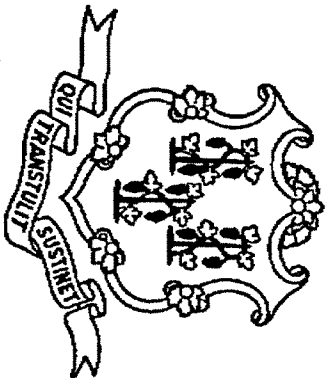


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2017

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 10/1/2016	Report for Year Ending 9/30/2017

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-MR
	2107C		

**For Department Use Only**

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



**MYERS AND  
STAUFFER** LLC  
CERTIFIED PUBLIC ACCOUNTANTS

December 11, 2013

Mr. Michael E. Mosier  
Chief Financial Officer  
Athena Health Care Systems  
135 South Road  
Farmington, CT 06032

Subject: Alternative Annual Report Approval

Dear Mr. Mosier:

This letter is a follow-up to your verbal approval regarding your request for alternative annual report utilization. We have reviewed your request for approval of the Athena Health Care Systems version of the 2013 Annual Report for the State of Connecticut. Based on our review, your version of the annual report has been approved.

It is not necessary to request approval on an annual basis. This approval will remain in effect until modifications have been made to the Annual Report by the Department of Social Services. The provider community will be notified should such changes occur. At that time, you will be required to submit a new request for approval based on the modified annual report.

Should you have any questions, please feel free to contact me at (860) 687-0790.

Sincerely,

Brittany L. Hester, Administrative Assistant

CC: Claudette B. Pickens, CPA

CC: Chris Lavigne

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

7 Waterside Crossing, Ste 202 | Windsor, CT 06095  
PH 860.687.0790 | PH 855.716.9377 | FX 860.687.0810  
[www.mslic.com](http://www.mslic.com)

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**General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2017	1	37

**Administrator's/Owner's Certification**

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Shady Knoll Health Care Center [facility name] for the cost report period beginning October 01, 2016 and ending September 30, 2017, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)	Date	Signed (Owner)	Date
	2-9-18		2-9-18
Printed Name (Administrator) Deborah S. Torrey		Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	State of CT	Date 2-9-18	Signed (Notary Public) 
		Comm. Expires 6/30/21	
Address of Notary Public 505 Persich Hill Rd Portland, CT 06480			

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility <b>Shady Knoll Health Care Center</b>	Period Covered:	From <b>10/1/2016</b>	To <b>9/30/2017</b>	
Address of Facility <b>44 Skokorat Street Seymour, CT 06483</b>				
Report Prepared By <b>Athena Health Care Associates, Inc</b>	Phone Number <b>(860) 751-3900</b>	Date <b>2/9/2018</b>		
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 <b>203-881-2555</b>		Report for Year Ended <b>09/30/17</b>	Page <b>2</b>	of <b>37</b>
Name of Facility (as shown on license) <b>Shady Knoll Health Care Center</b>		Address (No. & Street, City, State, Zip) <b>44 Skokorat Street Seymour, CT 06483</b>		
License Numbers:	CCNH <b>2107C</b>	RHNS	(Specify)	Medicare Provider No. <b>07-5386</b>
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="checkbox"/> PROPRIETORSHIP <input type="checkbox"/> LLC <input type="checkbox"/> PARTNERSHIP <input checked="" type="checkbox"/> PROFIT CORP. <input type="checkbox"/> NON-PROFIT CORP. <input type="checkbox"/> GOVERNMENT <input type="checkbox"/> TRUST				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                 If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator <b>Deborah S.Torrey</b>		Nursing Home Administrator's License No.:	<b>001800</b>	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		
<b>Not Applicable</b>				



**General Information and Questionnaire**  
**Corporate Owners**

Name of Facility	License No.	Report for Year Ended	Page	of
<b>Shady Knoll Health Care Center</b>	<b>2107C</b>	<b>9/30/2017</b>	<b>3A</b>	<b>37</b>
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		
<b>Shady Knoll Health Center, Inc.</b>	<b>41 Skokorat St, Seymour, CT 06483</b>	<b>CT</b>		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
<b>Lawrence G. Santilli</b>	<b>41 Skokorat St, Seymour, CT 06483</b>	<b>President</b>	<b>7602.02</b>	
<b>Debra M Soucey</b>	<b>41 Skokorat St, Seymour, CT 06483</b>	<b>Secretary</b>		
<b>Michael E. Mosier</b>	<b>41 Skokorat St, Seymour, CT 06483</b>	<b>Treasurer</b>		
Names of Stockholders Owning at Least 10% of Shares				
<b>Custodians for Lawrence E. Santilli</b>	<b>41 Skokorat St, Seymour, CT 06483</b>		<b>2397.98</b>	





## General Information and Questionnaire Related Parties\*

Name of Facility	License No.	Report for Year Ended	Page	of		
Shady Knoll Health Care Center	2107C	9/30/2017	4	37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <span style="float: right;"> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                     </span>						
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? <span style="float: right;"> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                     </span>						
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Indicate Where Costs are Included in Annual Report Page # / Line #	Actual Cost Reported	Actual Cost Related Party
		Yes	No %**			
Laurel Ridge Health Care Center	642 Danbury Road Ridgefield, CT 06877	<input checked="" type="checkbox"/>	>98%	Pg 16 ln m13	\$7,521	\$7,521
Athena 401 (K) Plan	135 South Road, Farmington, CT 06032	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Facility Participates in a Multi Facility 401(K) Plan		
Northbridge Health Care	2875 Main Street, Bridgeport, CT 06606	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Legal fee allocation	\$450	\$450
Shady Knoll Landlord	135 South Road, Farmington, CT 06032	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Lease of Facility	\$784,395	\$784,395
Misc. Facilities	Various	<input checked="" type="checkbox"/>	>98%	Interfacility Loans		
Abbott Terrace Healthcare Center	44 Abbott Terrace, Waterbury CT 06702	<input checked="" type="checkbox"/>	>98%	Transfer Legal Fee	\$3,297	\$3,297
Procure LTC	1492 Highland Ave, Cheshire CT 06410	<input checked="" type="checkbox"/>	>50%	Pharmacy	\$387,278	\$387,278
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/>	>50%	See Attached		
Athena Health Insurance	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/>	>50%	Self Insured Employee Health & Dental Insurance	\$1,420,592	\$1,420,592

\* Use additional sheets if necessary.

