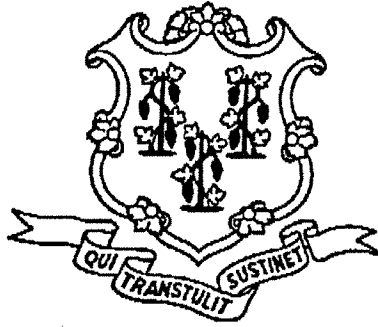


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Sharon SNF CT LLC, d/b/a Sharon Health Care Center	
Address (No. & Street, City, State, Zip Code) 27 Hospital Hill Road Sharon, CT 06069	
Type of Facility <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 2382	RHNS	(Specify)	Medicare Provider No. 075379
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Medicaid Provider Numbers:	CCNH 2382	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) Sharon SNF CT LLC, d/b/a Sharon Health Care Center	License No. 2382	Report for Year Ended 9/30/2017	Page 1	of 37
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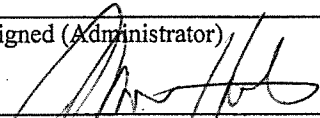
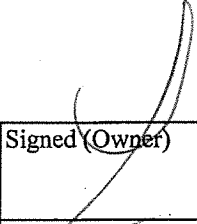
Administrator's/Owner's Certification

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 Sharon SNF CT LLC, d/b/a Sharon 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 2-9-18	Signed (Owner) 		Date 2-9-18
Printed Name (Administrator) John Hortsman			Printed Name (Owner) Lawrence Santilli		
Subscribed and Sworn to before me:	State of CT	Date 2-9-18	Signed (Notary Public) Yvonne Seaplino	Comm. Expires 6/30/21	
Address of Notary Public			505 Pensfield 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 Sharon SNF CT LLC, d/b/a Sharon Health Care Center	Period Covered:	From 10/1/2016	To 9/30/2017	
Address of Facility 27 Hospital Hill Road Sharon, CT 06069				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900	Date 2/9/2018		
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 860-364-1002		Report for Year Ended 09/30/17	Page 2	of 37
Name of Facility (as shown on license) Sharon SNF CT LLC, d/b/a Sharon Health Care Center		Address (No. & Street, City, State, Zip) 27 Hospital Hill Road Sharon, CT 06069		
License Numbers:	CCNH 2382	RHNS (Specify)	Medicare Provider No. 075379	
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 checked="" type="checkbox"/> LLC <input type="checkbox"/> PARTNERSHIP <input 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 John Hortsman		Nursing Home Administrator's License No.:	359	
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-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of			
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2017	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							
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 Name/Address and complete the information on Page 11 of the report.							
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 #	Actual Cost Reported	Actual Cost Related Party
		Yes	No %**				
Sharon Landlord CT LLC	135 South Road, Farmington, CT 06032	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Lease of Real Property	Pg 22, 19 and L10b; pg 27, ln 14a	\$354,470	\$354,470
Athena Captive	135 South Road, Farmington, CT 06032	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Worker's Compensation Captive	Pg 15 1a1	\$300,793	\$300,793
Athena Health Care Assoc. 401 K Plan	135 South Road, Farmington, CT 06032	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Facility participates in common 401k plan			
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Management fees	Pg. 17	\$647	\$137,686
Procure, LTC	111 Executive Blvd., Farmingdale, NY 11735	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Pharmacy	Pg 13 B3, Pg20 5a	\$223,795	\$223,795
Miscellaneous Facilities	Various	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Interfacility loans	Pg 33, A2		
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	see attached			
		<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.

Sharon Health Care
 RELATED PARTIES QUESTIONNAIRE
 PAGE 4

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties %**		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	135 South Rd Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Nursing Department Consultant Employee Relations Purchased Service-Administration Data processing, Payroll processing, Advertising-help wanted Maintenance & Repairs Postage Cyber security insurance Office Supplies	Pg 13 B 11a2 Pg 16 15 Pg 16 m12 Pg 16 m13 Pg 22 6a Pg 16, m7 Pg 27, 14a Pg 15, 1g	\$2,349 3,240 647 8,619 7,382 355 1,696 164	\$2,349 \$3,240 \$647 \$8,619 \$7,382 \$355 \$1,696 164
Athena Health Care Insurance	135 South Rd Farmington, CT 06032	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Health Insurance		973,897	973,897
TOTAL						\$998,348	\$998,348

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care Center	License No. 2382	Report for Year Ended 9/30/2017	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary.....	Number of meals served to residents
Laundry.....	Number of pounds processed
Housekeeping.....	Number of square feet serviced
Nursing.....	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants.....	Number of hours of resident care provided by EACH specialist (<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
Accounting Basis

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care Center	License No. 2382	Report for Year Ended 9/30/2017	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual Cash Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1 2017 Audit fees(22,000-allowed), 2017Tax Return (4,125-allowed)	\$ 26,125
2 2016 Medicare Cost report-allowed	\$ 2,700
3 2015 affiliate tax return -disallowed	\$ 2,200
4 2015 Form 8752-disallowed	\$ 500
	Charge for Services Provided
	\$31,525

