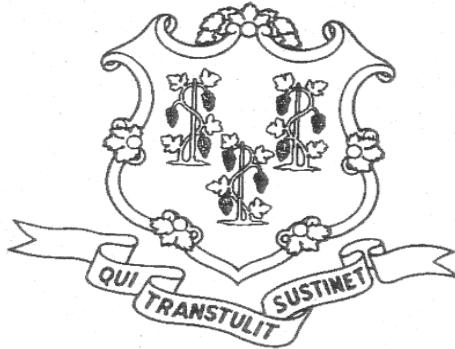


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Wadsworth Glen Health Care and Rehabilitation Center, Inc	
Address (No. & Street, City, State, Zip Code) 30 Boston Rd, Middletown, CT 06457	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 2025C	RHNS	(Specify)	Medicare Provider 07-5312
------------------	---------------	------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 2025C	RHNS	ICF-IID
----------------------------	---------------	------	---------

For Department Use Only

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

General Information

Name of Facility (as licensed) Wadsworth Glen Health Care and Rehabilitation Center	License No. 2025C	Report for Year Ended 9/30/2021	Page 1	of 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 Wadsworth Glen Health Care and Rehabilitation Center, Inc [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) Joseph Bray			Printed Name (Owner) Lawrence G. Santilli	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Leases	6
General Information and Questionnaire - Accounting Basis	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Wadsworth Glen Health Care and Rehabilitation Center, Inc	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 30 Boston Rd, Middletown, CT 06457				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900	Date 2/12/2021		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire

Type of Facility - Organization Structure

	Phone No. of Facility 860-346-9299	Report for Year Ended 9/30/2021	Page 2
Name of Facility (as shown on license) Wadsworth Glen Health Care and Rehabilitation Center, Inc		Address (No. & Street, City, State, Zip) 30 Boston Rd, Middletown, CT 06457	
License Numbers:	CCNH 2025C	RHNS (Specify)	Medicare Provider No. 07-5312
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes	<input checked="" type="radio"/> No
		If "Yes," explain fully.	
Administrator Name of Administrator Joseph Bray			
		Nursing Home Administrator's License No.:	1873
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name Not Applicable			License No.:

General Information and Questionnaire Partners/Members

General Information and Questionnaire
Corporate Owners

Name of Facility Wadsworth Glen Health Care and Rehabilitation	License No. 2025C	Report for Year Ended 9/30/2021	Page of 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	
Wadsworth Glen, Inc	30 Boston Rd, Middletown, CT 06457	CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G Santilli	30 Boston Rd, Middletown, CT 06457	President	499.66
Michael E Mosier	30 Boston Rd, Middletown, CT 06457	Treasurer/Secretary	
Names of Stockholders Owning at Least 10% of Shares			
Conservators for Lawrence E. Santilli	30 Boston Rd, Middletown, CT 06457		102.59

General Information and Questionnaire

Individual Proprietorship

General Information and Questionnaire

Related Parties*

Name of Facility Wadsworth Glen Health Care and Rehabilitation Center	License No. 2025C	Report for Year Ended 9/30/2021			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes <input checked="" type="radio"/> No	If "Yes," provide the Name/Address and complete the information on Page 11 of the report.			
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input checked="" type="radio"/> Yes <input type="radio"/> 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	%**				
ProCare LTC	1492 Highland Ave, Cheshire, CT 06410	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Pharmacy	Pg 20 5a2, Pg 13b3	342,770	342,770
Athena Captive	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Workers Comp Captive	Pg 15 1a1	212,357	212,357
CT Health Center of Middletown	30 Boston Rd, Middletown, CT 06457	<input checked="" type="radio"/>	<input type="radio"/>		Rental of Property	Pg 22, Ln 9, 10b; Pg 21	634,862	634,862
Athena Health Care Assoc 410k Plan	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Facility participates in related 401k Plan			
Laurel Ridge HCC	642 Danbury Rd, Ridgefield, CT 06877	<input checked="" type="radio"/>	<input type="radio"/>	>98%	Bank Fees	P16 L m13	6,182	6,182
Athena Health Care	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		See Attached		65,224	260,806
Athena Health Care Insurance	135 South Rd, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>		Self Insured Employee Health & Dental Ins	Pg 15, 1a5	791,976	791,976
		<input checked="" type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Wadsworth Glen Health Care and Rehabilitation	License No. 2025C	Report for Year Ended 9/30/2021	Page 5	of 37
---	----------------------	------------------------------------	-----------	----------

