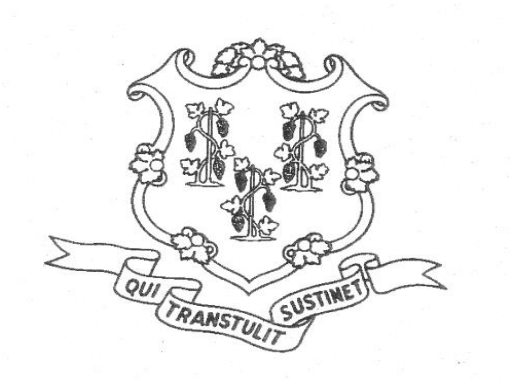
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2023

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 (CCNH) & RHNS Combined ☐ (Specify) ☐ (Specify)	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

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

Medicaid Provider Numbers:	CCNH / RHNS 2004C	(Specify)	(Specify)

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	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 Sheriden Woods 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) Brett Stewart			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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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 10/1/2022	To 9/30/2023
Address of Facility 321 Stonecrest Drive, Bristol, CT 06010				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900		Date	

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 9/30/2023	Page 2	of 37

Name of Facility (as shown on license) Sheriden Woods Health Care Center		Address (*No. & Street, City, State, Zip*) 321 Stonecrest Drive, Bristol, CT 06010		
License Numbers:	CCNH / RHNS 2004C	(Specify)	(Specify)	Medicare Provider No. 07-5350

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 Brett Stewart, MHA, LNHA	Nursing Home Administrator's License No.:	001706

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
Sheriden Woods Health Care Center	2004C	9/30/2023	3	37

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

Name of Partners/Members	Business Address	Title	% Owned
NA			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2023	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
Sherden 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	reasurer, Secreat	
Names of Stockholders Owning at Least 10% of Shares			
Conservators for Lawrence E Santilli	321 Stonecrest Rd, Bristol, CT 06010		2054.73

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2023	3B	37

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

Owner(s) of Facility
NA

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2023	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	%**				
Misc Facilities	Various	⊙	○	>50%	Interfacility Loans	Pg 33 A2		
Athena Health 401K Plan	135 South Road, Farmington, CT	○	⊙		Facility partcipates in a common 401k plan			
Athena Health Care	135 South Road, Farmington, CT	⊙	○	>50%	See Attached			
Athena Health Care Insurance	135 South Road, Farmington, CT	○	⊙		Self Insured Employee Health and Dental Ins	Pg 15 1a5	1,224,846	1,224,846
Sheriden Wooods Landlord	321 Stonectest Drive, Bristol, CT 06010	⊙	○	>95%	Lease of Propoerty	Pg 22 9 Ln 10B	737,301	737,301
Procare LTC Pharmacy of CT LLC	1492 Highland Ave. Cheshire, CT 06410	⊙	○	<5%	Pharmacy	Pg 20 5a2	370,826	370,826
Laurel Ridge Healthcare Center	642 Danbury Rd. Ridgefield, CT 06877	⊙	○	>50%	Bank Service Charges	Pg 16, m13	5,101	5,101
Procare LTC Pharmacy of CT LLC	1492 Highland Ave. Cheshire, CT 06410	⊙	○	<5%	Note Payable	Pg 34, B4 Pg 12D	76,570	76,570
		○	⊙					

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

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

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

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

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

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.