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

Shady Knoll  
RELATED PARTIES  
PAGE 4

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No				

Athena Health Care Systems	135 South Road Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<p>Management, Legal, Marketing, Bank Fees, A/R, MIS, mortgage fees, Insurance, Lobbying, Health Insurance</p> <p>Bank Charges, LOC Interest, payroll processing fees</p> <p>Computer conversion, data processing employee relations</p> <p>maintenance &amp; repairs</p> <p>Nursing consulting</p>	<p>Pg 15, 1e &amp; 1g, 1a5</p> <p>Pg 16, m3, m13, Pg 17</p> <p>Pg 27, 12D &amp; 14a, Pg 16, L2</p> <p>Pg 16, m13</p> <p>pg 23 D2c, pg 16 m13</p> <p>pg 16 L3</p> <p>pg 22, 6a</p> <p>pg 13, B5 &amp; B11</p>	\$707,732	\$290,870
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**General Information and Questionnaire**  
**Basis for Allocation of Costs**

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2017	5	37

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

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



**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2017	7	37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Cash <input type="checkbox"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "No," explain.				
<b>Independent Accounting Firm</b>				
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	Dworken, Hillman, Lamorte & Sterczala	4 Corporate Drive, Suite 488, Shelton, CT 06484		
3				
4				
Services Provided by This Firm ( <i>describe fully</i> )				
1	2016 Medicare Cost Report		\$	2,700
2	2017 Audit, Year End Financials & Tax Return		\$	9,500
3			\$	-
4			\$	-
			Charge for Services Provided	
			\$12,200	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                    Pg 15, Line 1d				
<b>Legal Services Information</b>				
Name of Legal Firm or Independent Attorney			Telephone Number	
1	Schiff Hardin	312-258-5500		
2	Murtha Cullina, LLP	860-240-6000		
3				
4	Goldman Gruder & Woods	203-899-8900		
5				
Address ( <i>No. &amp; Street, City, State, Zip Code</i> )				
1	600 Sears Tower, Chicago, IL 60606			
2	185 Asylum St, Hartford, CT 06103			
3				
4	200 Connecticut Ave, Norwalk, CT 06854			
5				
Services Provided by This Firm ( <i>describe fully</i> )				
1	Line of credit amendment: Disallow		\$	450
2	Annual Report&Audit Letter:Allow(\$2,179)/Misc:Disallow(\$177)		\$	1,346
3	Collections: Disallow		\$	12,480
4			\$	-
5			\$	-
			Charge for Services Provided	
			\$14,276	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                    Pg 15, Line 1e				

### Schedule of Resident Statistics

Name of Facility		License No.			Report for Year Ended				Page	of			
Shady Knoll Health Care Center		2107C			09/30/17				8	37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period.....	128	128			128	128			128	128			
B. On last day of THIS report period.....	128	128			128	128			128	128			
2. Number of Residents													
A. As of midnight of PREVIOUS report period.....	124	124			127	127			124	124			
B. As of midnight of THIS report period.....	126	126			126	126			126	126			
3. Total Number of Days Care Provided During Period													
A. Medicare.....	5,625	5,625			4,382	4,382			1,243	1,243			
B. Medicaid (Conn.).....	30,596	30,596			23,017	23,017			7,579	7,579			
C. Medicaid (other states).....													
D. Private Pay.....	3,167	3,167			2,374	2,374			793	793			
E. State SSI for RCH.....													
F. Other (Specify)      Contract Other/VA	5,230	5,230			3,693	3,693			1,537	1,537			
G. Total Care Days During Period (3A thru F).....	44,618	44,618			33,466	33,466			11,152	11,152			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days.....	217	217			156	156			61	61			
B. Other Bed Reserve Days.....	138	138			104	104			34	34			
5. Total Resident Days (3G + 4A + 4B).....	44,973	44,973			33,726	33,726			11,247	11,247			

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

Name of Facility	License No.	Report for Year Ended	Page	of
<b>Shady Knoll Health Care Center</b>	<b>2107C</b>	<b>9/30/2017</b>	<b>9</b>	<b>37</b>

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	12	86		8			20	
Per Diem Rate								
a. One bed rm.	528.97	232.48		521.00			327.31	
b. Two bed rms.	528.97	232.48		511.00			327.31	
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	5,657	5,657		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,356	1,356		
2. Restorative Treatments				
C. Other	18,155	18,155		
D. Total Physical Therapy Treatments	25,168	25,168		

8. Total Number of Speech Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	1,305	1,305		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	179	179		
2. Restorative Treatments				
C. Other	2,386	2,386		
D. Total Speech Therapy Treatments	3,870	3,870		

9. Total Number of Occupational Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	4,401	4,401		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,880	1,880		
2. Restorative Treatments				
C. Other	16,256	16,256		
D. Total Occupational Therapy Treatments	22,537	22,537		



### Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
<b>Shady Knoll Health Care Center</b>	<b>2107C</b>	<b>9/30/2017</b>	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<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)	104,671	2,074				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	277,359	11,449				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	53,407	1,673				
c. Dietary Workers	399,263	27,520				
6. Housekeeping Service						
a. Head Housekeeper	70,273	2,695				
b. Other Housekeeping Workers	198,457	14,976				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	75,188	2,483				
b. Other Maintenance Workers	47,679	2,393				
8. Laundry Service						
a. Supervisor	-612					
b. Other Laundry Workers	123,706	8,040				
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	174,963	3,517				
b. RN						
1. Direct Care	422,841	10,781				
2. Administrative**	558,419	20,084				
c. LPN						
1. Direct Care	1,147,124	43,786				
2. Administrative**						
d. Aides and Attendants	1,692,237	112,438				
e. Physical Therapists	615,822	17,413				
f. Speech Therapists	127,449	2,562				
g. Occupational Therapists	310,449	8,786				
h. Recreation Workers	149,319	7,301				
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	178,210	7,387				
n. Marketing						
o. Other (Specify)						
<i>A-13. Total Salary Expenditures</i>	6,726,224	307,358				

\* 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)**

Position	\$ CCNH	Hours CCNH	\$ RHNS	Hours RHNS	\$ (Specify)	Hours (Specify)
<b>Total</b>	\$ -	-	\$ -	-	\$ -	-

**Schedule of Physician: Other Fees (Page 13)**

Service	\$ CCNH	Hours CCNH	\$ RHNS	Hours RHNS	\$ (Specify)	Hours (Specify)
<b>Total</b>	\$ -	-	\$ -	-	\$ -	-

**Schedule of Other Fees (Page 13)**

Service	\$ CCNH	Hours CCNH	\$ RHNS	Hours RHNS	\$ (Specify)	Hours (Specify)
<b>Total</b>	\$ -	-	\$ -	-	\$ -	-

**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		9/30/2017		11	37		
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS (Specify)							
<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		9/30/2017		12	37		
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS (Specify)							
<b>Section III - Administrators***</b>									
Deborah S. Torrey (10/1/16-9/30/17)	104,671		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,074	A2			
<b>Section IV - Assistant Administrators</b>									

\* 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	9/30/2017	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.....	24,327	654				
2. Dentist.....	7,680	59				
3. Pharmacist.....	10,834	198				
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	191				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**.....	32,584					
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.....						
b. Other.....						
10. Occupational Therapist						
a. Resident Care.....						
b. Other.....						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	8,065	138				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides.....						
d. Other.....						
12. Other (Specify) See Attached Schedule						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>143,490</b>	<b>1,240</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		License No.	Report for Year Ended		Page	of
Shady Knoll Health Care Center		2107C	9/30/2017		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Annie Worthingtin, 14 Hockanum Glen Road, Beacon Falls, CT 06403	Dietician	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Frankie Maderia, 11 Grieb Trail, Wallingford, CT 06492	Dietician	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
CT Dental, 240 Pomeroy Ave, Suite 2015, Meriden, CT 06450	Dentist	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Alycia Mulhern, 24 Shawmut Ave, North Haven, CT 06473	Dietician	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Margaret Holden, 255 Cooper Pl. New Haven, CT 06511	Dietician	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Procure LTC, 111 Executive Blvd, Farmingdale, NY 11735	Pharmacist	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Owners; Minority Interest		
Yale New Haven Hospital, PO Box 1403, New Haven, CT 06505	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Pact LLC, 322 East Maine St, Suite 1B, Branford, Ct 06405	Physician Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Garumuni Desilva, MD, West Haven Medical Group, 387 Campell Ave, Suite 2, West Haven,	Medical Director	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Athena Health Care Associates	MDS fill-in	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Owners		
Dr. Hafsa Nawaz, West Haven Medical Group, 387 Campell Ave, Suite 2, West Haven, CT	Asst. Medical Director	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			