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

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

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

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

N/A

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

N/A

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.

N/A - No non nursing home cost centers

General Information and Questionnaire Leases (Excluding Real Property)

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

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

⊕ No

Total ***

13,967

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.

General Information and Questionnaire

Accounting Basis

Name of Facility Wadsworth Glen Health Care and F	License No. 2025C	Report for Year Ended 9/30/2021	Page 7	of 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 1 PKF O'Connor Davies 2 Marcum LLP 3 MidCap Financial Services LLC 4	Address (No. & Street, City, State, Zip Code) Four Corporate Dr, Shelton, CT 06484 555 Long Wharf Dr, 12th Floor, New Haven, CT 06511 7255 Woodmont Ave, Suite 200, Bethesda, MD 20814
--	---

Services Provided by This Firm (*describe fully*)

1 2020 Audit, Year End Financials & Tax Return	\$ 10,400
2 Medicare Cost Report Preparation	\$ 2,700
3 Audit relating to Line of Credit-Disallowed	\$ 3,418
4	\$
	Charge for Services Provided \$ 16,518

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

Yes No Pg 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Treasurer State of CT/State Of CT Marshall Fees 2 MidCap Financial Services 3 Goldman, Gruder, & Woods, LLC 4 Jackson Lewis 5	Telephone Number 860-274-0018 240-383-1605 203-899-8900
---	--

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

1 P.O. Box 849, 49 Leavenworth St, Canaan, CT 06018/P.O. Box 760 365 Main St, Watertown, CT 06795
2 7255 Woodmont Ave, Suite 200, Bethesda, MD 20814
3 200 Connecticut Avenue, Norwalk, CT 06854
4 44 South Broadway, White Plains, NY
5

Services Provided by This Firm (*describe fully*)

1 Probate/Conservator Fees - Disallowed	\$ 550
2 Legal Fees - LOC-Disallowed	\$ 32
3 Legal fee reimbursement	\$ (1,205)
4 Teleconference-employee issues:Disallow	\$ 467
5	\$
	Charge for Services Provided \$ (156)

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

Yes No Pg 15, Line 1e

Schedule of Resident Statistics

Name of Facility Wadsworth Glen Health Care and Rehabilitation Center, Inc			License No. 2025C				Report for Year Ended 9/30/2021				Page 8		of 37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				Total	CCNH	RHNS	(Specify)
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)				
1. Certified Bed Capacity					102	102										
A. On last day of PREVIOUS report period	102	102														
B. On last day of THIS report period	102	102												102	102	
2. Number of Residents					83	83			83	83						
A. As of midnight of PREVIOUS report period	83	83														
B. As of midnight of THIS report period	92	92												92	92	
3. Total Number of Days Care Provided During Period					4,481	4,481								1,864	1,864	
A. Medicare	6,345	6,345														
B. Medicaid (Conn.)	22,767	22,767			16,601	16,601								6,166	6,166	
C. Medicaid (other states)																
D. Private Pay	1,193	1,193			699	699								494	494	
E. State SSI for RCH																
F. Other (Specify) 0	231	231			172	172								59	59	
G. Total Care Days During Period (3A thru F)	30,536	30,536			21,953	21,953								8,583	8,583	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds																
A. Medicaid Bed Reserve Days	28	28												28	28	
B. Other Bed Reserve Days	2	2												2	2	
5. Total Resident Days (3G + 4A + 4B)	30,566	30,566			21,953	21,953								8,613	8,613	

Schedule of Resident Statistics (Cont'd)

Name of Facility Wadsworth Glen Health Care and Rehabilitation	License No. 2025C	Report for Year Ended 9/30/2021	Page 9	of 37
---	----------------------	------------------------------------	-----------	----------

4. Were there any changes in the certified bed capacity during the report year? 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			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.

