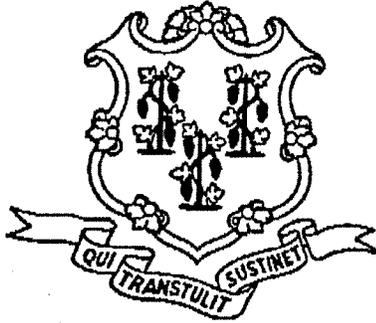


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

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	
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)
<input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH 2004C	RHNS	(Specify)	Medicare Provider No. 07-5350
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Medicaid Provider Numbers:	CCNH 2004C	RHNS	ICF-MR
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For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2017	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 IMPRISONMENT 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 01, 2016 and ending September 30, 2017, 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 penalties 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
		2/9/18			2/9/18
Printed Name (Administrator)			Printed Name (Owner)		
Robert Guastella			Lawrence Santilli		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires	
	CT	2-9-18		6/30/21	
Address of Notary Public			505 Penfield Hill Rd Portland, CT 06480		

(Notary Seal)

State of Connecticut
Department of Social Services
 25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Sheriden Woods Health Care Center	Period Covered:	From 10/1/2016	To 9/30/2017	
Address of Facility 321 Stonecrest Drive, Bristol, CT 06010				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900	Date 2/8/2018		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid..... \$				
2. Laundry wages paid..... \$				
3. Housekeeping wages paid..... \$				
4. Nursing wages paid..... \$				
5. All other wages paid..... \$				
6. Total Wages Paid \$				
7. Total salaries paid..... \$				
8. Total Wages and Salaries Paid (As per page 10 of Report) \$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-583-1827	Report for Year Ended 09/30/17	Page 2	of 37
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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))			
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Type of Ownership (Check appropriate box)			
<input type="checkbox"/> PROPRIETORSHIP <input type="checkbox"/> LLC <input type="checkbox"/> PARTNERSHIP <input checked="" type="checkbox"/> PROFIT CORP. <input type="checkbox"/> NON-PROFIT CORP. <input type="checkbox"/> GOVERNMENT <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," explain fully.			
Administrator			
Name of Administrator Robert Guastella		Nursing Home Administrator's License No.:	936
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name		License No.:	
Not Applicable			

**General Information and Questionnaire
 Corporate Owners**

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2017	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	6216.77
Debra M Soucey	321 Stonecrest Rd, Bristol, CT 06010	Secretary	
Michael E Mosier	321 Stonecrest Rd, Bristol, CT 06010	Treasurer	
Names of Stockholders Owning at Least 10% of Shares			
Other than listed above:			
Conservators for Lawrence E Santilli	321 Stonecrest Rd, Bristol, CT 06010		1968.23

General Information and Questionnaire
Related Parties*

Name of Facility		License No.	Report for Year Ended		Page	of		
Sheriden Woods Health Care Center		2004C	9/30/2017		4	37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?					<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?					<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	>98%	Interfacility Loans	pg 33 A2		
Athena Health 401K plan	135 South Road, Farmington, CT	<input checked="" type="checkbox"/>	<input type="checkbox"/>		Facility participates in a common 401(K) plan			
Athena Health Care	135 South Road, Farmington, CT	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<50%	See Attached	pg 16 m12		
Athena Health Care Insurance	135 South Road, Farmington, CT	<input checked="" type="checkbox"/>	<input type="checkbox"/>		Self Insured Employee Health and Dental Insurance	pg 15 1a5	\$1,236,307	\$1,236,307
Sheriden Woods Landlord	321 Stonecrest Drive, Bristol, CT 06010	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Lease of Property	pg 22 9. 10b, pg 27 14	\$717,679	\$717,679
Procure LTC Pharmacy of CT LLC	1492 Highland Ave, Cheshire, CT 06410	<input checked="" type="checkbox"/>	<input type="checkbox"/>		Pharmacy	pg 20 5a2	\$391,608	\$391,608
Laurel Ridge Healthcare Center	642 Danbury Rd, Ridgefield, CT 06877	<input checked="" type="checkbox"/>	<input type="checkbox"/>	>98%	Bank Service Charges	pg 16, m13	\$7,178	\$7,178
		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					

* Use additional sheets if necessary.

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

Sheriden Woods Healthcare Center
 RELATED PARTIES
 PAGE 4

FACILITY NAME	ADDRESS	Also Provided Goods/Services In-Related Party			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No	%**				
Athena Health Care Systems	135 South Road Farmington, CT 06032	X		>50%	Management, Legal, Marketing, Bank Fees, A/R, MIS, mortgage fees, Insurance, Lobbying, Health Insurance Payroll processing fees Computer conversion, data processing employee relations maintenance & repairs Nursing consulting	Pg 15, 1e & 1g, 1a5 Pg 16, m3, m13, Pg 17 Pg 27, 12D & 14a, Pg 16, L2 Pg 16, m13 pg 23 D2c, pg 16 m13 pg 16 L3 pg 22, 6a pg 13, B5 & B11	\$776,438	\$366,021

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	9/30/2017	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 (<i>See listing page 13</i>)
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

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		9/30/2017			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Postal Machines	Automatic Renewal	39 months	\$1,219	\$1,219	
Leaf	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Copier	Automatic Renewal	48 months	\$11,894	\$11,894	
Hewlett-Packard	<input type="checkbox"/>	<input checked="" type="checkbox"/>	PCC Equipment	08/27/13	60 months	\$7,534	\$7,534	
	<input type="checkbox"/>	<input type="checkbox"/>						
	<input type="checkbox"/>	<input type="checkbox"/>						
	<input type="checkbox"/>	<input type="checkbox"/>						
	<input type="checkbox"/>	<input type="checkbox"/>						
	<input type="checkbox"/>	<input type="checkbox"/>						
	<input type="checkbox"/>	<input type="checkbox"/>						
	<input type="checkbox"/>	<input type="checkbox"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ? <u>Not Applicable - No Vehicles</u> <input type="checkbox"/> Yes <input type="checkbox"/> No Total ***							\$20,647	

* 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.

