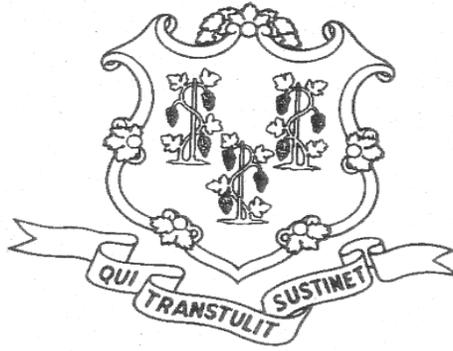


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Shady Knoll Health Care Center	
Address (No. & Street, City, State, Zip Code) 44 Skokorat Street Seymour, CT 06483	
Type of Facility <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 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 2107C	RHNS	(Specify)	Medicare Provider 07-5386
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Medicaid Provider Numbers:	CCNH 2107C	RHNS	ICF-IID
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**For Department Use Only**

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

**General Information**

Name of Facility (as licensed) Shady Knoll Health Care Center	License No. 2107C	Report for Year Ended 9/30/2021	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 Shady Knoll Health Care Center [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Patrick McDonnell			Printed Name (Owner) Lawrence Santilli		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires  / /	
Address of Notary Public					

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Shady Knoll Health Care Center	Period Covered:	From 10/1/2020	To 9/30/2021	
Address of Facility 44 Skokorat Street Seymour, CT 06483				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900	Date 2/12/2021		
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. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (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 203-881-2555		Report for Year Ended 9/30/2021	Page 2	of 37
Name of Facility (as shown on license) Shady Knoll Health Care Center		Address (No. & Street, City, State, Zip ) 44 Skokorat Street Seymour, CT 06483		
License Numbers:	CCNH 2107C	RHNS (Specify)	Medicare Provider No. 07-5386	
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="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> 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="radio"/> Yes <input checked="" type="radio"/> No      If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator Patrick Mcdonnell		Nursing Home Administrator's License No.:	1574	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name Not Applicable		License No.:		



**General Information and Questionnaire  
 Corporate Owners**

Name of Facility Shady Knoll Health Care Center	License No. 2107C	Report for Year Ended 9/30/2021	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address		State(s) in Which Incorporated	
Shady Knoll Health Center, Inc.	41 Skokorat St, Seymour, CT 06483		CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Lawrence G. Santilli	41 Skokorat St, Seymour, CT 06483	President	7602.02	
Michael E. Mosier	41 Skokorat St, Seymour, CT 06483	Treasurer/Secretary		
Names of Stockholders Owning at Least 10% of Shares				
Custodians for Lawrence E. Santilli	41 Skokorat St, Seymour, CT 06483		2397.98	



**General Information and Questionnaire  
Related Parties\***

Name of Facility Shady Knoll Health Care Center	License No. 2107C	Report for Year Ended 9/30/2021	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?     Yes     No    If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Laurel Ridge Health Care Center	642 Danbury Road Ridgefield, CT 06877	<input checked="" type="radio"/>	<input type="radio"/>	>98%	Bank Fees	Pg 16 ln m13	4,580	4,580
Athena 401 (K) Plan	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Facility Participates in a Multi Facility 401(k)			
Athena Captive	135 South Rd, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	>98%	Workers Comp Captive	Pg 15 1a1	238,980	238,980
Shady Knoll Landlord	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Lease of Facility	Pg 22, ln 9, 10b; Pg 27	800,120	800,120
Misc. Facilities	Various	<input checked="" type="radio"/>	<input type="radio"/>	>98%	Interfacility Loans	Pg 33, Ln A2		
Athena Health Insurance	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Self Insured Employee Health & Dental Insu	Pg 15, Ln 1a5	1,143,317	1,143,317
Procare LTC	1492 Highland Ave, Cheshire CT 06410	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Pharmacy	Pg 20 Ln 5a2	447,680	447,680
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	>50%	See Attachment			
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.