1st change	Change in Resident Days			CCNH	RHNS	(Specify)
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	8	68		6			10	
Per Diem Rate								
a. One bed rm.	534.36	282.57		622.00		367.15		
b. Two bed rms.	534.36	282.57		604.00		367.15		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	1,522	1,522	(Specify)
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	905	905	
2. Restorative Treatments			
C. Other	11,647	11,647	
D. Total Physical Therapy Treatments	14,074	14,074	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	858	858	(Specify)
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	233	233	
2. Restorative Treatments			
C. Other	2,367	2,367	
D. Total Speech Therapy Treatments	3,458	3,458	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	2,206	2,206	(Specify)
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	891	891	
2. Restorative Treatments			
C. Other	11,341	11,341	
D. Total Occupational Therapy Treatments	14,438	14,438	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2021		10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No			
		Total Cost and Hours			
Item	CCNH	Hours	RHNS	Hours	(Specify)
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	136,101	2,083			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	233,466	9,893			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor	65,501	2,051			
c. Dietary Workers	354,125	23,709			
6. Housekeeping Service					
a. Head Housekeeper	50,955	1,840			
b. Other Housekeeping Workers	150,419	10,882			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	72,228	2,057			
b. Other Maintenance Workers	43,929	1,794			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	116,242	7,996			
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	172,914	3,132			
b. RN					
1. Direct Care	542,116	10,835			
2. Administrative**	428,166	12,463			
c. LPN					
1. Direct Care	969,608	28,853			
2. Administrative**					
d. Aides and Attendants	1,498,377	67,618			
e. Physical Therapists	394,205	11,272			
f. Speech Therapists	89,665	2,251			
g. Occupational Therapists	164,397	4,078			
h. Recreation Workers	147,100	5,839			
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	221,735	7,181			
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
A-13. Total Salary Expenditures	5,851,249	215,827			

* 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)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

**Schedule A1 - Salary Information for Operators/Owners; Administrators,
Assistant Administrators and Other Related Parties***

Name of Facility Wadsworth Glen Health Care and Rehabilitation Center, Inc				License No. 2025C		Report for Year Ended 9/30/2021			Page 11	of 37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Not Applicable										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
Not Applicable										

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

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

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

**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
Wadsworth Glen Health Care and Rehabilitation Center, Inc				2025C		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***										
Joseph Bray	136,101			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,083	A2			
Section IV - Assistant Administrators										

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

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

*** If more than one Administrator is reported, include dates of employment for each.

B. Report of Expenditures - Professional Fees

Name of Facility Wadsworth Glen Health Care and Rehabilitation Ce	License No. 2025C	Report for Year Ended 9/30/2021		Page 13	of 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	36,169	908			
2. Dentist	9,690	20			
3. Pharmacist	9,606	282			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	65,000	642			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**	2,450				
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
9. Speech Therapist					
a. Resident Care	1,195	5			
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	77,886	804			
2. Administrative***					
b. LPN					
1. Direct Care	70,345	1,686			
2. Administrative***					
c. Aides	242,302	5,048			
d. Other					
12. Other (Specify)					
See Attached Schedule					
B-13 Total Fees Paid in Lieu of Salaries	514,643	9,396			

