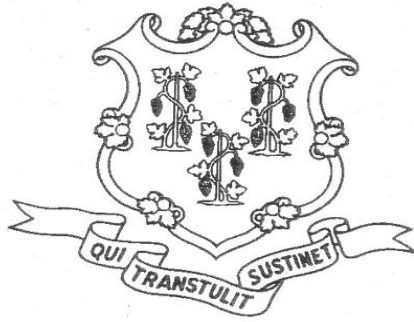


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2023

Name of Facility (as licensed) Glastonbury Health Care Center, Inc.	
Address (No. & Street, City, State, Zip Code) 1175 Hebron Ave, Glastonbury, CT 06033	
Type of Facility Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 2028C	(Specify)	(Specify)	Medicare Provider 07-5316
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Medicaid Provider Numbers:	CCNH / RHNS 2028C	(Specify)	(Specify)
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**General Information**

Name of Facility (as licensed) Glastonbury Health Care Center, Inc.	License No. 2028C	Report for Year Ended 9/30/2023	Page 1	of 37
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**Administrator's/Owner's Certification**

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Glastonbury Health Care Center, Inc. [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Glastonbury Health Care Center, Inc.		Period Covered:	From 10/1/2022	To 9/30/2023
Address of Facility 1175 Hebron Ave, Glastonbury, CT 06033				
Report Prepared By Athena Health Care Associates, Inc		Phone Number (860) 751-3900	Date 2/28/2024	
Item	Total	CCNH / RHNS	(Specify)	(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	Report for Year Ended 9/30/2023	Page 2	of 37
Name of Facility (as shown on license) Glastonbury Health Care Center, Inc.			Address (No. & Street, City, State, Zip) 1175 Hebron Ave, Glastonbury, CT 06033		
License Numbers:	CCNH / RHNS 2028C	(Specify)	(Specify)	Medicare Provider No. 07-5316	
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <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="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No   If "Yes," explain fully.					
<b>Administrator</b>					
Name of Administrator Patrick McDonnell			Nursing Home Administrator's License No.:	1574	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		
Not Applicable					



**General Information and Questionnaire  
 Corporate Owners**

Name of Facility Glastonbury Health Care Center, Inc.	License No. 2028C	Report for Year Ended 9/30/2023	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
Glastonbury Health Care Center, Inc.	1175 Hebron Ave, Glastonbury, CT 06033	CT		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Lawrence G Santilli	1175 Hebron Ave, Glastonbury, CT 06033	President	4098.425	
Michael E. Mosier	1175 Hebron Ave, Glastonbury, CT 06033	Treasurer/Secretary	25	
Names of Stockholders Owning at Least 10% of Shares				
Conservators For Lawrence E. Santilli	1175 Hebron Ave, Glastonbury, CT 06033		701.575	





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

Name of Facility Glastonbury Health Care Center, Inc.	License No. 2028C	Report for Year Ended 9/30/2023	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?  Yes  No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Laurelridge Healthcare Center	642 Danbur Rd, Ridgetfield, CT 06877	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Bank Fees	Pg16,M13	4,677	4,677
Misc Facilities	Various	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Interfacility loans	Pg34,B4		
Athena Captive	135 South Rd, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>		Workers Comp Captive	Pg15,1a1	357,062	357,062
Athena Health Care Associates 401k Plan	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Facility Participates in Common 401k Plan			
Athena Health Care	135 South Rd, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	>50%	See Attached			
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	<5%	Pharmacy Services	Pg 20, 5a2	490,523	490,523
Glastonbury Landlord	1175 Hebron Ave, Glastonbury, CT 06033	<input checked="" type="radio"/>	<input type="radio"/>	>95%	Lease of Propoerty	Pg22 L9, 10b; Pg 27L	823,311	823,311
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	<5%	Note Payable	Pg34 B4, Pg 27 12D	65,393	65,393
		<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 Glastonbury Health Care Center, Inc.	License No. 2028C	Report for Year Ended 9/30/2023	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