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

**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended		Page	of
Shady Knoll Health Care Center	2107C	9/30/2017		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation.....	\$ 404,892	404,892			
2. Disability Insurance.....	\$				
3. Unemployment Insurance.....	\$ 107,752	107,752			
4. Social Security (F.I.C.A.).....	\$ 500,934	500,934			
5. Health Insurance.....	\$ 1,149,501	1,149,501			
6. Life Insurance (employees only (not-owners and not-operators).....	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators).....	\$ 30,603	30,603			
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*.....	\$ 43,581	43,581			
d. Accounting and Auditing.....	\$ 12,200	12,200			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 14,276	14,276			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*.....	\$				
g. Office Supplies.....	\$ 52,795	52,795			
h. Telephone and Cellular Phones.....					
1. Telephone & Pagers.....	\$ 45,336	45,336			
2. Cellular Phones.....	\$ 1,860	1,860			
i. Appraisal ( <i>Specify purpose and        attach copy</i> )*.....	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> ).	\$				
k. Other Taxes ( <i>Not related to property - See Page 22</i> )					
1. Income*.....	\$				
2. Other ( <i>Specify</i> ) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 827,747	827,747			
<b>Subtotal</b>	\$ 3,191,477	3,191,477			

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

(Carry Subtotals forward to next page)

**Schedule of Other Employee Benefits**

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

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**Schedule of Other Taxes**

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

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**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	9/30/2017		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>	3,191,477	3,191,477			
1. Travel and Entertainment					
1. Resident Travel and Entertainment.....	\$				
2. Holiday Parties for Staff.....	\$ 2,791	2,791			
3. Gifts to Staff and Residents.....	\$ 19,611	19,611			
4. Employee Travel.....	\$ 8,865	8,865			
5. Education Expenses Related to Seminars and Conventions	\$ 4,694	4,694			
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> ).....	\$ 4,115	4,115			
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )***.....	\$ 32,888	32,888			
See Attached Schedule					
4. Fund-Raising***.....	\$				
5. Medical Records.....	\$ (339)	(339)			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***.....	\$ 235	235			
7. Postage.....	\$ 13,244	13,244			
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 9,799	9,799			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions.....	\$ 394	394			
10. Contributions*** See Attached Schedule	\$ 480	480			
11. Services Provided by Contract ( <i>Specify and Complete         Schedule C-2, Page 21 for each firm or individual</i> )	\$				
12. Administrative Management Services**.....	\$ 428,629	428,629			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 82,591	82,591			
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 3,799,474	3,799,474			

\* 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	\$ 32,888		
<b>Total Other Advertising</b>	\$ 32,888	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 9,799		
<b>Total Dues</b>	\$ 9,799	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Miscellaneous	\$ 480		
<b>Total Contributions</b>	\$ 480	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Data Processing Fees	\$ 25,394		
Bank Charges	\$ 7,978		
Payroll Processing Fees	\$ 23,353		
Employee Physicals	\$ 15,584		
Clear Energy-Utility Audit	\$ 8,592		
Treasurer-license renewal	\$ 1,080		
Licenses	\$ 610		
<b>Total Other Administrative and General</b>	\$ 82,591	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
<b>Shady Knoll Health Care Center</b>	<b>2107C</b>	<b>9/30/2017</b>	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	\$597,978	Contract Attached to a Prior Year	See Below
Allocation of the above	\$394,665 \$95,676 \$107,636	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 18, Line 2C Pg 20, Line 5J
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	\$33,964	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	9/30/2017	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food.....	\$ 288,434	288,434		
2. Non-Food Supplies.....	\$ 29,703	29,703		
3. Other (Specify) _____	\$ 59	59		
Dishes = \$59				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$			
c. Management Services**.....	\$ 95,676	95,676		
d. Other (Specify) _____	\$			
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 413,872</b>	<b>413,872</b>		
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*	367	367		
H. Is cost of employee meals included in 2E?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No		
I. Did you receive revenue from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		If yes, specify amount.
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No		If yes, specify cost. = \$231
L. Is any revenue collected from these people?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No		If yes, specify amount. = \$0
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				<b>Pg 18 ln 2a1</b>
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		If yes, specify cost.
O. Is any revenue collected from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		If yes, specify amount.
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Shady Knoll Health Care Center		2107C	9/30/2017		19	37
Item		Total	CCNH	RHNS	(Specify)	
3. Laundry						
a. In-House Processing*	Lbs.					
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$					
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.					
	Amt. \$					
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.					
	Amt. \$					
4. Repair and/or purchase of linens.***	Lbs.					
	Amt. \$	11,083	11,083			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$					
c. Management Services** .....	\$					
d. Other (Specify) Supplies = \$10,712	\$	10,712	10,712			
<b>3E. Total Laundry Expenditures (3a + b + c + d)</b>	<b>\$</b>	<b>21,795</b>	<b>21,795</b>			
<b>3F. Laundry Questionnaire</b>						
G. Is cost of employee laundry included in 3E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.			
H. Did you receive revenue from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.			
I. Where is the revenue received reported in the Cost Report?	(Page/Line Item)					
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.			
K. Did you receive revenue from these people?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.			
L. Where is the revenue received reported in the Cost Report?	(Page/Line Item)					

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

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

Name of Facility	License No.	Report for Year Ended	Page	of		
Shady Knoll Health Care Center	2107C	9/30/2017	20	37		
<b>Item</b>						
4. Housekeeping	Sq. Ft. Serviced by Personnel		Total	CCNH	RHNS	(Specify)
a. In-House Care	Amt.	\$	35,783	35,783		
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )						
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel	Amt.				
c. Management Services*						
d. Other ( <i>Specify</i> )						
4E. <b>Total Housekeeping Expenditures (4a + b + c + d)....</b>			\$ 35,783	\$ 35,783		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy.....						
2. Purchased from <i>Procure</i>			\$ 337,194	\$ 337,194		
b. Medicine Cabinet Drugs.....			\$ 19,130	\$ 19,130		
c. Medical and Therapeutic Supplies.....			\$ 274,175	\$ 274,175		
d. Ambulance/Limousine***						
e. Oxygen						
1. For Emergency Use.....						
2. Other***			\$ 65,582	\$ 65,582		
f. X-rays and Related Radiological Procedures***			\$ 41,721	\$ 41,721		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> ).....						
h. Laboratory***			\$ 41,973	\$ 41,973		
i. Recreation.....			\$ 27,015	\$ 27,015		
j. Other (Specify)*** See Attached Schedule			\$ 198,048	\$ 198,048		
5K. <b>Total Resident Care Expenditures (5a - 5j).....</b>			\$ 1,004,838	\$ 1,004,838		

\* 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.  
 \*\*\*\*\* ICFMRS should provide a detailed schedule of all Day Program Costs.

