State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2021

Name of Facility (as licensed) Sheriden Woods Health Care Center		
Address (No. & Street, City, State, Zip Code) 321 Stonecrest Drive, Bristol, CT 06010		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	2004C		

For Department Use Only

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

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

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	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, 2020 and ending September 30, 2021, 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) Lizbeth Carmichael			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)

Table of Contents

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

State of Connecticut
Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Sheriden Woods Health Care Center	Period Covered:		From 10/1/2020	To 9/30/2021
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)
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 10/2005

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility 860-583-1827	Report for Year Ended 9/30/2021	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 2004C	RHNS	(Specify)	Medicare Provider No. 07-5350

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

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

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 Krista Wagner	Nursing Home Administrator's License No.:	001750

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

Name Not Applicable	License No.:

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

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	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
Not Applicable			

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

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	3A	37

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

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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G Santilli	321 Stonecrest Rd, Bristol, CT 06010	President	6445.27
Michael E Mosier	321 Stonecrest Rd, Bristol, CT 06010	reasurer, Secreta	
Names of Stockholders Owning at Least 10% of Shares			
Other than listed above:			
Conservators for Lawrence E Santilli	321 Stonecrest Rd, Bristol, CT 06010		2054.73

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

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	3B	37

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

Owner(s) of Facility
Not Applicable

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

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Misc Facilities	Various	⊙	○	>98%	Interfacility Loans	pg 33 A2		
Athena Health 401K plan	135 South Road, Farmington, CT	○	⊙		Facility participates in a common 401(K) pla			
Athena Health Care	135 South Road, Farmington, CT	⊙	○	<50%	See Attached			
Athena Health Care Insurance	135 South Road, Farmington, CT	○	⊙		Self Insured Employee Health and Dental In	pg 15 1a5	1,153,606	1,153,606
Sheriden Woods Landlord	321 Stonecrest Drive, Bristol, CT 06010	○	⊙		Lease of Property	pg 22 9. 10b, pg 27	745,921	745,921
Procare LTC Pharmacy of CT LLC	1492 Highland Ave, Cheshire, CT 06410	⊙	○	>50%	Pharmacy	pg 20 5a2	468,856	468,856
Laurel Ridge Healthcare Center	642 Danbury Rd, Ridgefield, CT 06877	⊙	○	>98%	Bank Service Charges	pg 16, m13	4,590	4,590
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

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

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	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

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

General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	6	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
Leaf	○	⊙	Copier	08/23/17	48 months	819	819
Wells Fargo Financials	○	⊙	Xerox Printer	04/06/20	48 months	13,681	13,681
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	○	⊙	Postal Machines	Automatic Renewal	39 months	1,219	1,219
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 15,719

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

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

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Cente	2004C	9/30/2021	7	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 Midcap Financial Services, LLC	7255 Woodmont Avenue Suite 300, Bethesda, Maryland 20814
2 Marcum LLP	555 Long Wharf Drive, New Haven, CT
3	
4	

Services Provided by This Firm (*describe fully*)

1	Line of Credit Audit Fee: Disallow	$ 3,418
2	Medicare cost report preparation	$ 2,700
3		$
4		$
		Charge for Services Provided $ 6,118

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	301-760-7600
3 Probate Court	860-584-6230
4	
5	

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

1 200 Connecticut Ave, Norwalk, CT
2 7255 Woodmont Avenue Suite 300, Bethesda, Maryland 20814
3 240 Stafford Ave, Bristol, 06010
4
5

Services Provided by This Firm (*describe fully*)

1	General Matters: Disallow	$ 21,400
2	HFG: $32.14: Disallow	$ 32
3	Conservatorship: Disallow	$ 780
4		$
5		$
		Charge for Services Provided $ 22,212

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

⊙ Yes ○ No — Pg 15, Line1e

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

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	8	37

					Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	146	146			146	146						
B. On last day of THIS report period	146	146							146	146		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	93	93			93	93						
B. As of midnight of THIS report period	132	132							132	132		
3. Total Number of Days Care Provided During Period												
A. Medicare	7,668	7,668			5,460	5,460			2,208	2,208		
B. Medicaid (Conn.)	35,095	35,095			26,079	26,079			9,016	9,016		
C. Medicaid (other states)												
D. Private Pay	1,695	1,695			1,285	1,285			410	410		
E. State SSI for RCH												
F. Other (Specify) Contract Other/VA	255	255			251	251			4	4		
G. Total Care Days During Period (3A thru F)	44,713	44,713			33,075	33,075			11,638	11,638		
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	9	9							9	9		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	44,722	44,722			33,075	33,075			11,647	11,647		