**General Information and Questionnaire**  
**Other Lines of Business**

Name of Facility Glastonbury Health Care Center, Inc.	License No. 2028C	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility. <span style="float:right; border: 1px solid black; padding: 2px;">0</span>				
<b>Outpatient Therapy</b>				
Does the Facility provide outpatient therapy services?		No		
<i>If yes, please complete the following:</i>				
	Square footage of therapy space.			
<b>Meals on Wheels</b>				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
	Square footage of kitchen			
	Number of meals served per week			
No	Are meals included in meals served on page 18 of the Annual Report?			
No	Are direct costs included in the Annual Report?			
<i>If yes, please state where costs are reported.</i>				
No	Are drivers for the program included in the facility's payroll?			
<i>If yes, please complete the following:</i>				
		Amount Reported		
		Annual Report page and line		
Please state the salary amounts of specific cooks and/or dietary aides				
Please state where the cooks and/or dietary aides are reported in the Annual Report				
<b>Apartments, Independent Living, Assisted Living</b>				
Does the facility have apartments, independent living, and/or assisted living?		No		
<i>If yes, please complete the following:</i>				
	Square footage of apartments			
	Square footage of independent living			
	Square footage of assisted living			
	Please identify the services provided:			

**General Information and Questionnaire**  
**Other Lines of Business (Continued)**

Name of Facility Glastonbury Health C	License No. 2028C	Report for Year Ended 9/30/2023	Page 7	of 37
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**Child Day Care**

Does the Facility provide Child Day Care?  No

*If yes, please complete the following:*

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

**Adult Day Care**

Does the Facility provide Adult Day Care?  No

*If yes, please complete the following:*

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

### Schedule of Resident Statistics

Name of Facility Glastonbury Health Care Center, Inc.			License No. 2028C		Report for Year Ended 9/30/2023				Page 8	of 37		
	Total All Levels	Total CCNH / RHNS Level	Total	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	105	105			105	105						
B. On last day of THIS report period	105	105							105	105		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	91	91			91	91						
B. As of midnight of THIS report period	97	97							97	97		
3. Total Number of Days Care Provided During Period												
A. Medicare	8,865	8,865			6,741	6,741			2,124	2,124		
B. Medicaid (Conn.)	23,164	23,164			17,254	17,254			5,910	5,910		
C. Medicaid (other states)												
D. Private Pay	1,713	1,713			1,171	1,171			542	542		
E. State SSI for RCH												
F. Other (Specify) Managed Care	606	606			513	513			93	93		
G. Total Care Days During Period (3A thru F)	34,348	34,348			25,679	25,679			8,669	8,669		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	5	5			5	5						
B. Other Bed Reserve Days	8	8			8	8						
5. <b>Total Resident Days (3G + 4A + 4B)</b>	34,361	34,361			25,692	25,692			8,669	8,669		

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

Name of Facility Glastonbury Health Care Center, Inc.	License No. 2028C	Report for Year Ended 9/30/2023	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?  Yes  No

If "YES", provide the following information:

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

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

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

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

Item	Medicare		Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	9	68			5		15		
Per Diem Rate									
a. One bed rm.	521.85	298.16			713.00		389.83		
b. Two bed rms.	521.85	298.00			688.00		390.00		
c. Three or more bed rms.									

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	5,341	5,341			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	698	698			
2. Restorative Treatments					
C. Other	15,053	15,053			
<b>D. Total Physical Therapy Treatments</b>	<b>21,092</b>	<b>21,092</b>			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	273	273			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	96	96			
2. Restorative Treatments					
C. Other	1,540	1,540			
<b>D. Total Speech Therapy Treatments</b>	<b>1,909</b>	<b>1,909</b>			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	3,782	3,782			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	621	621			
2. Restorative Treatments					
C. Other	16,160	16,160			
<b>D. Total Occupational Therapy Treatments</b>	<b>20,563</b>	<b>20,563</b>			

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

CSP-10 Rev. 3/2023

**Report of Expenditures - Salaries & Wages**

Name of Facility		License No.		Report for Year Ended		Page		of	
Glastonbury Health Care Center, Inc.		2028C		9/30/2023		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 / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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)	166,935		1,962						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	44,061		920						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	354,548		11,382						
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor	72,639		2,111						
c. Dietary Workers	473,379		23,711						
6. Housekeeping Service									
a. Head Housekeeper	61,056		2,167						
b. Other Housekeeping Workers	209,544		12,262						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	78,607		2,172						
b. Other Maintenance Workers	53,617		2,126						
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers	94,677		5,228						
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	280,477		4,166						
b. RN									
1. Direct Care	587,529		10,188						
2. Administrative**	521,680		13,334						
c. LPN									
1. Direct Care	1,461,246		35,079						
2. Administrative**									
d. Aides and Attendants	1,680,844		67,648						
e. Physical Therapists	411,972		10,505						
f. Speech Therapists	48,016		1,259						
g. Occupational Therapists	275,099	(275,099)	7,122						
h. Recreation Workers	219,576		8,047						
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	300,083	(4,139)	8,166						
n. Marketing									
o. Other (Specify) See Attached Schedule									
<i>A-13. Total Salary Expenditures</i>	<i>7,395,585</i>	<i>(279,238)</i>	<i>229,555</i>						