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2017	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 Dworkin, Hillman, Lamorte & Sterczala	Four Corporate Dr, Shelton, CT
2 Marcum LLP	555 Long Wharf Drive, New Haven, CT
3	
4	

Services Provided by This Firm (describe fully)		
1	2016 Year-end Audit and tax return preparation	\$ 9,500
2	Medicare cost report preparation	\$ 2,675
3		\$ -
4		\$ -
		Charge for Services Provided
		\$12,175

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 Murtha Cullina/Schiff Hardin	860-240-6000
3 Shipman & Goodwin/Halloran & Sage	860-561-3100
4 probate court	860-584-6230
5 Megann, Barlett, & Brown	860-282-4670

Address (No. & Street, City, State, Zip Code)	
1	200 Connecticut Ave, Norwalk, CT
2	185 Asylum Street, Hartford, CT
3	12 N.Main St., West Hartford, Ct 06107
4	111 North Main Street, Bristol
5	111 Founders Plaza, E. Hartford, CT

Services Provided by This Firm (describe fully)		
1	Collections:Disallowed	\$ 3,545
2	Annual Reports\$350 allowed,Misc \$3,187 disallowed	\$ 3,537
3	Employee Claims : disallowed	\$ 8,979
4	Probate Matters:Disallowed	\$ 264
5	Employee Claims : disallowed	\$ 753
		Charge for Services Provided
		\$17,078

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

Yes No **Pg 15, Line1e**

Schedule of Resident Statistics

Name of Facility		License No.			Report for Year Ended				Page	of			
Sheriden Woods Health Care Center		2004C			09/30/17				8	37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period.....	146	146			146	146			146	146			
B. On last day of THIS report period.....	146	146			146	146			146	146			
2. Number of Residents													
A. As of midnight of PREVIOUS report period.....	136	136			130	130			136	136			
B. As of midnight of THIS report period.....	144	144			132	132			144	144			
3. Total Number of Days Care Provided During Period													
A. Medicare.....	5,750	5,750			4,519	4,519			1,231	1,231			
B. Medicaid (Conn.).....	37,517	37,517			27,690	27,690			9,827	9,827			
C. Medicaid (other states).....													
D. Private Pay.....	4,690	4,690			3,300	3,300			1,390	1,390			
E. State SSI for RCH.....													
F. Other (Specify) Managed Care	760	760			626	626			134	134			
G. Total Care Days During Period (3A thru F).....	48,717	48,717			36,135	36,135			12,582	12,582			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days.....	38	38							38	38			
B. Other Bed Reserve Days.....	21	21			6	6			15	15			
5. <i>Total Resident Days (3G + 4A + 4B).....</i>	48,776	48,776			36,141	36,141			12,635	12,635			

Schedule of Resident Statistics (Cont'd)

Name of Facility Sheriden Woods Health Care Center	License No. 2004C	Report for Year Ended 9/30/2017	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? YES NO
 If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH	RHNS	(Specify)	
				(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)
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	6	117		15			6	
Per Diem Rate								
a. One bed rm.	572.20	214.44		521.00			458.62	
b. Two bed rms.	572.20	214.44		507.00			458.62	
c. Three or more bed rms.				502.00			458.62	

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	7,768	7,768		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	2,219	2,219		
2. Restorative Treatments				
C. Other	15,573	15,573		
D. Total Physical Therapy Treatments	25,560	25,560		

8. Total Number of Speech Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	585	585		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	110	110		
2. Restorative Treatments				
C. Other	1,105	1,105		
D. Total Speech Therapy Treatments	1,800	1,800		

9. Total Number of Occupational Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	7,365	7,365		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,738	1,738		
2. Restorative Treatments				
C. Other	14,654	14,654		
D. Total Occupational Therapy Treatments	23,757	23,757		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Sheriden Woods Health Care Center	2004C	9/30/2017	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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)	122,784	1,920				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	242,818	11,076				
5. Dietary Service						
a. Head Dietitian	63,791	1,692				
b. Food Service Supervisor	64,760	2,172				
c. Dietary Workers	420,266	30,361				
6. Housekeeping Service						
a. Head Housekeeper	69,775	2,269				
b. Other Housekeeping Workers	239,089	17,408				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	68,424	2,121				
b. Other Maintenance Workers	61,022	3,227				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	107,761	9,382				
9. Barber and Beautician Services						
10. Protective Services	271					
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	173,840	3,440				
b. RN						
1. Direct Care	541,675	13,736				
2. Administrative**	465,587	16,623				
c. LPN						
1. Direct Care	1,252,269	51,679				
2. Administrative**						
d. Aides and Attendants	1,904,271	128,744				
e. Physical Therapists	455,590	14,048				
f. Speech Therapists	93,933	1,948				
g. Occupational Therapists	387,088	9,939				
h. Recreation Workers	202,864	9,980				
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	201,184	8,076				
n. Marketing						
o. Other (Specify)						
<i>A-13. Total Salary Expenditures</i>	7,139,062	339,841				

* 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 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	9/30/2017			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.