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

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	17	99		4		12		
Per Diem Rate								
a. One bed rm.	515.26	262.43		597.00		408.58		
b. Two bed rms.	515.26	262.43		592.00		408.58		
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,700	3,700		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,472	1,472		
2. Restorative Treatments				
C. Other	9,082	9,082		
D. ***Total Physical Therapy Treatments***	14,254	14,254		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	392	392		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	132	132		
2. Restorative Treatments				
C. Other	882	882		
D. ***Total Speech Therapy Treatments***	1,406	1,406		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	4,602	4,602		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,431	1,431		
2. Restorative Treatments				
C. Other	9,363	9,363		
D. ***Total Occupational Therapy Treatments***	15,396	15,396		

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

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	151,131	2,090				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	255,006	10,317				
5. Dietary Service						
a. Head Dietitian	83,741	2,118				
b. Food Service Supervisor	71,725	2,149				
c. Dietary Workers	461,974	29,611				
6. Housekeeping Service						
a. Head Housekeeper	80,110	2,429				
b. Other Housekeeping Workers	279,558	17,429				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	70,473	1,990				
b. Other Maintenance Workers	66,333	3,423				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	127,466	9,399				
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	197,753	3,401				
b. RN						
1. Direct Care	700,669	15,365				
2. Administrative**	471,513	14,300				
c. LPN						
1. Direct Care	1,164,170	39,686				
2. Administrative**						
d. Aides and Attendants	1,943,762	92,391				
e. Physical Therapists	509,125	13,663				
f. Speech Therapists	99,271	2,046				
g. Occupational Therapists	324,823	8,394				
h. Recreation Workers	213,527	8,605				
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	278,620	9,915				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	7,550,750	288,721				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Not Applicable										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
Not Applicable										

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

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Lizbeth Carmichael (10/1/20-10/30/20)	17,740			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	172	A2			
Janet Shahen (10/14/20-07/5/21)	99,892					1,474	A2			
Krista Wagner (07/6/21-9/30/21)	33,499					444	A2			
Section IV - Assistant Administrators										

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	16,644	104				
3. Pharmacist	11,271	344				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	30,689	252				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
Medical Staff Meetings	600	3				
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	161,425	1,392				
2. Administrative***	3,962	90				
b. LPN						
1. Direct Care	377,856	4,238				
2. Administrative***						
c. Aides	527,465	11,247				
d. Other						
12. Other (Specify)						
See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	1,129,912	17,670				

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

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
HealthDrive Dental Group, 1 Prestige Drive,Suite 107, Meriden, CT, 06450	Dentist	○	⊙	
Dr. C. Licata, ProHealth Physicians, 625 Clark Ave., Bristol, CT 06010	Medical Director	○	⊙	
Procare LTC Pharmacy of CT LLC, 1492 Highland Ave, Cheshire, CT 06410	Pharmacist	⊙	○	Common Owners; Minority Interest
Dr. A. Scappaticci, ProHealth Physicians, 625 Clark Ave. Bristol, CT 06010	Asst. Medical Director	○	⊙	
Norton and Associates, Inc. 97 Elm St, Cohasset, MA 02025	Nurse Pool	○	⊙	
The Nurse Network, 653 Main St, Plantsville, CT 06479	Nurse Pool	○	⊙	
Laura C. Brenes, MD, CMD, Claim, LLC, 76 Batterson Park Road, Suite 106 Farmington, CT [illegible]	Medical Director	○	⊙	
Gary Miller MD LLC, 100 North Mountain Rd, Canton CT 06019	Asst. Medical Director	○	⊙	
Dedicated Nursing Associates, Inc. 6536 William Penn Hwy Rt. 22 Suite 201, Delmont, PA 15626	Nurse Pool	○	⊙	
Gale Healthcare Solutions LLC, PO Box 4729, Winter Park, FL 32793	Nurse Pool	○	⊙	
MAS Staffing, 156 Harvey Rd, Londonderry, NH 03053	Nurse Pool	○	⊙	
Solomon Page Staffing & Executive Search, 260 Madison Ave, 4th floor, New York, NY 10016	Nurse Pool	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 9/2018

