State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2021

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 ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2382			07-5379

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	2382		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Cente	2382	9/30/2021	1	37

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISIONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Sharon SNF CT LLC, d/b/a Sharon 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) Antonio Porcheddu			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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Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

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 10/1/2020	To 9/30/2021
Address of Facility 27 Hospital Hill Road Sharon, CT 06069				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900		Date	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$				
5. All other wages paid	$				
6. ***Total Wages Paid***	$				
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-364-1002	9/30/2021	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	27 Hospital Hill Road Sharon, CT 06069

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	2382			07-5379

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Antonio Porcheddu	2102

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

Name	License No.:
Not Applicable	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Cente	2382	9/30/2021	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Sharon SNF CT LLC	27 Hospital Hill Road, Sharon, CT	CT

Name of Partners/Members	Business Address	Title	% Owned
Lawrence G Santilli	135 South Road, Farmington, CT 06032	Manager	71.34

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Ca	2382	9/30/2021	3A	37

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Not Applicable			
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Ce	2382	9/30/2021	3B	37

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

Owner(s) of Facility
Not Applicable

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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	9/30/2021	4	37

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Sharon Landlord CT LLC	135 South Road, Farmington, CT 06032	○	⊙		Lease of Real Property	Pg 22, l9 and L10b; pg	227,198	227,198
Athena Captive	135 South Road, Farmington, CT 06032	○	⊙		Worker's Compensation Captive	Pg 15 1a1	150,209	150,209
Athena Health Care Assoc. 401 K Plan	135 South Road, Farmington, CT 06032	○	⊙		Facility participates in common 401k plan			
Athena Health Care Insurance	135 South Road, Farmington, CT 06032	⊙	○	<50%	Self Insured Employee Health & Dental	Pg 15 1a5	773,230	773,230
Procare, LTC	111 Executive Blvd., Farmingdale, NY 11735	⊙	○	>50%	Pharmacy	Pg 13 B3, Pg20 5a	310,110	310,110
Miscellaneous Facilities	Various	⊙	○	>98%	Interfacility loans	Pg 33, A2		
Athena Health Care	135 South Rd, Farmington, CT 06032	⊙	○	<50%	See attached			
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care	2382	9/30/2021	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required? ⊙ Yes ○ No If "No," explain fully why such allocation was not made.

Not Applicable

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.

Not Applicable

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

○ Yes ⊙ No If "No," explain fully why such allocation was not made.

Not Applicable: No Non-Nursing Home Cost Centers

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2021	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Pitney Bowes PO Box 371887, Pittsburgh, PA 15250	○	⊙	Postage Meter	01/10/16	51 months	820	820
Leaf Capital Funding, LLC 1720A Crete St, Moberly, MO 65270	○	⊙	Xerox 3655i Copier System	03/25/18	29 months	1,081	1,081
Hewlett Packard, PO Box 402582, Atlanta, GA	○	⊙	Fortiphone system	04/29/16	60 months	14,142	3,498
Leaf Capital Funding, LLC 1720A Crete St, Moberly, MO 65270	○	⊙	Xerox 7970 Copier/Xerox 3655 Copier	10/01/20	50 months	11,996	11,996
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total** *** 17,395

* 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.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon	2382	9/30/2021	7	37

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1	2020 Tax Return (Disallowed)	$ 1,360
2	Medicare Cost report-(allowed)	$ 2,700
3	2020 Partnership Tax Return (disallowed)	$ 5,155
4	2020 Form 8752 (allowed)	$ 515
		Charge for Services Provided $ 9,730

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/Pilicy & Ryan PC	203-899-8900/860-274-0018
3 State Marshall	860-485-0153
4 CT Treasurer	
5	

Address (*No. & Street, City, State, Zip Code*)
1 City Place, 185 Asylum St., Hartford, CT 06103
2 200 Connecticut Ave, Norwalk, CT/365 Main St, Watertown, CT
3 PO Box 471, Torrington, CT 06790
4 Litchfield Court of Probate
5

Services Provided by This Firm (*describe fully*)