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	9/30/2017			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***										
Donna C. Orefice (7/27/2016-4/7/2017)	64,428			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	1,053	A2			
Robert S. Guastella (5/1/2017-9/30/2017)	58,356			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	867	A2			
Tom Walkuski (4/8/2017-5/1/2017)	11,077			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	128	A2	Wadsworth Glen 30 Boston Rd, Middletown, CT 06457	832	72,001
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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Sheriden Woods Health Care Center	2004C	9/30/2017	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.....	8,589	105				
3. Pharmacist.....	18,687	245				
4. Podiatrist.....						
5. Physical Therapy						
a. Resident Care.....	16,399	139				
b. Other.....						
6. Social Worker.....						
7. Recreation Worker.....						
8. Physicians						
a. Medical Director (entire facility).....	36,729	169				
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) See Attached Schedule	989	8				
9. Speech Therapist						
a. Resident Care.....	360	1				
b. Other.....						
10. Occupational Therapist						
a. Resident Care.....						
b. Other.....						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	39,046	564				
2. Administrative***	8,897	144				
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	129,696	1,375				

* 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.

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	9/30/2017		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Gerident Solutions LLC P.O.Box 290539, Wethersfield, CT	Dentist	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Dr. C. Licata, ProHealth Physicians, 625 Clark Ave., Bristol, CT 06010	Medical Director and Medical Staff	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Procure LTC Pharmacy of CT LLC, 1492 Highland Ave, Cheshire, CT 06410	Pharmacist	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Owners; Minority Interest		
Athena Health Care Systems 135 South Road, Farmington, CT 06032	MDS Fill In, Nursing	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Owners		
Access Therapies, 5980 W 71st St, Suite 102, Indianapolis, IN 46278	Physical Therapy	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Dr. A. Scappaticci, ProHealth Physicians, 625 Clark Ave. Bristol, CT 06010	Medical Staff and Asst. Medical Director	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
Swallowing Diagnostics, 21 Waterville RD, Avon, CT	Speech Therapy Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
Fusion Medical Staffing, 11808 Grant St #100, Omaha, NE 68164	Physical Therapy	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
The Nurse Network, 653 Main St, Plantsville, CT 06479	Nurse Pool	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
Health Drive Podiatry Group, 85 Barnes Rd Suite 207, Wallingford, CT 06492	Podiatrist	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Vista Behavioral Health, 152 Simsbury Rd, Avon, CT 06001	Medical Staff	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			

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

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	9/30/2017		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation.....	\$ 570,205	570,205			
2. Disability Insurance.....	\$				
3. Unemployment Insurance.....	\$ 115,836	115,836			
4. Social Security (F.I.C.A.).....	\$ 530,816	530,816			
5. Health Insurance.....	\$ 1,109,147	1,109,147			
6. Life Insurance (employees only) (not-owners and not-operators).....	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators).....	\$ 23,992	23,992			
8. Uniform Allowance.....	\$				
9. Other (<i>Specify</i>)..... See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*.....	\$ 34,206	34,206			
d. Accounting and Auditing.....	\$ 12,175	12,175			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 17,078	17,078			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*.....	\$				
g. Office Supplies.....	\$ 55,364	55,364			
h. Telephone and Cellular Phones.....					
1. Telephone & Pagers.....	\$ 43,964	43,964			
2. Cellular Phones.....	\$ 2,231	2,231			
i. Appraisal (<i>Specify purpose and attach copy</i>)*.....	\$				
j. Corporation Business Taxes (<i>franchise tax</i>).	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*.....	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 906,212	906,212			
Subtotal	\$ 3,421,226	3,421,226			

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

(Carry Subtotals forward to next page)

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	9/30/2017		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	3,421,226	3,421,226			
l. Travel and Entertainment					
1. Resident Travel and Entertainment.....	\$				
2. Holiday Parties for Staff.....	\$ 3,137	3,137			
3. Gifts to Staff and Residents.....	\$ 27,924	27,924			
4. Employee Travel.....	\$ 1,829	1,829			
5. Education Expenses Related to Seminars and Conventions	\$ 6,617	6,617			
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).....	\$ 3,480	3,480			
2. Advertising Telephone Directory (all such expenses)***	\$ 770	770			
3. Advertising Other (Specify)***..... See Attached Schedule	\$ 26,172	26,172			
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.....	\$ 6,615	6,615			
* 8. Dues and Membership Fees to Professional Associations (Specify) See Attached Schedule	\$ 9,168	9,168			
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**.....	\$ 438,004	438,004			
13. Other (Specify) See Attached Schedule	\$ 108,927	108,927			
C-14 Total Administrative & General Expenditures	\$ 4,053,869	4,053,869			

* 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	\$ 26,172		
Total Other Advertising	\$ 26,172	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 9,168		
Total Dues	\$ 9,168	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Licenses	\$ 1,720		
Bank Charges	\$ 13,907		
Payroll Processing Fees	\$ 27,014		
Background Checks/Physicals	\$ 38,046		
Data Processing	\$ 26,070		
CMS penalty #2016-01-LTC-191	\$ 1,950		
Energy Audit	\$ 220		
Total Other Administrative and General	\$ 108,927	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Sheriden Woods Health Care Center	2004C	9/30/2017	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	\$604,944	Contract Attached to a Prior Year	See Below
Allocation of the above	\$399,263 \$96,791 \$108,890	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 18, Line 2C Pg 20, Line 5J
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	\$38,741	Admin/General	Pg 16, Line 12