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	9/30/2021	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	276,036	276,036		
2. Disability Insurance	$				
3. Unemployment Insurance	$	75,935	75,935		
4. Social Security (F.I.C.A.)	$	506,924	506,924		
5. Health Insurance	$	1,056,362	1,056,362		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	19,808	19,808		
(not-owners and not-operators)					
8. Uniform Allowance	$	110	110		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	181,678	181,678		
d. Accounting and Auditing	$	6,118	6,118		
e. Legal (*Services should be fully described on Page 7)*	$	22,212	22,212		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	80,440	80,440		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	112,781	112,781		
2. Cellular Phones	$	1,620	1,620		
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. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	778,875	778,875		
Subtotal	$	3,118,899	3,118,899		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,118,899	3,118,899		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	6,092	6,092		
3. Gifts to Staff and Residents	$	22,237	22,237		
4. Employee Travel	$	344	344		
5. Education Expenses Related to Seminars and Conventions	$	8,033	8,033		
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*)	$	21,060	21,060		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	18,352	18,352		
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	$	5,003	5,003		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	11,085	11,085		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	175	175		
10. Contributions***	$	500	500		
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**	$	431,630	431,630		
13. Other (*Specify*)	$	97,083	97,083		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	3,740,493	3,740,493		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	$ 18,352		
Total Other Advertising	$ 18,352	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	$ -		
CAHCF	$ 11,085		
Total Dues	$ 11,085	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Miscellaneous	$ 500		
Total Contributions	$ 500	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
LICENSES	$ 1,620		
BANK CHARGES	$ 15,316		
PAYROLL PROCESSING FEES	$ 19,948		
DATA PROCESSING FEES	$ 47,014		
EMPLOYEE PHYSICALS	$ 6,865		
CT TREASURER (Citation 2020-34) & CMS (CMP)	$ 6,320		
Total Other Administrative and General	$ 97,083	$ -	$ -

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

Schedule C-1 - Management Services*

Name of Facility Sheriden Woods Health Care Center	License No. 2004C	Report for Year Ended 9/30/2021	Page 17 | of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	596,858	Contract Attached to a Prior Year	See Below
Allocation of the above	393,926	Admin/Gen 66%	Pg 16, Line 12
	95,497	Indirect 16%	Pg 18, Line 2C
	107,435	Direct 18%	Pg 20, Line 5J
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	37,704	Admin/Gen - Other Exp	Pg 16, Line 12

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 9/2018

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	9/30/2021	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	372,961	372,961		
2. Non-Food Supplies	$	70,785	70,785		
3. Other (*Specify*)_____ Dishes	$	268	268		
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)	$	444,014	444,014		
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*		368	368		
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.	$316
K. Is any revenue collected from these people?		⊙ Yes	○ No	If yes, specify amt.	$158
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 9/2018

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	9/30/2021	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	23,786	23,786		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Supplies	$	10,850	10,850		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	34,636	34,636		

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 9/2018

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	9/30/2021	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	54,851	54,851		
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)		$	54,851	54,851		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Procare		$	433,920	433,920		
b. Medicine Cabinet Drugs		$	19,249	19,249		
c. Medical and Therapeutic Supplies		$	459,310	459,310		
d. Ambulance/Limousine***		$	17,837	17,837		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	25,016	25,016		
f. X-rays and Related Radiological Procedures***		$	16,125	16,125		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	49,403	49,403		
i. Recreation		$	11,040	11,040		
j. Direct Management Services*		$	107,435	107,435		
k. Indirect Management Services*		$	95,497	95,497		
l. Other (Specify)**** See Attached Schedule		$	126,297	126,297		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,361,129	1,361,129		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Oxygen Concentrator Rentals	$ 30,408		
	$ -		
Medical Equip Rentals-Medicaid	$ 21,402		
Cable TV Services	$ 15,764		
Physical Therapy Supplies	$ 50,319		
Medical Equip Rentals-Other	$ 8,404		
Total Other Resident Care	$ 126,297	$ -	$ -