* 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
		9/30/2021		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Starling Physicians, 2110 Silas Deane Hwy, Rocky Hill, CT 06067	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
T. Nuzzolo, 26 Breeds Hill Rd, Glastonbury, CT 06033	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
ProCare, 110 Bi-County Blvd, Farmingdale, NY 11735	Pharmacist	<input checked="" type="radio"/>	<input type="radio"/>	Common owners Minority interest	
Healthdrive Dental, 888 Worcester Street, Suite 130, Wellesley, MA 02482	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
SDX Dysphagia Experts, 21 Waterville, Avon, CT 06001	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>		
MassTex, 3 Electronics Ave, Suite 201, Danvers, MA 01923	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>		
David Fenton, 2110 Silas Dean Highway, Rocky Hill, CT 06067	Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Emily Siegel, 78 Andover Dr, Rocky Hill, CT	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>		
Nurse Network, 653 Main Street, Plantsville, CT 06479	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Solomon Page Staffing, 260 Madison Ave, New York, NY	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Norton & Associates, 97 Elm Street, Cohasset, MA 02025	Nurse Pool	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>	Common Owners	
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2021		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	212,357	212,357		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	45,405	45,405		
4. Social Security (F.I.C.A.)	\$	389,434	389,434		
5. Health Insurance	\$	791,976	791,976		
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	23,325	23,325		
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*	\$	37,741	37,741		
d. Accounting and Auditing	\$	16,518	16,518		
e. Legal (Services should be fully described on Page 7)	\$	(156)	(156)		
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$	40,871	40,871		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	98,377	98,377		
2. Cellular Phones	\$				
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*	\$				
2. Other (Specify) See Attached Schedule	\$				
3. Resident Day User Fee	\$	509,125	509,125		
Subtotal		\$ 2,164,973	2,164,973		

* 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**

Attachment Page 15

Schedule of Other Employee Benefits

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2021		16	37
Item		Total	CCNH	RHNS	(Specify)
	<i>Subtotals Brought Forward:</i>	2,164,973	2,164,973		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	2,107	2,107		
3. Gifts to Staff and Residents	\$	3,885	3,885		
4. Employee Travel	\$	301	301		
5. Education Expenses Related to Seminars and Conventions	\$	4,266	4,266		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	18,060	18,060		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	4,781	4,781		
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	\$	5,305	5,305		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	625	625		
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$	53,423	53,423		
C-14 Total Administrative & General Expenditures	\$	2,257,726	2,257,726		

* 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	\$ 4,781		
Total Other Advertising	\$ 4,781	\$ -	\$ -

Schedule of Dues

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

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Employee Physicals/Background Checks	\$ 9,709		
Bank Charges	\$ 22,779		
Payroll Processing Fees	\$ 17,435		
	\$ -		
Energy Audit	\$ 3,500		
	\$ -		
	\$ -		
Total Other Administrative and General	\$ 53,423	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Wadsworth Glen Health Care and Rehabil	License No. 2025C	Report for Year Ended 9/30/2021	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032		Contract Attached to a Prior Year	See Below
Allocation of the above		Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12
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.**

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
	2025C	9/30/2021		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 232,626	232,626		
2. Non-Food Supplies	\$ 47,416	47,416		
3. Other (Specify) _____ Dishes	\$ 3,888	3,888		
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$			
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 283,930	283,930		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	251	251		
G. Is cost of employee meals included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility Wadsworth Glen Health Care and Rehabilitation Center,	License No. 2025C	Report for Year Ended 9/30/2021	Page 19	of 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
	Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
	Amt. \$			
4. Repair and/or purchase of linens.***	Lbs.			
	Amt. \$	9,478	9,478	
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (<i>Specify</i>) Supplies	\$	6,240	6,240	
3D. Total Laundry Expenditures (3a + b + c)	\$	15,718	15,718	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify amt.
H. Where is the revenue received reported in the Cost Report?				(Page/Line Item)
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify amt.
K. Where is the revenue received reported in the Cost Report?				(Page/Line Item)