**Schedule of Other Resident Care**

Description	CCNH	RHNS	(Specify)
Management Fee Direct	\$ 107,636		
Physical Therapy Supplies	\$ 26,016		
Medical Equipment Rental-Other	\$ 17,076		
Cable TV Services	\$ 15,630		
Medical Equipment Rental-Medicaid	\$ 31,690		
<b>Total Other Resident Care</b>	\$ 198,048	\$ -	\$ -

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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
Shady Knoll Health Care Center	2107C	9/30/2017			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance..... \$	138,852	138,852				
b. Heat..... \$	50,097	50,097				
c. Light & Power..... \$	122,363	122,363				
d. Water..... \$	64,210	64,210				
e. Equipment Lease ( <i>Provide detail on page 6</i> )..... \$	30,510	30,510				
f. Other ( <i>itemize</i> )..... \$	75,874	75,874				
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)..... \$</b>	<b>481,906</b>	<b>481,906</b>				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements..... \$	5,339	5,339				
b. Building & Building Improvements..... \$	94,470	94,470				
c. Non-Movable Equipment..... \$	33,055	33,055				
d. Movable Equipment..... \$	52,256	52,256				
<b>*7e. Total Depreciation Costs (7a + b + c + d)..... \$</b>	<b>185,120</b>	<b>185,120</b>				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense..... \$						
b. Mortgage Expense..... \$						
c. Leasehold Improvements..... \$	5,959	5,959				
d. Other ( <i>Specify</i> )..... \$						
<b>*8e. Total Amortization Costs (8a + b + c + d)..... \$</b>	<b>5,959</b>	<b>5,959</b>				
9. Rental payments on leased real property less real estate taxes included in item 10b..... \$	557,686	557,686				
10. Property Taxes						
a. Real estate taxes paid by owner..... \$						
b. Real estate taxes paid by lessor..... \$	146,034	146,034				
c. Personal property taxes..... \$	12,030	12,030				
<b>11. Total Property Expenses (7e + 8e + 9 + 10)..... \$</b>	<b>906,829</b>	<b>906,829</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	\$ 7,516		
Rubbish Removal	\$ 30,162		
Snow Removal	\$ 10,294		
Supplies	\$ 27,902		
<b>Total Other Repairs and Maintenance</b>	\$ 75,874	\$ -	\$ -

### Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of								
Shady Knoll Health Care Center	2107C	9/30/2017	23	37								
Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals				
<b>A. Land Improvements</b>												
1. Acquired prior to this report period	70,380		70,380	59,018	SL	Var	5,339					
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal.....									5,339			
<b>B. Building and Building Improvements</b>												
1. Acquired prior to this report period	2,747,855		2,747,855	1,821,846	SL	Var	94,470					
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
B-4. Subtotal.....									94,470			
<b>C. Non-Movable Equipment</b>												
1. Acquired prior to this report period	630,911		630,911	233,830	SL	Var	33,055					
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal.....									33,055			
	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	2016	917,482		917,482	736,453	S/L	Var	51,896	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2017	7,190		7,190		S/L	Var	360	
D-3. Subtotal.....												52,256
<b>E. Total Depreciation</b> .....												185,120

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 Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Land Improvements</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 Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</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





### Amortization Schedule\*

Name of Facility			License No.		Report for Year Ended			Page	of
Shady Knoll Health Care Center			2107C		9/30/2017			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal.....									
<b>B. Mortgage Expense</b>									
1. Finance Fees-Key Bank	6	2007	7 years	305,597	305,597	SL	0		
2. Finance Fees									
3. Finance Fees									
B-4. Subtotal.....									
<b>C. Leasehold Improvements and Other (Specify)</b>									
1. Acquired prior to this report period		2016	Various	1,142,005	378,138	62,005	Var	4,268	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2017	Various	26,477			Var	1,691	
C-4. Subtotal.....									5,959
<b>D. Total Amortization .....</b>									<b>5,959</b>

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

**Amortization Schedule - Detail of Leasehold Improvements & Other**

Name of Facility	License No.		Report for Year Ended		Page	of
Shady Knoll Health Care Center	2107C		9/30/2017		24A	37
<b>C. Leasehold Improvements (Specify)</b>						
1. Acquired prior to this report period	2016		62,005	9,327	62,005	Varior
2. Disposals (attach schedule)						
3. Acquired during this report period	9 2017	Various	26,477			Varior
C-4. Subtotal.....						5,959
<b>C. Other (Specify)</b>						
1. Bed License Purchase	9 1997	30 yrs	1,080,000	368,811		0
2.						
C-4. Subtotal.....						
Total Acquired prior to this report period	2016	Various	1,142,005	378,138	62,005	Var
Total Disposals						
Total Acquired during this report period	9 2017	Various	26,477			Var



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

Name of Facility Shady Knoll Health Care Center	License No. 2107C	Report for Year Ended 9/30/2017	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="checkbox"/> Yes <input type="checkbox"/> No			If "Yes," complete Part B. If "No," complete Part C.		
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased	1991				
2. Date Structure Completed	5/21/1993				
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure	05/21/93				
5. Total Licensed Bed Capacity	128				
6. Square Footage					
7. Acquisition Cost					
a. Land	652,528				
b. Building	5,696,463				
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
<b>1. Financing</b>					
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 9/30/2017	6,467,491				
<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	9/30/2017			26	37
Item			Total	CCNH	RHNS	(Specify)	
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage.....			\$				
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage.....			\$				
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage.....			\$				
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage.....			\$				
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount.....			\$				
2. Loan Origination Date.....							
3. Interest Rate %.....							
4. Term.....							
5. CHEFA Interest Expense.....							
12 B7. <b>Total Building Interest Expense (A1 - A4 + B5)</b>			\$				

*(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	9/30/2017	27	37	
Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:					
12. C. Movable Equipment					
1. Automotive Equipment.....	\$				
A. Item	Rate	Amount			
Lender					
Address of Lender					
2. Other (Specify).....	\$	10,472	10,472		
A. Item	Rate	Amount			
Boiler Capital Lease	6.04%	390,250			
Lender					
Graybar Financial Services					
Address of Lender					
PO Box 644006, Cincinnati, OH 45264					
B. Item	Rate	Amount			
Lender					
Address of Lender					
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2).....	\$	10,472	10,472		
12. D. Other Interest Expense (Specify).....	\$	158,254	158,254		
Vender Interest = \$8,506; Key Bank Line of Credit Interest = \$128,589; Key Bank Term Loan Int & Fees = \$21,159					
13. Total All Interest Expense (12B7 + 12C3 + 12D).....	\$	168,726	168,726		
14. Insurance					
a. Insurance on Property (buildings only).....	\$	82,213	82,213		
b. Insurance on Automobiles.....	\$				
c. Insurance other than Property (as specified above)					
1. Umbrella (Blanket Coverage).....	\$				
2. Fire and Extended Coverage.....	\$				
3. Other (Specify).....	\$				
14d. Total Insurance Expenditures (14a + b + c)...	\$	82,213	82,213		
15. Total All Expenditures (A-13 thru C-14).....	\$	13,785,150	13,785,150		