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

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	9/30/2017		18	37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food.....	\$ 334,194	334,194			
2. Non-Food Supplies.....	\$ 62,823	62,823			
3. Other (Specify) _____	\$ 168	168			
Dishes = \$168					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Management Services**.....	\$ 96,791	96,791			
d. Other (Specify) _____	\$				
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 493,976	493,976			
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)	
G. Resident Meals: Total no. of meals served per day:*	400	400			
H. Is cost of employee meals included in 2E?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No			
I. Did you receive revenue from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No			If yes, specify amount.
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No			If yes, specify cost. = \$146
L. Is any revenue collected from these people?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No			If yes, specify amount.
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No			If yes, specify cost.
O. Is any revenue collected from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No			If yes, specify amount.
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

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

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

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	9/30/2017	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. \$	24,874	24,874	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$			
c. Management Services**	\$			
d. Other (Specify) Supplies = \$9,450	\$	9,450	9,450	
3E. Total Laundry Expenditures (3a + b + c + d)	\$	34,324	34,324	
3F. Laundry Questionnaire				
G. Is cost of employee laundry included in 3E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.	
H. Did you receive revenue from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.	
I. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.	
K. Did you receive revenue from these people?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.	
L. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
 All allocations should add to total recorded in 3E.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 *** Pounds of Laundry only required for multi-level facilities.

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

Name of Facility	License No.	Report for Year Ended		Page	of
Sheriden Woods Health Care Center	2004C	9/30/2017		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	43,516	43,516		
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
	Amt. \$				
c. Management Services*	\$				
d. Other (<i>Specify</i>)	\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)....	\$	43,516	43,516		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy.....	\$				
2. Purchased from Pro Care	\$	307,570	307,570		
b. Medicine Cabinet Drugs.....	\$	36,034	36,034		
c. Medical and Therapeutic Supplies.....	\$	303,380	303,380		
d. Ambulance/Limousine***	\$	814	814		
e. Oxygen					
1. For Emergency Use.....	\$				
2. Other***	\$	45,400	45,400		
f. X-rays and Related Radiological Procedures***	\$	33,176	33,176		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	25,576	25,576		
i. Recreation.....	\$	15,162	15,162		
j. Other (Specify)**** See Attached Schedule	\$	266,028	266,028		
5K. Total Resident Care Expenditures (5a - 5j).....	\$	1,033,140	1,033,140		

* 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)
Management Fee Direct	\$ 108,890		
Oxygen Concentrator Rentals	\$ 27,751		
Medical Equip Rentals-Medicaid	\$ 37,259		
Physical Therapy Supplies	\$ 54,676		
Cable TV Services	\$ 18,557		
Occupational Therapy Supplies	\$ 262		
Medical Equip Rentals-other	\$ 18,633		
Total Other Resident Care	\$ 266,028	\$ -	\$ -

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	9/30/2017			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	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Payroll Processing	27,014			16	m13
Procure LTC Pharmacy of CT LLC	1492 Highland Ave, Cheshire, CT 06410	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common owners/Minority share	Pharmacy	362,454			20	5a2
CWPM, Inc.	25 Norton Place, Plainville, CT	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Rubbish Removal	23,771			22	6f
Landscaping/Winterberry Landscaping & Garden Center	Burlington, CT/2070 West St., Southington, CT	<input type="checkbox"/>	<input checked="" type="checkbox"/>		Landscaping and Snow Removal	27,469			22	6f
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							
		<input type="checkbox"/>	<input type="checkbox"/>							

* 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).

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

Name of Facility	License No.	Report for Year Ended			Page	of
Sheriden Woods Health Care Center	2004C	9/30/2017			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance..... \$	93,561	93,561				
b. Heat..... \$	67,292	67,292				
c. Light & Power..... \$	101,661	101,661				
d. Water..... \$	60,749	60,749				
e. Equipment Lease (<i>Provide detail on page 6</i>)..... \$	20,647	20,647				
f. Other (<i>itemize</i>)..... \$	89,042	89,042				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)..... \$	432,952	432,952				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements..... \$	4,780	4,780				
b. Building & Building Improvements..... \$	87,549	87,549				
c. Non-Movable Equipment..... \$	28,011	28,011				
d. Movable Equipment..... \$	78,392	78,392				
*7e. Total Depreciation Costs (7a + b + c + d)..... \$	198,732	198,732				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense..... \$						
b. Mortgage Expense..... \$						
c. Leasehold Improvements..... \$	28,280	28,280				
d. Other (<i>Specify</i>)..... \$						
*8e. Total Amortization Costs (8a + b + c + d)..... \$	28,280	28,280				
9. Rental payments on leased real property less real estate taxes included in item 10b..... \$	495,092	495,092				
10. Property Taxes						
a. Real estate taxes paid by owner..... \$						
b. Real estate taxes paid by lessor..... \$	133,593	133,593				
c. Personal property taxes..... \$	24,980	24,980				
11. Total Property Expenses (7e + 8e + 9 + 10)..... \$	880,677	880,677				