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

**General Information and Questionnaire**  
**Basis for Allocation of Costs**

Name of Facility Shady Knoll Health Care Center	License No. 2107C	Report for Year Ended 9/30/2021	Page 5	of 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? <input checked="" type="radio"/> Yes <input type="radio"/> 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.)				
<div style="text-align: right;"> <input checked="" type="radio"/> Yes      <input type="radio"/> No      If "No," explain fully why such allocation was not made.         </div>				

### 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 Shady Knoll Health Care Center		License No. 2107C		Report for Year Ended 9/30/2021			Page 6	of 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						
Leaf Capital Funding, 1720A Crete Street, Moherly, MO 65270	<input type="radio"/>	<input checked="" type="radio"/>	Copier	04/25/19	48 Months	12,800	12,800	
Graphic Savings Group, 457 Castle Ave., Fairfield, CT 06825	<input type="radio"/>	<input checked="" type="radio"/>	Copier	04/30/14	60 months	8,244	4,123	
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	<input type="radio"/>	<input checked="" type="radio"/>	Postal Equipment	09/21/18	48 Months	2,502	2,502	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes	<input checked="" type="radio"/> No
<b>Total ***</b>							19,425	

\* 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 Shady Knoll Health Care Center	License No. 2107C	Report for Year Ended 9/30/2021	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	555 Long Wharf Dr, 12th Floor, New Haven, CT 06511
2 PFK O'Connor Davies	4 Corporate Drive, Suite 488, Shelton, CT 06484
3 Midcap Financial Services, LLC	7255 Woodmont Ave, Bethesda, MD 20814
4	

Services Provided by This Firm (*describe fully*)

1 Medicare Cost Report Preparations	\$ 2,700
2	\$
3 Line of credit audit fees: Disallowed	\$ 3,418
4	\$
	Charge for Services Provided
	\$ 6,118

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    Pg 15, Line 1d

**Legal Services Information**

Name of Legal Firm or Independent Attorney	Telephone Number
1 Midcap Financial Services	301-760-7600
2 State of Connecticut Treasurer	860-702-3000
3 Goldman Gruder & Woods	203-899-8900
4 Murtha Cullina	860-240-6000
5	

Address (*No. & Street, City, State, Zip Code*)  
 1 7255 Woodmont Ave, Bethesda, MD 20814  
 2 55 Elm st, Hartford CT 06106  
 3 200 Connecticut Ave, Norwalk, CT 06854  
 4 280 Trumbull St 12th Floor, Hartford CT 06103  
 5

Services Provided by This Firm (*describe fully*)

1 Line of Credit: Disallow	\$ 32
2 Conservator: Disallow	\$ 1,065
3 Collections: Disallow	\$ 7,275
4 Annual Reports	\$ 300
5	\$
	Charge for Services Provided
	\$ 8,672

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 Shady Knoll Health Care Center		License No. 2107C			Report for Year Ended 9/30/2021				Page 8	of 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	128	128			128	128						
B. On last day of THIS report period	128	128							128	128		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	93	93			93	93						
B. As of midnight of THIS report period	113	113							113	113		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,932	5,932			4,195	4,195			1,737	1,737		
B. Medicaid (Conn.)	24,324	24,324			17,477	17,477			6,847	6,847		
C. Medicaid (other states)												
D. Private Pay	1,819	1,819			1,287	1,287			532	532		
E. State SSI for RCH												
F. Other (Specify) Contract Other/VA	4,786	4,786			3,518	3,518			1,268	1,268		
G. Total Care Days During Period (3A thru F)	36,861	36,861			26,477	26,477			10,384	10,384		
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	143	143			105	105			38	38		
5. <b>Total Resident Days (3G + 4A + 4B)</b>	37,004	37,004			26,582	26,582			10,422	10,422		