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2021		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced				
a. In-House Care	by Personnel				
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	43,421	43,421		
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel				
	Amt. \$				
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	43,421	43,421		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Procare	\$	362,182	362,182		
b. Medicine Cabinet Drugs	\$	9,558	9,558		
c. Medical and Therapeutic Supplies	\$	283,315	283,315		
d. Ambulance/Limousine***	\$	4,505	4,505		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	35,769	35,769		
f. X-rays and Related Radiological Procedures***	\$	20,971	20,971		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	46,157	46,157		
i. Recreation	\$	8,963	8,963		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	69,870	69,870		
5M. Total Resident Care Expenditures (5a - 5j)	\$	841,290	841,290		

* 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	\$ 26,711		
Medical Equip Rentals-Medicaid	\$ 15,814		
Cable TV Services	\$ 18,505		
Medical Equip Rentals-Other	\$ 8,840		
	\$ -		
Total Other Resident Care	\$ 69,870	\$ -	\$ -

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

Name of Facility Wadsworth Glen Health Care and Rehabilitation Center, Inc				License No. 2025C	Report for Year Ended 9/30/2021				Page of 21 37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
CT Waste Processing	PO Box 99, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal	19,066			22	6f
ADP	100 Corporate Drive, Windsor, CT 06095	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	14,685			16	m13
Allen Lawn Care	16 Sunset Drive, Rockfall, CT 06481	<input type="radio"/>	<input checked="" type="radio"/>		Snow Removal & Landscaping	12,975			22	6f
Winterberry Landscape Management	2070 West St, Southington, CT 06489	<input checked="" type="radio"/>	<input type="radio"/>		Groundskeeping	17,334			22	6f
ProCare	111 Executive Blvd, Farmingdale, NY	<input checked="" type="radio"/>	<input type="radio"/>	common owners Minority interest	Pharmacy	225,089			20	5a2
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

* List all contracted services over \$10,000. Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended		Page of
Wadsworth Glen Health Care and Rehabilitati	2025C	9/30/2021		22 37
Item	Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance	\$ 114,524	114,524		
b. Heat	\$ 49,764	49,764		
c. Light & Power	\$ 94,007	94,007		
d. Water	\$ 34,691	34,691		
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 13,967	13,967		
f. Other (<i>itemize</i>)	\$ 63,056	63,056		
See Attached Schedule				
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 370,009	370,009		
7. Depreciation (<i>complete schedule page 23*</i>)				
a. Land Improvements	\$			
b. Building & Building Improvements	\$			
c. Non-Movable Equipment	\$ 11,195	11,195		
d. Movable Equipment	\$ 58,481	58,481		
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 69,676	69,676		
8. Amortization (<i>Complete att. Schedule Page 24*</i>)				
a. Organization Expense	\$			
b. Mortgage Expense	\$ 295	295		
c. Leasehold Improvements	\$ 57,168	57,168		
d. Other (<i>Specify</i>)	\$			
*8e. Total Amortization Costs (8a + b + c + d)	\$ 57,463	57,463		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 421,604	421,604		
10. Property Taxes				
a. Real estate taxes paid by owner	\$			
b. Real estate taxes paid by lessor	\$ 161,421	161,421		
c. Personal property taxes	\$ 7,863	7,863		
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 718,027	718,027		

* 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

Depreciation Schedule

Schedule of Land Improvements Acquired during this report period

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
1/0/1900		0	\$ -	\$ -
1/31/2021	Fire Alarm Control Panel	\$ 7,468	10	\$ 373
3/31/2021	Food Processor	5237	10	262
3/31/2021	Heat exchanger	5769	10	288
1/0/1900		0	0	0
1/0/1900		0	0	0
Total additions for Movable Equipment		\$ 18,474		\$ 923 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
5/31/2021	Backflow valve	\$ 1,894	20	\$ 47
8/31/2021	boiler pump replacement	\$ 5,338	10	\$ 267
9/30/2021	boiler replacement	8530	10	427
Total additions for Leasehold Improvements		\$ 15,762		\$ 741 *
Deletions:				
Total deletions for Leasehold Improvements		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Wadsworth Glen Health Care and Rehabilitation Center, Inc			License No. 2025C		Report for Year Ended 9/30/2021			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1. Bed License									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Deferred Finance Fees	2	2018	3 years	2,655				294	
2. Finance Fees		2018							
3.									
B-4. Subtotal									294
C. Leasehold Improvements and Other									
1. Acquired prior to this report period		2020		1,818,204	1,443,230	SL	Various	56,427	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2021	Various	15,762			Various	741	
C-4. Subtotal									57,168
D. Total Amortization									57,462