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General Information and Questionnaire
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	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
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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
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	Total All Levels	Total CCNH / RHNS Level	Total	Total (Specify)	Period 10/1 Thru 6/30 Total	Period 10/1 Thru 6/30 CCNH / RHNS	Period 10/1 Thru 6/30 (Specify)	Period 10/1 Thru 6/30 (Specify)	Period 7/1 Thru 9/30 Total	Period 7/1 Thru 9/30 CCNH / RHNS	Period 7/1 Thru 9/30 (Specify)	Period 7/1 Thru 9/30 (Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	146	146			146	146						
B. On last day of THIS report period	146	146							146	146		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	136	136			136	136						
B. As of midnight of THIS report period	127	127							127	127		
3. Total Number of Days Care Provided During Period												
A. Medicare	6,323	6,323			4,878	4,878			1,445	1,445		
B. Medicaid (Conn.)	41,365	41,365			31,381	31,381			9,984	9,984		
C. Medicaid (other states)												
D. Private Pay	845	845			432	432			413	413		
E. State SSI for RCH												
F. Other (Specify)	157	157			138	138			19	19		
G. Total Care Days During Period (3A thru F)	48,690	48,690			36,829	36,829			11,861	11,861		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	12	12			12	12						
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	48,702	48,702			36,841	36,841			11,861	11,861		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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	4	112				11		
Per Diem Rate								
a. One bed rm.	529.32	######		671.00		369.77		
b. Two bed rms.	529.32	######		652.00		369.77		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	7,656	7,656			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	1,606	1,606			
2. Restorative Treatments	10	10			
C. Other	8,241	8,241			
D. ***Total Physical Therapy Treatments***	17,513	17,513			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	1,740	1,740			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	150	150			
2. Restorative Treatments					
C. Other	735	735			
D. ***Total Speech Therapy Treatments***	2,625	2,625			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	9,931	9,931			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	2,465	2,465			
2. Restorative Treatments	9	9			
C. Other	8,416	8,416			
D. ***Total Occupational Therapy Treatments***	20,821	20,821			

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2023	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)	169,574		2,157						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	341,553		12,335						
5. Dietary Service									
a. Head Dietitian	92,361		2,144						
b. Food Service Supervisor	76,462		2,111						
c. Dietary Workers	569,277		31,694						
6. Housekeeping Service									
a. Head Housekeeper	91,693		2,204						
b. Other Housekeeping Workers	322,535		16,742						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	55,620		1,708						
b. Other Maintenance Workers	62,254		3,158						
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers	193,402		10,944						
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	167,561		2,631						
b. RN									
1. Direct Care	182,574		3,669						
2. Administrative**	406,129		6,754						
c. LPN									
1. Direct Care	2,208,664		53,386						
2. Administrative**	404,230		12,704						
d. Aides and Attendants	2,587,953		102,117						
e. Physical Therapists	496,505		13,155						
f. Speech Therapists	96,370		2,037						
g. Occupational Therapists	307,474	(307,474)	7,779						
h. Recreation Workers	256,778		8,656						
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	252,565	(6,486)	8,302						
n. Marketing									
o. Other (Specify) See Attached Schedule									
A-13. Total Salary Expenditures	9,341,534	(313,960)	306,387						

* 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
Sheriden Woods Health Care Center	2004C	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										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	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* **										
Brett N. Stewart, MHA, LNHA, License #001706 (7/5/23-9/30/23)	35,623			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility	464	A2		464	35,623
Christine M. McKinney, License #001627 (6/3/2023-7/4/23)	5,528			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility	88	A2		464	5,528
Amanda Penamon, License #002106 (10/1/2022-6/2/23)	128,423			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility	1,598	A2		464	128,423
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	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	13,937		382						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	14,400		160						
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	67,275		434						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**									
d. Administrative Services facility									
1. Infection Control Committee (Quarterly meetings)									
2. Pharmaceutical Committee (Quarterly meetings)									
3. Staff Development Committee (Once annually)									
e. Other (Specify)									
9. Speech Therapist									
a. Resident Care	3,240		9						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	159,720		1,473						
2. Administrative***									
b. LPN									
1. Direct Care	8,641		92						
2. Administrative***									
c. Aides	249,895		5,586						
d. Other									
12. Other (Specify) See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	517,108		8,136						