**D. Adjustments to Statement of Expenditures**

Name of Facility				License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center				2107C	9/30/2017	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.	10	A12g	Occupational Therapy.....	\$ 310,449	310,449		
4.	Var	Var	Other - See attached Schedule.....	\$ 3,011	3,011		
<b>Page 13 - Professional Fees</b>							
5.	13	B8c	Resident Care Physicians **.....	\$ 32,584	32,584		
6.			Occupational Therapy.....	\$			
7.			Other - See attached Schedule.....	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.	15	1a9	Discriminatory Benefits.....	\$			
9.	15	1c	Bad Debts.....	\$ 43,581	43,581		
10.	15	1d&e	Accounting & Legal.....	\$ 12,097	12,097		
11.	30	IV3	Telephone.....	\$			
12.	15	1h2	Cellular Telephone.....	\$ 1,500	1,500		
13.			Life insurance premiums on the life of Owners, Partners, Operators.....	\$			
14.	16	13	Gifts, flowers and coffee shops.....	\$ 19,611	19,611		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees.....	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative....	\$			
17.			Automobile Expense (e.g. personal use).	\$			
18.	16	m2&3	Unallowable Advertising *.....	\$ 32,888	32,888		
19.			Income Tax / Corporate Business Tax...	\$			
20.	16	m4&10	Fund Raising / Contributions.....	\$ 480	480		
21.	16	m12	Unallowable Management Fees.....	\$ 275,129	275,129		
	18	2c		\$ 66,698	66,698		
	20	5j		\$ 75,035	75,035		
22.	16	m6	Barber and Beauty.....	\$ 235	235		
23.	Var	Var	Other - See attached Schedule.....	\$ 7,978	7,978		
<b>Page 18 - Dietary Expenditures</b>							
24.	18	2a1	Meals to employees, guests and others who are not residents.....	\$ 2,630	2,630		
<b>Page 19 - Laundry Expenditures</b>							
25.	19	3d	Laundry services to employees, guests and others who are not residents.....	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.	20	4d	Housekeeping services to employees and others who are not residents.....	\$			
Subtotal (Items 1 - 26)				\$ 883,906	883,906		

\* All except "Help Wanted".

*(Carry Subtotal forward to next page)*

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



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

Name of Facility				License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center				2107C	9/30/2017	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 883,906	883,906		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a1&2	Prescription Drugs.....	\$ 337,194	337,194		
28.			Ambulance/Limousine.....	\$			
29.	20	5f	X-rays, etc.....	\$ 41,721	41,721		
30.	20	5h	Laboratory.....	\$ 41,973	41,973		
31.	20	5c	Medical Supplies.....	\$ 12,800	12,800		
32.	20	5e2	Oxygen (non emergency).....	\$ 65,582	65,582		
33.			Occupational Therapy.....	\$			
34.	Var	Var	Other - See Attached Schedule.....	\$ 24,621	24,621		
<b>Page 22 - Maintenance and Property</b>							
35.	Var	Var	Excess Movable Equipment Depreciation See Attached Schedule.....	\$ 4,578	4,578		
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.			Research or Experimental Activities.....	\$			
43.	20	5j	Radio and Television Revenue.....	\$ 12,030	12,030		
44.			Vending Machine Revenue.....	\$			
45.			Purchase Discounts and Allowances.....	\$			
46.			Duplications of functions or services....	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest.....	\$			
48.	30	iv5	Interest Income on Accounts Rec.....	\$ 99	99		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule.....	\$			
<b>Not For Profit Providers Only</b>							
50.	Var	Var	Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule.....	\$			
51.	<b>Total Amount of Decrease (Items 1 - 50)</b>			\$ 1,424,504	1,424,504		

\*\*\* 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	17,076		
		EBOX	7,545		
<b>Total Other Ancillary Costs</b>			\$ 24,621	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Movable Equipment (See Attached)	4,578		
<b>Total Excess Movable Equipment Depreciation</b>			4,578		

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

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







**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended			Page of
Shady Knoll Health Care Center	2107C	9/30/2017			30   37
Item	Total	CCNH	RHNS	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents (CT only).....	\$ 15,711,560	15,711,560			
b. Medicaid Room and Board Contractual Allowance **.....	\$ (8,548,853)	(8,548,853)			
2. a. Medicaid (All other states).....	\$				
b. Other States Room and Board Contractual Allowance **.....	\$				
3. a. Medicare Residents (all inclusive).....	\$ 2,034,817	2,034,817			
b. Medicare Room and Board Contractual Allowance **.....	\$ 466,207	466,207			
4. a. Private-Pay Residents and Other.....	\$ 5,159,638	5,159,638			
b. Private-Pay Room and Board Contractual Allowance **.....	\$ (1,150,316)	(1,150,316)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare.....	\$ 264,420	264,420			
b. Prescription Drugs - Medicare Contractual Allowance **.....	\$ (260,451)	(260,451)			
c. Prescription Drugs - Non-Medicare.....	\$ 240,995	240,995			
d. Prescription Drugs - Non-Medicare Contractual Allowance **.....	\$ (204,574)	(204,574)			
2. a. Medical Supplies - Medicare.....	\$				
b. Medical Supplies - Medicare Contractual Allowance **.....	\$				
c. Medical Supplies - Non-Medicare.....	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **.....	\$				
3. a. Physical Therapy - Medicare.....	\$ 633,160	633,160			
b. Physical Therapy - Medicare Contractual Allowance **.....	\$ (470,305)	(470,305)			
c. Physical Therapy - Non-Medicare.....	\$ 206,257	206,257			
d. Physical Therapy - Non-Medicare Contractual Allowance **.....	\$ (206,257)	(206,257)			
4. a. Speech Therapy - Medicare.....	\$ 184,534	184,534			
b. Speech Therapy - Medicare Contractual Allowance **.....	\$ (118,883)	(118,883)			
c. Speech Therapy - Non-Medicare.....	\$ 41,150	41,150			
d. Speech Therapy - Non-Medicare Contractual Allowance **.....	\$ (41,150)	(41,150)			
5. a. Occupational Therapy - Medicare.....	\$ 573,888	573,888			
b. Occupational Therapy - Medicare Contractual Allowance **.....	\$ (451,292)	(451,292)			
c. Occupational Therapy - Non-Medicare.....	\$ 212,417	212,417			
d. Occupational Therapy - Non-Medicare Contractual Allowance **.....	\$ (212,417)	(212,417)			
6. a. Other (Specify) - Medicare.....	\$				
b. Other (Specify) - Non-Medicare.....	\$ (10,131)	(10,131)			
<b>III Total Resident Revenue (Section I thru Section II).....</b>	<b>\$ 14,054,414</b>	<b>14,054,414</b>			
<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 (Specify).....	\$ 99	99			
6. Private Duty Nurses' Fees.....	\$				
7. Barber, Coffee, Beauty and Gift shops.....	\$				
8. Other (Specify).....	\$ 9,206	9,206			
<b>V. Total Other Revenue (1 thru 8).....</b>	<b>\$ 9,305</b>	<b>9,305</b>			
<b>VI. Total All Revenue (III + V).....</b>	<b>\$ 14,063,719</b>	<b>14,063,719</b>			