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADP	PO Box 7247, Philadelphia, PA	○	⊙		Payroll Processing	16,840			16	m13
Procare LTC Pharmacy of CT LLC	1492 Highland Ave, Cheshire, CT 06410	⊙	○	Common owners/Minority share	Pharmacy	468,856			20	5a2
CWPM, Inc.	25 Norton Place, Plainville, CT	○	⊙		Rubbish Removal	25,547			22	6f
Winterberry Landscaping & Garden Center	2070 West St., Southington, CT	○	⊙		Landscaping	12,967			22	6f
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* List all contracted services over $10,000. Use additional sheets if necessary.
** Refer to Page 4 for definition of related.
*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	$ 13,419		
Rubbish Removal	$ 29,407		
Snow Removal	$ 10,784		
Supplies	$ 25,576		
Total Other Repairs and Maintenance	$ 79,186	$ -	$ -

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Cente	2004C	9/30/2021	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	96,816	96,816		
b. Heat	$	62,050	62,050		
c. Light & Power	$	95,495	95,495		
d. Water	$	31,952	31,952		
e. Equipment Lease (*Provide detail on page 6*)	$	15,719	15,719		
f. Other (*itemize*)	$	79,186	79,186		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	381,218	381,218		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	1,172	1,172		
b. Building & Building Improvements	$	46,224	46,224		
c. Non-Movable Equipment	$	12,128	12,128		
d. Movable Equipment	$	60,516	60,516		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	120,040	120,040		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	8,700	8,700		
c. Leasehold Improvements	$	86,316	86,316		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	95,016	95,016		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	516,508	516,508		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	87,855	87,855		
c. Personal property taxes	$	25,113	25,113		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	844,532	844,532		

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	151,417		151,417	148,266	S/L	Var	1,172	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								1,172
B. **Building and Building Improvements**								
1. Acquired prior to this report period	2,318,266		2,318,266	1,944,191	S/L	Various	46,224	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								46,224
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	559,159		559,159	500,125	S/L	Various	12,128	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								12,128

	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	2020	1,684,155		1,684,155	1,431,161	S/L	Various	56,276	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2021	77,627		77,627		S/L	Various	4,240	
D-3. Subtotal												60,516
E. ***Total Depreciation***												120,040

Schedule of Land Improvements Acquired during this report peri

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

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

Schedule of Building Improvements Acquired during this report peri

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

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

Schedule of Non-Movable Equipment Acquired during this report peri

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

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Dat	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Various	Various	$ 77,627	Various	$ 4,240	
Total additions for Movable Equipmen		$ 77,627		$ 4,240	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report peri

Acquisition Dat	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Various	Various	$ 81,079	Various	$ 3,772	
Total additions for Leasehold Improvemer		$ 81,079		$ 3,772	*
Deletions:					
Total deletions for Leasehold Improvemer		$ -		$ -	**

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

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

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	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. Finance Fees - Midcap	2	2021	3	60,186	46,398	SL		8,700	
3.									
B-4. Subtotal									8,700
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period		2020	Various	1,782,820	347,570			82,544	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2021	Various	81,079		SL	variou	3,772	
C-4. Subtotal									86,316
D. ***Total Amortization***									95,016

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ⊙ Yes ○ No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	11/18/86
4. Date of Initial Licensure	11/06/86
5. Total Licensed Bed Capacity	146
6. Square Footage	
7. Acquisition Cost	
a. Land	143,268
b. Building	3,443,098

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	03/29/12			
c. Interest Rate for the Cost Year	3.22%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	10,969,330			
f. Principal balance outstanding as of _____	2,887,485			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	2004C	9/30/2021	26 | 37

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

(*Carry Subtotals forward to next page*)

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Cent	2004C	9/30/2021	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment 1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $	123,604	123,604		
Vendor Interst=$4,791 Key Bank Line of Credit=$118,81				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	123,604	123,604		
14. Insurance a. Insurance on Property (buildings only) $	148,776	148,776		
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)*** $	148,776	148,776		
15. ***Total All Expenditures (A-13 thru C-14)*** $	15,813,915	15,813,915		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2018

