State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2024

Name of Facility (as licensed) Shady Knoll Health Care Center	
Address (No. & Street, City, State, Zip Code) 44 Skokorat Street Seymour, CT 06483	
Type of Facility ☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined ☐ (Specify) ☐ (Specify)	
Report for Year Beginning 10/1/2023	Report for Year Ending 9/30/2024

License Numbers:	CCNH / RHNS 2107C	(Specify)	(Specify)	Medicare Provider 07-5386

Medicaid Provider Numbers:	CCNH / RHNS 2107C	(Specify)	(Specify)

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
Shady Knoll Health Care Center	2107C	9/30/2024	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 Shady Knoll Health Care Center [facility name], for the cost report period beginning October 1, 2023 and ending September 30, 2024, 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) Elza Augustin			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. 3/2023

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 Shady Knoll Health Care Center	Period Covered:		From 10/1/2023	To 9/30/2024
Address of Facility 44 Skokorat Street Seymour, CT 06483				
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 3/2023

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-881-2555	9/30/2024	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Shady Knoll Health Care Center	44 Skokorat Street Seymour, CT 06483

License Numbers:	CCNH / RHNS	(Specify)	(Specify)	Medicare Provider No.
	2107C			07-5386

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.

No change of ownership during the 2024 cost report year, there was a sale/ change of ownership on 10/10/2024

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Elza Augustin	2074

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

Name	License No.:
Not Applicable	

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
Shady Knoll Health Care Center	2107C	9/30/2024	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Shady Knoll Health Care Center	41 Skokorat St., Seymour, CT 06483	CT

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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
Shady Knoll Health Care Center	2107C	9/30/2024	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
Shady Knoll Health Care Center	41 Skokorat St., Seymour, CT 06483	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G. Santilli	41 Skokorat St, Seymour, CT 06483	President	7602.02
Michael E. Mosier	41 Skokorat St, Seymour, CT 06483	reasurer/Secreta	
Names of Stockholders Owning at Least 10% of Shares			
Custodians for Lawrence E. Santilli	41 Skokorat St, Seymour, CT 06483		2397.98

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
Shady Knoll Health Care Center	2107C	9/30/2024	3B	37

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

Owner(s) of Facility
N/A

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
Shady Knoll Health Care Center	2107C	9/30/2024	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	%**				
Laurel Ridge Health Care Center	642 Danbury Road Ridgefield, CT 06877	⊙	○	>50%	Bank Fees	Pg 16 ln m13	1,407	1,407
Athena 401 (K) Plan	135 South Road, Farmington, CT 06032	⊙	○	>50%	Facility Participates in a Multi Facility 401(k			
Athena Captive	135 South Rd, Farmington, CT 06032	⊙	○		Workers Comp Captive	Pg 15 1a1	351,460	351,460
Shady Knoll Landlord	135 South Road, Farmington, CT 06032	○	⊙	>95%	Lease of Facility	Pg 22, ln 9, 10b; Pg 27	777,629	777,629
Misc. Facilities	Various	⊙	○	>50%	Interfacility Loans	Pg 33, Ln A2		
Athena Health Insurance	135 South Road, Farmington, CT 06032	○	⊙		Self Insured Employee Health & Dental Insu	Pg 15, Ln 1a5	926,004	926,004
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	⊙	○	<5%	Pharmacy	Pg 20 Ln 5a2	245,301	245,301
Athena Health Care	135 South Road, Farmington, CT 06032	○	⊙	>50%	See Attachment			
		○	⊙					

* 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
Shady Knoll Health Care Center	2107C	9/30/2024	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 3/2023

General Information and Questionnaire
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2024	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:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 3/2023

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health C	2107C	9/30/2024	7	37

Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

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

Adult Day Care

Does the Facility provide Adult Day Care?	No

If yes, please complete the following:

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 3/2023

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2024	8	37

	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	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	128	128			128	128						
B. On last day of THIS report period	128	128							128	128		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	120	120			120	120						
B. As of midnight of THIS report period	105	105							105	105		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,273	4,273			3,201	3,201			1,072	1,072		
B. Medicaid (Conn.)	34,496	34,496			26,149	26,149			8,347	8,347		
C. Medicaid (other states)												
D. Private Pay	1,951	1,951			1,707	1,707			244	244		
E. State SSI for RCH												
F. Other (Specify) Contract Other/VA	284	284			254	254			30	30		
G. Total Care Days During Period (3A thru F)	41,004	41,004			31,311	31,311			9,693	9,693		
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												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	41,004	41,004			31,311	31,311			9,693	9,693		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-9 Rev. 3/2023

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2024	9	37

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	13	88		3		1		
Per Diem Rate								
a. One bed rm.	546.14	######		709.00		403.77		
b. Two bed rms.	546.14	######		691.00		403.77		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	2,886	2,886			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	2,233	2,233			
2. Restorative Treatments					
C. Other	11,371	11,371			
D. ***Total Physical Therapy Treatments***	16,490	16,490			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	404	404			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	422	422			
2. Restorative Treatments					
C. Other	1,534	1,534			
D. ***Total Speech Therapy Treatments***	2,360	2,360			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	2,006	2,006			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	1,904	1,904			
2. Restorative Treatments					
C. Other	10,884	10,884			
D. ***Total Occupational Therapy Treatments***	14,794	14,794			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2024	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)	161,894		2,169						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	283,209		10,867						
5. Dietary Service									
a. Head Dietitian	28,916		760						
b. Food Service Supervisor	68,792		2,177						
c. Dietary Workers	523,352		29,353						
6. Housekeeping Service									
a. Head Housekeeper	62,195		2,106						
b. Other Housekeeping Workers	297,261		16,325						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	68,955		2,208						
b. Other Maintenance Workers	52,426		2,119						
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers	180,434		8,489						
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	96,728		1,301						
b. RN									
1. Direct Care	643,755		12,250						
2. Administrative**	469,406		12,531						
c. LPN									
1. Direct Care	1,670,348		41,798						
2. Administrative**									
d. Aides and Attendants	2,370,830		94,375						
e. Physical Therapists	483,569		11,650						
f. Speech Therapists	102,012		1,986						
g. Occupational Therapists	226,627	(226,627)	5,740						
h. Recreation Workers	172,934		7,119						
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	181,304		5,338						
n. Marketing									
o. Other (Specify) See Attached Schedule									
A-13. Total Salary Expenditures	8,144,947	(226,627)	270,661						

* 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	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-

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
Shady Knoll Health Care Center	2107C	9/30/2024	11	37

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

* 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
Shady Knoll Health Care Center	2107C	9/30/2024	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* **										
Elza Augustine (10/1/23-10/7/23)	161,894			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home	2,169	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. 3/2023

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2024	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	4,480		15						
3. Pharmacist	25,374		634						
4. Podiatrist	3,937								
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	60,000		119						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**	11,846	(11,846)							
d. Administrative Services facility									
1. Infection Control Committee (Quarterly meetings)									
2. Pharmaceutical Committee (Quarterly meetings)									
3. Staff Development Committee (Once annually)									
e. Other (Specify)									
9. Speech Therapist									
a. Resident Care	1,530		4						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	17,150		183						
2. Administrative***									
b. LPN									
1. Direct Care									
2. Administrative***									
c. Aides									
d. Other									
12. Other (Specify) See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	124,317	(11,846)	955						

* 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.