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Wadsworth Glen Health Care and Reh	License No. 2025C	Report for Year Ended 9/30/2021	Page 25	of 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				
4. Date of Initial Licensure	06/01/87			
5. Total Licensed Bed Capacity	102			
6. Square Footage				
7. Acquisition Cost				
a. Land	200,000			
b. Building	5,160,429			

Part B - Owner and Related Parties

1st Mortgage 2nd Mortgage 3rd Mortgage 4th Mortgage

1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	12/30/20			
c. Interest Rate for the Cost Year	295.00%			
d. Term of Mortgage (number of years)	25			
e. Amount of Principal Borrowed	4,496,200			
f. Principal balance outstanding as of				

Complete if Mortgage was Refinanced

During Current Cost Year

g. Type of Financing (e.g., fixed, variable)	HUD			
h. Date of Refinancing	12/30/20			
i. New Interest Rate	295.00%			
j. Term of Mortgage (number of years)	25			
k. Amount of Principal Borrowed	4,496,200			
l. Principal Outstanding on Note Paid-Off	4,396,079			

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

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

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

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

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount	\$					
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$					

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 27	of 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)		\$	106,820	106,820		
Vendor Interst=\$21,507 Key Bank Line of Credit=\$30,23						
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$	106,820	106,820		
14. Insurance						
a. Insurance on Property (buildings only)		\$	106,934	106,934		
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)		\$	106,934	106,934		
15. Total All Expenditures (A-13 thru C-14)		\$	11,109,767	11,109,767		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of
Item No.	Page No.	Line No.	2025C	9/30/2021		28 37
			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	\$ 164,397	164,397	
4.			Other - See attached Schedule	\$ 54,396	54,396	
Page 13 - Professional Fees						
5.			Resident Care Physicians **	\$ 2,450	2,450	
6.			Occupational Therapy	\$		
7.			Other - See attached Schedule	\$		
Pages 15 & 16 - Administrative and General						
8.			Discriminatory Benefits	\$		
9.			Bad Debts	\$ 37,741	37,741	
10.			Accounting	\$ 3,262	3,262	
10a.			Legal	\$		
11.			Telephone	\$		
12.			Cellular Telephone	\$		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$		
14.			Gifts, flowers and coffee shops	\$ 3,885	3,885	
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 *	\$ 4,781	4,781	
19.			Income Tax / Corporate Business Tax	\$		
20.			Fund Raising / Contributions	\$		
21.			Unallowable Management Fees	\$ (129,084)	(129,084)	
22.			Barber and Beauty	\$		
23.			Other - See attached Schedule	\$ 22,779	22,779	
Page 18 - Dietary Expenditures						
24.			Meals to employees, guests and others who are not residents	\$		
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)			\$ 164,607	164,607		

* 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 Salary & Benefits	\$ 54,396		
Total Other Salaries Adjustment			\$ 54,396	\$ -	\$ -

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	\$ 22,779		
0	0		\$ -		
Total Other A&G Adjustments			\$ 22,779	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-29 Rev. 9/2018