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	\$ 17,807		
Rubbish Removal	\$ 23,771		
Snow Removal	\$ 9,662		
Supplies	\$ 37,802		
Total Other Repairs and Maintenance	\$ 89,042	\$ -	\$ -

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

SHERIDEN WOODS HEALTH CARE
1942- Leasehold Improvements
9/30/2017

DATE	VENDOR	description	YEARS	AMOUNT
	BEG BALANCE			\$ 485,460.86
10/1/2016	All Trade Industries	Asphalt surfacing front walkway and rear area	8	4,785.75
10/1/2016	Paul Casey & Son Roofing, LLC	Roofing repairs and debris cleanup	10	2,483.27
5/1/2017	HD Supply	Flush/Tilt/DbI Arm w/Security Hardware	10	2,931.27
11/1/2016	E. F. and G Fence Works Inc.	8' Vinyl Fence with swing gates	15	3,802.01
12/1/2016	All Trade Industries	Smoking Shed w/ vinyl siding and cement piers	15	6,327.83
5/1/2017	All Towns Plumbing & Heating	Replaced Gas Valve	15	1,411.03
7/1/17	American Rooter LLC	Excavation/install new sewer line	25	6,751.61
		Total Acquisitions 2017		\$ 28,492.77
		BALANCE, 9/30/2017		<u>\$ 513,953.63</u>

SHERIDEN WOODS HEALTH CARE
1952 - FURNITURE & EQUIPMENT
9/30/2017

DATE	VENDOR	DESCRIPTION	YEARS	AMOUNT
	BEG BALANCE			\$ 1,470,630.43
10/1/2016	TB&A Hospital Television	(5) 32" LG slim edge LED TVs	5	1,825.00
12/1/2016	Hill-Rom	(7) Mattress types and (3) mattress removals-Pymt Plan	5	11,037.29
1/1/2017	TB&A Hospital Television	(3) 32" LG Slim Edge TVs	5	1,080.00
2/1/2017	TB&A Hospital Television	(6) 32" Commercial Grade LG TVs	5	2,160.00
4/1/2017	Joerns Healthcare	(1) Foam 1000lb limit Mattress	5	689.61
5/1/2017	TB&A Hospital Television	(3) 32" Slim Edge LG TVs w/Wall Mounts	5	1,239.00
6/1/2017	HD Supply	(49) RCA 32" Televisions	5	15,959.15
6/1/2017	Proline	Dishwasher repair-new valve & nozzles	5	917.24
6/1/2017	Mckesson Medical	1 case of Mattresses (5 per case)	5	627.36
	Mckesson	(3) Mattresses	5	853.28
8/1/2017	Geriatric Medical	Fall mat safety risk (1 case of 25)	5	597.69
	Geriatric Medical	Fall mat safety risk (2 cases of 25)	5	1,195.37
	Joerns Healthcare	(3) Linak Hand Controllers	5	633.45
9/1/2017	Joerns Healthcare	Actuator Linak Leg & Kit	5	703.38
	Joerns Healthcare	Control Box & PC Board	5	1,089.99
	Mckesson	Chair lift-button back	5	681.71
				41,289.52
10/1/2016	McKesson	Digital scale w/ mounting kit	10	639.17
11/1/2016	Joerns Healthcare	Control Box (3) and Deluxe Bumper (10)	10	1,052.89
1/1/2017	Joerns Healthcare	Steering Device and Control Box (2)	10	1,213.79
1/1/2017	Emerald Resources	Transmitter and System Tester	10	654.83
4/1/2017	Kittredge Foodservice Equipment	Food Slicer Electric/Manual	10	2,743.83
4/1/2017	Joerns Healthcare	Pivot Sleep Surface Bed w/ Bumpers & Controls	10	1,453.56
5/1/2017	Label Tape Systems	Epson Dot Matrix Printer	10	554.61
6/1/2017	HD Supply	Frigidaire Refrigerator	10	641.29
7/1/2017	Joerns Healthcare	(1) 6pt crad lift	10	907.44
	Mckesson	Chair lift-chestnut	10	1,319.81
				11,181.22
11/1/2016	Direct Supply	Heartland Wardrobe - Natural Maple	15	559.40
12/1/2016	Joerns Healthcare	(6) Overbed Tables	15	880.30
1/1/2017	Joerns Healthcare	(6) Overbed Tables	15	880.30
2/1/2017	Mckesson	Chair Lift-Chestnut	15	706.06
5/1/2017	Supreme Industrial Products, Inc.	(6) Deluxe Linen Hampers w/Lids	15	1,461.25
5/1/2017	Joerns Healthcare	(6) Overbed Tables	15	880.30
5/1/2017	Joerns Healthcare	(6) Overbed Tables	15	880.30
6/1/2017	Supreme Industrial Products, Inc.	(3) Deluxe linen hampers	15	730.62
	Mckesson	(1) Chair Lift w/ Hand Control	15	1,309.17
	Mckesson Medical	Chair lift chestnut xxl	15	1,118.34
				9,406.04
Total Acquisitions through 9/30/17				61,876.78
BALANCE, 9/30/2017				\$ 1,532,507.21

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
Sheriden Woods Health Care Center			2004C		9/30/2017			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal.....									
B. Mortgage Expense									
1.									
2.									
3. Finance Fees - Key Bank	6	2007	5 yrs	285,130	285,130	s/l	5 year		
B-4. Subtotal.....									
C. Leasehold Improvements and Other (Specify)									
1. Acquired prior to this report period	9	2016	Various	973,462	136,512		Var	27,190	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2017	Various	28,493		s/l	Var	1,090	
C-4. Subtotal.....									28,280
D. Total Amortization									28,280

* 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.