\* 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 in the Adjustment column.





**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	
Glastonbury Health Care Center, Inc.				2028C	9/30/2023			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)	(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>										

\* 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
Glastonbury Health Care Center, Inc.				2028C	9/30/2023				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)	(Specify)							
<b>Section III - Administrators***</b>										
Andrew Goodsell (10/1/22-8/26/23)	148,146			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility	1,710	A2			
Patrick McDonnell (8/27/23-9/30/23)	18,789			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility	252	A2			
<b>Section IV - Assistant Administrators</b>										
Brian Reynolds (10/1/22-3/4/23)	44,061			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility	920				

\*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.

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

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**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended						Page	of
Glastonbury Health Care Center, Inc.	2028C	9/30/2023						13	37
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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	38,060		952						
2. Dentist									
3. Pharmacist	12,226		335						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	74,100		201						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**									
d. Administrative Services facility									
1. Infection Control Committee (Quarterly meetings)									
2. Pharmaceutical Committee (Quarterly meetings)									
3. Staff Development Committee (Once annually)									
e. Other (Specify)									
9. Speech Therapist									
a. Resident Care	4,291		12						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	69,478		694						
2. Administrative***									
b. LPN									
1. Direct Care	26,345		379						
2. Administrative***									
c. Aides	255,070		5,428						
d. Other									
12. Other (Specify) See Attached Schedule									
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>479,570</b>		<b>8,001</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 in the Adjustment column.

\*\*\* 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.



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

Name of Facility	License No.	Report for Year Ended					Page	of
Glastonbury Health Care Center, Inc.	2028C	9/30/2023					15	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
<b>I. Administrative and General</b>								
<b>a. Employee Health &amp; Welfare Benefits</b>								
1. Workmen's Compensation	\$ 357,062	357,062						
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 72,036	72,036						
4. Social Security (F.I.C.A.)	\$ 525,076	525,076						
5. Health Insurance	\$ 830,084	830,084						
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 105,459	105,459						
8. Uniform Allowance	\$ (821)	(821)						
9. Other ( <i>Specify</i> ) See Attached Schedule	\$							
<b>b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*</b>	\$							
<b>c. Bad Debts*</b>	\$	339,279	(339,279)					
<b>d. Accounting and Auditing</b>	\$ 10,235	17,731	(7,496)					
<b>e. Legal (<i>Services should be fully described on Page 15b</i>)</b>	\$ 150	63,134	(62,984)					
<b>f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*</b>	\$							
<b>g. Office Supplies</b>	\$ 65,753	65,753						
<b>h. Telephone and Cellular Phones</b>								
1. Telephone & Pagers	\$ 45,583	45,583						
2. Cellular Phones	\$ 3,405	3,405						
<b>i. Appraisal (<i>Specify purpose and attach copy</i>)*</b>	\$							
<b>j. Corporation Business Taxes (<i>franchise tax</i>)</b>	\$							
<b>k. Other Taxes (<i>Not related to property - See Page 22</i>)</b>								
1. Income*	\$	(14,991)	14,991					
2. Other ( <i>Specify</i> ) See Attached Schedule	\$							
3. Resident Day User Fee	\$ 535,926	535,926						
<b>Subtotal</b>	\$ 2,549,948	2,944,716	(394,768)					

\* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)



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

Name of Facility Glastonbury Health Care Center, In	License No. 2028C	Report for Year Ended 9/30/2023	Page 15b	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 PKF O'Connor Davie	Four Corporate Drive, Suite 488, Shelton, CT 06484
2 Marcum LLP	555 Long Wharf Drive, 12th Floor, New Haven, CT 06511
3 Midcap Financial Services, LLC	7255 Woodmont Ave Suite 200, Bethesda, MD 20814
4	