\* 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)
<b>Total Other Resident Revenue - Medicare</b>		\$ -	\$ -	\$ -

**Schedule of Other Non-Medicare Resident Revenue**

Related Exp Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Retroactives	\$ (10,131)		
<b>Total Other Resident Revenue</b>		\$ (10,131)	\$ -	\$ -

**Interest Income**

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
pg 31, L A2	Interest on A/R	N/A	\$ 99		
<b>Total Interest Income</b>			\$ 99	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
NA	Bad Debt Recoveries	\$ 9,206		
<b>Total Other Revenue</b>		\$ 9,206	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2017	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> ).....			\$	183,892
2. Resident Accounts Receivable (Less Allowance for Bad Debts).....			\$	1,191,477
3. Other Accounts Receivable (Excluding Owners or Related Parties).....			\$	
4 Inventories.....			\$	19,845
5. Prepaid Expenses.....			\$	212,294
a. Prepaid Insurance	193,970			
b. October expenses booked in Sept	13,312			
c. Prepaid Health insurance	5,012			
d.				
6. Interest Receivable.....			\$	
7. Medicare Final Settlement Receivable.....			\$	
8. Other Current Assets ( <i>itemize</i> ).....			\$	200,546
Due From Related Parties	200,546			
A-9. <b>Total Current Assets</b> (Lines A1 thru 8)			\$	1,808,054
B. Fixed Assets				
1. Land.....			\$	
2. Land Improvements	*Historical Cost.....	70,380	\$	6,024
	Accum. Depreciation	(64,356) Net.....		
3. Buildings	*Historical Cost.....	2,747,856	\$	831,538
	Accum. Depreciation	(1,916,318) Net.....		
4. Leasehold Improvements	*Historical Cost.....	88,483	\$	73,197
	Accum. Depreciation	(15,286) Net.....		
5. Non-Movable Equipment	*Historical Cost.....	630,911	\$	364,025
	Accum. Depreciation	(266,886) Net.....		
6. Movable Equipment	*Historical Cost.....	913,844	\$	125,137
	Accum. Depreciation	(788,707) Net.....		
7. Motor Vehicles	*Historical Cost.....		\$	
	Accum. Depreciation	Net.....		
8. Minor Equipment-Not Depreciable.....			\$	
9. Other Fixed Assets ( <i>itemize</i> ).....			\$	10,829
Excluded Movable Equipment	10,829			
B-10. <b>Total Fixed Assets</b> (Lines B1 thru 9).....			\$	1,410,750

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

**SHADY KNOLL HEALTH CENTER**  
**Prepaid Expense**  
**September 30, 2017**

**ACCT. # 1580**

<b>Beginning Balance</b>	<u><u>(12,558.59)</u></u>
FY17 AMORTIZATION OF REBATE RECEIPT (535.28 X 12)	6,423.36
DHLS LL Audit invoice paid by SNF - LL to reimburse SNF in FY17	(3,500.00)
Accrue out October Shifthound invoice	\$356.00
cap. in oct-H&R bed frame	\$2,642.80
Oct inv-frontier comm.	\$1,417.83
oct inv-ct care	\$2,434.08
oct inv-ct care	\$27.66
oct inv-delta dental	\$5,169.90
JJ Keller fmla license 12/1/17-12/31/20	\$1,262.50
<b>G/L BALANCE at 9/30/17</b>	<u><u>3,675.54</u></u>

RECEIVED A REFUND FROM CL&P IN NOVEMBER 2014 AS A REBATE FOR THE BOILER CONVERSION THAT SHADY KNOLL HAS A CAPITAL LEASE FOR. PER MIKE MOSIER & JIM BOVE, AMORTIZE THE CASH RECEIPT OVER THE TERM OF THE 5 YEAR LEASE, (OR 60 MONTHS).

\*\*AS OF 9/30/16, 30 PAYMENTS HAD BEEN MADE ON THE LEASE

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

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2017	32	37
Account			Amount	
Total Brought Forward:			\$	3,218,804
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	(4,528,353)	Net.....	\$ 1,074,095
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>			\$	1,723,450
D. Investment and Other Assets				
1. Deferred Deposits.....			\$	
2. Escrow Deposits.....			\$	
3. Organization Expense				
	*Historical Cost.....	_____		
	Accum. Depreciation	_____	Net.....	\$
4. Goodwill (Purchased Only).....			\$	711,189
5. Investments Related to Resident Care ( <i>itemize</i> ).....			\$	
_____			\$	
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	(18,180,047)
Name and Address		Amount	Loan Date	
Related Party Facilities		(18,180,047)	3/29/2012	
7. Other Assets ( <i>itemize</i> ).....			\$	83,350
	Desposits-Taxes	44,930		
	Deposits-Lease	14,192		
	Project Development/ Finance Fees	24,228		
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7).....</b>			\$	(17,385,508)
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8).....</b>			\$	(12,443,254)

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2017	33	37
Account			Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable.....			\$	1,584,919
2. Notes Payable ( <i>itemize</i> ).....			\$	1,619,845
line of credit				
1,985,845				
loans				(366,000)
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> ).....			\$	
	Name of Lender	Purpose	Amount	Date Due
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> ).....			\$	175,601
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> ).....			\$	
6. Accrued Payroll Taxes Payable.....			\$	5,290
7. Medicare Final Settlement Payable.....			\$	
8. Medicare Current Financing Payable.....			\$	
9. Mortgage Payable ( <i>Current Portion</i> ).....			\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> ).....			\$	
11. Accrued Income Taxes*.....			\$	
12. Other Current Liabilities ( <i>itemize</i> ).....			\$	318,402
Accd Health Insurance				5,289
Acc'd Operating Expenses				104,415
Acc'd Expense - CT Sales & Use Tax				446
Provider Taxes Due				211,083
Acc'd Expense-Personal Property Tax				(2,831)
<b>A-13. Total Current Liabilities (Lines A1 thru 12).....</b>			<b>\$</b>	<b>3,704,057</b>

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

(Carry Total forward to next page)

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

**SHADY KNOLL HEALTH CENTER  
ACCRUED EXPENSES - OPERATING  
September 30, 2017**

**ACCT. # 2170**

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Health Insurance IBNR 12/31/16	\$55,384.78
September Relay Health invoice	\$123.46
final-sept aqua water	\$1,656.43
sept inv-direct energy	\$1,661.52
sept inv-eversource gas	\$1,247.71
sept pharm inv	\$34,223.77
sept inv-colonial ins	\$6,076.05
medical director fees-july	\$4,000.00
medical director fees-july	\$1,000.00
sept-ct dental	\$640.00
correct mtg fee adj sept	(\$1,763.37)
September bank charge	\$78.61
September bank charge	\$305.41
E. Stockmal-Painter September	\$1,543.18
HR Healthcare August	\$197.81
HR Healthcare August	\$197.81
HR Healthcare July	\$197.81
HR Healthcare July	\$197.81
ADP E Time - August	\$490.03
ADP E Time - July	\$426.18
HB Solutions - July	\$571.13
HB Solutions - September	\$571.13
9/30 Nursing Rebate	\$4,612.46
	<hr/>
9/30/2017	<b>\$113,639.72</b>