Amortization Schedule - Detail of Leasehold Improvements & Other

Name of Facility			License No.		Report for Year Ended			Page	of
Sheriden Woods Health Care Center			2004C		9/30/2017			24A	37
C. Leasehold Improvements (Specify)									
1. Acquired prior to this report period	9	2016	Various	485,462	30,712			27,190	
2. Disposals (attach schedule)									
3. Acquired during this report period	9	2017	Various	28,493		s/l	various	1,090	
C-4. Subtotal.....									28,280
C. Other (Specify)									
1. Bed License	9	1997	None	488,000	105,800	S/L	None		
2.									
C-4. Subtotal.....									
Total Acquired prior to this report period	9	2016	Various	973,462	136,512		Var	27,190	
Total Disposals									
Total Acquired during this report period	9	2017	Various	28,493		s/l	Var	1,090	

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

Name of Facility Sheriden Woods Health Care Center	License No. 2004C	Report for Year Ended 9/30/2017	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party*? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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)	22/8			
e. Amount of Principal Borrowed	10,969,330			
f. Principal balance outstanding as of 9/30/2017	3,586,244			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
Sheriden Woods Health Care Center		2004C	9/30/2017			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)

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 Center	2004C	9/30/2017			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).....		\$	6,776	6,776		
A. Item	Rate	Amount				
Generator		-				
Lender						
Webster Capital						
Address of Lender						
P.O Box 330, Hartford, CT 06141						
B. Item	Rate	Amount				
		-				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2).....		\$	6,776	6,776		
12. D. Other Interest Expense (Specify).....		\$	132,247	132,247		
Vender Interest = \$4,955; Line of Credit Interest = \$127,292						
13. Total All Interest Expense (12B7 + 12C3 + 12D).....		\$	139,023	139,023		
14. Insurance						
a. Insurance on Property (buildings only).....		\$	91,163	91,163		
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)...		\$	91,163	91,163		
15. Total All Expenditures (A-13 thru C-14).....		\$	14,471,398	14,471,398		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Sheriden Woods Health Care Center			2004C	9/30/2017	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs.....	\$			
2.			Salaries not related to Resident Care....	\$			
3.	10	A12g	Occupational Therapy.....	\$ 387,088	387,088		
4.	Var	Var	Other - See attached Schedule.....	\$ 2,566	2,566		
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.	15	1c	Bad Debts.....	\$ 34,206	34,206		
10.	15	1d&e	Accounting & Legal.....	\$ 16,728	16,728		
11.	30	IV3	Telephone.....	\$			
12.	15	1h2	Cellular Telephone.....	\$ 1,871	1,871		
13.			Life insurance premiums on the life of Owners, Partners, Operators.....	\$			
14.	16	13	Gifts, flowers and coffee shops.....	\$ 27,924	27,924		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees.....	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative....	\$			
17.			Automobile Expense (e.g. personal use).	\$			
18.	16	m2&3	Unallowable Advertising *.....	\$ 26,942	26,942		
19.			Income Tax / Corporate Business Tax...	\$			
20.			Fund Raising / Contributions.....	\$			
21.	16	m12	Unallowable Management Fees.....	\$ 270,875	270,875		
	18	2c		\$ 65,667	65,667		
	20	5j		\$ 73,875	73,875		
22.	16	6	Barber and Beauty.....	\$			
23.	Var	Var	Other - See attached Schedule.....	\$ 15,857	15,857		
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents.....	\$ 146	146		
Page 19 - Laundry Expenditures							
25.	19	3d	Laundry services to employees, guests and others who are not residents.....	\$			
Page 20 - Housekeeping Expenditures							
26.	20	4d	Housekeeping services to employees and others who are not residents.....	\$			
Subtotal (Items 1 - 26)				\$ 923,745	923,745		

* 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	2,566		
Total Other Salaries Adjustment			\$ 2,566	\$ -	\$ -

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	13,907		
16	M13	CMS Penalty	1,950		
Total Other A&G Adjustments			\$ 15,857	\$ -	\$ -

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	9/30/2017	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 923,745	923,745		
Page 20 - Resident Care Supplies ***							
27.	20	5a1&2	Prescription Drugs.....	\$ 307,570	307,570		
28.	20	5d	Ambulance/Limousine.....	\$ 814	814		
29.	20	5f	X-rays, etc.....	\$ 33,176	33,176		
30.	20	5h	Laboratory.....	\$ 25,576	25,576		
31.	20	5c	Medical Supplies.....	\$ 42,407	42,407		
32.	20	5e2	Oxygen (non emergency).....	\$ 45,400	45,400		
33.	20	5j	Occupational Therapy.....	\$ 262	262		
34.	Var	Var	Other - See Attached Schedule.....	\$ 48,036	48,036		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule.....	\$ 7,381	7,381		
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.			Research or Experimental Activities.....	\$			
43.	20	5j	Radio and Television Revenue.....	\$ 14,957	14,957		
44.	30	rv8	Vending Machine Revenue.....	\$ 821	821		
45.			Purchase Discounts and Allowances.....	\$			
46.			Duplications of functions or services....	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest.....	\$			
48.	30	iv5	Interest Income on Accounts Rec.....	\$ 702	702		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule.....	\$			
Not For Profit Providers Only							
50.	Var	Var	Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule.....	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 1,450,847	1,450,847		