Services Provided by This Firm (*describe fully*)

1 Tax Returns	\$ 7,400
2 Medicare Cost Reports	\$ 2,835
3 Line of Credit Audit (Disallowed)	\$ 7,496
4	\$
	Charge for Services Provided
	\$ 17,731

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

- Yes     No    Pg 15, Line 1d

**Legal Services Information**

Name of Legal Firm or Independent Attorney	Telephone Number
1 Midcap Financial Services, LLC	312-258-5500
2 Goldman, Gruder, & Woods	203-899-8900
3 Jackson Lewis/Brenner, Saltzman & Wallman LLP	203-772-2600
4 Murtha Cullina	860-240-6000
5 Treasurer State of CT/State Marshal	

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

1 7255 Woodmont Ave Suite 200, Bethesda, MD 20814
2 200 Connecticut Ave, Norwalk, CT 06854
3 1133 Westchester Ave Suite 5125, West Harrison, NY 10604 / 271 Whitney Ave., New Haven, CT 06511
4 280 Trumbell St, 12th Floor, Hartford, CT 06103
5

Services Provided by This Firm (*describe fully*)

1 Line of Credit: Disallow	\$ 12,826
2 AR Collections: Disallow	\$ 7,225
3 Employee Matters: Disallow PPP Loan Reliance: Disallow	\$ 6,808
4 Annual Reports \$150: Allow, LOC \$2471: Disallow	\$ 35,575
5 AR Collections: Disallow	\$ 700
	Charge for Services Provided
	\$ 63,134

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

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

Name of Facility	License No.	Report for Year Ended				Page	of
Glastonbury Health Care Center, Inc.	2028C	9/30/2023				16	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
<b>Subtotals Brought Forward:</b>	2,549,948	2,944,716	(394,768)				
<b>l. Travel and Entertainment</b>							
1. Resident Travel and Entertainment	\$	2,720					
2. Holiday Parties for Staff	\$ 2,720	25,562					
3. Gifts to Staff and Residents	\$	10,117	(25,562)				
4. Employee Travel	\$ 10,117	6,100					
5. Education Expenses Related to Seminars and Conventions	\$ 6,100	#REF!					
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$						
7. Other ( <i>Specify</i> ) See Attached Schedule	\$						
<b>m. Other Administrative and General Expenses</b>							
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 6,090	6,090					
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$	43	(43)				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	6,511	(6,511)				
4. Fund-Raising***	\$ 5,663	5,663					
5. Medical Records	\$						
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$						
7. Postage	\$						
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 7,265	7,265					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$						
9. Subscriptions	\$ 640	640					
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**	\$ 184,089		184,089				
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 91,678	1,109,203	(1,017,525)				
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 2,864,310	4,124,630	(1,260,320)				

\* 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 in the Adjustment column.



Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Promotional	\$ 6,511	\$ (6,511)				
<b>Total Other Advertising</b>	\$ 6,511	\$ (6,511)	\$ -	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF Dues	\$ 7,265					
<b>Total Dues</b>	\$ 7,265	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Facility License renewal	\$ 1,040					
Bank Charges	\$ 31,438	\$ (31,438)				
Payroll Processing Fees	\$ 20,984					
Employee Physicals/Background Checks	\$ 7,766					
Other Professional Fees	\$ 986,087	\$ (986,087)				
Data Processing/Software Maint Fees	\$ 61,888					
<b>Total Other Administrative and General</b>	\$ 1,109,203	\$ (1,017,525)	\$ -	\$ -	\$ -	\$ -

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

Name of Facility Glastonbury Health Care Center, Inc.	License No. 2028C	Report for Year Ended 9/30/2023	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 #

**\* 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
Glastonbury Health Care Center, Inc.		2028C	9/30/2023				18	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 327,493	327,493						
2. Non-Food Supplies	\$ 42,992	42,992						
3. Other (Specify) _____ Dishes	\$ 2,150	2,150						
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$							
c. Other (Specify) _____	\$							
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 372,635</b>	<b>372,635</b>						
2E. Dietary Questionnaire		Total	CCNH / RHNS	(Specify)	(Specify)			
F. Resident Meals:	Total no. of meals served per day:*	282	282					
G. Is cost of employee meals included in 2D?	<input checked="" type="radio"/> Yes <input type="radio"/> No							
H. Did you receive revenue from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.			
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)								
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input 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)								
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.			
N. Is any revenue collected from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.			
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)								

