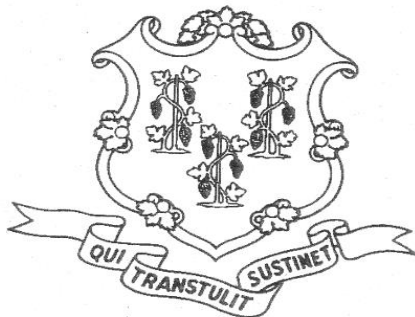
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2023

Name of Facility (as licensed)	
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	
Address (No. & Street, City, State, Zip Code) 27 Hospital Hill Road Sharon, CT 06069	
Type of Facility ☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined ☐ (Specify) ☐ (Specify)	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

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

Medicaid Provider Numbers:	CCNH / RHNS	(Specify)	(Specify)
	20941		

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CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Cente	2382	9/30/2023	1	37

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISIONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Sharon SNF CT LLC, d/b/a Sharon Health Care Center [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, 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
Printed Name (Administrator) Edward Baker			Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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Department of Social Services

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care Center	Period Covered:		From 10/1/2022	To 9/30/2023
Address of Facility 27 Hospital Hill Road Sharon, CT 06069				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900		Date 2/29/2024	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-364-1002	9/30/2023	2	37

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

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

Type of Facility (Check appropriate box(es))

- ☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined
- ☐ (Specify)
- ☐ (Specify)

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Edward Baker	1629

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

Name	License No.:
Not Applicable	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Cente	2382	9/30/2023	3	37

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

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

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health C	2382	9/30/2023	3A	37

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

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

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

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Ce	2382	9/30/2023	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2023	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	%**				
Athena Captive	135 South Road, Farmington, CT 06032	○	◉		Worker's Compensation Captive	Pg 15 1a1	230,894	230,894
Athena Health Care Assoc. 401 K Plan	135 South Road, Farmington, CT 06032	○	◉		Facility participates in common 401k plan			
Athena Health Care Insurance	135 South Road, Farmington, CT 06032	◉	○		Self Insured Employee General Health & De	Pg 15 1a5	909,453	909,453
Procare, LTC	111 Executive Blvd., Farmingdale, NY 11735	◉	○	<5%	Pharmacy	Pg 13 B3, Pg20 5a	263,283	263,283
Miscellaneous Facilities	Various	◉	○	>50%	Interfacility loans	Pg 33, A2		
Athena Health Care	135 South Rd, Farmington, CT 06032	◉	○	>50%	See attached			
Procare, LTC	111 Executive Blvd., Farmingdale, NY 11735	◉	○	<5%	Note Payable	Pg 34, B4	37,535	37,535
		○	◉					
		○	◉					

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care	2382	9/30/2023	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:No Non-Nursing Home Cost Centers

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General Information and Questionnaire
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon H	2382	9/30/2023	6	37

Square footage of entire facility.	0

Outpatient Therapy

Does the Facility provide outpatient therapy services?	No

If yes, please complete the following:

	Square footage of therapy space.

Meals on Wheels

Does the facility provide Meals on Wheels?	No

If yes, please complete the following:

	Square footage of kitchen	
	Number of meals served per week	
No	Are meals included in meals served on page 18 of the Annual Report?	
No	Are direct costs included in the Annual Report?	
	If yes, please state where costs are reported.	
No	Are drivers for the program included in the facility's payroll?	
	If yes, please complete the following:	
		Amount Reported
		Annual Report page and line
	Please state the salary amounts of specific cooks and/or dietary aides	
	Please state where the cooks and/or dietary aides are reported in the Annual Report	

Apartments, Independent Living, Assisted Living

Does the facility have apartments, independent living, and/or assisted living?	No

If yes, please complete the following:

	Square footage of apartments
	Square footage of independent living
	Square footage of assisted living
	Please identify the services provided:

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General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC,	2382	9/30/2023	7	37

Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care?	No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2023	8	37

					Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
	Total All Levels	Total CCNH / RHNS Level	Total	Total (Specify)	Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(Specify)
1. Certified Bed Capacity A. On last day of PREVIOUS report period	88	88			88	88						
B. On last day of THIS report period	88	88							88	88		
2. Number of Residents A. As of midnight of PREVIOUS report period	67	67			67	67						
B. As of midnight of THIS report period	69	69							69	69		
3. Total Number of Days Care Provided During Period A. Medicare	3,965	3,965			3,017	3,017			948	948		
B. Medicaid (Conn.)	18,684	18,684			14,258	14,258			4,426	4,426		
C. Medicaid (other states)												
D. Private Pay	3,577	3,577			2,443	2,443			1,134	1,134		
E. State SSI for RCH												
F. Other (Specify) Managed Care	83	83			74	74			9	9		
G. Total Care Days During Period (3A thru F)	26,309	26,309			19,792	19,792			6,517	6,517		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	54	54			40	40			14	14		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	26,363	26,363			19,832	19,832			6,531	6,531		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Ce	2382	9/30/2023	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)	(Specify)	Lost			Gained			CCNH / RHNS	(Specify)	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	9	47		13				
Per Diem Rate								
a. One bed rm.	572.43	######		660.00		411.28		
b. Two bed rms.	572.43	######		645.00		411.28		
c. Three or more bed rms.								

	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
7. Total Number of Physical Therapy Treatments					
A. Medicare - Part B	4,541	4,541			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	803	803			
2. Restorative Treatments					
C. Other	8,312	8,312			
D. ***Total Physical Therapy Treatments***	13,656	13,656			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	582	582			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	197	197			
2. Restorative Treatments					
C. Other	1,069	1,069			
D. ***Total Speech Therapy Treatments***	1,848	1,848			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	4,797	4,797			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	947	947			
2. Restorative Treatments					
C. Other	8,803	8,803			
D. ***Total Occupational Therapy Treatments***	14,547	14,547			

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2023	10	37

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

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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)	143,059		2,074						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	224,803		8,691						
5. Dietary Service									
a. Head Dietitian	27,398		726						
b. Food Service Supervisor	59,294		1,557						
c. Dietary Workers	429,843		21,508						
6. Housekeeping Service									
a. Head Housekeeper	68,205		2,459						
b. Other Housekeeping Workers	181,252		9,847						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	65,584		1,854						
b. Other Maintenance Workers	49,896		1,483						
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers	67,465		3,952						
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	148,677		2,185						
b. RN									
1. Direct Care	654,714		11,040						
2. Administrative**	434,001		12,241						
c. LPN									
1. Direct Care	884,333		21,568						
2. Administrative**									
d. Aides and Attendants	1,493,108		55,359						
e. Physical Therapists	452,348		11,433						
f. Speech Therapists	81,967		1,605						
g. Occupational Therapists	245,733	(245,733)	6,021						
h. Recreation Workers	202,160	(1,043)	7,395						
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	183,230		5,539						
n. Marketing									
o. Other (Specify) See Attached Schedule									
A-13. Total Salary Expenditures	6,097,070	(246,776)	188,537						

* 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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

	CCNH / RHNS			(Specify)			(Specify)		
Position	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
Total	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-

Schedule of Other Fees (Page 13)

	CCNH / RHNS			(Specify)			(Specify)		
Service	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
Total	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2023	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)	(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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Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Related Parties*

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center				2382		9/30/2023			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)	(Specify)							
Section III - Administrators* **										
Elise Cecil (10/19/22-4/16/23)	61,538			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	1,024	A2			
Raymond Wilkens (4/17/23-7/20/23)	45,681			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	560	A2			
Edward Baker (8/29/23-9/30/23) $12,308 160 hr	12,308			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	160	A2			
Section IV - Assistant Administrators										
Administrators continued:										
Joanne Mumley (10/1/22-10/19/22)	6,604					106				
Patrick McDonnell (07/21/23-8/28/23)	16,928					224				

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

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

*** If more than one Administrator is reported, include dates of employment for each.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Cen	2382	9/30/2023	13	37

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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									
3. Pharmacist	9,704		48						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	90,000		221						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**	1,070	(1,070)	7						
d. Administrative Services facility									
1. Infection Control Committee (Quarterly meetings)									
2. Pharmaceutical Committee (Quarterly meetings)									
3. Staff Development Committee (Once annually)									
e. Other (Specify)									
Psych Consulting Services	49,200		52						
9. Speech Therapist									
a. Resident Care	2,880		8						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	143,288		1,340						
2. Administrative***									
b. LPN									
1. Direct Care	100,721		1,454						
2. Administrative***									
c. Aides	113,457		2,722						
d. Other									
12. Other (Specify)									
See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	510,320	(1,070)	5,852						

* 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 in the Adjustment column.