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 Murtha, Cullina, LLP	860-240-6000
2 Goldman, Gruder, & Woods	203-899-8900
3 Donald Light	860567-0451
4 Litchfield Hills Probate	860-824-7012
5 Shipman & Goodwin /Senior Planning	860 251-5000/732 961-8430

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

- 1 **City Place, 185 Asylum St., Hartford, CT 06103**
- 2 **200 Connecticut Ave, Norwalk, CT 06854**
- 3 **204 Goodhouse Rd., Litchfield, CT 06759**
- 4 **100 Pease St., Canaan, CT 06018**
- 5 **One Constitution Plaza, Hartford, CT 7 Randolph Rd., Howell, NJ**

Services Provided by This Firm (*describe fully*)

1 Refinancing -\$2,282 (disallowed)/Annual report \$249 (allowed)	\$ 2,530
2 A/R Collections \$31,140 (disallowed);Audit letter \$420 (allowed)	\$ 31,560
3 Conservatorship/probate-disallowed	\$ 634
4 Probate Hearings-disallowed	\$ 2,986
5 General matters \$5,438 (disallowed)/Medicaid appl/vendor settlement	\$ 7,896
	Charge for Services Provided
	\$45,606

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**

Schedule of Resident Statistics

Name of Facility		License No.			Report for Year Ended				Page	of			
Sharon SNF CT LLC, d/b/a Sharon Health Care Center		2382			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.....	88	88			88	88			88	88			
B. On last day of THIS report period.....	88	88			88	88			88	88			
2. Number of Residents													
A. As of midnight of PREVIOUS report period.....	81	81			75	75			81	81			
B. As of midnight of THIS report period.....	80	80			75	75			80	80			
3. Total Number of Days Care Provided During Period													
A. Medicare.....	4,031	4,031			3,273	3,273			758	758			
B. Medicaid (Conn.).....	18,533	18,533			13,277	13,277			5,256	5,256			
C. Medicaid (other states).....	2,875	2,875			2,169	2,169			706	706			
D. Private Pay.....	2,549	2,549			2,042	2,042			507	507			
E. State SSI for RCH.....													
F. Other (Specify) Managed Care	779	779			608	608			171	171			
G. Total Care Days During Period (3A thru F).....	28,767	28,767			21,369	21,369			7,398	7,398			
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.....	23	23			8	8			15	15			
5. Total Resident Days (3G + 4A + 4B).....	28,790	28,790			21,377	21,377			7,413	7,413			

Schedule of Resident Statistics (Cont'd)

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care Center	License No. 2382	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								
Per Diem Rate								
a. One bed rm.	614.96	247.84		510.00			491.88	
b. Two bed rms.	614.96	247.84		495.00			491.88	
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	6,095	6,095		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	315	315		
2. Restorative Treatments				
C. Other	12,242	12,242		
D. Total Physical Therapy Treatments	18,652	18,652		

8. Total Number of Speech Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	826	826		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	104	104		
2. Restorative Treatments				
C. Other	723	723		
D. Total Speech Therapy Treatments	1,653	1,653		

9. Total Number of Occupational Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	4,054	4,054		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	831	831		
2. Restorative Treatments				
C. Other	11,651	11,651		
D. Total Occupational Therapy Treatments	16,536	16,536		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2017	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)	130,271	2,052				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	216,433	9,430				
5. Dietary Service						
a. Head Dietitian	5,315	139				
b. Food Service Supervisor	66,205	2,073				
c. Dietary Workers	332,045	21,175				
6. Housekeeping Service						
a. Head Housekeeper	53,996	2,060				
b. Other Housekeeping Workers	175,907	12,093				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	57,132	2,105				
b. Other Maintenance Workers	41,181	2,038				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	67,611	5,132				
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	119,343	2,078				
b. RN						
1. Direct Care	307,311	8,450				
2. Administrative**	378,804	13,123				
c. LPN						
1. Direct Care	638,585	23,331				
2. Administrative**						
d. Aides and Attendants	1,048,499	60,957				
e. Physical Therapists	494,385	13,117				
f. Speech Therapists	48,929	1,162				
g. Occupational Therapists	314,337	7,502				
h. Recreation Workers	151,885	7,493				
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	154,868	5,460				
n. Marketing						
o. Other (Specify)						
<i>A-13. Total Salary Expenditures</i>	4,803,042	200,970				

* 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		
		9/30/2017	37				
Name	Sharon SNF CT LLC, d/b/a Sharon Health Care Center	Salary Paid		Total Hours Worked	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
		CCNH	RHNS (Specify)				
Section I - Operators/Owners	2382						
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		
Sharon SNF CT LLC, d/b/a Sharon Health Care Center		2382		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***									
John Hortsman (10/01/16-09/30/17)	130,271		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,052	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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	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.....	1,201	48				
3. Pharmacist.....	8,362	100				
4. Podiatrist.....						
5. Physical Therapy						
a. Resident Care.....						
b. Other.....						
6. Social Worker.....						
7. Recreation Worker.....						
8. Physicians						
a. Medical Director (entire facility).....	87,250	798				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**.....	10,916	72				
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	49,200	468				
9. Speech Therapist						
a. Resident Care.....	2,880	8				
b. Other.....						
10. Occupational Therapist						
a. Resident Care.....	4,997	75				
b. Other.....						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	282,488	3,144				
2. Administrative***	2,349					
b. LPN						
1. Direct Care	61,887	1,180				
2. Administrative***						
c. Aides.....	154,179	5,108				
d. Other.....						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	665,709	11,001				