1	Audit & Ann. Filing $160(Allowed),	$ 160
2	A/R Collections/General Matters (disallowed)	$ 29,728
3	Conservatorship (Disallowed)	$ 1,050
4		$
5		$
		Charge for Services Provided $ 30,938

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

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	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						
B. On last day of THIS report period	88	88							88	88		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	50	50			50	50						
B. As of midnight of THIS report period	67	67							67	67		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,683	5,683			4,594	4,594			1,089	1,089		
B. Medicaid (Conn.)	14,969	14,969			10,665	10,665			4,304	4,304		
C. Medicaid (other states)	7	7			7	7						
D. Private Pay	3,120	3,120			2,156	2,156			964	964		
E. State SSI for RCH												
F. Other (Specify) Managed Care	201	201			182	182			19	19		
G. Total Care Days During Period (3A thru F)	23,980	23,980			17,604	17,604			6,376	6,376		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	5	5			3	3			2	2		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	23,985	23,985			17,607	17,607			6,378	6,378		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Ca	2382	9/30/2021	9	37

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	2	6		7		52		
Per Diem Rate								
a. One bed rm.	399.50	302.86		600.00		342.13		
b. Two bed rms.	399.50	302.86		585.00		342.13		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	5,028	5,028		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	591	591		
2. Restorative Treatments				
C. Other	12,603	12,603		
D. ***Total Physical Therapy Treatments***	18,222	18,222		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	382	382		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	36	36		
2. Restorative Treatments				
C. Other	1,083	1,083		
D. ***Total Speech Therapy Treatments***	1,501	1,501		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,981	3,981		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	718	718		
2. Restorative Treatments				
C. Other	13,161	13,161		
D. ***Total Occupational Therapy Treatments***	17,860	17,860		

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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	9/30/2021	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	108,133	2,275				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	231,180	9,806				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	72,137	2,108				
c. Dietary Workers	344,281	20,638				
6. Housekeeping Service						
a. Head Housekeeper	52,884	2,182				
b. Other Housekeeping Workers	143,011	9,462				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	66,529	2,180				
b. Other Maintenance Workers	49,127	2,166				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	78,490	5,648				
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	121,347	2,164				
b. RN						
1. Direct Care	461,067	9,943				
2. Administrative**	333,354	10,672				
c. LPN						
1. Direct Care	450,293	14,226				
2. Administrative**						
d. Aides and Attendants	1,010,929	47,854				
e. Physical Therapists	445,476	12,043				
f. Speech Therapists	70,747	1,496				
g. Occupational Therapists	226,810	5,911				
h. Recreation Workers	145,820	6,728				
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	223,087	6,313				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	4,634,702	173,815				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

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

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

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

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

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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	9/30/2021	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Sawyer Thornton (10/1/20-4/26/21)	68,012			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	1,460	A2			
Joanne Gabriel (4/26/21-9/20/21)	36,621					775	A2			
Antonio Procheddu (9/20/21-9/30/21)	3,500					40	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.

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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 Cer	2382	9/30/2021	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	9,548	25				
3. Pharmacist	9,442	48				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	89,250	195				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
Psych Consulting Services	49,200	52				
9. Speech Therapist						
a. Resident Care	4,680	14				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	496,600	5,053				
2. Administrative***						
b. LPN						
1. Direct Care	373,053	4,145				
2. Administrative***						
c. Aides	598,325	13,114				
d. Other						
12. Other (Specify)						
See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	1,630,098	22,646				

* 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.