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

Name of Facility			License No.	Report for Year Ended		Page of	
Wadsworth Glen Health Care and Rehabilitation Center, Inc			2025C	9/30/2021		29 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 164,607	164,607		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$ 362,182	362,182		
28.			Ambulance/Limousine	\$ 4,505	4,505		
29.			X-rays, etc	\$ 20,971	20,971		
30.			Laboratory	\$ 46,157	46,157		
31.			Medical Supplies	\$ 13,949	13,949		
32.			Oxygen (non emergency)	\$ 35,769	35,769		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ (33,195)	(33,195)		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 15,809	15,809		
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.	\$ 4	4		
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
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)				\$ 630,758	630,758		

*** 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)
	0		0	\$ -	
20	5j	Medical Equip Rentals Other	\$ 8,840		
20	5b	Ebox	\$ 9,558		
20	5k	Unallowable Management Fees.....-Indirect Care	\$ (31,293)		
20	5j	Unallowable Management Fees.....-Direct Care	\$ (35,205)		
20	5j	Radio + Television Revenue	\$ 14,905		
Total Other Ancillary Costs			\$ (33,195)	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 30	of 37
Item		Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 13,893,666	13,893,666				
b. Medicaid Room and Board Contractual Allowance **	\$ (7,899,821)	(7,899,821)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,063,291	2,063,291				
b. Medicare Room and Board Contractual Allowance **	\$ (46,137)	(46,137)				
4. a. Private-Pay Residents and Other	\$ 2,782,874	2,782,874				
b. Private-Pay Room and Board Contractual Allowance **	\$ (679,752)	(679,752)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 116,019	116,019				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (116,019)	(116,019)				
c. Prescription Drugs - Non-Medicare	\$ 169,510	169,510				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (169,510)	(169,510)				
2. a. Medical Supplies - Medicare	\$ 7,498	7,498				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (3,749)	(3,749)				
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 417,278	417,278				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (382,770)	(382,770)				
c. Physical Therapy - Non-Medicare	\$ 339,450	339,450				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (339,450)	(339,450)				
4. a. Speech Therapy - Medicare	\$ 220,390	220,390				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (181,359)	(181,359)				
c. Speech Therapy - Non-Medicare	\$ 122,985	122,985				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (122,985)	(122,985)				
5. a. Occupational Therapy - Medicare	\$ 490,609	490,609				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (435,887)	(435,887)				
c. Occupational Therapy - Non-Medicare	\$ 348,375	348,375				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (348,375)	(348,375)				
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$ 109,149	109,149				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 10,355,280	10,355,280				
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 (<i>Specify</i>)	\$ 23,526	23,526				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 7,780	7,780				
V. Total Other Revenue (1 thru 8)	\$ 31,306	31,306				
VI. Total All Revenue (III +V)	\$ 10,386,586	10,386,586				

* 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)
	Retroactives	\$ 109,149		
	0	\$ -		
	Total Other Resident Revenue	\$ 109,149	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
pg 31, L A	Interest on A/R	\$ 4			
PG 32, l6	Interest on related party note	\$ 23,522			
	Total Interest Income	\$ 23,526	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Bad debt recovery	\$ 7,780		
	0	\$ -		
	Total Other Revenue	\$ 7,780	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2021	31	37
		Account	Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	39,231
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,133,123
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(17,369)
4. Inventories			\$	15,647
5. Prepaid Expenses			\$	170,756
a. Prepaid Insurance		145,957		
b. Prepaid Other		8,681		
c. Prepaid Health Insurance		16,118		
d. See Schedule				
6. Interest Receivable			\$	110,988
7. Medicare Final Settlement Receivable			\$	(16,126)
8. Other Current Assets (<i>itemize</i>)			\$	168,680
A/R Related Parties		168,198		
A/R Non-Related Parties		482		
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,604,930
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	1,833,964	\$	333,566
	Accum. Depreciation	1,500,398	Net	
5. Non-Movable Equipment	*Historical Cost	494,389	\$	39,288
	Accum. Depreciation	455,101	Net	
6. Movable Equipment	*Historical Cost	1,264,070	\$	90,061
	Accum. Depreciation	1,174,009	Net	
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	13,622
Moveable Equip Carry Forward Adj		13,622		
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	476,537