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2023	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Dr. Sabooh Mubbashar, 123 Peck Hill Road, Woodbridge, CT 06525	Psychiatrist	○	⦿	
All American Healthcare, P.O. Box 825968, Philadelphia PA 19182-5968	Nurse Pool	○	⦿	
Clipboard Health, P.O. Box 103125, Pasadena, CA 91189-3125	Nurse Pool	○	⦿	
Nurse Network, 653 Main Street, Plantsville, CT 06479	Nurse Pool	○	⦿	
Procare, LTC, 111 Executive Blvd., Farmingdale, NY 11735	Pharmacist	⦿	○	Common Owners/Minority Interest
Delta-T-Group Hartford Inc. P.O. Box 884 Bryn Mawr, PA 19010	Nurse Pool	○	⦿	
Mark Marshall, DO, 32 Burton Road, Salisbury, CT 06068	Medical director	○	⦿	
Quotidian, 52 Seneff Road, Washington, CT 06793	Assistant Medical Director	○	⦿	
SDX Dysphagia Experts, 21 Waterville Rd, Avon, CT 06001	Dysphagia Consultant	○	⦿	
Norton and Associates, Inc., 34 Elm Street, Cohasset, MA, 02025	Nurse Pool	○	⦿	
Fusion Medical Staffing, LLC. P.O. Box 82674 Lincoln NE 68501-2674	Nurse Pool	○	⦿	
Genie Healthcare, 50 Milestone Road, Building 100, Suite 100. East Windsor, NJ 08520	Nurse Pool	○	⦿	
Staff On Tap, 21 Waterville Road, Avon, CT 06001	Nurse Pool	○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care (	2382	9/30/2023	15	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	230,894	230,894					
2. Disability Insurance	$							
3. Unemployment Insurance	$	42,171	42,171					
4. Social Security (F.I.C.A.)	$	431,510	431,510					
5. Health Insurance	$	825,054	825,054					
6. Life Insurance (employees only) (not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	84,306	84,306					
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*	$		193,107	(193,107)				
d. Accounting and Auditing	$	2,835	3,736	(901)				
e. Legal (*Services should be fully described on Page 15b*)	$		31,816	(31,816)				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	57,454	57,454					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	17,994	17,994					
2. Cellular Phones	$	720	2,199	(1,479)				
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*	$		(2,381)	2,381				
2. Other (*Specify*) See Attached Schedule	$							
3. Resident Day User Fee	$	470,806	470,806					
Subtotal	$	2,163,744	2,388,666	(224,922)				

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon	2382	9/30/2023	15b	37

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

◉ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	Medicare Cost report and Software License-(allowed)	$ 2,835
2	Related to sales analysis:disallow	$ 901
3		$
4		$
	Charge for Services Provided	$ 3,736

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

◉ Yes ○ No   Pg 15, Line1d

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	Athena Healthcare Systems, Saltzman Brenner	
2	Goldman, Gruder, & Woods/Pilicy & Ryan PC	203-899-8900/860-274-0018
3	State Marshall	860-485-0153
4	CT Treasurer/ Litchfield Probate	
5	Jackson Lewis	

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

1
2 200 Connecticut Ave, Norwalk, CT/365 Main St, Watertown, CT
3 PO Box 471 Torrington, CT 06790
4 Litchfield Court of Probate
5

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	PPP Loan: disallow	$ 1,549
2	A/R Collections/General Matters (disallowed)	$ 23,405
3	Conservatorship (Disallowed)	$ 420
4	Conservatorship (Disallowed)	$ 500
5	Employee Settlement: disallow	$ 5,942
	Charge for Services Provided	$ 31,816