**Annual Report of Long-Term Care Facility**

**Schedule of Resident Statistics (Cont'd)**

Name of Facility Shady Knoll Health Care Center			License No. 2107C			Report for Year Ended 9/30/2021			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> 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	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	12		77		6		18						
Per Diem Rate													
a. One bed rm.	551.28		246.77		611.00		330.21						
b. Two bed rms.	551.28		246.77		601.00		330.21						
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									5,879	5,879			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									1,756	1,756			
2. Restorative Treatments													
C. Other									15,438	15,438			
D. <b>Total Physical Therapy Treatments</b>									23,073	23,073			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									615	615			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									209	209			
2. Restorative Treatments													
C. Other									1,948	1,948			
D. <b>Total Speech Therapy Treatments</b>									2,772	2,772			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									3,659	3,659			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									1,669	1,669			
2. Restorative Treatments													
C. Other									24,128	24,128			
D. <b>Total Occupational Therapy Treatments</b>									29,456	29,456			

**Annual Report of Long-Term Care Facility**

CSP-10 Rev. 9/2002

**Report of Expenditures - Salaries & Wages**

Name of Facility Shady Knoll Health Care Center	License No. 2107C	Report for Year Ended 9/30/2021	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	140,628	2,059				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	273,368	11,525				
5. Dietary Service						
a. Head Dietitian	22,869	619				
b. Food Service Supervisor	51,623	1,690				
c. Dietary Workers	429,690	27,019				
6. Housekeeping Service						
a. Head Housekeeper	64,320	2,437				
b. Other Housekeeping Workers	207,886	13,025				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	72,523	2,314				
b. Other Maintenance Workers	46,519	2,040				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	146,962	8,175				
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	156,664	2,912				
b. RN						
1. Direct Care	337,162	6,774				
2. Administrative**	506,044	16,144				
c. LPN						
1. Direct Care	1,071,268	36,541				
2. Administrative**						
d. Aides and Attendants	1,600,123	85,905				
e. Physical Therapists	642,044	16,102				
f. Speech Therapists	113,165	2,276				
g. Occupational Therapists	308,726	7,315				
h. Recreation Workers	134,189	5,695				
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	214,001	6,450				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	6,539,774	257,017				

\* 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
Shady Knoll Health Care Center				2107C	9/30/2021				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
Not Applicable										
<b>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).</b>										
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	
Shady Knoll Health Care Center				2107C	9/30/2021			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Michael Chiappinelli (10/1/20-01/02/21)	33,895			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	517	A2			
Timothy Flaherty (1/3/21-5/29/21)	53,000					840	A2			
Patrick McDonnell (5/30/21-9/30/21)	52,333					702	A2			
<b>Section IV - Assistant Administrators</b>										
Deborah Torrey	1,400			Severnce Pay			A2			

\*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		
Shady Knoll Health Care Center	2107C	9/30/2021	13	37		
<b>Total Cost and Hours</b>						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian						
2. Dentist	7,680	75				
3. Pharmacist	13,240	77				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	60,000	163				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	2,182	6				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	1,743	5				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	24,022	207				
2. Administrative***	3,360	54				
b. LPN						
1. Direct Care	560,433	5,843				
2. Administrative***						
c. Aides	184,864	3,869				
d. Other						
12. Other (Specify) See Attached Schedule						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>857,524</b>	<b>10,299</b>				

\* 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 Shady Knoll Health Care Center		License No. 2107C	Report for Year Ended 9/30/2021	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Garumuni Desilva, MD, West Haven Medical Group, 387 Campell Ave, Suite 2, West Haven, CT	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Hafsa Nawaz, West Haven Medical Group, 387 Campell Ave, Suite 2, West Haven, CT 06516	Asst. Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
CT Dental, 240 Pomeroy Ave, Suite 2015, Meriden, CT 06450	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
Northeast Medical Group INC, 367 Grand ST, Bridgeport CT 06610	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Valley Orthodaedic Specialists, LLC 2 Trap Falls Suite 404, Sheton CT 06484	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Procure LTC, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners; Minority Interest	
Patient Choice Medical Care, LLC 2080 Whitney Ave Suite #250 Hamden, CT 06518	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Star Medical Care LLC, 2560 Dixwell Ave #1A Hamden, CT 06514	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Masstex, 3 Electronics Ave Ste #201, Danvers, MA 01923	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
SDX Dysphagia Experts, 21 Waterville Rd, Avon CT 06001	Speech Services	<input type="radio"/>	<input checked="" type="radio"/>		
Athena Healthcare Associates, 135 Soth Rd, Farmington, CT 06032	MDS Fill-in	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners	
Gale Healthcare Solutions, 11274 W Hillsborough Ave, Tampa FL 33635	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Norton & Associates INC, 97 Elm Street, Cohasset MA 02025	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Soloman Page Staffing Solutions, 350 Motor Pkwy Suite 207, Hauppauge NY 11788	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input checked="" type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		