* 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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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	9/30/2023	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Jackson Therapy Partners, Lucien Way, Suite 112 Middletown, CT 06457	Physical Therapy	○	⊙	
DELTA-T-GROUP Hartford, Inc. P.O. Box 884 Bryn Mawr, PA 19010	Nurse Pool	○	⊙	
Procare LTC Pharmacy of CT LLC, 1492 Highland Ave, Cheshire, CT 06410	Pharmacist	○	⊙	Common Owners; Minority Interest
The Nurse Network, 653 Main St, Plantsville, CT 06479	Nurse Pool	○	⊙	
The Nurse Network, 653 Main St, Plantsville, CT 06479	Nurse Pool	○	⊙	
Amor C. Lomiboa MD, 6 Frey Road, Canton, CT 06019	Asst. Medical Director	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
Vista Behavioral Health, LLC, 152 Simsbury Rd Avon, CT 06001	Psychologist/Psychiatrist	○	⊙	
		○	⊙	
Claudia Kastner, 143 Orchard St, Rocky Hill, CT 06067	Dietician	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* 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
Sheriden Woods Health Care Center	2004C	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	$	453,319	453,319					
2. Disability Insurance	$							
3. Unemployment Insurance	$	76,283	76,283					
4. Social Security (F.I.C.A.)	$	627,168	627,168					
5. Health Insurance	$	1,110,419	1,110,419					
6. Life Insurance (employees only) (not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	190,056	190,056					
8. Uniform Allowance	$	8,283	8,283					
9. Other (*Specify*) See Attached Schedule	$							
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$		215,050	(215,050)				
d. Accounting and Auditing	$	10,235	17,731	(7,496)				
e. Legal (*Services should be fully described on Page 15b)*	$		37,795	(37,795)				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	48,514	48,514					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	73,190	73,490	(300)				
2. Cellular Phones	$	1,440	1,440					
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*	$		27,206	(27,206)				
2. Other (*Specify*) See Attached Schedule	$							
3. Resident Day User Fee	$	890,807	890,807					
Subtotal	$	3,489,714	3,777,561	(287,847)				

* 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
Sheriden Woods Health Care Cente	2004C	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	If "No," explain.
	○ No	

Independent Accounting Firm

	Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1	Midcap Financial Services, LLC	7255 Woodmont Avenue Suite 300, Bethesda, Maryland 20814
2	Marcum LLP	555 Long Wharf Drive, New Haven, CT
3	PKF O'Connor Davies, LLP	Four Corporate Drive, Suite 488 Shelton, CT 06484
4		

Services Provided by This Firm (*describe fully*)

1	Line of Credit Audit Fee: Disallow	$ 7,496
2	Medicare cost report preparation	$ 2,835
3	Tax Return preparation	$ 7,400
4		$
		Charge for Services Provided $ 17,731

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	Goldman, Gruder & Woods LLC	203-899-8900
2	Midcap Financial	800-970-9997
3	Probate Court / State Marshall/Sandra Couture/ Pilicy & Ryan	860-584-6230
4	Brenner, Saltzman & Wallman LLP/Athena Health Care	203-772-2600
5	Jackson Lewis	914-872-8060

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

1 200 Connecticut Ave, Norwalk, CT
2 433 S Main St #212, West Hartford, CT 06110
3 240 Stafford Ave, Bristol, CT 06010
4 271 Whitney Ave, New Haven, CT 06511
5 44 South Broadway 14th Floor, White Plains, NY 10601

Services Provided by This Firm (*describe fully*)

1	Collections: Disallow	$ 14,452
2	LOC Matters: Disallow	$ 12,825
3	Conservatorship: Disallow	$ 7,876
4	PPP Loan: Disallow	$ 2,570
5	Employee Matters: Disallow	$ 72
		Charge for Services Provided $ 37,795