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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	9/30/2021	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	○	⊙	
Solomon Page Staffing Solutions, 260 Madison Avenue, 4th floor, New York, NY 10016	Nurse Pool	○	⊙	
Procare Professional Healthcare, P.O. Box 823461, Philadelphia, PA 19182	Nurse Pool	○	⊙	
Nurse Network, 653 Main Street, Plantsville, CT 06479	Nurse Pool	○	⊙	
Procare, LTC, 111 Executive Blvd., Farmingdale, NY 11735	Pharmacist	⊙	○	Common Owners/Minority Interest
Healthdrive, 85 Barnes Rd, Wallingford, CT 06492	Dental	○	⊙	
Mark Marshall, DO, 32 Burton Road, Salisbury, CT 06068	Medical director	○	⊙	
Quotidian, 52 Seneff Road, Washington, CT 06793	Assistant Medical Director	○	⊙	
SDX Dysphagia Experts, 21 Waterville Rd, Avon, CT 06001	Dysphagia Consultant	○	⊙	
Norton and Associates, Inc., 34 Elm Street, Cohasset, MA, 02025	Nurse Pool	○	⊙	
Fusion Medical Staffing, LLC. P.O. Box 82674 Lincoln NE 68501-2674	Nurse Pool	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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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 C	2382	9/30/2021	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	150,209	150,209		
2. Disability Insurance	$				
3. Unemployment Insurance	$	46,255	46,255		
4. Social Security (F.I.C.A.)	$	319,381	319,381		
5. Health Insurance	$	704,902	704,902		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	13,928	13,928		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	71,854	71,854		
d. Accounting and Auditing	$	9,730	9,730		
e. Legal (*Services should be fully described on Page 7)*	$	30,938	30,938		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	44,218	44,218		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	10,233	10,233		
2. Cellular Phones	$	2,710	2,710		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$	(5,208)	(5,208)		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	384,708	384,708		
Subtotal	$	1,783,858	1,783,858		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2021	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,783,858	1,783,858		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	3,407	3,407		
3. Gifts to Staff and Residents	$	17,398	17,398		
4. Employee Travel	$	238	238		
5. Education Expenses Related to Seminars and Conventions	$	3,960	3,960		
6. Automobile Expense (*not purchase or depreciation*)	$	4,905	4,905		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	15,562	15,562		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	12,436	12,436		
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	$	6,155	6,155		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	7,765	7,765		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	1,897	1,897		
10. Contributions***	$	500	500		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	180,499	180,499		
13. Other (*Specify*)	$	109,353	109,353		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,147,933	2,147,933		

* 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	$ 12,436		
Total Other Advertising	$ 12,436	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	$ -		
CAHCF Dues	$ 6,355		
ACHCA Dues	$ 1,410		
Total Dues	$ 7,765	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Data Processing Fees	$ 62,519		
Bank Charges	$ 19,981		
Payroll Processing Fees	$ 15,045		
Employee Physicals and background checks	$ 10,330		
Licenses	$ 1,478		
Total Other Administrative and General	$ 109,353	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Health	2382	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	273,484	Full Management Services	See Below
Amounts Added Back on Page 28	180,499	Admin/Gen 66%	Pg 16, L 12
	43,757	Indirect 16%	Pg 18, L2C
	49,227	Direct 18%	Pg 20, L5J
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032		Admin/Gen - Other Exp	Pg 16, Line 12

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

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CSP-18 Rev. 9/2018

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

Name of Facility	License No.	Report for Year Ended	Page of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2021	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	266,503	266,503		
2. Non-Food Supplies	$	29,163	29,163		
3. Other (*Specify*)_____ Dishes	$	1,763	1,763		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	297,429	297,429		
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*		197	197		

G.	Is cost of employee meals included in 2D?	⦿ Yes	○ No		
H.	Did you receive revenue from employees?	○ Yes	⦿ No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	⦿ Yes	○ No	If yes, specify cost.	$143
K.	Is any revenue collected from these people?	⦿ Yes	○ No	If yes, specify amt.	$11
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg 18, L2a1
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⦿ No	If yes, specify cost.	
N.	Is any revenue collected from employees?	○ Yes	⦿ No	If yes, specify amt.	
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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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	9/30/2021	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*					
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	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. $	10,523	10,523		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Supplies	$	6,428	6,428		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	16,951	16,951		

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
H.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
K.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3D.