\* 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
Shady Knoll Health Care Center	2107C	9/30/2021	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 238,980	238,980		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 63,011	63,011		
4. Social Security (F.I.C.A.)	\$ 476,273	476,273		
5. Health Insurance	\$ 978,545	978,545		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 23,547	23,547		
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*	\$ 100,111	100,111		
d. Accounting and Auditing	\$ 6,118	6,118		
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 8,672	8,672		
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 53,329	53,329		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 94,756	94,756		
2. Cellular Phones	\$ 180	180		
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*	\$ 10,986	10,986		
2. Other ( <i>Specify</i> ) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 653,133	653,133		
<b>Subtotal</b>	\$ 2,707,641	2,707,641		

\* 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
Shady Knoll Health Care Center	2107C	9/30/2021		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>	2,707,641	2,707,641			
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 5,139	5,139			
3. Gifts to Staff and Residents	\$ 13,262	13,262			
4. Employee Travel	\$ 2,179	2,179			
5. Education Expenses Related to Seminars and Conventions	\$ 2,302	2,302			
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$				
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 18,060	18,060			
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 8,932	8,932			
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	\$ 6,048	6,048			
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 1,453	1,453			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
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**	\$ 388,296	388,296			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 119,806	119,806			
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 3,273,118	3,273,118			

\* 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)
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 8,932		
<b>Total Other Advertising</b>	\$ 8,932	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 1,453		
<b>Total Dues</b>	\$ 1,453	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
<b>Total Contributions</b>	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Data Processing Fees	\$ 51,089		
Bank Charges	\$ 18,176		
Payroll Processing Fees	\$ 19,264		
Employee Physicals	\$ 6,190		
Administrator Recruitment	\$ 10,000		
CMS 2021-010-LTC-415	\$ 13,507		
Licenses	\$ 1,580		
<b>Total Other Administrative and General</b>	\$ 119,806	\$ -	\$ -

**Schedule C-1 - Management Services\***

Name of Facility	License No.	Report for Year Ended	Page of
Shady Knoll Health Care Center	2107C	9/30/2021	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	538,255	Contract Attached to a Prior Year	See Below
Allocation of the above	\$96,886	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	33,048	Admin/Gen - Other Exp	Pg 16, Line 12

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Shady Knoll Health Care Center		2107C	9/30/2021		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 334,422	334,422			
2.	Non-Food Supplies	\$ 37,080	37,080			
3.	Other ( <i>Specify</i> ) _____ Dishes	\$ 602	602			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )		\$				
c. Other ( <i>Specify</i> ) _____		\$				
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>		\$ 372,104	372,104			
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)	
F.	Resident Meals: Total no. of meals served per day:*	303	303			
G.	Is cost of employee meals included in 2D?	<input checked="" type="radio"/> Yes	<input type="radio"/> No			
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input checked="" type="radio"/> Yes	<input type="radio"/> No	If yes, specify cost.		\$320
K.	Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
N.	Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)						

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

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

Name of Facility Shady Knoll Health Care Center		License No. 2107C	Report for Year Ended 9/30/2021		Page 19	of 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. \$	13,068	13,068		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Other (Specify) Supplies		\$	8,550	8,550		
3D. <b>Total Laundry Expenditures</b> (3a + b + c)		\$	21,618	21,618		
3E. Laundry Questionnaire						
F. Is cost of employee laundry included in 3D?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				

\* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

\*\*\* Pounds of Laundry only required for multi-level facilities.