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
Sheriden Woods Health Care Center	2004C	9/30/2023	16	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:		3,489,714	3,777,561	(287,847)				
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$	3,669	3,669					
3. Gifts to Staff and Residents	$		34,531	(34,531)				
4. Employee Travel	$	1,527	1,527					
5. Education Expenses Related to Seminars and Conventions	$	19,888	19,888					
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*)	$	9,079	9,079					
2. Advertising Telephone Directory (*all such expenses*)***	$		50	(50)				
3. Advertising Other (*Specify*)***	$		9,467	(9,467)				
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	$	4,650	4,650					
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	9,433	9,433					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$	1,503	1,503					
10. Contributions***	$		1,150	(1,150)				
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**	$	399,165	399,165					
13. Other (*Specify*)	$	84,219	121,748	(37,529)				
See Attached Schedule								
C-14 Total Administrative & General Expenditures	$	4,022,847	4,393,421	(370,574)				

* 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	$ 9,467	$ (9,467)				
Total Other Advertising	$ 9,467	$ (9,467)	$ -	$ -	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF	$ 9,433					
Total Dues	$ 9,433	$ -	$ -	$ -	$ -	$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Donations	$ 1,150	$ (1,150)				
Total Contributions	$ 1,150	$ (1,150)	$ -	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Professional Fees	$ (22,885)					
BANK CHARGES	$ 37,529	$ (37,529)				
PAYROLL PROCESSING FEES	$ 25,157					
DATA PROCESSING FEES	$ 71,238					
EMPLOYEE PHYSICALS	$ 10,709					
Total Other Administrative and General	$ 121,748	$ (37,529)	$ -	$ -	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	2004C	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 Associates Inc	547,668	contract attached to a prior year	See below
135 South Rd	361,461	admin/gen 66%	Pg 16, line 12
Farmington CT, 06032	87,627	indirect 16%	Pg 18, line 2c
Allocation of the above	98,580	direct 18%	Pg 20, line 5j
	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.**

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2023	18	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	541,338	545,679	(4,341)				
2. Non-Food Supplies	$	67,912	67,912					
3. Other (*Specify*)_____ Dishes	$	2,394	2,394					
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)	$	611,644	615,985	(4,341)				

		Total	CCNH / RHNS	(Specify)	(Specify)
2E.	Dietary Questionnaire				
F.	Resident Meals: Total no. of meals served per day:*	400	400		

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.	4341
K.	Is any revenue collected from these people?	⦿ Yes	○ No	If yes, specify amt.	442
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				18 2a1
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⦿ No	If yes, specify cost.	
N.	Is any revenue collected from employees?	○ Yes	⦿ No	If yes, specify amt.	
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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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	9/30/2023	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. $	24,714	24,714					
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. $							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*) Supplies	$	10,759	10,759					
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	35,473	35,473					

3E.	Laundry Questionnaire			
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
Sheriden Woods Health Care Center	2004C	9/30/2023	20	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4. Housekeeping	Sq. Ft. Serviced by Personnel							
a. In-House Care								
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt. $	69,520	69,520					
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)	$	69,520	69,520					
5. Resident Care (Supplies)**								
a. Prescription Drugs***								
1. Own Pharmacy	$							
2. Purchased from Procare	$		340,050	(340,050)				
b. Medicine Cabinet Drugs	$	912	29,823	(28,911)				
c. Medical and Therapeutic Supplies	$	467,066	493,827	(26,761)				
d. Ambulance/Limousine***	$		36,192	(36,192)				
e. Oxygen								
1. For Emergency Use	$							
2. Other***	$		22,839	(22,839)				
f. X-rays and Related Radiological Procedures***	$		24,312	(24,312)				
g. Dental (*Not dentists who should be included under salaries or fees*)	$							
h. Laboratory***	$		37,167	(37,167)				
i. Recreation	$	18,262	18,262					
j. Direct Management Services*	$	(9,469)		(9,469)				
k. Indirect Management Services*	$	(8,417)		(8,417)				
l. Cable TV	$	3,600	18,687	(15,087)				
m. Other (Specify)**** See Attached Schedule	$	103,350	124,795	(21,445)				
n. Physical Therapy Expense	$							
o. Speech Therapy Expense	$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)	$	575,304	1,145,954	(570,650)				