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

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CSP-20 Rev. 9/2018

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care	2382	9/30/2021	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel		40,000	40,000		
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	31,226	31,226		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	31,226	31,226		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Procare		$	287,902	287,902		
b. Medicine Cabinet Drugs		$	12,815	12,815		
c. Medical and Therapeutic Supplies		$	244,185	244,185		
d. Ambulance/Limousine***		$	9,206	9,206		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	3,415	3,415		
f. X-rays and Related Radiological Procedures***		$	16,174	16,174		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	20,604	20,604		
i. Recreation		$	12,618	12,618		
j. Direct Management Services*		$	49,227	49,227		
k. Indirect Management Services*		$	43,757	43,757		
l. Other (Specify)**** See Attached Schedule		$	68,185	68,185		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	768,088	768,088		

* 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	$ 9,493		
Medical Equipment Rental-Medicaid	$ 6,955		
Cable TV Services	$ 22,796		
Medical Equipment Rental-Other	$ 7,569		
Oxygen Equipment Rental	$ 21,372		
Total Other Resident Care	$ 68,185	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health Care Center	2382	9/30/2021	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADP	100 Corporate Drive, Windsor, CT 06095	○	⊙		Payroll Processing	12,296			16	m13
Welsh Sanitation	PO Box 1209, Hopewell Junction, NY 12533	○	⊙		Rubbish Removal	35,414			22	6f
Procare	111 Executive Blvd., Farmingdale, NY 11735	⊙	○	Common Owners/Minority Interest	Pharmacy	310,110			16	m13
Haab Landscaping	66 Skunks Misery Rd, Millerton, NY 12546	○	⊙		Snow Removal/Landscaping	32,938			22	6f
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	$ 17,135		
Rubbish Removal	$ 37,343		
Snow Removal	$ 15,803		
Supplies	$ 18,482		
Total Other Repairs and Maintenance	$ 88,763	$ -	$ -

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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 Ca	2382	9/30/2021	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	196,616	196,616		
b. Heat	$	66,564	66,564		
c. Light & Power	$	83,608	83,608		
d. Water	$	66,439	66,439		
e. Equipment Lease (*Provide detail on page 6*)	$	17,395	17,395		
f. Other (*itemize*)	$	88,763	88,763		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	519,385	519,385		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	13,343	13,343		
d. Movable Equipment	$	37,594	37,594		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	50,937	50,937		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	66,869	66,869		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	66,869	66,869		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	227,198	227,198		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	46,110	46,110		
c. Personal property taxes	$	3,183	3,183		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	394,297	394,297		

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

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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	9/30/2021	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
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	129,438	SL	Various	13,343	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								13,343

	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	10,000	SL	10		
b. Bus Graphics			9	2014	4,668		4,668	4,668	SL	5		
c. Ford Econoline, 2014	x		1	2021	28,183		28,183		SL	5	2,818	
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	2020	493,638		493,638	344,169	S/L	Var	34,281	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2021	6,771		6,771		S/L	Var	495	
D-3. Subtotal												37,594
E. ***Total Depreciation***												50,937

Schedule of Land Improvements Acquired during this report period

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

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

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

Schedule of Building Improvements Acquired during this report period

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

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

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

Schedule of Non-Movable Equipment Acquired during this report peri

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

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

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
3/1/2021	Wifi Phones and Port	$ 1,379	5	$ 138	
3/1/2021	Bed	$ 1,482	10	$ 74	
3/1/2021	Bed and Parts	1843	10	92.15	
4/1/2021	Bed	1654	10	82.7	
4/1/2021	Matresses	1085	5	108.5	
1/1/2021	Nursing Computer	-672			
Total additions for Movable Equipmen		$ 6,771		$ 495	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
1/1/2021	Wander Guard System	$ 12,974	10	$ 649	
6/1/2021	Water Filtration	$ 16,650	10	$ 833	
9/1/2021	Replacement Compressor	5349	10	267.45	
9/1/2021	Fire Dampers and Motor	2192	10	109.6	
9/1/2021	Replacement AC Coil	11911	10	595.55	
Total additions for Leasehold Improvemer		$ 49,076		$ 2,454	*
Deletions:					
Total deletions for Leasehold Improvemer		$ -		$ -	**

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

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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	9/30/2021	24	37

Item	Date of Acquisition Month	Date of Acquisition Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				904,923	342,566	SL		64,415	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)	9	2021		49,076			Var	2,454	
C-4. Subtotal									66,869
D. ***Total Amortization***									66,869

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon He	2382	9/30/2021	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	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 _____	2,848,643			
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.