* 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

Total Other Other Fixed Assets (Itemize)		\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

	Deposit IRS	\$ 45,064
	Deferred Finance Fees	\$ 5,870
	Project Development	\$ 7,861
Total Other Assets		\$ 58,795

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)		\$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2021	32	37
Account				Amount
Total Brought Forward:				\$ 2,081,467
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				\$ (2,655)
2. Escrow Deposits				\$
3. Organization Expense	*Historical Cost			\$
	Accum. Depreciation			Net
4. Goodwill (Purchased Only)				\$
5. Investments Related to Resident Care (itemize)				\$
6. Loans to Owners or Related Parties (itemize)				\$ 700,162
Name and Address	Amount	Loan Date		
Related Party Note	700,162	3/29/12		
7. Other Assets (itemize)				\$ 58,795
See Attached				
See Schedule	58,795			
D-8. Total Investments and Other Assets (Lines D1 thru 7)				\$ 756,302
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)				\$ 2,837,769

* 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
Wadsworth Glen Health Care and Rehabilitati	2025C	9/30/2021	33 37
Account			Amount
Liabilities			
A. Current Liabilities			
1. Trade Accounts Payable			\$ 1,643,627
2. Notes Payable (<i>itemize</i>)			\$ 1,418,620
Loans			1,418,620
See Schedule			
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)			\$
Name of Lender			
Purpose			
Amount			
Date Due			
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)			\$ 266,696
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$
6. Accrued Payroll Taxes Payable			\$ 266,358
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>)			\$ 1,313,555
Provider Taxes Due			974,424
Accrued Health Insurance			17,528
Acc'd Operating Expenses			321,426
Acc'd Expense - CT Sales Tax			177 See Schedule
A-13. Total Current Liabilities (Lines A1 thru 12)			\$ 4,908,856

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Wadsworth Glen Health Care and Rehabilita	License No. 2025C	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			4,908,856	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)			\$	1,440,571
Name and Address of Lender	Amount	Loan Date		
Accrued Rent	(2,500)			
Due to Partnership	1,443,071			
4. Other Long-Term Liabilities (<i>itemize</i>)			\$	
Key Bank Term Loan				
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	1,440,571
C. Total All Liabilities (Lines A-13 + B-5)			\$	6,349,427

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

Name of Facility	License No.	Report for Year Ended	Page	of
		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 (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(2,673,607)
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ (864,886)
7. Total Net Worth			\$	(3,538,493)
C. Total Reserves and Net Worth				\$ (3,538,493)
D. Total Liabilities, Reserves, and Net Worth				\$ 2,810,934

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Wadsworth Glen Health Care and Rehab	2025C	9/30/2021	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ (3,262,589)		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 10,386,586		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 11,251,472		
D. Net Income or Deficit				\$ (864,886)		
E. Balance				\$ (4,127,475)		
F. Additions						
1. Additional Capital Contributed (<i>itemize</i>)						
HHS Funds				686,412		
IBNR adjmt 2020/rent adjmt 2020				(222,563)		
health insurance adjmt 2020				(39,538)		
state tax reclass 2020				164,671		
2. Other (<i>itemize</i>)						
F-3. Total Additions				\$ 588,982		
G. Deductions						
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$		
Name and Address (No., City, State, Zip)		Title	Amount			
2. Other Withdrawings (<i>Specify</i>)				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. Balance at End of Period				\$ (3,538,493)		
Report for Year Ended 09/30/21						

I. Preparer's/Reviewer's Certification

Name of Facility Wadsworth Glen Health Care and	License No. 2025C	Report for Year Ended 9/30/2021	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Athena Health Care Associates, Inc		
Address Address 135 South Road Farmington, CT 06032		Phone Number (860) 751-3900
Contacted Person Regarding Additional Information Needed Regarding This Report Lynn Rinaldi		Phone Number (860) 751-3900
Contact Email Address Irinadli@athenahealthcare.com		