* 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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center		2382	9/30/2017		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Dr. Sabooh Mubbashar, 123 Peck Hill Road, Woodbridge, CT 06525	Psychiatrist	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Athena Health Care, 135 South Road, Farmington, CT 06032	MDS Nurse - Fill-in	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Owners		
N M Orthopedic Associates, 131 Kent Rd, New Milford, CT 06776	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Nurse Network, 653 Main Street, Plantsville, CT 06479	Nurse Pool	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Procare, LTC, 111 Executive Blvd., Farmingdale, NY 11735	Pharmacist	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Owners/Minority Interest		
Healthdrive, 85 Barnes Rd, Wallingford, CT 06492	Podiatrist, Ophthalmologist, & Dental	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Mark Marshall, DO, 32 Burton Road, Salisbury, CT 06068	Medical director	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Quotidian, 52 Seneff Road, Washington, CT 06793	Assistant Medical Director	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Procare Professional Healthcare, P.O. Box 823461, Philadelphia, PA 19182	Nurse Pool	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Access Therapies, Inc., P.O. Box 823461, Philadelphia, PA 19182	Physical Therapist	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Ready Nurse Staffing Services, PO Box 200528, Houston, TX 77216	Nurse Pool	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Sharon Hospital, 50 Hospital Hill Road, Sharon, CT 06069	Radiology/Lab	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
MobileXUSA, PO Box 17462, Baltimore, MD 21297	Radiology	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Advanced Medical Personnel, 5535 South Williamson Blvd., Port Orange, FL 32128	Occupational Theapist	<input type="checkbox"/>	<input type="checkbox"/>			
Vascular Group, P.O. Box 25, Albany, NY 12201	Radiologist	<input type="checkbox"/>	<input type="checkbox"/>			
SDX Dysphagia, 21 Waterville Rd., Avon, CT 06001	Speech Therapist	<input type="checkbox"/>	<input type="checkbox"/>			
Charlotte Hungerford Hospital, New Litchfield Street, Torrington, CT 06790	Lab	<input type="checkbox"/>	<input type="checkbox"/>			
Litchfield Hills Orthopedics, 245 Alvord Park Rd, Torrington, CT 06790	Physicians	<input type="checkbox"/>	<input type="checkbox"/>			
Western Ct Medical Group, PO box 8932, Belfast, ME 04915	Lab	<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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2017		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation.....	\$ 300,793	300,793			
2. Disability Insurance.....	\$				
3. Unemployment Insurance.....	\$ 71,461	71,461			
4. Social Security (F.I.C.A.).....	\$ 361,493	361,493			
5. Health Insurance.....	\$ 913,907	913,907			
6. Life Insurance (employees only) (not-owners and not-operators).....	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators).....	\$ 13,932	13,932			
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*	\$ 78,286	78,286			
d. Accounting and Auditing.....	\$ 31,525	31,525			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 45,606	45,606			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*.....	\$				
g. Office Supplies.....	\$ 60,930	60,930			
h. Telephone and Cellular Phones.....					
1. Telephone & Pagers.....	\$ 8,146	8,146			
2. Cellular Phones.	\$ 1,260	1,260			
i. Appraisal (<i>Specify purpose and attach copy</i>)*.....	\$				
j. Corporation Business Taxes (<i>franchise tax</i>).	\$ 250	250			
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	\$ 564,598	564,598			
Subtotal	\$ 2,452,187	2,452,187			

* 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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2017		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	2,452,187	2,452,187			
l. Travel and Entertainment					
1. Resident Travel and Entertainment.....	\$				
2. Holiday Parties for Staff.....	\$ 2,850	2,850			
3. Gifts to Staff and Residents.....	\$ 17,828	17,828			
4. Employee Travel.....	\$ 820	820			
5. Education Expenses Related to Seminars and Conventions	\$ 13,784	13,784			
6. Automobile Expense (<i>not purchase or depreciation</i>).....	\$ 12,386	12,386			
7. Other (<i>Specify</i>).....	\$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>).....	\$ 18,226	18,226			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$ 1,455	1,455			
3. Advertising Other (<i>Specify</i>)***.....	\$ 17,650	17,650			
See Attached Schedule					
4. Fund-Raising***.....	\$				
5. Medical Records.....	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***.....	\$				
7. Postage.....	\$ 6,580	6,580			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 6,551	6,551			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions.....	\$ 748	748			
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**.....	\$ 647	647			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 79,264	79,264			
C-14 Total Administrative & General Expenditures	\$ 2,630,976	2,630,976			

* 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	\$ 17,650		
Total Other Advertising	\$ 17,650	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF DUES	\$ 6,551		
Total Dues	\$ 6,551	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Data Processing Fees	\$ 25,524		
Bank Charges	\$ 15,764		
Payroll Processing Fees	\$ 18,356		
Employee Physicals and background checks	\$ 10,772		
Compliance Consulting	\$ 3,750		
Licenses	\$ 340		
CMS Case #2017-01-LTC-212	\$ 4,758		
Total Other Administrative and General	\$ 79,264	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care Center	License No. 2382	Report for Year Ended 9/30/2017	Page of 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		Full Management Services	See Below
Amounts added back on Page 28		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	\$647	Admin/Gen-Other Expense	Pg 16, Line 12