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

◉ Yes ○ No   Pg 15, Line 1e

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Cente	2382	9/30/2023	16	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:		2,163,744	2,388,666	(224,922)				
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$	1,900	1,900					
3. Gifts to Staff and Residents	$		20,587	(20,587)				
4. Employee Travel	$	561	561					
5. Education Expenses Related to Seminars and Conventions	$	15,035	15,035					
6. Automobile Expense (*not purchase or depreciation*)	$	6,490	6,490					
7. Other (*Specify*)	$							
See Attached Schedule								
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (*all such expenses*)	$	3,017	3,017					
2. Advertising Telephone Directory (*all such expenses*)***	$							
3. Advertising Other (*Specify*)***	$		9,563	(9,563)				
See Attached Schedule								
4. Fund-Raising***	$							
5. Medical Records	$							
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$							
7. Postage	$	4,078	4,078					
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	8,415	8,415					
See Attached Schedule								
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$	1,452	1,452					
10. Contributions***	$		200	(200)				
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**	$	141,240		141,240				
13. Other (*Specify*)	$	135,705	176,098	(40,393)				
See Attached Schedule								
C-14 Total Administrative & General Expenditures	$	2,481,637	2,636,062	(154,425)				

* 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 expensein the Adjustment column.

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Promotional	$ 9,563	$ (9,563)				
Total Other Advertising	$ 9,563	$ (9,563)	$ -	$ -	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF / ACHCA Dues	$ 8,415					
Total Dues	$ 8,415	$ -	$ -	$ -	$ -	$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Miscellaneous	$ 200	$ (200)				
Total Contributions	$ 200	$ (200)	$ -	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Other Professional Fees	$ 32,627					
Data Processing Fees	$ 76,761					
Bank Charges	$ 20,393	$ (20,393)				
Payroll Processing Fees	$ 19,728					
Employee Physicals and bavkground checks	$ 6,589					
Penalty: Citation # 2023-10	$ 10,000	$ (10,000)				
Penalty: Violation 19a-527	$ 10,000	$ (10,000)				
Total Other Administrative and General	$ 176,098	$ (40,393)	$ -	$ -	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Healtl	2382	9/30/2023	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc, 135 South Road, Farmington, CT 06032	214,000	Full Management Services	See Below
Amounts added back on Page 28	141,240	Admin/Gen 66%	Pg 16, Line 12
	34,240	Indirect 16%	Pg 20, Line 5K
	38,520	Direct 18%	Pg 20, Line 5J
Athena Health Care Assoc., Inc, 135 South Road, Farmington, CT 06032		Admin/Gen-Other Expense	Pg 16, Line 12

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2023	18	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	371,442	371,442					
2. Non-Food Supplies	$	59,099	59,099					
3. Other (*Specify*)______________________ Dishes	$	3,031	3,031					
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)	$	433,572	433,572					

2E. Dietary Questionnaire	Total	CCNH / RHNS	(Specify)	(Specify)
F. Resident Meals: Total no. of meals served per day:*	216	216		

	Question	Yes	No		
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.	982
K.	Is any revenue collected from these people?	⦿ Yes	○ No	If yes, specify amt.	857
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg 18, Line 2a1
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⦿ No	If yes, specify cost.	
N.	Is any revenue collected from employees?	○ Yes	⦿ No	If yes, specify amt.	
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2023	19	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
3. Laundry								
a. In-House Processing*	Lbs.							
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $							
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.							
	Amt. $							
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.							
	Amt. $							
4. Repair and/or purchase of linens.***	Lbs.							
	Amt. $	13,161	13,161					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*) Supplies	$	9,954	9,954					
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	23,115	23,115					

3E. Laundry Questionnaire

	Question	Yes	No	
F.	Is cost of employee laundry included in 3D?	○ Yes	⦿ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ 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?	○ Yes	⦿ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⦿ No	If yes, specify amt.
K.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3D.
*** Pounds of Laundry only required for multi-level facilities.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care	2382	9/30/2023	20	37