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
Shady Knoll Health Care Center	2107C	9/30/2024	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Garumuni Desilva, MD, West Haven Medical Group, 387 Campell Ave, Suite 2, West Haven,	Medical Director	○	⊙	
Dr. Hafsa Nawaz, West Haven Medical Group, 387 Campell Ave, Suite 2, West Haven, CT 06516	Asst. Medical Director	○	⊙	
CT Dental, 240 Pomeroy Ave, Suite 2015, Meriden, CT 06450	Dentist	○	⊙	
HealthDrive Podiatry Group, 100 Crossing Boulevard Suite 300, Framingham, MA 01702	Podiatry Services	○	⊙	
Valley Orthodaedic Specialists, LLC 2 Trap Falls Suite 404, Sheton CT 06484	Physician Services	○	⊙	
Procare LTC, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist	⊙	○	Common Owners, Minority Interest
The Nurse Network, 400 Park Ave, New York, NY 10022	Nurse Pool	○	⊙	
Star Medical Care LLC, 2560 Dixwell Ave #1A Hamden, CT 06514	Physician Services	○	⊙	
		○	⊙	
SDX Dysphagia Experts, 21 Waterville Rd, Avon CT 06001	Speech Services	○	⊙	
Wound Surgeon Specialists, 4 Research Parkway, Wallingford CT, 06492	Physcician Services	○	⊙	
Jackson Therapy Partners, PO Box 277637 Atlanta GA, 30384	Physcician Services	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 3/2023

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2024	15	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	351,460	351,460					
2. Disability Insurance	$							
3. Unemployment Insurance	$	50,178	50,178					
4. Social Security (F.I.C.A.)	$	595,850	595,850					
5. Health Insurance	$	964,585	964,585					
6. Life Insurance (employees only) (not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	159,140	159,140					
8. Uniform Allowance	$							
9. Other (*Specify*) See Attached Schedule	$							
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$		329,139	(329,139)				
d. Accounting and Auditing	$	11,285	11,285					
e. Legal (*Services should be fully described on Page 15b)*	$		92,402	(92,402)				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	37,757	37,757					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	61,753	61,753					
2. Cellular Phones	$	6,585	6,585					
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	$	772,086	772,086					
Subtotal	$	3,010,679	3,432,220	(421,541)				

* 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	$ -	$ -	$ -	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15b Rev. 3/2023

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2024	15b	37

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Marcum LLP	555 Long Wharf Dr, 12th Floor, New Haven, CT 06511
2 PFK O'Connor Davies	4 Corporate Drive, Suite 488, Shelton, CT 06484
3	
4	

Services Provided by This Firm (*describe fully*)

1	Medicare Cost Report Preperations	$ 2,885
2	Audited Financials + Income Tax Returns	$ 8,400
3		$
4		$
		Charge for Services Provided $ 11,285

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 Midcap Financial Services	301-760-7600
2 State of Connecticut Treasurer	860-702-3000
3 Goldman Gruder & Woods	203-899-8900
4 Pilicy & Ryan, P.C.	860-274-0018
5 Derby/ Shelton/ Waterbury Probate Court	

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

1 7255 Woodmont Ave, Bethesda, MD 20814
2 55 Elm st, Hartford CT 06106
3 200 Connecticut Ave, Norwalk, CT 06854
4 235 Main St., PO Box 760, Watertown, CT 06795
5

Services Provided by This Firm (*describe fully*)

1	Line of Credit: Disallow	$ 3,533
2	Conservator: Disallow	$ 260
3	Collections: Disallow	$ 86,776
4	Conservator: Disallow	$ 500
5	Conservator: Disallow	$ 1,333
		Charge for Services Provided $ 92,402

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-16 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2024	16	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:		3,010,679	3,432,220	(421,541)				
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$	2,840	2,840					
3. Gifts to Staff and Residents	$		14,280	(14,280)				
4. Employee Travel	$	2	2					
5. Education Expenses Related to Seminars and Conventions	$	510	510					
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*)	$							
2. Advertising Telephone Directory (*all such expenses*)***	$							
3. Advertising Other (*Specify*)***	$		3,261	(3,261)				
See Attached Schedule								
4. Fund-Raising***	$							
5. Medical Records	$	(20)	(20)					
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$							
7. Postage	$	5,806	5,806					
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	1,839	1,839					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$							
10. Contributions*** See Attached Schedule	$							
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$							
12. Administrative Management Services**	$	442,226	442,226					
13. Other (*Specify*) See Attached Schedule	$	80,699	113,472	(32,773)				
C-14 Total Administrative & General Expenditures	$	3,544,581	4,016,436	(471,855)				