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2017		18	37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food.....	\$ 214,441	214,441			
2. Non-Food Supplies.....	\$ 19,743	19,743			
3. Other (<i>Specify</i>).....	\$ 1,321	1,321			
Dishes = \$1,321					
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	\$				
c. Management Services**.....	\$				
d. Other (<i>Specify</i>).....	\$				
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 235,505	235,505			
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)	
G. Resident Meals: Total no. of meals served per day:*	236	236			
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. = \$2401
L. Is any revenue collected from these people?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No			If yes, specify amount. = \$2229
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					Pg 18, Line 2a1
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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	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. \$	10,866	10,866		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Management Services**.....	\$				
d. Other (Specify) Supplies = \$4,604	\$	4,604	4,604		
3E. Total Laundry Expenditures (3a + b + c + d)	\$	15,470	15,470		
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 Sharon SNF CT LLC, d/b/a Sharon Health Care Center		License No. 2382	Report for Year Ended 9/30/2017		Page 20	of 37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced	40,000	40,000		
a.	In-House Care	by Personnel				
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	25,122	25,122		
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	40,000	40,000		
		Amt. \$				
c.	Management Services*	\$				
d.	Other (<i>Specify</i>)	\$				
4E.	Total Housekeeping Expenditures (4a + b + c + d)....	\$	25,122	25,122		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy.....	\$				
2.	Purchased from Procare	\$	209,158	209,158		
b.	Medicine Cabinet Drugs.....	\$	6,835	6,835		
c.	Medical and Therapeutic Supplies.....	\$	186,351	186,351		
d.	Ambulance/Limousine***	\$	21,086	21,086		
e.	Oxygen					
1.	For Emergency Use.....	\$				
2.	Other***	\$	34,943	34,943		
f.	X-rays and Related Radiological Procedures***	\$	15,702	15,702		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	27,974	27,974		
i.	Recreation.....	\$	32,418	32,418		
j.	Other (Specify)**** See Attached Schedule	\$	100,797	100,797		
5K.	Total Resident Care Expenditures (5a - 5j).....	\$	635,264	635,264		

* 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)
Physical Therapy Supplies	\$ 29,407		
Medical Equipment Rental-Medicaid	\$ 25,996		
Cable TV Services	\$ 21,704		
Oxygen Equipment Rental	\$ 3,515		
Medical Equipment Rental-Other	\$ 20,175		
Total Other Resident Care	\$ 100,797	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended			Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2017			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance..... \$	79,919	79,919				
b. Heat..... \$	56,548	56,548				
c. Light & Power..... \$	77,456	77,456				
d. Water..... \$	53,004	53,004				
e. Equipment Lease (<i>Provide detail on page 6</i>)..... \$	26,472	26,472				
f. Other (<i>itemize</i>)..... \$	91,325	91,325				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)..... \$	384,724	384,724				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements..... \$						
b. Building & Building Improvements..... \$						
c. Non-Movable Equipment..... \$	17,529	17,529				
d. Movable Equipment..... \$	49,871	49,871				
*7e. Total Depreciation Costs (7a + b + c + d)..... \$	67,400	67,400				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense..... \$						
b. Mortgage Expense..... \$						
c. Leasehold Improvements..... \$	50,335	50,335				
d. Other (<i>Specify</i>)..... \$						
*8e. Total Amortization Costs (8a + b + c + d)..... \$	50,335	50,335				
9. Rental payments on leased real property less real estate taxes included in item 10b..... \$	354,470	354,470				
10. Property Taxes						
a. Real estate taxes paid by owner..... \$						
b. Real estate taxes paid by lessor..... \$	57,564	57,564				
c. Personal property taxes..... \$	3,731	3,731				
11. Total Property Expenses (7e + 8e + 9 + 10)..... \$	533,500	533,500				

* 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	\$ 10,682		
Rubbish Removal	\$ 22,663		
Snow Removal	\$ 18,550		
Supplies	\$ 39,430		
Total Other Repairs and Maintenance	\$ 91,325	\$ -	\$ -

Depreciation Schedule

Name of Facility				License No.			Report for Year Ended			Page	of		
Sharon SNF CT LLC, d/b/a Sharon Health Care Center				2382			9/30/2017			23	37		
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
A. Land Improvements													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal.....													
B. Building and Building Improvements													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal.....													
C. Non-Movable Equipment													
1. Acquired prior to this report period				209,765		209,765	68,207	SL	Various	17,529			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal.....											17,529		
		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. Ford, E35YCUTA, 2003		x		4	2013	10,000		10,000	9,000	SL	10	1,000	
b. Bus Graphics				9	2014	4,668		4,668	3,268	SL	5	933	
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period				9	2013	365,720		365,720	175,887	S/L	Var	43,461	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)				9	2014	44,082		44,082		S/L	Var	4,477	
D-3. Subtotal.....													49,871
E. Total Depreciation													67,400