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

Name of Facility		License No.	Report for Year Ended		Page	of
Shady Knoll Health Care Center		2107C	9/30/2021		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. \$	53,795	53,795		
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.	Other ( <i>Specify</i> )	\$				
<b>4D.</b>	<b>Total Housekeeping Expenditures (4a + b + c)</b>	\$	53,795	53,795		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from Procure	\$	414,109	414,109		
b.	Medicine Cabinet Drugs	\$	20,478	20,478		
c.	Medical and Therapeutic Supplies	\$	360,776	360,776		
d.	Ambulance/Limousine***	\$	4,586	4,586		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	20,891	20,891		
f.	X-rays and Related Radiological Procedures***	\$	22,352	22,352		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h.	Laboratory***	\$	38,430	38,430		
i.	Recreation	\$	5,142	5,142		
j.	Direct Management Services*	\$	96,886	96,886		
k.	Indirect Management Services*	\$	86,121	86,121		
l.	Other (Specify)**** See Attached Schedule	\$	179,004	179,004		
<b>5M.</b>	<b>Total Resident Care Expenditures (5a - 5j)</b>	\$	1,248,775	1,248,775		

\* 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**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
Management Fee Direct	\$ 96,886		
Physical Therapy Supplies	\$ 7,289		
Medical Equipment Rental-Other	\$ 22,732		
Cable TV Services	\$ 17,360		
Oxygen equipment rentals	\$ 24,723		
Medical Equipment Rental-Medicaid	\$ 10,014		
<b>Total Other Resident Care</b>	<b>\$ 179,004</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility Shady Knoll Health Care Center			License No. 2107C		Report for Year Ended 9/30/2021			Page of 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	100 Corporate Drive, Windsor, CT 06095	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	14,350			16	m13
CWPM	PO Box 99, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal	28,960			22	6f
Gold Coast Property Maintenance LLC	151 Monroe Turnpike, Monroe, CT 06468	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping/Snow Removal	25,237			22	6f
Procure LTC	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners; Minority Interest	Pharmacy	447,680			20	5a2
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

\* 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
Shady Knoll Health Care Center	2107C	9/30/2021			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 112,121	112,121				
b. Heat	\$ 51,887	51,887				
c. Light & Power	\$ 145,899	145,899				
d. Water	\$ 69,416	69,416				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 19,425	19,425				
f. Other ( <i>itemize</i> )	\$ 72,510	72,510				
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 471,258</b>	<b>471,258</b>				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 559	559				
b. Building & Building Improvements	\$ 82,905	82,905				
c. Non-Movable Equipment	\$ 23,646	23,646				
d. Movable Equipment	\$ 47,259	47,259				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 154,369</b>	<b>154,369</b>				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 5,859	5,859				
c. Leasehold Improvements	\$ 30,382	30,382				
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 36,241</b>	<b>36,241</b>				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 531,884	531,884				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 140,785	140,785				
c. Personal property taxes	\$ 13,630	13,630				
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 876,909</b>	<b>876,909</b>				

\* 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	\$ 11,739		
Rubbish Removal	\$ 30,891		
Snow Removal	\$ 11,736		
Supplies	\$ 18,144		
<b>Total Other Repairs and Maintenance</b>	\$ 72,510	\$ -	\$ -

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### Depreciation Schedule

Name of Facility Shady Knoll Health Care Center			License No. 2107C			Report for Year Ended 9/30/2021			Page 23	of 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			
<b>A. Land Improvements</b>													
1. Acquired prior to this report period			70,380			68,424	SL	Var	559				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal										559			
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period			2,747,855			2,177,660	SL	Var	82,905				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal										82,905			
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period			630,911			353,391	SL	Var	23,646				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal										23,646			
		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								
<b>D. Movable Equipment</b>													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period				9	2020	1,070,910			919,967	S/L	Var	45,478	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)				9	2021	34,884				S/L	Var	1,781	
D-3. Subtotal													47,259
<b>E. Total Depreciation</b>													154,369