Item			Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel		40,000	40,000					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	34,015	34,015					
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel		40,000	40,000					
(Complete Schedule C-2 att. Page 21)	Amt.	$							
C. Other (*Specify*)		$							
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	34,015	34,015					
5. Resident Care (Supplies)** a. Prescription Drugs***									
1. Own Pharmacy		$							
2. Purchased from Procare		$		220,534	(220,534)				
b. Medicine Cabinet Drugs		$	28,505	30,146	(1,641)				
c. Medical and Therapeutic Supplies		$	188,304	202,369	(14,065)				
d. Ambulance/Limousine***		$		546	(546)				
e. Oxygen									
1. For Emergency Use		$							
2. Other***		$		3,812	(3,812)				
f. X-rays and Related Radiological Procedures***		$		14,391	(14,391)				
g. Dental (*Not dentists who should be included under salaries or fees)*		$							
h. Laboratory***		$		5,688	(5,688)				
i. Recreation		$	19,043	19,043					
j. Direct Management Services*		$	38,520		38,520				
k. Indirect Management Services*		$	34,240		34,240				
l. Cable TV		$							
m. Other (Specify)**** See Attached Schedule		$	41,540	80,501	(38,961)				
n. Physical Therapy Expense		$							
o. Speech Therapy Expense		$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)		$	350,152	577,030	(226,878)				

* 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 in the Adjustment column.
**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Physical Therapy Supplies	$ 11,248					
Medical Equipment Rental-Medicaid	$ 4,597					
Cable TV Services	$ 25,491	$ (21,891)				
Oxygen Equipment Rental	$ 22,095					
Medical Equipment Rental-Other	$ 17,070	$ (17,070)				
Total Other Resident Care	$ 80,501	$ (38,961)	$ -	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2023	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)	(Specify)	Pg	Line
ADP	100 Corporate Drive, Windsor, CT 06095	○	⊙		Payroll Processing	19,728			16	m13
Welsh Sanitation	PO Box 1209, Hopewell Junction, NY 12533	○	⊙		Rubbish Removal	35,999			22	6f
Procare	111 Executive Blvd., Farmingdale, NY 11735	⊙	○	Common Owners/Minority Interest	Pharmacy	263,283			16	m13
Haab Landscaping	66 Skunks Misery Rd, Millerton, NY 12546	○	⊙		Snow Removal/Landscaping	14,231			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).

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

Name of Facility	License No.	Report for Year Ended					Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Car	2382	9/30/2023					22	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	127,671	127,671					
b. Heat	$	104,599	104,599					
c. Light & Power	$	70,588	70,588					
d. Water	$	51,147	51,147					
e. Equipment Lease (*Provide detail on page 22b*)	$	13,898	13,898					
f. Other (*itemize*)	$	91,236	91,236					
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	459,139	459,139					
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$							
b. Building & Building Improvements	$							
c. Non-Movable Equipment	$	12,064	12,064					
d. Movable Equipment	$	42,779	43,625	(846)				
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	54,843	55,689	(846)				
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$	10,920	10,920					
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	10,920	10,920					
9. Rental payments on leased real property less real estate taxes included in item 10b	$	700,927	700,927					
10. Property Taxes								
a. Real estate taxes paid by owner	$							
b. Real estate taxes paid by lessor	$	45,792	45,792					
c. Personal property taxes	$	3,189	3,189					
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	815,671	816,517	(846)				

* 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	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Groundskeeping	$ 20,118					
Rubbish Removal	$ 35,999					
Snow Removal	$ 14,231					
Supplies	$ 20,888					
Total Other Repairs and Maintenance	$ 91,236	$ -	$ -	$ -	$ -	$ -

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2023	22b	37

Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Leaf Capital Funding, LLC 1720A Crete St, Moberly, MO 65270	○	⦿	Xerox 7970 Copier/Xerox 3655 Copier	10/01/20	50 months	11,996	11,996
Pitney Bowes PO Box 371887, Pittsburgh, PA 15250	○	⦿	Postage Meter	01/10/16	51 months	820	820
Leaf Capital Funding, LLC 1720A Crete St, Moberly, MO 65270	○	⦿	Xerox 3655i Copier System	03/25/18	29 months	1,082	1,082
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⦿ No **Total ***** 13,898

* 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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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2023	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	209,765		209,765	155,427	S/L	Various	12,064	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								12,064

Property Item	Is a mileage logbook maintained? Yes	No	Date of Acquisition Month	Year	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
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. Ford, E35YCUTA, 2003	x		4	2012	10,000		10,000	10,000	S/L	10		
b. Bus Graphics			9	2013	4,668		4,668	4,668	S/L	5		
c. Ford Econoline, 2014	x		1	2022	28,183		28,183	8,455	S/L	5	5,637	
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	2022	572,653		572,653	413,375	S/L	Various	31,409	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative					98,845						5,700	
d. Standard Resident					10,167						879	
e. Specialized Resident												
Total Acquired during this report period					109,012						6,579	
D-3. Subtotal												43,625
E. ***Total Depreciation***												55,689