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	2004C	9/30/2021	28 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages								
1.			Outpatient Service Costs	$				
2.			Salaries not related to Resident Care	$				
3.			Occupational Therapy	$	324,823	324,823		
4.			Other - See attached Schedule	$	5,388	5,388		
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.			Bad Debts	$	181,678	181,678		
10.			Accounting	$	3,418	3,418		
10a.			Legal	$	22,212	22,212		
11.			Telephone	$				
12.			Cellular Telephone	$	900	900		
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.			Gifts, flowers and coffee shops	$	22,237	22,237		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	$				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	$				
17.			Automobile Expense (e.g. personal use)	$				
18.			Unallowable Advertising *	$	18,352	18,352		
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$	500	500		
21.			Unallowable Management Fees	$	198,012	198,012		
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	21,636	21,636		
Page 18 - Dietary Expenditures								
24.			Meals to employees, guests and others who are not residents	$	316	316		
Page 19 - Laundry Expenditures								
25.			Laundry services to employees, guests and others who are not residents	$				
Page 20 - Housekeeping Expenditures								
26.			Housekeeping services to employees, guests and others who are not residents	$				
			Subtotal (Items 1 - 26)	$	799,472	799,472		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12m	Marketing Salaries & Benefits	$ 5,388		
Total Other Salaries Adjustment			$ 5,388	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Charges	$ 15,316		
16	M13	Penalties: DPH: Citaton 2020-34 & CMS: CMP F0880	$ 6,320		
Total Other A&G Adjustments			$ 21,636	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 9/2018

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

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	2004C	9/30/2021	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	799,472	799,472		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $	433,920	433,920		
28.			Ambulance/Limousine $	17,837	17,837		
29.			X-rays, etc $	16,125	16,125		
30.			Laboratory $	49,403	49,403		
31.			Medical Supplies $	17,911	17,911		
32.			Oxygen (non emergency) $	25,016	25,016		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	10,505	10,505		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $	6,298	6,298		
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $	927	927		
44.			Other - Miscellaneous Administrative $	12,164	12,164		
45.			Management Fees Direct $	54,003	54,003		
46.			Management Fees Indirect $	48,003	48,003		
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49.			***Total Amount of Decrease (Items 1 - 48)*** $	1,491,584	1,491,584		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental	$ 8,404		
20	5b	EBOX	$ 1,703		
30	IV8	Nursing Supply Rebate	$ 398		
Total Other Ancillary Costs			$ 10,505	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Movable Equipment (See Attached)	$ 6,298		
Total Excess Movable Equipment Depreciation			$ 6,298	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Radio and Televsion	$ 12,164		
Total Other Adjustments			$ 12,164	$ -	$ -

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Cente	2004C	9/30/2021	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	21,096,171	21,096,171		
b. Medicaid Room and Board Contractual Allowance **	$	(12,521,004)	(12,521,004)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,402,463	2,402,463		
b. Medicare Room and Board Contractual Allowance **	$	47,789	47,789		
4. a. Private-Pay Residents and Other	$	3,272,219	3,272,219		
b. Private-Pay Room and Board Contractual Allowance **	$	(683,389)	(683,389)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	163,724	163,724		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(163,724)	(163,724)		
c. Prescription Drugs - Non-Medicare	$	264,742	264,742		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(264,742)	(264,742)		
2. a. Medical Supplies - Medicare	$	3,311	3,311		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	25,004	25,004		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(25,004)	(25,004)		
3. a. Physical Therapy - Medicare	$	648,673	648,673		
b. Physical Therapy - Medicare Contractual Allowance **	$	(479,735)	(479,735)		
c. Physical Therapy - Non-Medicare	$	385,157	385,157		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(385,157)	(385,157)		
4. a. Speech Therapy - Medicare	$	165,050	165,050		
b. Speech Therapy - Medicare Contractual Allowance **	$	(119,452)	(119,452)		
c. Speech Therapy - Non-Medicare	$	76,805	76,805		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(76,805)	(76,805)		
5. a. Occupational Therapy - Medicare	$	726,240	726,240		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(528,119)	(528,119)		
c. Occupational Therapy - Non-Medicare	$	382,870	382,870		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(382,570)	(382,570)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	161,653	161,653		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	14,192,170	14,192,170		
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)*	$	927	927		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	139,476	139,476		
V. Total Other Revenue (1 thru 8)	$	140,403	140,403		
VI. Total All Revenue (III +V)	$	14,332,573	14,332,573		