* 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
Oxygen Concentrator Rentals	$ 41,766					
Medcial Equip Rentals-Medicaid	$ 36,767					
Physical Therapy Supplies	$ 24,817					
Medical Equip Rentals-Other	$ 21,445	$ (21,445)				
Total Other Resident Care	$ 124,795	$ (21,445)	$ -	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2023	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	PO Box 7247, Philadelphia, PA	○	⊙		Payroll Processing	20,238			16	m13
Procare LTC Pharmacy of CT LLC	1492 Highland Ave, Cheshire, CT 06410	○	⊙	Common owners/Minority Share	Pharmacy	447,396			20	5a2
CWPM, Inc.	25 Norton Place, Plainville, CT	○	⊙		Rubbish Removal	32,271			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
Sheriden Woods Health Care Center	2004C	9/30/2023	22	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	112,788	112,788					
b. Heat	$	68,371	68,371					
c. Light & Power	$	96,318	96,318					
d. Water	$	72,438	72,438					
e. Equipment Lease (*Provide detail on page 22b*)	$	14,870	14,870					
f. Other (*itemize*)	$	90,299	90,299					
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	455,084	455,084					
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$	640	640					
b. Building & Building Improvements	$	44,652	44,652					
c. Non-Movable Equipment	$	7,558	7,558					
d. Movable Equipment	$	63,601	63,601					
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	116,451	116,451					
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$	90,104	90,104					
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	90,104	90,104					
9. Rental payments on leased real property less real estate taxes included in item 10b	$	472,670	472,670					
10. Property Taxes								
a. Real estate taxes paid by owner	$	99,743	99,743					
b. Real estate taxes paid by lessor	$							
c. Personal property taxes	$	20,489	20,489					
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	799,457	799,457					

* 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	$ 20,342					
Rubbish Removal	$ 33,937					
Snow Removal	$ 14,864					
Supplies	$ 20,600					
Geriatric Med - Control Box	$ 556					
Total Other Repairs and Maintenance	$ 90,299	$ -	$ -	$ -	$ -	$ -

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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
Sheriden Woods Health Care Center	2004C	9/30/2023	22b	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	○	⊙	Postal Machines	Automatic Renewal	39 months	1,734	1,734
Leaf	⊙	○	Copier	08/23/21	48 months	614	613
Wells Fargo Financials	○	⊙	Xerox Printers	04/06/20	48 months	12,541	12,541
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	14,888

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

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	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	151,417			150,303	S/L	Various	640	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								640
B. **Building and Building Improvements**								
1. Acquired prior to this report period	2,318,266			2,037,122	S/L	Various	44,652	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								44,652
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	556,370			522,917	S/L	Various	7,558	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								7,558

	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	2022	1,883,746			1,552,735	S/L	Various	60,350	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative			9	2023	36,935					Various	1,981	
d. Standard Resident					20,211						1,270	
e. Specialized Resident												
Total Acquired during this report period					57,146						3,251	
D-3. Subtotal												63,601
E. ***Total Depreciation***												116,451