Schedule of Land Improvements Acquired during this report period

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

\*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
<b>Additions:</b>				
<b>Total additions for Building Improvement</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Building Improvement</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
2/1/2021	Laptops	\$ 1,141	3	\$ 190
3/31/2021	Beds	\$ 5,761	15	\$ 192
7/31/2021	Dryer	11586	10	579.3
8/31/2021	Washer	16396	10	819.8
1/0/1900		0	0	0
1/0/1900		0	0	0
<b>Total additions for Movable Equipmen</b>		<b>\$ 34,884</b>		<b>\$ 1,781 *</b>
<b>Deletions:</b>				
<b>Total deletions for Movable Equipmen</b>		<b>\$ -</b>		<b>\$ - **</b>

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

## Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
See attached schedule	See attached schedule	\$ 51,325		\$ -
			20	\$ 293
			10	1979.95
				0
				0
				0
<b>Total additions for Leasehold Improvemen</b>		<b>\$ 51,325</b>		<b>\$ 2,273 *</b>
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvemen</b>		<b>\$ -</b>		<b>\$ - **</b>

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Annual Report of Long-Term Care Facility**

CSP-24 Rev. 10/2006

**Amortization Schedule\***

Name of Facility			License No.		Report for Year Ended			Page	of
Shady Knoll Health Care Center			2107C		9/30/2021			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							
<b>A. Organization Expense</b>									
1. Bed License									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1. Finance Fees-Key Bank	6	2007	7 years	305,597	305,597	SL			
2. Finance Fees	2	2018	36 Months	52,729	46,870	SL		5,859	
3.									
B-4. Subtotal									5,859
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period		2020		1,508,075	423,239	1,508,075	Various	28,109	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2021	Various	51,325			Various	2,273	
C-4. Subtotal									30,382
<b>D. Total Amortization</b>									36,241

\* 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.

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

Name of Facility Shady Knoll Health Care Center	License No. 2107C	Report for Year Ended 9/30/2021	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description		Total		
1. Date Land Purchased		1991		
2. Date Structure Completed		5/21/1993		
3. If <b>NOT</b> Original Owner, Date of Purchase				
4. Date of Initial Licensure		05/21/93		
5. Total Licensed Bed Capacity		128		
6. Square Footage				
7. Acquisition Cost				
a. Land		652,528		
b. Building		5,696,463		
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	03/29/12			
c. Interest Rate for the Cost Year	3.22%			
d. Term of Mortgage (number of years)	31			
e. Amount of Principal Borrowed	10,237,067			
f. Principal balance outstanding as of	5,736,093			
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
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				
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
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
Shady Knoll Health Care Center		2107C	9/30/2021			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. <b>Total Building Interest Expense</b> (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
Shady Knoll Health Care Center		2107C		9/30/2021		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify)				\$	21,453	21,453	
Vendor Interst=\$21,507 Key Bank Line of Credit=\$30,238							
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$	21,453	21,453	
14. Insurance							
a. Insurance on Property (buildings only)				\$	132,254	132,254	
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. <b>Total Insurance Expenditures (14a + b + c)</b>				\$	132,254	132,254	
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$	13,868,582	13,868,582	

### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center				2107C	9/30/2021	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$ 308,726	308,726		
4.			Other - See attached Schedule	\$ 2,906	2,906		
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$ 2,182	2,182		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$ 100,111	100,111		
10.			Accounting	\$ 3,418	3,418		
10a.			Legal	\$ 8,372	8,372		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$ 13,262	13,262		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.			Unallowable Advertising *	\$ 8,932	8,932		
19.			Income Tax / Corporate Business Tax	\$ 10,986	10,986		
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$ 215,209	215,209		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 31,683	31,683		
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$ 320	320		
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
<b>Subtotal (Items 1 - 26)</b>				<b>\$ 706,107</b>	<b>706,107</b>		

\* 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	\$ 2,906		
<b>Total Other Salaries Adjustment</b>			\$ 2,906	\$ -	\$ -

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Fees Adjustments</b>			\$ -	\$ -	\$ -