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

**SHARON HEALTH CARE
FURNITURE & EQUIPMENT #1952
September 30, 2017**

Date	Vendor	Description	Life	Amount
11/30/2016	Modern Mechanical Services, Inc.	Potable Water Expansion Tank	10	3,625.00
12/31/2016	GLASTONBURY HEALTH CARE	POINT CLICK CARE Project	3	\$1,547.41
12/31/2016	PATHWAYS HEALTH SERVICES	POINT CLICK CARE Project	3	312.50
12/31/2016	ALEXANDRA LAGOUTIS	POINT CLICK CARE Project	3	252.00
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	632.67
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	210.89
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	113.62
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	210.89
12/31/2016	PATHWAY HEALTH SERVICES	POINT CLICK CARE Project	3	1,346.43
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	86.53
12/31/2016	PATHWAY HEALTH SERVICES	POINT CLICK CARE Project	3	1,099.28
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	262.32
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	210.89
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	41.96
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	210.89
12/31/2016	PATHWAY HEALTH SERVICES	POINT CLICK CARE Project	3	1,124.63
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	152.14
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	210.89
12/31/2016	PATHWAYS HEALTH SERVICES	POINT CLICK CARE Project	3	885.11
12/31/2016	PATHWAY HEALTH SERVICES	POINT CLICK CARE Project	3	947.29
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	152.14
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	210.89
12/31/2016	PATHWAY HEALTH SERVICES	POINT CLICK CARE Project	3	1,210.79
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	152.14
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	210.89
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	152.14
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	210.89
12/31/2016	PATHWAY HEALTH SERVICES	POINT CLICK CARE Project	3	1,389.53
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	110.18
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	210.89
12/31/2016	PATHWAY HEALTH SERVICES	POINT CLICK CARE Project	3	1,425.57
12/31/2016	PATHWAYS HEALTH SERVICES	POINT CLICK CARE Project	3	1,022.46
12/31/2016	PATHWAYS HEALTH SERVICES	POINT CLICK CARE Project	3	335.71
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	220.36
12/31/2016	PATHWAY HEALTH SERVICES	POINT CLICK CARE Project	3	550.24
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	110.18
12/31/2016	PATHWAY HEALTH SERVICES	POINT CLICK CARE Project	3	29.08
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	110.18
12/31/2016	PATHWAY HEALTH SERVICES	POINT CLICK CARE Project	3	85.75
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	110.18
12/31/2016	PATHWAY HEALTH SERVICES	POINT CLICK CARE Project	3	244.91
12/31/2016	RELAY HEALTH	POINT CLICK CARE Project	3	115.69
12/31/2016	Richter Invoice	POINT CLICK CARE Project	3	1205.00
12/31/2016	Richter Invoice	POINT CLICK CARE Project	3	622.5
1/31/2017	McKesson	(6) Tables/ (8) Dining Chairs	15	7,143.88
2/28/2017	Proline	Washer Control Box installation	5	2,208.85
3/31/2017	Joerns Healthcare	(2) Ultracare Beds/bumpers/rails	10	4,424.95
4/30/2017	Weld-Power Generator	Gland plate for generator cables	15	3,507.42
7/31/2017	Weld-Power Generator	Oil Cooler for generator	10	3,115.44
TOTAL MOVEABLE EQUIPMENT EXPENDITURES 10/01/16-09/30/17				\$44,082.17

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center			2382		9/30/2017			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. Finance Fees									
2.									
3.									
B-4. Subtotal.....									
C. Leasehold Improvements and Other (Specify)									
1. Acquired prior to this report period				387,602	133,411	SL		45,181	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2017	Various	149,138		SL	Var	5,154	
C-4. Subtotal.....									50,335
D. Total Amortization									50,335

* 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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2017	24A	37
C. Leasehold Improvements (Specify)				
1. Acquired prior to this report period	387,602	133,411 SL	45,181	
2. Disposals (attach schedule)				
3. Acquired during this report period	149,138	SL	5,154	
C-4. Subtotal.....				50,335
C. Other (Specify)				
1. Goodwill				
2.				
C-4. Subtotal.....				
Total Acquired prior to this report period	387,602	133,411 SL	45,181	
Total Disposals				
Total Acquired during this report period	149,138	SL	5,154	Var

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

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care Center	License No. 2382	Report for Year Ended 9/30/2017	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party*? Yes No If "Yes," complete Part B.
If "No," complete Part C.

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

Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase	04/10/12				
4. Date of Initial Licensure	04/10/12				
5. Total Licensed Bed Capacity	88				
6. Square Footage	40,000				
7. Acquisition Cost					
a. Land	430,400				
b. Building	6,024,600				