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:						
Various	H&R Healthcare - Patient Lifts (x7), Med Part Patient Lift	Standard Resident	$ 15,045	10	$ 753	
Various	Air Temp Pump, D'amato Construction Backflow Preventor, Hartford Provi	Administrative	$ 30,679	10	$ 1,534	
1/31/2023	Geriatric Medical - Bladder Scanner	Administrative	$ 6,256	7	$ 447	
12/31/2022	Medline - Wheelchairs, RLW Supply - Recliner	Standard Resident	$ 2,734	5	$ 274	
4/20/2023	H&R Healthcare - Recliner	Standard Resident	$ 1,409	5	$ 141	
6/30/2023	Geriatric Medical - Mattresses	Standard Resident	$ 1,023	5	$ 102	
Total additions for Movable Equipment			$ 57,146		$ 3,251	*
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:					
2/23/2024	Installation Plus - 1000 DE Door Locking Panel	1,160	10	$ 58	
4/23/2024	Encore Fire Protection - Sprinkler Replacements	3,159	15	$ 105	
6/23/2024	Fire Service Group - Sprinkler Heads	5,228	15	$ 174	
8/23/2024	D'amato Construction Co. - Fire Hydrant	13,748	20	$ 344	
Total additions for Leasehold Improvement		$ 23,295		$ 681	*
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
Sheriden Woods Health Care Center	2004C	9/30/2023	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3. Finance Fees - Midcap	2	2022	3	60,186	55,098	S/L	3 year		
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2022	Various	1,384,689	418,526			89,423	
2. Disposals (attach schedule)			Various						
3. Acquired during this report period									
(attach schedule)	9	2023	Various	23,295				681	
C-4. Subtotal									90,104
D. ***Total Amortization***									90,104

* 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
Sheriden Woods Health Care Center	2004C	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	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	11,148,181			
f. Principal balance outstanding as of _____	2,519,443			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Cente	2004C	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*) $							
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $							
14. Insurance							
a. Insurance on Property (buildings only) $	170,676	170,676					
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)*** $	170,676	170,676					
15. ***Total All Expenditures (A-13 thru C-14)*** $	16,284,687	17,544,212	(1,259,525)				

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	2004C	9/30/2023	30 | 37

Item		Total	CCNH / RHNS	(Specify)	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	26,970,855	26,970,855		
b. Medicaid Room and Board Contractual Allowance **	$	(16,042,784)	(16,042,784)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,886,532	1,886,532		
b. Medicare Room and Board Contractual Allowance **	$	19,010	19,010		
4. a. Private-Pay Residents and Other	$	2,970,286	2,970,286		
b. Private-Pay Room and Board Contractual Allowance **	$	(961,100)	(961,100)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	106,700	106,700		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(106,700)	(106,700)		
c. Prescription Drugs - Non-Medicare	$	222,336	222,336		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(222,336)	(222,336)		
2. a. Medical Supplies - Medicare	$	12,161	12,161		
b. Medical Supplies - Medicare Contractual Allowance **	$	(12,081)	(12,081)		
c. Medical Supplies - Non-Medicare	$	44,453	44,453		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(44,453)	(44,453)		
3. a. Physical Therapy - Medicare	$	630,592	630,592		
b. Physical Therapy - Medicare Contractual Allowance **	$	(459,570)	(459,570)		
c. Physical Therapy - Non-Medicare	$	368,025	368,025		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(367,500)	(367,500)		
4. a. Speech Therapy - Medicare	$	187,595	187,595		
b. Speech Therapy - Medicare Contractual Allowance **	$	(136,258)	(136,258)		
c. Speech Therapy - Non-Medicare	$	86,635	86,635		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(86,535)	(86,535)		
5. a. Occupational Therapy - Medicare	$	835,603	835,603		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(594,534)	(594,534)		
c. Occupational Therapy - Non-Medicare	$	430,985	430,985		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(430,535)	(430,535)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	(284,137)	(284,137)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	15,023,245	15,023,245		
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)*	$	48,033	48,522	(489)	
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	164,690	164,690		
V. Total Other Revenue (1 thru 8)	$	212,723	213,212	(489)	
VI. Total All Revenue (III +V)	$	15,235,968	15,236,457	(489)	