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Charges	\$ 18,176		
16	M13	CMS 2021-010LTC 415	\$ 13,507		
			\$ -		
<b>Total Other A&amp;G Adjustments</b>			\$ 31,683	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Shady Knoll Health Care Center			2107C	9/30/2021	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 706,107	706,107		
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$ 414,109	414,109		
28.			Ambulance/Limousine	\$ 4,586	4,586		
29.			X-rays, etc	\$ 22,352	22,352		
30.			Laboratory	\$ 38,430	38,430		
31.			Medical Supplies	\$ 17,040	17,040		
32.			Oxygen (non emergency)	\$ 20,891	20,891		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 58,518	58,518		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 11,599	11,599		
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	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$ 674	674		
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$ 58,693	58,693		
46.			Management Fees Indirect	\$ 52,172	52,172		
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 1,405,171	1,405,171		

\*\*\* 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	\$ 22,732		
20	5b	EBOX	\$ 19,941		
30	IV8	Nursing Supply Rebate	\$ 2,085		
20	5j	Radio + Television Revenue	\$ 13,760		
<b>Total Other Ancillary Costs</b>			\$ 58,518	\$ -	\$ -

## Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Movable Equipment (See Attached)	\$ 11,599		
<b>Total Excess Movable Equipment Depreciation</b>			\$ 11,599	\$ -	\$ -

## Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

## F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Shady Knoll Health Care Center	2107C	9/30/2021			30	37
Item	Total	CCNH	RHNS	(Specify)		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 14,651,784	14,651,784				
b. Medicaid Room and Board Contractual Allowance **	\$ (8,239,526)	(8,239,526)				
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 2,212,283	2,212,283				
b. Medicare Room and Board Contractual Allowance **	\$ 60,819	60,819				
4. a. Private-Pay Residents and Other	\$ 5,452,992	5,452,992				
b. Private-Pay Room and Board Contractual Allowance **	\$ (1,768,066)	(1,768,066)				
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 186,988	186,988				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (186,988)	(186,988)				
c. Prescription Drugs - Non-Medicare	\$ 208,083	208,083				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (202,555)	(202,555)				
2. a. Medical Supplies - Medicare	\$ 4,240	4,240				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (6,553)	(6,553)				
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 738,616	738,616				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (581,877)	(581,877)				
c. Physical Therapy - Non-Medicare	\$ 374,525	374,525				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (374,525)	(374,525)				
4. a. Speech Therapy - Medicare	\$ 153,925	153,925				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (126,283)	(126,283)				
c. Speech Therapy - Non-Medicare	\$ 133,350	133,350				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (133,350)	(133,350)				
5. a. Occupational Therapy - Medicare	\$ 593,133	593,133				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (491,887)	(491,887)				
c. Occupational Therapy - Non-Medicare	\$ 370,850	370,850				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (370,850)	(370,850)				
6. a. Other ( <i>Specify</i> ) - Medicare	\$					
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 1,121,486	1,121,486				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 13,780,614	13,780,614				
<b>IV. Other Revenue*</b>						
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 ( <i>Specify</i> )	\$ 674	674				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 107,207	107,207				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 107,881	107,881				
<b>VI. Total All Revenue</b> (III +V)	\$ 13,888,495	13,888,495				

\* 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
Shady Knoll Health Care Center	2107C	9/30/2021	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	91,786
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,320,067
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4 Inventories			\$	21,341
5. Prepaid Expenses			\$	144,692
a. Prepaid Insurance	131,223			
b. Prepaid Health insurance	5,898			
c. Operating - See Schedule	7,571			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	(105,985)
8. Other Current Assets ( <i>itemize</i> )			\$	190,108
Due From Related Parties	190,108			
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	1,662,009
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	70,380	\$	1,397
	Accum. Depreciation	68,983		
	Net			
3. Buildings	*Historical Cost	2,747,856	\$	487,290
	Accum. Depreciation	2,260,566		
	Net			
4. Leasehold Improvements	*Historical Cost	1,559,400	\$	1,105,779
	Accum. Depreciation	453,621		
	Net			
5. Non-Movable Equipment	*Historical Cost	630,911	\$	253,874
	Accum. Depreciation	377,037		
	Net			
6. Movable Equipment	*Historical Cost	1,073,711	\$	106,485
	Accum. Depreciation	967,226		
	Net			
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation			
	Net			
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	32,083
Excluded Movable Equipment	32,083			
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	1,986,908