Part B - Owner and Related Parties

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	04/10/12			
c. Interest Rate for the Cost Year	5.05%			
d. Term of Mortgage (number of years)	7			
e. Amount of Principal Borrowed	5,100,000			
f. Principal balance outstanding as of 9/30/2017	4,454,391			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	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
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	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).....		\$	4,078	4,078		
A. Item	Rate	Amount				
Energy efficient lighting proj	3.99%	134,398				
Lender						
GPE Financial						
Address of Lender						
82 Wolcott Rd., Wethersfield, CT						
B. Item	Rate	Amount				
		-				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)..... \$						
		\$	4,078	4,078		
12. D. Other Interest Expense (Specify)..... \$						
		\$	60,066	60,066		
Vender Interest = \$6,873; Interest Seller Note = \$53,193						
13. Total All Interest Expense (12B7 + 12C3 + 12D).....		\$	64,144	64,144		
14. Insurance						
a. Insurance on Property (buildings only)..... \$						
		\$	62,791	62,791		
b. Insurance on Automobiles..... \$						
		\$	1,516	1,516		
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)...		\$	64,307	64,307		
15. Total All Expenditures (A-13 thru C-14).....		\$	10,057,763	10,057,763		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center				2382	9/30/2017	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.....	\$ 314,337	314,337		
4.	Var	Var	Other - See attached Schedule.....	\$ 14,027	14,027		
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **.....	\$ 10,916	10,916		
6.	13	B10a	Occupational Therapy.....	\$ 4,997	4,997		
7.			Other - See attached Schedule.....	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits.....	\$			
9.	15	1c	Bad Debts.....	\$ 78,286	78,286		
10.	15	1d&e	Accounting & Legal.....	\$ 48,057	48,057		
11.			Telephone.....	\$			
12.	15	1h2	Cellular Telephone.....	\$ 540	540		
13.			Life insurance premiums on the life of Owners, Partners, Operators.....	\$			
14.	16	13	Gifts, flowers and coffee shops.....	\$ 17,828	17,828		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees.....	\$ 7,465	7,465		
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 *.....	\$ 19,105	19,105		
19.	15	1j&k1 &2	Income Tax / Corporate Business Tax...	\$ 250	250		
20.			Fund Raising / Contributions.....	\$			
21.	16	m12	Unallowable Management Fees.....	\$ (90,446)	(90,446)		
	18	2c		\$ (21,926)	(21,926)		
	20	5j		\$ (24,667)	(24,667)		
22.	16	m6	Barber and Beauty.....	\$			
23.	Var	Var	Other - See attached Schedule.....	\$ 24,272	24,272		
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents.....	\$ 172	172		
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)				\$ 403,213	403,213		

* 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.

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Sharon SNF CT LLC, d/b/a Sharon Health Care Center			2382	9/30/2017	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 403,213	403,213		
Page 20 - Resident Care Supplies***							
27.	20	5a1&2	Prescription Drugs.....	\$ 209,158	209,158		
28.	20	5d	Ambulance/Limousine.....	\$ 21,086	21,086		
29.	20	5f	X-rays, etc.....	\$ 15,702	15,702		
30.	20	5h	Laboratory.....	\$ 27,974	27,974		
31.	20	5c	Medical Supplies.....	\$ 8,800	8,800		
32.	20	5e2	Oxygen (non emergency).....	\$ 34,943	34,943		
33.			Occupational Therapy.....	\$			
34.	Var	Var	Other - See Attached Schedule.....	\$ 34,288	34,288		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation				
	Var	Var	See Attached Schedule.....	\$ 5,075	5,075		
36.			Depreciation on Unallowable				
	22	7d	Motor Vehicles.....	\$ 2,934	2,934		
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.....	\$ 18,104	18,104		
44.			Vending Machine Revenue.....	\$			
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	rv5	Interest Income on Accounts Rec.....	\$			
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)			\$ 781,277	781,277		

*** 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-Other	20,175		
20	5 a2	E box	7,533		
20	5 b	E box	6,580		
Total Other Ancillary Costs			\$ 34,288	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Movable Equipment (See Attached)	5,075		
Total Excess Movable Equipment Depreciation			5,075		

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 Sharon SNF CT LLC, d/b/a Sharon Health Care Center	License No. 2382	Report for Year Ended 9/30/2017			Page 30	of 37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only).....	\$ 9,167,484	9,167,484				
b. Medicaid Room and Board Contractual Allowance **.....	\$ (4,571,061)	(4,571,061)				
2. a. Medicaid (All other states).....	\$ 1,356,660	1,356,660				
b. Other States Room and Board Contractual Allowance **.....	\$ (668,443)	(668,443)				
3. a. Medicare Residents (all inclusive).....	\$ 1,852,325	1,852,325				
b. Medicare Room and Board Contractual Allowance **.....	\$ 470,369	470,369				
4. a. Private-Pay Residents and Other.....	\$ 1,631,062	1,631,062				
b. Private-Pay Room and Board Contractual Allowance **.....	\$ (11,839)	(11,839)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare.....	\$ 258,968	258,968				
b. Prescription Drugs - Medicare Contractual Allowance **.....	\$ (258,968)	(258,968)				
c. Prescription Drugs - Non-Medicare.....	\$ 121,168	121,168				
d. Prescription Drugs - Non-Medicare Contractual Allowance **.....	\$ (121,168)	(121,168)				
2. a. Medical Supplies - Medicare.....	\$					
b. Medical Supplies - Medicare Contractual Allowance **.....	\$					
c. Medical Supplies - Non-Medicare.....	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **.....	\$					
3. a. Physical Therapy - Medicare.....	\$ 834,756	834,756				
b. Physical Therapy - Medicare Contractual Allowance **.....	\$ (657,307)	(657,307)				
c. Physical Therapy - Non-Medicare.....	\$ 118,474	118,474				
d. Physical Therapy - Non-Medicare Contractual Allowance **.....	\$ (118,474)	(118,474)				
4. a. Speech Therapy - Medicare.....	\$ 150,674	150,674				
b. Speech Therapy - Medicare Contractual Allowance **.....	\$ (104,095)	(104,095)				
c. Speech Therapy - Non-Medicare.....	\$ 27,772	27,772				
d. Speech Therapy - Non-Medicare Contractual Allowance **.....	\$ (27,772)	(27,772)				
5. a. Occupational Therapy - Medicare.....	\$ 711,142	711,142				
b. Occupational Therapy - Medicare Contractual Allowance **.....	\$ (590,120)	(590,120)				
c. Occupational Therapy - Non-Medicare.....	\$ 140,208	140,208				
d. Occupational Therapy - Non-Medicare Contractual Allowance **.....	\$ (140,208)	(140,208)				
6. a. Other (Specify) - Medicare.....	\$					
b. Other (Specify) - Non-Medicare.....	\$ 7,684	7,684				
III Total Resident Revenue (Section I.thru Section II.).....	\$ 9,579,291	9,579,291				
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)	\$ 260	260				
6. Private Duty Nurses' Fees.....	\$					
7. Barber, Coffee, Beauty and Gift shops.....	\$					
8. Other (Specify).....	\$ 39,564	39,564				
V. Total Other Revenue (1 thru 8).....	\$ 39,824	39,824				
VI. Total All Revenue (III + V).....	\$ 9,619,115	9,619,115				