* *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)
	Medicaid Retro	$ 300,000		
	Medicare Retro	$ (584,137)		
Total Other Resident Revenue		$ (284,137)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
31, A2	Interest on A/R		489	$ (489)	
31, A3	ERC Interest		$ 48,033		
Total Interest Income			$ 48,522	$ (489)	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30, 8	United Healthcare Services Dividends	$ 4,580		
30, 8	Telehealth Services	$ 4,894		
30, 8	Bad Debt Recoveries	$ 155,216		
Total Other Revenue		$ 164,690	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2023	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 7,372
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,321,117
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 35,126
5. Prepaid Expenses				$ 158,284
a. Prepaid Insurance		150,179		
b.				
c.				
d. See Schedule		8,105		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,521,899
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	151,417		$ 474
	Accum. Depreciation	150,943	Net	
3. Buildings	*Historical Cost	2,318,266		$ 236,492
	Accum. Depreciation	2,081,774	Net	
4. Leasehold Improvements	*Historical Cost	1,407,982		$ 899,354
	Accum. Depreciation	508,628	Net	
5. Non-Movable Equipment	*Historical Cost	556,370		$ 25,895
	Accum. Depreciation	530,475	Net	
6. Movable Equipment	*Historical Cost	1,940,892		$ 324,556
	Accum. Depreciation	1,616,336	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 16,359
See Schedule		16,359		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,503,130

* 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	
		FMLA Manager Online	$ 70
		SNF Metrics	$ 4,426
		OnShift Scheduling	$ 1,924
		Cbord Group	$ 1,315
		Wellsky	$ 370
Total Prepaid Expenses			$ 8,105

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

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

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

Page Ref	Line Ref	Description	
		Misc Diff Fixed assets to books	$ (14,838)
		Project Development	$ 31,197
Total Other Other Fixed Assets (Itemize)			$ 16,359

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

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

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2023	32	37

Account				Amount
		Total Brought Forward:	$	4,025,029
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			$	
2. Land Improvements	*Historical Cost			
	Accum. Depreciation	Net	$	
3. Buildings	*Historical Cost	6,764,604		
	Accum. Depreciation	6,753,056 Net	$	11,548
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)			$	11,548
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*)			$	(1,049,514)
IRS Deposits/Finance Fees		36,474		
Goodwill		(1,085,988)		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$	(10,910,124)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	(6,873,547)

* 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
Sheriden Woods Health Care Center	2004C	9/30/2023	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 2,128,302
	2. Notes Payable (*itemize*)				$ 7,619,961
	Line of Credit		7,619,961		
	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*)				$ 362,369
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 384,209
	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*)				$ 3,194,037
	Provider Tax Due		3,069,130		
	Acc'd Operating Expenses		124,655		
	Acc'd Expense - CT Sales Tax		252		
	See Schedule				
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 13,688,878

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2023	34	37

Account				Amount
			Total Brought Forward:	13,688,878
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$ 199,184
Name and Address of Lender		Amount	Loan Date	
	Procare Investment	198,590		
	Accrued Rent	594		
4. Other Long-Term Liabilities (*itemize*)				$ (3,613,472)
	Due From Related Landlord	(5,856,963)		
	Due to Related Landlord	2,119,892		
	Notes Pay-Procare CT	123,599		
	See Schedule			
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ (3,414,288)
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 10,274,590

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2023	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	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (13,720,159)
	6. Gain or Loss for Period 10/1/2022 thru 9/30/2023	$ (3,428,978)
	7. Total Net Worth	$ (17,148,137)
C.	***Total Reserves and Net Worth***	$ (17,148,137)
D.	***Total Liabilities, Reserves, and Net Worth***	$ (6,873,547)

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2023	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2022			$ (16,445,790)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 15,236,457
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 18,143,445
D.	Net Income or Deficit			$ (2,906,988)
E.	Balance			$ (19,352,778)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	ERC Monies	2,726,631		
	2. Other (*itemize*)			
F-3.	Total Additions			$ 2,726,631
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		$ (16,626,147)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2023	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 Road, Farmington, CT 06032	

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
(860) 751-3900	

Contact Email Address