* *Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.*

** *Facility should report all contractual allowances and/or payer discounts.*

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Misc Revenue from CRF Funds	$ 161,653		
Total Other Resident Revenue		$ 161,653	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
pg 31, L A2	Interest on A/R	927	$ 927		
Total Interest Income			$ 927	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
p30,8	Nursing Supply Rebate	$ 398		
p30,8	Bad Debt Recoveries	$ 139,078		
Total Other Revenue		$ 139,476	$ -	$ -

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

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 53,589
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,686,097
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (24,500)
4 Inventories				$ 28,268
5. Prepaid Expenses				$ 225,787
a. Prepaid Insurance		162,057		
b. Prepaid Expenses		6,568		
c. Prepaid Insurance		29,956		
d. See Schedule		27,206		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$ (73,939)
8. Other Current Assets (*itemize*)				$ 59,051
A/R Related Facilities		59,051		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,954,353
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	151,417		$ 1,979
	Accum. Depreciation	149,438	Net	
3. Buildings	*Historical Cost	2,318,266		$ 327,851
	Accum. Depreciation	1,990,415	Net	
4. Leasehold Improvements	*Historical Cost	1,375,898		$ 1,047,812
	Accum. Depreciation	328,086	Net	
5. Non-Movable Equipment	*Historical Cost	559,160		$ 46,906
	Accum. Depreciation	512,254	Net	
6. Movable Equipment	*Historical Cost	1,758,207		$ 268,669
	Accum. Depreciation	1,489,538	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (11,397)
Moveable Equipment Carryforward		3,574		
See Schedule		(14,971)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,681,820

* 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	
		Deposit Taxes	$ 27,206
Total Prepaid Expenses			$ 27,206

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 Difference Fixed Assets to Books	$ (14,971)
Total Other Other Fixed Assets (Itemize)			$ (14,971)

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)			$ -

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	32	37

Account				Amount
			Total Brought Forward:	$ 3,636,173
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	6,750,285	Net	$ 14,319
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)				$ 14,319
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$ 382,200
		382,200		
6. Loans to Owners or Related Parties (*itemize*)				$ (10,242,810)
Name and Address	Amount	Loan Date		
Due to Related Parties	(10,242,810)			
7. Other Assets (*itemize*)				$ (558,626)
Goodwill		(563,714)		
IRS Deposits/ Finance Fees		5,088		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (10,419,236)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ (6,768,744)

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

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
1.	Trade Accounts Payable				$ 2,582,888
2.	Notes Payable (*itemize*)				$ 3,450,827
	Related Party		(912,786)		
	Line of Credit		4,363,613		
	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*)				$ 287,356
5.	Accrued Payroll (*Owners and/or Stockholders only*)				$
6.	Accrued Payroll Taxes Payable				$ 384,600
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*)				$ 1,526,319
	Provider Tax Due	1,317,260			
	Acc'd Health Ins	33,564			
	Acc'd Operating Expenses	174,926			
	Acc'd Expense - CT Sales Tax	569	See Schedule		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 8,231,990

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

(Carry Total forward to next page)

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	34	37

Account	Amount
Total Brought Forward:	8,231,990
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ (167,994)
Due From Related Landlord	(2,287,886)	
Due to Related Landlord	2,119,892	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ (167,994)
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 8,063,996

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	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)*	$ 14,319
	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	$ 14,319
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (13,366,717)
	6. Gain or Loss for Period 10/1/2020 thru 9/30/2021	$ (1,481,342)
	7. Total Net Worth	$ (14,847,059)
C.	***Total Reserves and Net Worth***	$ (14,832,740)
D.	***Total Liabilities, Reserves, and Net Worth***	$ (6,768,744)

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

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2020			$ (14,050,461)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 14,332,573
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 15,813,915
D.	Net Income or Deficit			$ (1,481,342)
E.	Balance			$ (15,531,803)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2020 Deferred HHS Funds		924,946	
	2020 AJE health insurance		(241,112)	
	Prior Year Expense Posting Error		25,411	
	Rent Expense ADJ		(24,500)	
	2. Other (*itemize*)			
	Rounding		(1)	
F-3.	Total Additions			$ 684,744
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***	09/30/21		$ (14,847,059)

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

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2021	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. 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	(860) 751-3900

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

Contact Email Address
pmyslinski@athenahealthcare.com