*** 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.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental	18,633		
20	5j	Ebox	29,403		
Total Other Ancillary Costs			\$ 48,036	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Moveable Equip Deprec Carryforwards	7,381		
Total Excess Movable Equipment Depreciation			7,381		

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Sheriden Woods Health Care Center	2004C	9/30/2017			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>).....	\$ 19,380,988	19,380,988				
b. Medicaid Room and Board Contractual Allowance **.....	\$ (11,327,337)	(11,327,337)				
2. a. Medicaid (<i>All other states</i>).....	\$					
b. Other States Room and Board Contractual Allowance **.....	\$					
3. a. Medicare Residents (<i>all inclusive</i>).....	\$ 1,770,354	1,770,354				
b. Medicare Room and Board Contractual Allowance **.....	\$ 353,634	353,634				
4. a. Private-Pay Residents and Other.....	\$ 3,762,673	3,762,673				
b. Private-Pay Room and Board Contractual Allowance **.....	\$ (170,425)	(170,425)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare.....	\$ 238,828	238,828				
b. Prescription Drugs - Medicare Contractual Allowance **.....	\$ (238,828)	(238,828)				
c. Prescription Drugs - Non-Medicare.....	\$ 314,128	314,128				
d. Prescription Drugs - Non-Medicare Contractual Allowance **.....	\$ (314,128)	(314,128)				
2. a. Medical Supplies - Medicare.....	\$ 27,807	27,807				
b. Medical Supplies - Medicare Contractual Allowance **.....	\$					
c. Medical Supplies - Non-Medicare.....	\$ 81,075	81,075				
d. Medical Supplies - Non-Medicare Contractual Allowance **.....	\$ (81,075)	(81,075)				
3. a. Physical Therapy - Medicare.....	\$ 682,533	682,533				
b. Physical Therapy - Medicare Contractual Allowance **.....	\$ (481,086)	(481,086)				
c. Physical Therapy - Non-Medicare.....	\$ 313,431	313,431				
d. Physical Therapy - Non-Medicare Contractual Allowance **.....	\$ (309,264)	(309,264)				
4. a. Speech Therapy - Medicare.....	\$ 90,675	90,675				
b. Speech Therapy - Medicare Contractual Allowance **.....	\$ (63,853)	(63,853)				
c. Speech Therapy - Non-Medicare.....	\$ 68,755	68,755				
d. Speech Therapy - Non-Medicare Contractual Allowance **.....	\$ (68,755)	(68,755)				
5. a. Occupational Therapy - Medicare.....	\$ 690,676	690,676				
b. Occupational Therapy - Medicare Contractual Allowance **.....	\$ (504,818)	(504,818)				
c. Occupational Therapy - Non-Medicare.....	\$ 241,510	241,510				
d. Occupational Therapy - Non-Medicare Contractual Allowance **.....	\$ (237,007)	(237,007)				
6. a. Other (<i>Specify</i>) - Medicare.....	\$					
b. Other (<i>Specify</i>) - Non-Medicare.....	\$ (47,039)	(47,039)				
III Total Resident Revenue (Section I.thru Section II.).....	\$ 14,173,452	14,173,452				
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.....	\$ 34,242	34,242				
5. Interest Income (<i>Specify</i>)	\$ 702	702				
6. Private Duty Nurses' Fees.....	\$					
7. Barber, Coffee, Beauty and Gift shops.....	\$					
8. Other (<i>Specify</i>).....	\$ 821	821				
V. Total Other Revenue (1 thru 8).....	\$ 35,765	35,765				
VI. Total All Revenue (III + V).....	\$ 14,209,217	14,209,217				

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Retroactives	\$ (47,039)		
Total Other Resident Revenue		\$ (47,039)	\$ -	\$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
31, A2	Interest on A/R	\$ 777,115	\$ 702		
Total Interest Income			\$ 702	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30, 8	Vending Machine	\$ 821		
Total Other Revenue		\$ 821	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>).....			\$	305,408
2. Resident Accounts Receivable (Less Allowance for Bad Debts).....			\$	910,554
3. Other Accounts Receivable (Excluding Owners or Related Parties).....			\$	
4. Inventories.....			\$	23,631
5. Prepaid Expenses.....			\$	232,505
a. Prepaid Insurance	210,244			
b. Prepaid Expenses	1,090			
c. Prepaid Insurance	21,171			
d.				
6. Interest Receivable.....			\$	
7. Medicare Final Settlement Receivable.....			\$	
8. Other Current Assets (<i>itemize</i>).....			\$	37,571
A/R Related Facilities	37,571			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,509,669
B. Fixed Assets				
1. Land.....			\$	
2. Land Improvements	*Historical Cost.....	151,417	\$	9,880
	Accum. Depreciation	(141,537) Net.....		
3. Buildings	*Historical Cost.....	2,318,267	\$	552,059
	Accum. Depreciation	(1,766,208) Net.....		
4. Leasehold Improvements	*Historical Cost.....	513,955	\$	454,963
	Accum. Depreciation	(58,992) Net.....		
5. Non-Movable Equipment	*Historical Cost.....	559,160	\$	114,909
	Accum. Depreciation	(444,251) Net.....		
6. Movable Equipment	*Historical Cost.....	1,492,465	\$	240,869
	Accum. Depreciation	(1,251,596) Net.....		
7. Motor Vehicles	*Historical Cost.....		\$	
	Accum. Depreciation	Net.....		
8. Minor Equipment-Not Depreciable.....			\$	
9. Other Fixed Assets (<i>itemize</i>).....			\$	20,219
Misc Diff Fixed assets to books	(14,871)			
Moveable Equipment Carryforward	35,090			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,392,899