* 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	$ 3,261	$ (3,261)				
Total Other Advertising	$ 3,261	$ (3,261)	$ -	$ -	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF	$ 1,839					
Total Dues	$ 1,839	$ -	$ -	$ -	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Bank charges	$ 27,179	$ (27,179)				
Payroll processing fees	$ 23,494					
Employee physicals/ background checks	$ 6,465					
Facility license	$ 1,333					
Administrator recruitment	$ 5,594	$ (5,594)				
Data processing fees	$ 49,407					
Total Other Administrative and General	$ 113,472	$ (32,773)	$ -	$ -	$ -	$ -

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

Schedule C-1 - Management Services*

Name of Facility Shady Knoll Health Care Center	License No. 2107C	Report for Year Ended 9/30/2024	Page 17 | 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc. 135 South Road, Farmington, CT 06032	670,039	Contract Attached to a prior year	see below
Allocation of the above	442,226	Admin/ Gen 66%	Pg 16, line 12
	107,206	Indirect 16%	Pg 18, Line 2C
	120,607	Direct 18%	Pg 20, Line 5J
Athena Health Care Assoc., Inc. 135 South Road, Farmington, CT 06032		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. 3/2023

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
Shady Knoll Health Care Center	2107C	9/30/2024	18	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	520,057	520,057					
2. Non-Food Supplies	$	42,760	42,760					
3. Other (*Specify*)_____ Dishes	$	321	321					
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)	$	563,138	563,138					

		Total	CCNH / RHNS	(Specify)	(Specify)
2E.	Dietary Questionnaire				
F.	Resident Meals: Total no. of meals served per day:*	336	336		

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.
K.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
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. 3/2023

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
Shady Knoll Health Care Center	2107C	9/30/2024	19	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
3. Laundry								
a. In-House Processing*	Lbs.							
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $							
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.							
	Amt. $							
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.							
	Amt. $							
4. Repair and/or purchase of linens.***	Lbs.							
	Amt. $	15,215	15,215					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*) Supplies	$	10,066	10,066					
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	25,281	25,281					

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. 3/2023

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
Shady Knoll Health Care Center	2107C	9/30/2024	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.	$	75,341	75,341					
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*) Temp Help $1,981		$	1,981	1,981					
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	77,322	77,322					
5. Resident Care (Supplies)**									
a. Prescription Drugs***									
1. Own Pharmacy		$							
2. Purchased from		$		207,367	(207,367)				
b. Medicine Cabinet Drugs		$	7,678	28,707	(21,029)				
c. Medical and Therapeutic Supplies		$	343,516	364,736	(21,220)				
d. Ambulance/Limousine***		$		19,595	(19,595)				
e. Oxygen									
1. For Emergency Use		$							
2. Other***		$		20,611	(20,611)				
f. X-rays and Related Radiological Procedures***		$		27,361	(27,361)				
g. Dental (*Not dentists who should be included under salaries or fees)*		$							
h. Laboratory***		$		45,199	(45,199)				
i. Recreation		$	16,684	16,684					
j. Direct Management Services*		$	120,607	120,607					
k. Indirect Management Services*		$	107,206	107,206					
l. Cable TV		$	7,200	19,315	(12,115)				
m. Other (Specify)**** See Attached Schedule		$	51,224	63,918	(12,694)				
n. Physical Therapy Expense		$							
o. Speech Therapy Expense		$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)		$	654,115	1,041,306	(387,191)				

