. Prescription Drugs - Non-Medicare	$	335,398	335,398		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(335,398)	(335,398)		
2. a. Medical Supplies - Medicare	$	13,224	13,224		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	68,299	68,299		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(68,299)	(68,299)		
3. a. Physical Therapy - Medicare	$	745,944	745,944		
b. Physical Therapy - Medicare Contractual Allowance **	$	(553,994)	(553,994)		
c. Physical Therapy - Non-Medicare	$	400,149	400,149		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(398,449)	(398,449)		
4. a. Speech Therapy - Medicare	$	130,899	130,899		
b. Speech Therapy - Medicare Contractual Allowance **	$	(99,301)	(99,301)		
c. Speech Therapy - Non-Medicare	$	104,085	104,085		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(104,085)	(104,085)		
5. a. Occupational Therapy - Medicare	$	744,288	744,288		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(568,265)	(568,265)		
c. Occupational Therapy - Non-Medicare	$	331,261	331,261		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(326,961)	(326,961)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	(47,187)	(47,187)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	13,982,563	13,982,563		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	400	400		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	249	249		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$				
V. Total Other Revenue (1 thru 8)	$	649	649		
VI. Total All Revenue (III +V)	$	13,983,212	13,983,212		

* *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	Retroactives	$ (47,187)	$ -	$ -
Total Other Resident Revenue		$ (47,187)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
31, A2	Interest on A/R	777,115	$ 249	$ -	$ -
Total Interest Income			$ 249	$ -	$ -

Schedule of Other Revenue

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2018	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 13,666
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,394,437
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 26,647
5. Prepaid Expenses				$ 380,444
a. Prepaid Insurance		351,716		
b. Prepaid Expenses		7,755		
c. Prepaid Insurance		20,973		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 37,571
A/R Related Facilities		37,571		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,852,765
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	151,417		$ 6,869
	Accum. Depreciation	144,548	Net	
3. Buildings	*Historical Cost	2,318,267		$ 480,810
	Accum. Depreciation	1,837,457	Net	
4. Leasehold Improvements	*Historical Cost	572,566		$ 482,173
	Accum. Depreciation	90,393	Net	
5. Non-Movable Equipment	*Historical Cost	559,160		$ 91,712
	Accum. Depreciation	467,448	Net	
6. Movable Equipment	*Historical Cost	1,556,154		$ 246,327
	Accum. Depreciation	1,309,827	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 10,678
Misc Diff Fixed assets to books		(14,871)		
See Schedule		25,549		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,318,569

* 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 9/30/18

Description	Sep-18
FMLA Manager Online 12/1/17-12/31/2020	$ 911.90
Generator Lease	6,843.30
Balance	**$ 7,755.20**
GL BALANCE 9/30/18	7,755.20

Cost Year	Amount	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	Totals
	Cost	$ 625	$ 2,426	$ 8,187	$ 14,424	$ 22,263	$ 180,944
	Term	$ 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	$ 8,177
2020	Book Value			$ -	$ 1,441	$ 6,677	$ 8,136
2021	Deprec				$ 1,441	$ 4,453	$ 5,912
2021	Book Value				$ 0	$ 2,224	$ 2,224

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2018	32	37

Account				Amount
			Total Brought Forward:	$ 3,171,334
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$ 143,268
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost	6,764,604		
	Accum. Depreciation	6,744,270	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)				$ 163,602
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$ 382,200
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$ (10,242,810)
Name and Address	Amount	Loan Date		
Due from Related Facilities	(10,242,810)			
7. Other Assets (*itemize*)				$ 380,562
IRS Deposits\Finance Fees		78,500		
Warranties		2,105		
See Schedule		299,957		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (9,480,048)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ (6,145,112)

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

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

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

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

Page Ref	Line Ref	Description	
31	B9	Moveable Equipment Carryforward	$ 25,549
Total Other Other Fixed Assets (Itemize)			$ 25,549

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	Project Development	$ 299,957
Total Other Assets			$ 299,957

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)			$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2018	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 1,842,277
2. Notes Payable (*itemize*)				$ 2,725,952
Related Party		100,000		
Line of Credit		2,625,952		
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*)				$ 192,509
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 7,137
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*)				$ 385,117
Provider Tax Due	237,988			
Acc'd Health Ins	22,248			
Acc'd Operating Expenses	124,700			
Acc'd Expense - CT Sales Tax	181	See Schedule		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 5,152,992

* 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, 2018

DESCRIPTION	DEBIT		CREDIT		BALANCE
Health Insurance			$91,542.07		$91,542.07
Management Fee			$14,843.25		$14,843.25
Electricity			$8,515.16		$8,515.16
Audit fees			$9,800.00		$9,800.00
					$124,700.48

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	2004C	9/30/2018	34 | 37

Account				Amount
Total Brought Forward:				5,152,992
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$ 31,557
Name of Lender	Purpose	Amount	Date Due	
	Boiler Upgrade	31,557		
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*)				$ (286,149)
Due From Related Landlord		(2,406,041)		
Due to Related Landlord		2,119,892		
See Schedule				
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ (254,592)
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 4,898,400

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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	9/30/2018	35	37

Account					Amount
A. **Reserves**					
1. Reserve for value of leased land				$	143,268
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				$	20,334
3. Reserve for depreciation value of leased personal property *(Equity)*				$	
4. Reserve for leasehold real properties on which fair rental value is based				$	
5. Reserve for funds set aside as donor restricted				$	
6. Total Reserves				$	163,602
B. **Net Worth**					
1. Owner's Capital				$	
2. Capital Stock				$	1,000
3. Paid-in Surplus				$	
4. Treasury Stock				$	
5. Cumulated Earnings				$	(10,374,925)
6. Gain or Loss for Period	10/1/2017	thru	9/30/2018	$	(833,189)
7. Total Net Worth				$	(11,207,114)
C. ***Total Reserves and Net Worth***				$	(11,043,512)
D. ***Total Liabilities, Reserves, and Net Worth***				$	(6,145,112)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	2004C	9/30/2018	36 | 37

	Account			Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2017			$ (10,472,109)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 13,983,212
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 14,816,401
D.	Net Income or Deficit			$ (833,189)
E.	Balance			$ (11,305,298)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2017 AJE health insurance		98,192	
	2. Other (*itemize*)			
	rounding		(8)	
F-3.	Total Additions			$ 98,184
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*** 09/30/18			$ (11,207,114)

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

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2018	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	2/15/19

Printed Name of Preparer	
Athena Health Care Associates, Inc	
Address	**Phone Number**
135 South Road Farmington, CT 06032	(860) 751-3900