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	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
10/1/2022	Snowblower	Administrative	$ 2,677	5	$ 268	
Various	Dishwasher, Dryer, Smoke Detectors	Administrative	$ 76,980	10	$ 3,848	
12/1/2022	Scale Wheelchair	Standard Resident	$ 2,761	10	$ 138	
Various	Mattresses, Covers	Standard Resident	$ 7,406	5	$ 741	
Various	Camera System, Computers	Administrative	$ 12,478	5	$ 1,248	
12/1/2022	Ice and Water Dispenser	Administrative	$ 6,710	10	$ 336	
Total additions for Movable Equipment			$ 109,012		$ 6,579	*
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:					
4/1/2023	Sprinkler	$ 12,143	5	$ 1,214	
4/1/2023	Grease Trap	$ 4,945	10	$ 247	
6/1/2023	Fire Alarm	$4,355	10	$218	
8/1/2023	Sprinkler	$4,440	5	$444	
Total additions for Leasehold Improvement		$ 25,883		$ 2,123	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2023	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.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2022		129,288	4,399	S/L	Variou	8,797	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2023		25,883				2,123	
C-4. Subtotal									10,920
D. ***Total Amortization***									10,920

* Straight-line method must be used.
** Specify which of the following bases were used:
A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon He	2382	9/30/2023	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	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	
6. Square Footage	
7. Acquisition Cost	
a. Land	430,400
b. Building	6,024,600

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of ___________				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon H	2382	9/30/2023	26	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
12. Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage	$							
Name of Lender	Rate							
Address of Lender								
2. Second Mortgage	$							
Name of Lender	Rate							
Address of Lender								
3. Third Mortgage	$							
Name of Lender	Rate							
Address of Lender								
4. Fourth Mortgage	$							
Name of Lender	Rate							
Address of Lender								
B. CHEFA Loan Information								
1. Original Loan Amount	$							
2. Loan Origination Date								
3. Interest Rate %								
4. Term								
5. CHEFA Interest Expense								
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)	$							

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon	2382	9/30/2023	27	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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	22,195	22,195					
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	22,195	22,195					
14. Insurance a. Insurance on Property (buildings only) $	109,796	109,796					
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)*** $	109,796	109,796					
15. ***Total All Expenditures (A-13 thru C-14)*** $	11,088,836	11,718,831	(629,995)				

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Healt	2382	9/30/2023	30 | 37

Item		Total	CCNH / RHNS	(Specify)	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	11,915,491	11,915,491		
b. Medicaid Room and Board Contractual Allowance **	$	(6,265,155)	(6,265,155)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,943,578	1,943,578		
b. Medicare Room and Board Contractual Allowance **	$	(18,603)	(18,603)		
4. a. Private-Pay Residents and Other	$	2,927,322	2,927,322		
b. Private-Pay Room and Board Contractual Allowance **	$	(262,927)	(262,927)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	104,605	104,605		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(104,605)	(104,605)		
c. Prescription Drugs - Non-Medicare	$	99,876	99,876		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(99,876)	(99,876)		
2. a. Medical Supplies - Medicare	$	5,265	5,265		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	700	700		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	592,410	592,410		
b. Physical Therapy - Medicare Contractual Allowance **	$	(447,829)	(447,829)		
c. Physical Therapy - Non-Medicare	$	132,675	132,675		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(131,600)	(131,600)		
4. a. Speech Therapy - Medicare	$	176,815	176,815		
b. Speech Therapy - Medicare Contractual Allowance **	$	(138,888)	(138,888)		
c. Speech Therapy - Non-Medicare	$	54,475	54,475		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(53,225)	(53,225)		
5. a. Occupational Therapy - Medicare	$	624,799	624,799		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(472,303)	(472,303)		
c. Occupational Therapy - Non-Medicare	$	147,630	147,630		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(147,530)	(147,530)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	54,292	54,292		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	10,637,392	10,637,392		
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)*	$	5	5		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	25,514	25,514		
V. Total Other Revenue (1 thru 8)	$	25,519	25,519		
VI. Total All Revenue (III +V)	$	10,662,911	10,662,911		