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

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2017	34	37
Account			Amount	
Total Brought Forward:			3,704,057	
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> ).....			\$	129,640
Name of Lender	Purpose	Amount	Date Due	
Graybar Financial Services	Boiler/Solar Panel	129,640	05/31/19	
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)	03/29/12		
4. Other Long-Term Liabilities ( <i>itemize</i> ).....			\$	(2,207,679)
N/P L/T Related Party Landlord		(2,217,315)		
Deferred Energy Credit		9,636		
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4).....			\$	(11,432,387)
C. <b>Total All Liabilities</b> (Lines A-13 + B-5).....			\$	(7,728,330)

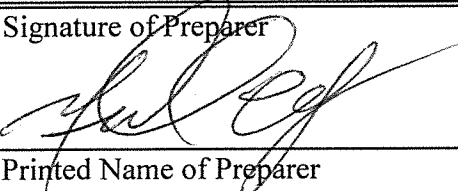
**G. Balance Sheet (cont'd)**  
**Reserves and Net Worth**

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2017	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.....			\$	1,074,095
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.....			\$	1,723,450
<b>B. Net Worth</b>				
1. Owner's Capital.....			\$	
2. Capital Stock.....			\$	1,000
3. Paid-in Surplus.....			\$	
4. Treasury Stock.....			\$	
5. Cumulated Earnings.....			\$	(6,717,943)
6. Gain or Loss for Period 10/1/2016 thru 9/30/2017			\$	278,569
7. Total Net Worth.....			\$	(6,438,374)
<b>C. Total Reserves and Net Worth .....</b>			\$	(4,714,924)
<b>D. Total Liabilities, Reserves, and Net Worth .....</b>			\$	(12,443,254)

### H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2017	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	(6,751,508)
B. Total Revenue (From Statement of Revenue Page 30 ) .....			\$	14,063,719
C. Total Expenditures (From Statement of Expenditures Page 27 ) .....			\$	13,785,150
D. Net Income or Deficit.....			\$	278,569
E. Balance.....			\$	(6,472,939)
F. Additions				
1. Additional Capital Contributed (itemize )				
	SWAP Change	4,280		
	2016 Pension reversal	9,000		
	2016 AJE - Health insurance accrual	21,285		
2. Other (itemize )				
F-3. Total Additions.....			\$	34,565
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	09/30/17		\$	(6,438,374)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Shady Knoll Health Care Center	2107C	9/30/2017	37	37
<i>Check appropriate category</i>				
CCNH	RHNS	Other ( <i>Specify</i> )		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<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		
	CFO	2/9/18		
Printed Name of Preparer				
Athena Health Care Associates, Inc				
Address		Phone Number		
135 South Road Farmington, CT 06032		(860) 751-3900		

Name of Facility	License No.	Report for Year Ended	Page
Shady Knoll Health Care Center	2198-C/2198-C	9/30/2017	ERROR REPORT

**INCOME/EXPENSE STATEMENT  
ERROR CHECK LIST**

**\*\*\*RED CELLS INDICATE POSSIBLE ERROR\*\*\***

**\*\*\* REVIEW THE FOLLOWING FOR POSSIBLE ERRORS \*\*\***

**RECONCILIATION OF COST REPORT PAGES TO INTERFACE:**

**(NUMBERS FROM INTERFACE MUST EQUAL COST REPORT PAGES)**

	TOTAL	CCNH	RHNS	OTHER: (Specify)
PG 1A PER INTERFACE				
PG 1A PER COST REPORT				
DIFFERENCE				
PG 10 PER INTERFACE	6,726,224	6,726,224		
PG 10 PER COST REPORT	6,726,224	6,726,224		
DIFFERENCE				
PG 1A PER COST REPORT				
PG 10 PER COST REPORT				
DIFFERENCE				
PG 13 PER INTERFACE	143,490	143,490		
PG 13 PER COST REPORT	143,490	143,490		
DIFFERENCE				
PG 15 & 16 PER INTERFACE	3,799,474	3,799,474		
PG 15 & 16 PER COST REPORT	3,799,474	3,799,474		
DIFFERENCE				
PG 18 PER INTERFACE	413,872	413,872		
PG 18 PER COST REPORT	413,872	413,872		
DIFFERENCE				
PG 19 PER INTERFACE	21,795	21,795		
PG 19 PER COST REPORT	21,795	21,795		
DIFFERENCE				
PG 20 PER INTERFACE	1,040,621	1,040,621		
PG 20 PER COST REPORT	1,040,621	1,040,621		
DIFFERENCE				
PG 22 PER INTERFACE	1,388,735	1,388,735		
PG 22 PER COST REPORT	1,388,735	1,388,735		
DIFFERENCE				
PG 26 & 27 PER INTERFACE	250,939	250,939		
PG 26 & 27 PER COST REPORT	250,939	250,939		
DIFFERENCE				
TOTAL EXPENSES PER INTERFACE	13,785,150	13,785,150		
TOTAL EXPENSES PER COST REPORT	13,785,150	13,785,150		
DIFFERENCE				
TOTAL REVENUES PER INTERFACE	14,063,719	14,063,719		
TOTAL REVENUES PER COST REPORT	14,063,719	14,063,719		
DIFFERENCE				
EQUIPMENT LEASES PER PAGE 6	30,510			
EQUIPMENT LEASES PER PAGE 22,LINE 6e	30,510			
DIFFERENCE				

Name of Facility	License No.	Report for Year Ended	Page
Shady Knoll Health Care Center	2198-C/2198-C	9/30/2017	ERROR REPORT