* 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..

G. Balance Sheet

Name of Facility		License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center		2382	9/30/2017	31	37
Account				Amount	
Assets					
A. Current Assets					
1.	Cash (<i>on hand and in banks</i>).....			\$	45,989
2.	Resident Accounts Receivable (Less Allowance for Bad Debts).....			\$	1,184,451
3.	Other Accounts Receivable (Excluding Owners or Related Parties).....			\$	
4.	Inventories.....			\$	15,727
5.	Prepaid Expenses.....			\$	135,067
	a. Prepaid Insurance	115,734			
	b. Prepaid Expenses-Other	8,443			
	c. Prepaid Insurance	10,890			
	d.				
6.	Interest Receivable.....			\$	
7.	Medicare Final Settlement Receivable.....			\$	
8.	Other Current Assets (<i>itemize</i>).....			\$	137,686
	Related Party	136,037			
	A/R Other-food rebate	1,649			
A-9. Total Current Assets (Lines A1 thru 8)				\$	1,518,920
B. Fixed Assets					
1.	Land.....			\$	
2.	Land Improvements	*Historical Cost.....		\$	
		Accum. Depreciation	Net.....		
3.	Buildings	*Historical Cost.....		\$	
		Accum. Depreciation	Net.....		
4.	Leasehold Improvements	*Historical Cost.....	536,741	\$	352,994
		Accum. Depreciation	(183,747) Net.....		
5.	Non-Movable Equipment	*Historical Cost.....	209,765	\$	124,029
		Accum. Depreciation	(85,736) Net.....		
6.	Movable Equipment	*Historical Cost.....	407,422	\$	183,597
		Accum. Depreciation	(223,825) Net.....		
7.	Motor Vehicles	*Historical Cost.....	14,668	\$	467
		Accum. Depreciation	(14,201) Net.....		
8.	Minor Equipment-Not Depreciable.....			\$	
9.	Other Fixed Assets (<i>itemize</i>).....			\$	2,455
	Excluded Movable Equipment/move equip accun	1,988			
	Excluded Vehicles	467			
B-10. Total Fixed Assets (Lines B1 thru 9).....				\$	663,542

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

(Carry Total forward to next page)

Sharon Moveable Equipment Carryforward Schedule

Cost Year	Amount	Amount	Amount	Total
	Excess on Change in Ownership	TV's 2013 cost report	2015 audit adjmt - lease expense	TV's 2016 cost report
Cost Term	\$ 19,023	(1) \$ 2,080	\$ 7,290	\$ 1,638
	5.00	5.00	3.00	5.00
2012	Deprec \$ 1,902			\$ 1,902
2012	Book Value \$ 17,121			\$ 17,121
2013	Deprec \$ 3,805	\$ 208		\$ 4,013
2013	Book Value \$ 13,316	\$ 1,872		\$ 15,188
2014	Deprec \$ 3,805	\$ 416		\$ 4,385
2014	Book Value \$ 9,511	\$ 1,456		\$ 12,441
2015	Deprec \$ 3,805	\$ 416	\$ 1,215	\$ 328
2015	Book Value \$ 5,706	\$ 1,040	\$ 6,075	\$ 1,146
2016	Deprec \$ 3,805	\$ 416	\$ 2,430	\$ 328
2016	Book Value \$ 1,901	\$ 624	\$ 3,645	\$ 818
2017	Deprec \$ 1,901	\$ 416	\$ 2,430	\$ 328
2017	Book Value \$ -	\$ 208	\$ 1,215	\$ 490
2018	Deprec	\$ 208	\$ 1,215	\$ 328
2018	Book Value	\$ -	\$ -	\$ 162
				\$ 162
				\$ 0