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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 H	2382	9/30/2021	26 | 37

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

(*Carry Subtotals forward to next page*)

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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	2382	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*) $	23,034	23,034		
Vendor Interst=$23,034				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	23,034	23,034		
14. Insurance				
a. Insurance on Property (buildings only) $	99,462	99,462		
b. Insurance on Automobiles $	1,113	1,113		
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)*** $	100,575	100,575		
15. ***Total All Expenditures (A-13 thru C-14)*** $	10,563,718	10,563,718		

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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	9/30/2021	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $	226,810	226,810		
4.			Other - See attached Schedule $	5,014	5,014		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $	71,854	71,854		
10.			Accounting $	6,515	6,515		
10a.			Legal $	30,778	30,778		
11.			Telephone $				
12.			Cellular Telephone $	1,990	1,990		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $	17,398	17,398		
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 * $	12,436	12,436		
19.			Income Tax / Corporate Business Tax $	(5,208)	(5,208)		
20.			Fund Raising / Contributions $	500	500		
21.			Unallowable Management Fees $	79,208	79,208		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	19,981	19,981		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $	143	143		
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	467,419	467,419		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12m	Marketing Salaries & Benefits	$ 5,014		
Total Other Salaries Adjustment			$ 5,014	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Charges	$ 19,981		
Total Other A&G Adjustments			$ 19,981	$ -	$ -

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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	9/30/2021	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	467,419	467,419		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $	287,902	287,902		
28.			Ambulance/Limousine $	9,206	9,206		
29.			X-rays, etc $	16,174	16,174		
30.			Laboratory $	20,604	20,604		
31.			Medical Supplies $	8,800	8,800		
32.			Oxygen (non emergency) $	3,415	3,415		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	7,940	7,940		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $	1,853	1,853		
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $	16	16		
44.			Other - Miscellaneous Administrative $	19,196	19,196		
45.			Management Fees Direct $	21,602	21,602		
46.			Management Fees Indirect $	19,202	19,202		
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49.			***Total Amount of Decrease (Items 1 - 48)*** $	883,329	883,329		

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

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental	$ 7,569		
20	5b	EBOX	$ 371		
Total Other Ancillary Costs			$ 7,940	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Movable Equipment (See Attached)	$ 1,853		
Total Excess Movable Equipment Depreciation			$ 1,853	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Radio & Television Revenue	$ 19,196		
Total Other Adjustments			$ 19,196	$ -	$ -