* *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)	(Specify)
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
N/A	Retro	$ 54,292		
Total Other Resident Revenue		$ 54,292	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
	Interest on A/R		$ 5		
Total Interest Income			$ 5	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	Bad Debt Recoveries	$ 25,514		
Total Other Revenue		$ 25,514	$ -	$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Hea	2382	9/30/2023	31 | 37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 19,954
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,968,338
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 20,012
5. Prepaid Expenses				$ 93,269
a. Prepaid Insurance		78,282		
b. Prepaid Expenses (other)		14,987		
c.				
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,101,573
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	155,171		$ 139,852
	Accum. Depreciation	15,319	Net	
5. Non-Movable Equipment	*Historical Cost	209,766		$ 42,274
	Accum. Depreciation	167,492	Net	
6. Movable Equipment	*Historical Cost	681,521		$ 230,301
	Accum. Depreciation	451,220	Net	
7. Motor Vehicles	*Historical Cost	42,850		$ 14,091
	Accum. Depreciation	28,759	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 69
Fixed Asset Variance		69		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 426,587

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Deferred Finance Fees	$ (14,534)
Total Other Assets			$ (14,534)

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
Sharon SNF CT LLC, d/b/a Sharon Hea	2382	9/30/2023	32 | 37

Account				Amount
			Total Brought Forward:	$ 2,528,160
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$ 2,666,291
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 198,754
Deposits		173,927		
Project Development		39,361		
See Schedule		(14,534)		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 2,865,045
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 5,393,205

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Health Ca	2382	9/30/2023	33 | 37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 2,317,865
2. Notes Payable (*itemize*)				$
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*)				$ 233,258
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 366,392
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*)				$ 1,522,040
Acc'd Operating Expenses		(16,461)		
Acc'd Expense - CT Sales & Use Ta		58		
Provider Taxes Due		1,529,141		
Acc'd Expense - Real Estate Taxes		9,302	See Schedule	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 4,439,555

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Health (	2382	9/30/2023	34 | 37

Account	Amount
Total Brought Forward:	4,439,555
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 161,076

Name and Address of Lender	Amount	Loan Date
Procare Investments	161,076	

Account		Amount
4. Other Long-Term Liabilities (*itemize*)		$ 5,053,101
Notes Payable: Related Landlord	4,992,092	
NOTES PAY-PROCARE CT	61,009	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 5,214,177
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 9,653,732

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon He	2382	9/30/2023	35	37

Account	Amount
A. **Reserves**	
1. Reserve for value of leased land	$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
3. Reserve for depreciation value of leased personal property (*Equity)*	$
4. Reserve for leasehold real properties on which fair rental value is based	$
5. Reserve for funds set aside as donor restricted	$
6. Total Reserves	$
B. **Net Worth**	
1. Owner's Capital	$
2. Capital Stock	$
3. Paid-in Surplus	$
4. Treasury Stock	$
5. Cumulated Earnings	$ (3,204,607)
6. Gain or Loss for Period 10/1/2022 thru 9/30/2023	$ (1,055,920)
7. Total Net Worth	$ (4,260,527)
C. ***Total Reserves and Net Worth***	$ (4,260,527)
D. ***Total Liabilities, Reserves, and Net Worth***	$ 5,393,205

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Healt	2382	9/30/2023	36 | 37

	Account		Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2022	$	(3,189,604)
B.	Total Revenue (*From Statement of Revenue Page 30*)	$	10,662,911
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$	11,718,831
D.	Net Income or Deficit	$	(1,055,920)
E.	Balance	$	(4,245,524)
F.	Additions		
	1. Additional Capital Contributed (*itemize*)		
	2. Other (*itemize*)		
	Rounding (3)		
	Prior Year Audit Fees (15,000)		
F-3.	Total Additions	$	(15,003)
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*** 09/30/23	$	(4,260,527)

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health	2382	9/30/2023	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☐ (Specify)	☐ (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

Printed Name of Preparer

Athena Health Care Associates, Inc

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

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Amanda Doncet	860-751-3900

Contact Email Address

adoncet@athenahealthcare.com