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

(Carry Total forward to next page )

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
<b>Total Prepaid Expenses</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Current Assets (Itemize)</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Fixed Assets (Itemize)</b>			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Deposits-Taxes	\$ 13,926
		Deposits-Lease	\$ 14,192
		Project Development/ Finance Fees	\$ 125,368
<b>Total Other Assets</b>			\$ 153,486

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Long-Term Liabilities (Itemize)</b>			\$ -

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2021	32	37
Account			Amount	
Total Brought Forward:			\$	3,648,917
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	649,355
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	5,602,448		
	Accum. Depreciation	5,275,347	Net	\$ 327,101
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			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			<b>\$</b>	<b>976,456</b>
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care <i>(itemize)</i>			\$	
_____				
6. Loans to Owners or Related Parties <i>(itemize)</i>			\$	<b>(18,180,047)</b>
Name and Address		Amount	Loan Date	
Related Party Facilities		<b>(18,180,047)</b>	3/29/12	
7. Other Assets <i>(itemize)</i>			\$ 153,486	
See Attached				
_____				
See Schedule			153,486	
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			<b>\$</b>	<b>(18,026,561)</b>
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			<b>\$</b>	<b>(13,401,188)</b>

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

## Annual Report of Long-Term Care Facility

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## G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center		2107C	9/30/2021	33	37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	2,588,637
2. Notes Payable ( <i>itemize</i> )				\$	(670,034)
line of credit					
loans				(950,311)	
					280,277
See Schedule					
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> )				\$	279,675
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	369,138
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*				\$	(26,508)
12. Other Current Liabilities ( <i>itemize</i> )				\$	1,234,371
				Provider Taxes Due	1,177,247
Acc'd Health Insurance				6,384	
Acc'd Operating Expenses				47,239	Acc'd Expense-Personal 3,433
Acc'd Expense - CT Sales & Use Tax				68	See Schedule
A-13. <b>Total Current Liabilities</b> (Lines A1 thru 12)				\$	3,775,279

\* 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 Shady Knoll Health Care Center	License No. 2107C	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			3,775,279	
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$ (9,354,348)
Name and Address of Lender	Amount	Loan Date		
Related Party	(9,354,348)	3/29/12		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ (1,837,774)
N/P L/T Related Party Landlord		(1,837,774)		
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ (11,192,122)
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ (7,416,843)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2021	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	649,355
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	327,102
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			\$	976,457
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(7,076,829)
6. Gain or Loss for Period	10/1/2020	thru 9/30/2021	\$	115,027
7. Total Net Worth			\$	(6,960,802)
<b>C. Total Reserves and Net Worth</b>			\$	(5,984,345)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	(13,401,188)

### H. Changes in Total Net Worth

Name of Facility Shady Knoll Health Care Center	License No. 2107C	Report for Year Ended 9/30/2021	Page 36	of 37		
Account			Amount			
A. Balance at End of Prior Period as shown on Report of 09/30/2020			\$	(6,873,088)		
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	13,888,495		
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	13,773,468		
D. Net Income or Deficit			\$	115,027		
E. Balance			\$	(6,758,061)		
F. Additions						
1. Additional Capital Contributed <i>(itemize)</i>						
Health Insurance 2020	(172,645)					
Rent	(14,975)					
2020 Est Tax Payments	(15,124)					
Rounding	3					
2. Other <i>(itemize)</i>						
F-3. Total Additions					\$	(202,741)
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. <b>Balance at End of Period</b>			\$	(6,960,802)		

### I. Preparer's/Reviewer's Certification

Name of Facility Shady Knoll Health Care Center	License No. 2107C	Report for Year Ended 9/30/2021	Page 37	of 37
<i>Check appropriate category</i>				
<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)		
<b>Preparer/Reviewer Certification</b>				
<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
Printed Name of Preparer				
Athena Health Care Associates, Inc				
Address Address			Phone Number	
135 South Road Farmington, CT 06032			(860) 751-3900	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Lynn Rinaldi			(860) 751-3900	
Contact Email Address				
lrinadli@athenahealthcare.com				