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2017	32	37
Account			Amount	
Total Brought Forward:			\$ 2,902,568	
C. Leasehold or like property recorded for Equity Purposes.				
1. Land.....			\$ 143,268	
2. Land Improvements *Historical Cost..... _____				
Accum. Depreciation _____ Net.....			\$	
3. Buildings *Historical Cost..... 6,764,604				
Accum. Depreciation (6,740,718) Net.....			\$ 23,886	
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)			\$ 167,154	
D. Investment and Other Assets				
1. Deferred Deposits.....			\$	
2. Escrow Deposits.....			\$	
3. Organization Expense *Historical Cost..... _____				
Accum. Depreciation _____ Net.....			\$	
4. Goodwill (Purchased Only).....			\$ 382,200	
5. Investments Related to Resident Care (<i>itemize</i>).....			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$ (10,242,810)	
Name and Address		Amount	Loan Date	
Due from Related Facilities		(10,242,810)		
7. Other Assets (<i>itemize</i>).....			\$ 70,196	
IRS Deposits		40,402		
Warranties		4,210		
Project Development		25,584		
D-8. Total Investments and Other Assets (Lines D1 thru 7).....			\$ (9,790,414)	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8).....			\$ (6,720,692)	

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2017	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable.....			\$	2,073,750
2. Notes Payable (<i>itemize</i>).....			\$	1,448,845
<u>Related Party</u>				(517,000)
<u>Line of Credit</u>				1,965,845
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>).....			\$	
Name of Lender		Purpose	Amount	Date Due
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>).....			\$	161,178
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>).....			\$	
6. Accrued Payroll Taxes Payable.....			\$	4,663
7. Medicare Final Settlement Payable.....			\$	
8. Medicare Current Financing Payable.....			\$	
9. Mortgage Payable (<i>Current Portion</i>).....			\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>).....			\$	
11. Accrued Income Taxes*.....			\$	
12. Other Current Liabilities (<i>itemize</i>).....			\$	306,767
<u>Acc'd Operating Expenses</u>				42,410
<u>Acc'd Expense - CT Sales Tax</u>				2,112
<u>Provider Tax Due</u>				239,712
<u>Acc'd Health Ins</u>				22,533
A-13. Total Current Liabilities (Lines A1 thru 12).....			\$	3,995,203

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

(Carry Total forward to next page)

** Interest Bearing - Do Not Include in Return on Equity Calculation.

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center		2004C	9/30/2017	34	37
Account				Amount	
Total Brought Forward:				3,995,203	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>).....				\$	67,666
Name of Lender	Purpose	Amount	Date Due		
	Boiler Upgrade	67,666			
2. Mortgages Payable.....				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>).....				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities (<i>itemize</i>).....				\$	(478,606)
Due From Related Landlord		(2,598,498)			
Due to Related Landlord		2,119,892			
B-5. Total Long-Term Liabilities (Lines B1 thru 4).....				\$	(410,940)
C. Total All Liabilities (Lines A-13 + B-5).....				\$	3,584,263

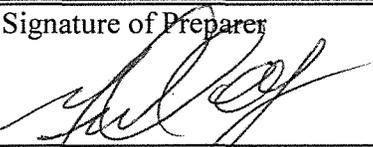
G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2017	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land.....			\$	143,268
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized.....			\$	23,886
3. Reserve for depreciation value of leased personal property (<i>Equity</i>) ..			\$	
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.....			\$	167,154
B. Net Worth				
1. Owner's Capital.....			\$	
2. Capital Stock.....			\$	1,000
3. Paid-in Surplus.....			\$	
4. Treasury Stock.....			\$	
5. Cumulated Earnings.....			\$	(10,210,928)
6. Gain or Loss for Period	10/1/2016	thru 9/30/2017	\$	(262,181)
7. Total Net Worth.....			\$	(10,472,109)
C. Total Reserves and Net Worth			\$	(10,304,955)
D. Total Liabilities, Reserves, and Net Worth			\$	(6,720,692)

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2017	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	(10,203,640)
B. Total Revenue (From Statement of Revenue Page 30)			\$	14,209,217
C. Total Expenditures (From Statement of Expenditures Page 27)			\$	14,471,398
D. Net Income or Deficit.....			\$	(262,181)
E. Balance.....			\$	(10,465,821)
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
Wage Enhancement			11,000	
Health Insurance			16,676	
Management Fee Adj			(33,663)	
prior year expense adjmt - Leases			(301)	
2. Other (<i>itemize</i>)				
F-3. Total Additions.....			\$	(6,288)
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>).....			\$	
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>).....			\$	
Purpose		Amount		
3. Total Deductions.....			\$	
H. <i>Balance at End of Period</i>			\$	(10,472,109)
				09/30/17

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Sheriden Woods Health Care Center	2004C	9/30/2017	37	37
<i>Check appropriate category</i>				
CCNH	RHNS	Other (<i>Specify</i>)		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
	CFO	2/9/18		
Printed Name of Preparer				
Athena Health Care Associates, Inc				
Address		Phone Number		
135 South Road Farmington, CT 06032		(860) 751-3900		