**BALANCE SHEET ERROR CHECK LIST**

\*\*\* REVIEW THE FOLLOWING FOR POSSIBLE ERRORS \*\*\*

**RECONCILIATION OF COST REPORT PAGES TO INTERFACE:  
(NUMBERS FROM INTERFACE MUST EQUAL COST REPORT PAGES)**

\*\*\*RED CELLS INDICATE POSSIBLE ERROR\*\*\*

TOTAL
-------

PG 31 CURRENT ASSETS PER INTERFACE	1,808,054
PG 31 CURRENT ASSETS PER COST REPORT	<u>1,808,054</u>
DIFFERENCE	
PG 31 FIXED ASSETS PER INTERFACE	1,410,750
PG 31 FIXED ASSETS PER COST REPORT	<u>1,410,750</u>
DIFFERENCE	
PG 32 LEASED ASSETS PER INTERFACE	1,723,450
PG 32 LEASED ASSETS PER COST REPORT	<u>1,723,450</u>
DIFFERENCE	
PG 32 OTHER ASSETS PER INTERFACE	(17,385,508)
PG 32 OTHER ASSETS PER COST REPORT	<u>(17,385,508)</u>
DIFFERENCE	
PG 32 TOTAL ASSETS PER INTERFACE	(12,443,254)
PG 32 TOTAL ASSETS PER COST REPORT	<u>(12,443,254)</u>
DIFFERENCE	
PG 33 CURRENT LIABS PER INTERFACE	3,704,057
PG 33 CURRENT LIABS PER COST REPORT	<u>3,704,057</u>
DIFFERENCE	
PG 34 LONG TERM LIABS PER INTERFACE	(11,432,387)
PG 34 LONG TERM LIABS PER COST REPORT	<u>(11,432,387)</u>
DIFFERENCE	
PG 34 TOTAL LIABS PER INTERFACE	(7,728,330)
PG 34 TOTAL LIABS PER COST REPORT	<u>(7,728,330)</u>
DIFFERENCE	
PG 35 RESERVES PER INTERFACE	1,723,450
PG 35 RESERVES PER COST REPORT	<u>1,723,450</u>
DIFFERENCE	
PG 35 NET WORTH PER INTERFACE	(6,438,374)
PG 35 NET WORTH PER COST REPORT	<u>(6,438,374)</u>
DIFFERENCE	
PG 35 TOTAL LIAB & WORTH PER INTERFACE	(12,443,254)
PG 35 TOTAL LIAB & WORTH PER COST REPORT	<u>(12,443,254)</u>
DIFFERENCE	
PG 32 TOTAL ASSETS PER COST REPORT	(12,443,254)
PG 35 TOTAL LIAB & WORTH PER COST REPORT	<u>(12,443,254)</u>
DIFFERENCE	
NET INCOME PER BALANCE SHEET	278,569
NET INCOME PER INCOME STATEMENT	<u>278,569</u>
DIFFERENCE	
PG 35 NET WORTH PER COST REPORT	(6,438,374)
TOTAL NET WORTH PER PG 36	<u>(6,438,374)</u>
DIFFERENCE	

Name of Facility	License No.	Report for Year Ended	Page
Shady Knoll Health Care Center	2198-C/2198-C	9/30/2017	ERROR REPORT

**INFORMATIONAL PAGES  
ERROR CHECK LIST**

**\*\*\*RED CELLS INDICATE POSSIBLE ERROR\*\*\***

**\*\*\* REVIEW THE FOLLOWING FOR POSSIBLE ERRORS \*\*\***

**RECONCILIATION OF COST REPORT PAGES TO INTERFACE INPUT:  
(NUMBERS FROM INTERFACE MUST EQUAL COST REPORT PAGES)**

	TOTAL	CCNH	RHNS	OTHER: (Specify)
PG 7 TOTAL LEGAL FEES DETAIL	14,276	NOT APPLICABLE		
PG 15, LINE 1e LEGAL FEES PER COST REPORT	14,276	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
PG 7 TOTAL ACCOUNTING FEES DETAIL	12,200	NOT APPLICABLE		
PG 15, LINE 1d ACCOUNTING FEES PER C/RPT	12,200	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
PG 11 OWNER'S SALARY PER COST REPORT	-			
PG 10 OWNER'S SALARY PER COST REPORT	-			
DIFFERENCE				
PG 12 ADMINISTRATOR'S SALARY PER C/RPT	104,671	104,671		
PG 10 ADMINISTRATOR'S SALARY PER C/RPT	104,671	104,671		
DIFFERENCE				
PG 12 ASST ADMIN'S SALARY PER COST REPORT	-			
PG 10 ASST ADMIN'S SALARY PER COST REPORT	-			
DIFFERENCE				
PT TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	25,168	NOT APPLICABLE		
HORIZONTAL TOTALS	25,168	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
ST TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	3,870	NOT APPLICABLE		
HORIZONTAL TOTALS	3,870	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
OT TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	22,537	NOT APPLICABLE		
HORIZONTAL TOTALS	22,537	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
<b>NO. OF CERTIFIED BEDS RECONCILIATION:</b>				
NUMBER OF BEDS-BEG OF REPORT PERIOD(PG 8)	128	128		
ADDITIONS/DELETIONS DURING PERIOD(PG 9)	-			
CALCULATED CERT. BEDS AT END OF PERIOD	128	128		
ACTUAL CERT. BEDS END OF PERIOD(PG 8)	128	128		
DIFFERENCE				

**COMPARISON OF ACTUAL PATIENT DAYS TO MAXIMUM POSSIBLE PATIENT DAYS:**

AVERAGE CERTIFIED BEDS	128.00000	128.00000
MAXIMUM PATIENT DAYS	46,720	46,720
ACTUAL PATIENT DAYS	44,973	44,973
PERCENT OCCUPIED(NOT TO EXCEED 100%)	96.2607%	96.2607%

Name of Facility	License No.	Report for Year Ended	Page
Shady Knoll Health Care Center	2198-C/2198-C	9/30/2017	ERROR REPORT

**DEPRECIATION TIE-IN  
ERROR CHECK LIST**

**\*\*\*RED CELLS INDICATE POSSIBLE ERROR\*\*\***

**\*\*\* REVIEW THE FOLLOWING FOR POSSIBLE ERRORS \*\*\***

**RECONCILIATION OF COST REPORT BALANCE SHEET TO DEPRECIATION PAGES:  
(BOOK VALUE NUMBERS FROM EACH COLUMN BELOW MUST EQUAL)**

FIXED ASSET CATEGORY	BOOK VALUE PG 23 OR 24	BOOK VALUE PG 31 OR 32	Difference
LAND IMPROVEMENTS	6,023	6,024	
BUILDING AND BUILDING IMPROVEMENTS	831,539	831,538	
LEASEHOLD IMPROVEMENTS	73,196	73,197	
NON-MOVEABLE EQUIPMENT	364,026	364,025	
MOTOR VEHICLES	-	-	-
MOVEABLE EQUIPMNT(NET OF LEASED EQUIP)	135,963	125,137	10,826
LEASED MOVEABLE EQUIPMENT	-	-	-
ORGANIZATION/START-UP	-	-	-
OTHER-PG 24	711,189	N/A **	

FIXED ASSET CATEGORY	EXPENSE PG 23 OR 24	EXPENSE PG 22	Difference
LAND IMPROVEMENTS	5,339	5,339	-
BUILDING AND BUILDING IMPROVEMENTS	94,470	94,470	-
NON-MOVEABLE EQUIPMENT	33,055	33,055	-
MOVEABLE EQUIPMENT(NET OF LEASED EQUIP) & MOTOR VEHICLES	52,256	52,256	-
LEASED MOVEABLE EQUIPMENT	-	N/A *	-
ORGANIZATION/START-UP	-	-	-
FINANCE FEES	-	-	-
LEASEHOLD IMPROVES	5,959	5,959	-
OTHER AMORTIZATION	-	-	-

\* NOT APPLICABLE BECAUSE THERE IS NO CORRESPONDING LINE ON PAGE 22.

\*\*NOT APPLICABLE BECAUSE THERE IS NO CORRESPONDING LINE ON PAGES 31 OR 32.

FIXED ASSET CATEGORY		PG 23a/24a	PG 23/24	Difference
<b>COMPARE DETAIL ADDITIONS TO PAGES 23 &amp; 24</b>				
LAND IMPROVEMENTS	ADDITIONS	-	-	-
	DEPREC	-	-	-
BUILDING IMPROVEMENTS	ADDITIONS	-	-	-
	DEPREC	-	-	-
NON-MOVEABLE EQUIPMENT	ADDITIONS	-	-	-
	DEPREC	-	-	-
MOVE EQUIP(NET OF LEASED EQUIP&VEHICLES	ADDITIONS	7,190	7,190	-
	DEPREC	360	360	
LEASEHOLD IMPROVES	ADDITIONS	26,477	26,477	-
	DEPREC	1,691	1,691	