(1) Calculation of Excess

Cost Additions Prior to 2011	\$ 1,021,759
Acc'd Deprec Additions Prior to 2011	\$ (1,021,759)
Cost 2011 Additions	\$ 30,397
Acc'd Deprec 2011 Additions	\$ (2,210)
Prior Owner Book Value 9/2010	\$ 28,187
Additional Deprec for 10/2011-3/2	\$ (2,210)
Carryforward Book Value	\$ 25,977
Amount Booked by Buyer	\$ 45,000
Excess Amount	\$ 19,023

Vehicle 467
 Book value 1939
2452

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2017	32	37
Account			Amount	
Total Brought Forward:			\$	2,182,462
C. Leasehold or like property recorded for Equity Purposes.				
1. Land..... \$				
2. Land Improvements *Historical Cost..... _____				
				Accum. Depreciation
				Net.....
\$				
3. Buildings *Historical Cost..... _____				
				Accum. Depreciation
				Net.....
\$				
4. Non-Movable Equipment *Historical Cost..... _____				
				Accum. Depreciation
				Net.....
\$				
5. Movable Equipment *Historical Cost..... _____				
				Accum. Depreciation
				Net.....
\$				
6. Motor Vehicles *Historical Cost..... _____				
				Accum. Depreciation
				Net.....
\$				
7. Minor Equipment-Not Depreciable..... \$				
C-8 Total Leasehold or Like Properties (C1 thru 7) \$				
D. Investment and Other Assets				
1. Deferred Deposits..... \$				
2. Escrow Deposits..... \$				
3. Organization Expense *Historical Cost..... _____				
				Accum. Depreciation
				Net.....
\$				
4. Goodwill (Purchased Only)..... \$ 2,719,776				
5. Investments Related to Resident Care (<i>itemize</i>)..... \$				

6. Loans to Owners or Related Parties (<i>itemize</i>) \$				
Name and Address		Amount	Loan Date	
7. Other Assets (<i>itemize</i>)..... \$ 13,792				

Project Development		13,792		
D-8. Total Investments and Other Assets (Lines D1 thru 7) \$ 2,733,568				
D-9. Total All Assets (Lines A9 + B10 + C8 + D8) \$ 4,916,030				

* 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 Sharon SNF CT LLC, d/b/a Sharon Health Care Center		License No. 2382	Report for Year Ended 9/30/2017	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable.....				\$	1,525,623
2. Notes Payable (<i>itemize</i>).....				\$	814,000
Loans - Related Parties					814,000
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>).....				\$	87,935
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>).....				\$	
6. Accrued Payroll Taxes Payable.....				\$	2,632
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>).....				\$	367,544
Accrued Health Insurance					11,502
Acc'd Expense-Personal Property Tax					215
Acc'd Operating Expenses					164,391
Acc'd Expense - CT Sales & Use Tax					142
Provider Taxes Due					186,869
Acc'd Expense-Real Property Tax					4,425
A-13. Total Current Liabilities (Lines A1 thru 12).....				\$	2,797,734

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care Center	License No. 2382	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount
Total Brought Forward:				2,797,734
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>).....				\$ 108,136
Name of Lender	Purpose	Amount	Date Due	
Energy Efficiency Project		108,136		
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>).....				\$ 2,596,530
N/P United Methodist		1,798,803		
N/P Related Landlord		797,727		
B-5. Total Long-Term Liabilities (Lines B1 thru 4).....				\$ 2,704,666
C. Total All Liabilities (Lines A-13 + B-5).....				\$ 5,502,400

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2017	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land.....			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized.....			\$	
3. Reserve for depreciation value of leased personal property (<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.....			\$	
B. Net Worth				
1. Owner's Capital.....			\$	
2. Capital Stock.....			\$	
3. Paid-in Surplus.....			\$	
4. Treasury Stock.....			\$	
5. Cumulated Earnings.....			\$	(147,722)
6. Gain or Loss for Period			\$	(438,648)
	10/1/2016	thru 9/30/2017		
7. Total Net Worth.....			\$	(586,370)
C. Total Reserves and Net Worth			\$	(586,370)
D. Total Liabilities, Reserves, and Net Worth			\$	4,916,030

H. Changes in Total Net Worth


Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2017	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	(153,719)
B. Total Revenue (From Statement of Revenue Page 30)			\$	9,619,115
C. Total Expenditures (From Statement of Expenditures Page 27)			\$	10,057,763
D. Net Income or Deficit.....			\$	(438,648)
E. Balance.....			\$	(592,367)
F. Additions				
1. Additional Capital Contributed (itemize)				
2016 Pension reversal			6,000	
Rounding			(3)	
2. Other (itemize)				
F-3. Total Additions.....			\$	5,997
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			\$	(586,370)
				09/30/17

I. Preparer's/Reviewer's Certification

Name of Facility Sharon SNF CT LLC, d/b/a Sharon Health Care Center	License No. 2382	Report for Year Ended 9/30/2017	Page 37	of 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

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer 	Title CFO	Date Signed 2/2/18
Printed Name of Preparer Athena Health Care Associates, Inc		
Address 135 South Road Farmington, CT 06032		Phone Number (860) 751-3900

Cost report forms generated by Athena Health Care Associates, Inc as approved in letter dated 12/11/13.