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Healtl	2382	9/30/2021	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	8,792,393	8,792,393		
b. Medicaid Room and Board Contractual Allowance **	$	(4,566,284)	(4,566,284)		
2. a. Medicaid (*All other states*)	$	4,095	4,095		
b. Other States Room and Board Contractual Allowance **	$	(2,670)	(2,670)		
3. a. Medicare Residents *(all inclusive)*	$	2,591,235	2,591,235		
b. Medicare Room and Board Contractual Allowance **	$	90,230	90,230		
4. a. Private-Pay Residents and Other	$	2,592,677	2,592,677		
b. Private-Pay Room and Board Contractual Allowance **	$	(290,169)	(290,169)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	219,146	219,146		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(219,146)	(219,146)		
c. Prescription Drugs - Non-Medicare	$	79,457	79,457		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(79,457)	(79,457)		
2. a. Medical Supplies - Medicare	$	2,953	2,953		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	774,236	774,236		
b. Physical Therapy - Medicare Contractual Allowance **	$	(618,660)	(618,660)		
c. Physical Therapy - Non-Medicare	$	180,300	180,300		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(180,300)	(180,300)		
4. a. Speech Therapy - Medicare	$	135,545	135,545		
b. Speech Therapy - Medicare Contractual Allowance **	$	(109,510)	(109,510)		
c. Speech Therapy - Non-Medicare	$	44,940	44,940		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(44,940)	(44,940)		
5. a. Occupational Therapy - Medicare	$	753,120	753,120		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(623,500)	(623,500)		
c. Occupational Therapy - Non-Medicare	$	194,090	194,090		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(194,090)	(194,090)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	81,166	81,166		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	9,606,857	9,606,857		
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)*	$	16	16		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	37,823	37,823		
V. Total Other Revenue (1 thru 8)	$	37,839	37,839		
VI. Total All Revenue (III +V)	$	9,644,696	9,644,696		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Misc Revenue from CRF funding	$ 81,166		
Total Other Resident Revenue		$ 81,166	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
pg 31, L A2	Interest on A/R	16	$ 16		
Total Interest Income			$ 16	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Bad Debt Recoveries	$ 37,823		
Total Other Revenue		$ 37,823	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Hea	2382	9/30/2021	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 192,604
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,469,753
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 87,063
4 Inventories				$ 15,935
5. Prepaid Expenses				$ 163,825
a. Prepaid Insurance		129,777		
b. Prepaid Expenses-Other		20,899		
c. Prepaid Insurance		13,149		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$ 98,400
8. Other Current Assets (*itemize*)				$ 136,037
Related Party		136,037		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,163,617
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	953,999		$ 544,564
	Accum. Depreciation	409,435	Net	
5. Non-Movable Equipment	*Historical Cost	209,766		$ 66,984
	Accum. Depreciation	142,782	Net	
6. Movable Equipment	*Historical Cost	497,729		$ 118,927
	Accum. Depreciation	378,802	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 2,606
Excluded Movable Equipment/move equip accun		2,537		
See Schedule		69		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 733,081

* 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	
Total Prepaid Expenses			$ -

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

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

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

Page Ref	Line Ref	Description	
		Fixed Asset Variance	$ 69
Total Other Other Fixed Assets (Itemize)			$ 69

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

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

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Hea	2382	9/30/2021	32	37

Account				Amount
			Total Brought Forward:	$ 2,896,698
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)				$ 2,666,291
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 187,471
Project Development		137,451		
Deferred Finance Fees		50,020		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 2,853,762
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 5,750,460

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

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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 Ca	2382	9/30/2021	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 2,151,293
2. Notes Payable (*itemize*)					$ 2,794,205
Loans - Related Parties			2,794,205		
See Schedule					
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 184,268
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 282,351
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 742,717
Acc'd Health Insurance	14,453	Provider Taxes Due	606,658		
Acc'd Operating Expenses	121,606				
See Schedule					
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 6,154,834

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

(Carry Total forward to next page)

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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 C	2382	9/30/2021	34	37

Account	Amount
Total Brought Forward:	6,154,834
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 1,814,473
Notes Payable: Related Landlord	1,814,473	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 1,814,473
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 7,969,307

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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 He	2382	9/30/2021	35	37

Account		Amount
A.	**Reserves**	
1.	Reserve for value of leased land	$
2.	Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
3.	Reserve for depreciation value of leased personal property (*Equity)*	$
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	$ (1,274,461)
6.	Gain or Loss for Period 10/1/2020 thru 9/30/2021	$ (919,022)
7.	Total Net Worth	$ (2,193,483)
C.	***Total Reserves and Net Worth***	$ (2,193,483)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 5,775,824

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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 Heal	2382	9/30/2021	36	37

	Account			Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2020			$ (1,669,473)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 9,644,696
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 10,563,718
D.	Net Income or Deficit			$ (919,022)
E.	Balance			$ (2,588,495)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2020 Health Insurance		(179,269)	
	2020 Medicare Cost Settlement		(39,000)	
	Rounding		(2)	
	Deferred HHS Funds		613,283	
	2. Other (*itemize*)			
F-3.	Total Additions			$ 395,012
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/21			$ (2,193,483)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Sharon SNF CT LLC, d/b/a Sharon Health	2382	9/30/2021	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Athena Health Care Associates, Inc

Addres Address	Phone Number
135 South Road Farmington, CT 06032	(860) 751-3900

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

Contact Email Address
pmyslinski@athenahealthcare.com