* 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
0	0					
Medical Equipment Rental-Other	12694	$ (12,694)				
Physical Therapy Supplies	8885					
	0					
Oxygen equipment rentals	13901					
Medical Equipment Rental-Medicaid	28438					
	0					
	0					
	0					
	0					
0	0					
0	0					
0	0					
0	0					
0	0					
0	0					
0	0					
0	0					
0	0					
0	0					
	0					
Total Other Resident Care	$ 63,918	$ (12,694)	$ -	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2024	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	(Specify)	Pg	Line
ADP	100 Corporate Drive, Windsor, CT 06095	○	⊙		Payroll Processing	23,494			16	m13
CWPM	PO Box 99, Plainville, CT 06062	○	⊙		Rubbish Removal	36,661			22	6f
Gold Coast Property Maintenance LLC	151 Monroe Turnpike, Monroe, CT 06468	○	⊙		Landscaping/Snow Removal	18,345			22	6f
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	⊙	○	Common Owners; Minority Interest	Pharmacy	245,301			20	5a2
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2024	22	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	130,527	130,527					
b. Heat	$	52,609	52,609					
c. Light & Power	$	169,870	169,870					
d. Water	$	64,544	64,544					
e. Equipment Lease (*Provide detail on page 22b*)	$	15,148	15,148					
f. Other (*itemize*)	$	67,690	67,690					
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	500,388	500,388					
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$	280	280					
b. Building & Building Improvements	$	66,790	66,790					
c. Non-Movable Equipment	$	19,689	19,689					
d. Movable Equipment	$	20,139	23,848	(3,709)				
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	106,898	110,607	(3,709)				
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$	38,825	38,825					
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	38,825	38,825					
9. Rental payments on leased real property less real estate taxes included in item 10b	$	511,219	511,219					
10. Property Taxes								
a. Real estate taxes paid by owner	$							
b. Real estate taxes paid by lessor	$	121,204	121,204					
c. Personal property taxes	$	16,269	16,269					
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	794,415	798,124	(3,709)				

* 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	$ 11,539					
Rubbish Removal	$ 37,846					
Snow Removal	$ 7,545					
Supplies	$ 10,760					
0	$ -					
0	$ -					
0	$ -					
0	$ -					
0	$ -					
0	$ -					
0	$ -					
Total Other Repairs and Maintenance	$ 67,690	$ -	$ -	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22b Rev. 3/2023

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
Shady Knoll Health Care Center	2107C	9/30/2024	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
	○	⊙					
Leaf Capital Funding, 1720A Crete Street, Moherly, MO 65270	○	⊙	Copier	04/25/19	48 Months	12,800	12,608
	○	⊙					
	○	⊙					
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	○	⊙	Postal Equipment	09/21/18	48 Months	2,540	2,540
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ⊙ Yes ○ No **Total ***** 15,148

* 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-23 Rev. 10/2022

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2024	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	70,380		70,380	70,100	SL	Var	280	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								280
B. **Building and Building Improvements**								
1. Acquired prior to this report period	2,747,855		2,747,855	2,418,473	SL	Var	66,790	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								66,790
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	630,911		630,911	418,015	SL	Var	19,689	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								19,689

	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	2023	1,154,950		1,154,950	1,039,822	S/L	Various	23,125	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative												
d. Standard Resident			9	2024	11,912		11,912		S/L	Various	723	
e. Specialized Resident												
Total Acquired during this report period					11,912		11,912				723	
D-3. Subtotal												23,848
E. ***Total Depreciation***												110,607

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:						
12/31/2023	garbage disposal	Standard Resident	$ 2,548	5	$ 255	
9/30/2024	cubicle curtains	Standard Resident	$ 9,364	10	$ 468	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			$ 11,912		$ 723	*
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:					
10/31/2023	bronze glass unit	$ 2,826	5	$ 283	
10/31/2023	cooling tower belts	$ 3,380	5	$ 338	
12/31/2023	fire inspection	$ 4,598	10	$ 230	
12/31/2023	fuel polishing	$ 4,193	10	$ 210	
12/31/2023	fire alarm	$ 3,104	10	$ 155	
12/31/2023	temps	1807	10	90	
6/30/2024	elevator	9678	20	242	
9/30/2024	replacement of concrete sidewalk	11167	10	558	
Total additions for Leasehold Improvement		$ 40,753		$ 2,106	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

***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
Shady Knoll Health Care Center	2107C	9/30/2024	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. Finance Fees-Key Bank	6	2007	7 years	305,597	305,597	SL	0		
2. Finance Fees	2	18	36 Months	52,729	52,729	SL			
3. Finance Fees									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period		2023		1,666,308	522,758	1,666,308	Variou	36,719	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2024	Various	40,753			Variou	2,106	
C-4. Subtotal									38,825
D. ***Total Amortization***									38,825

* 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
Shady Knoll Health Care Center	2107C	9/30/2024	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	1991
2. Date Structure Completed	5/21/1993
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	05/21/93
5. Total Licensed Bed Capacity	128
6. Square Footage	
7. Acquisition Cost	
a. Land	652,528
b. Building	5,696,463

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)	31			
e. Amount of Principal Borrowed	10,237,067			
f. Principal balance outstanding as of _____	5,306,466			
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. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2024	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			(32)				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $			(32)				

(*Carry Subtotals forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2024	27	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:			(32)				
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*) $	31,416	31,416					
Vendor Interest $31,416							
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	31,384	31,416	(32)				
14. Insurance							
a. Insurance on Property (buildings only) $	150,102	150,102					
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)*** $	150,102	150,102					
15. ***Total All Expenditures (A-13 thru C-14)*** $	14,371,517	15,472,777	(1,101,260)				

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev. 3/2023

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Shady Knoll Health Care Center	2107C	9/30/2024	30 | 37

Item		Total	CCNH / RHNS	(Specify)	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	23,136,179	23,136,179		
b. Medicaid Room and Board Contractual Allowance **	$	(12,959,580)	(12,959,580)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,317,930	1,317,930		
b. Medicare Room and Board Contractual Allowance **	$	(23,110)	(23,110)		
4. a. Private-Pay Residents and Other	$	3,112,407	3,112,407		
b. Private-Pay Room and Board Contractual Allowance **	$	(733,162)	(733,162)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	111,883	111,883		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(111,883)	(111,883)		
c. Prescription Drugs - Non-Medicare	$	240,871	240,871		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(240,871)	(240,871)		
2. a. Medical Supplies - Medicare	$	10,480	10,480		
b. Medical Supplies - Medicare Contractual Allowance **	$	(14,899)	(14,899)		
c. Medical Supplies - Non-Medicare	$	630	630		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(630)	(630)		
3. a. Physical Therapy - Medicare	$	545,870	545,870		
b. Physical Therapy - Medicare Contractual Allowance **	$	(376,863)	(376,863)		
c. Physical Therapy - Non-Medicare	$	360,475	360,475		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(360,225)	(360,225)		
4. a. Speech Therapy - Medicare	$	147,110	147,110		
b. Speech Therapy - Medicare Contractual Allowance **	$	(105,807)	(105,807)		
c. Speech Therapy - Non-Medicare	$	115,925	115,925		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(115,925)	(115,925)		
5. a. Occupational Therapy - Medicare	$	468,183	468,183		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(338,405)	(338,405)		
c. Occupational Therapy - Non-Medicare	$	347,850	347,850		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(347,850)	(347,850)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	(576)	(576)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	14,186,007	14,186,007		
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)*	$	32	32		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	203,169	203,169		
V. Total Other Revenue (1 thru 8)	$	203,201	203,201		
VI. Total All Revenue (III +V)	$	14,389,208	14,389,208		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
N/A	Retroactives	$ (576)		
Total Other Resident Revenue		$ (576)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
	Interest on A/R		$ 32		
	0		$ -		
	0		$ -		
	0				
Total Interest Income			$ 32	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	Nursing Supply Rebate	$ -		
	0	$ -		
	0	$ -		
	0	$ -		
	0	$ -		
	Bad Debt Recoveries	$ 203,169		
	0	$ -		
Total Other Revenue		$ 203,169	$ -	$ -

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
Shady Knoll Health Care Center	2107C	9/30/2024	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ (62,265)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,360,194
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (14,321)
4 Inventories				$ 27,585
5. Prepaid Expenses				$ 137,735
a.				
b.				
c.				
d. See Schedule		137,735		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,448,928
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	70,380		$
	Accum. Depreciation	70,380	Net	
3. Buildings	*Historical Cost	2,747,856		$ 262,593
	Accum. Depreciation	2,485,263	Net	
4. Leasehold Improvements	*Historical Cost	1,707,061		$ 1,145,478
	Accum. Depreciation	561,583	Net	
5. Non-Movable Equipment	*Historical Cost	630,911		$ 193,207
	Accum. Depreciation	437,704	Net	
6. Movable Equipment	*Historical Cost	1,166,862		$ 103,192
	Accum. Depreciation	1,063,670	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,704,470

* 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	
		Prepaid Insurance	$ 135,493
		0	$ -
		Operating - See Schedule	$ 2,242
		0	$ -
Total Prepaid Expenses			$ 137,735

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Desposits-Taxes	$ -
		Deposits-Lease	$ -
		Project Development/ Finance Fees	$ 157,990
Total Other Assets			$ 157,990

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	
		N/P L/T Related Party Landlord	$ (13,348,113)
		Note Payable - Procare CT	$ -
Total Other Current Liabilities (Itemize)			$ (13,348,113)

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
Shady Knoll Health Care Center	2107C	9/30/2024	32	37

Account				Amount
			Total Brought Forward:	$ 4,153,398
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$ 649,355
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost	5,602,448		
	Accum. Depreciation	5,602,448	Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$ 649,355
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*)				$
6. Loans to Owners or Related Parties (*itemize*)				$ (18,180,047)
Name and Address	Amount	Loan Date		
Related Party Facilities	(18,180,047)	3/29/12		
7. Other Assets (*itemize*)				$ 157,990
See Schedule		157,990		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (18,022,057)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ (13,219,304)

* 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
Shady Knoll Health Care Center	2107C	9/30/2024	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
1.	Trade Accounts Payable				$ 3,795,238
2.	Notes Payable (*itemize*)				$ (1,179,069)
	Line of Credit		(1,505,236)		
	Due to/ from facilities		326,167		
	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*)				$ 414,062
5.	Accrued Payroll (*Owners and/or Stockholders only*)				$
6.	Accrued Payroll Taxes Payable				$ 275,717
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*				$ (26,508)
12.	Other Current Liabilities (*itemize*)				$ 3,761,115
	Acc'd Operating Expenses	272,769			
	Provider tax due	3,472,042	Depr rounding	2	
	Acc'd Deferred Rent	11,946			
	Acc'd Expense - Personal Property ta	4,356	See Schedule		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 7,040,555

* 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
Shady Knoll Health Care Center	2107C	9/30/2024	34	37

Account				Amount
			Total Brought Forward:	7,040,555
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*)				$ 319,508
Name and Address of Lender	Amount	Loan Date		
Notes Payable Procare Investment	215,898			
Procare Note	103,610			
4. Other Long-Term Liabilities (*itemize*)				$ (13,348,113)
See Schedule	(13,348,113)			
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ (13,028,605)
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ (5,988,050)

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
Shady Knoll Health Care Center	2107C	9/30/2024	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$ 649,355
	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	$ 649,355
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (6,798,040)
	6. Gain or Loss for Period 10/1/2023 thru 9/30/2024	$ (1,083,569)
	7. Total Net Worth	$ (7,880,609)
C.	***Total Reserves and Net Worth***	$ (7,231,254)
D.	***Total Liabilities, Reserves, and Net Worth***	$ (13,219,304)

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
Shady Knoll Health Care Center	2107C	9/30/2024	36 |	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2023			$ (6,780,155)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 14,389,208
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 15,472,777
D.	Net Income or Deficit			$ (1,083,569)
E.	Balance			$ (7,863,724)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	prior year expense accruals		(16,889)	
	rounding		2	
	2. Other (*itemize*)			
F-3.	Total Additions			$ (16,887)
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***	09/30/24		$ (7,880,611)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 3/2023

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2024	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 in the Adjustments columns. 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 RoadFarmington, CT 06032	(860) 751-3900

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Lynn Rinaldi	860-751-3955

Contact Email Address
lrinaldi@athenahealthcare.com