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

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

Name of Facility		License No.	Report for Year Ended				Page	of
Glastonbury Health Care Center, Inc.		2028C	9/30/2023				19	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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. \$	8,855	8,855				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$						
c. Other (Specify) Supplies		\$	5,098	5,098				
<b>3D. Total Laundry Expenditures (3a + b + c)</b>		\$	13,953	13,953				
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 checked="" type="radio"/> Yes <input type="radio"/> No		If yes, specify cost.			1741	
J. Did you receive revenue from these people?		<input checked="" type="radio"/> Yes <input type="radio"/> No		If yes, specify amt.			1741	
K. Where is the revenue received reported in the Cost Report?		(Page/Line Item)						
		30 IV8						

\* 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
Glastonbury Health Care Center, Inc.		2028C	9/30/2023				20	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4.	Housekeeping							
a.	In-House Care	Sq. Ft. Serviced by Personnel						
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	39,891	39,891				
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.	<b>Total Housekeeping Expenditures</b> (4a + b + c)	\$	39,891	39,891				
5.	Resident Care (Supplies)**							
a.	Prescription Drugs***							
	1. Own Pharmacy	\$						
	2. Purchased from Procure	\$	469,422	(469,422)				
b.	Medicine Cabinet Drugs	\$	11,550	11,550				
c.	Medical and Therapeutic Supplies	\$	241,261	252,016	(10,755)			
d.	Ambulance/Limousine***	\$	42,110	(42,110)				
e.	Oxygen							
	1. For Emergency Use	\$						
	2. Other***	\$	8,774	(8,774)				
f.	X-rays and Related Radiological Procedures***	\$	35,890	(35,890)				
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$						
h.	Laboratory***	\$	167,613	(167,613)				
i.	Recreation	\$	18,787	18,787				
j.	Direct Management Services*	\$	50,206	50,206				
k.	Indirect Management Services*	\$	44,628	44,628				
l.	Cable TV	\$	3,600	16,223	(12,623)			
m.	Other (Specify)**** See Attached Schedule	\$	74,739	84,138	(9,399)			
n.	Physical Therapy Expense	\$						
o.	Speech Therapy Expense	\$						
5P.	<b>Total Resident Care Expenditures</b> (5a - 5o)	\$	444,771	1,106,523	(661,752)			

\* 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 in the Adjustment column.  
 \*\*\*\* ICFMR's should provide a detailed schedule of all Day Program Costs.



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

Name of Facility Glastonbury Health Care Center, Inc.			License No. 2028C		Report for Year Ended 9/30/2023				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)	(Specify)	Pg	Line
ADP	100 Corporate Drive, Windsor, CT 06095	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	20,984			16	m13
CT Waste Processing	PO Box 99, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal	36,937			22	6f
Winterberry Landscape Management	2070 West St. Southington, CT 06489	<input type="radio"/>	<input checked="" type="radio"/>		Groundskeeping & Snow Removal	40,796			22	6f
Procure LTC	111 Executive Blvd. Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners: Minority Interest	Pharmacy	490,523			20	5A2
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

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

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

Name of Facility	License No.	Report for Year Ended		Page	of		
Glastonbury Health Care Center, Inc.	2028C	9/30/2023		22	37		
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant							
a. Repairs & Maintenance	\$ 120,076	120,076					
b. Heat	\$ 50,775	50,775					
c. Light & Power	\$ 125,537	125,537					
d. Water	\$ 45,439	74,749	(29,310)				
e. Equipment Lease (Provide detail on page 22b)	\$ 42,664	42,664					
f. Other (itemize)	\$ 102,717	102,717					
See Attached Schedule							
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	\$ 487,208	516,518	(29,310)				
7. Depreciation (complete schedule page 23*)							
a. Land Improvements	\$ 211	211					
b. Building & Building Improvements	\$ 74,461	74,461					
c. Non-Movable Equipment	\$ 1,816	1,816					
d. Movable Equipment	\$ 25,670	25,688	(18)				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	\$ 102,158	102,176	(18)				
8. Amortization (Complete att. Schedule Page 24*)							
a. Organization Expense	\$						
b. Mortgage Expense	\$						
c. Leasehold Improvements	\$ 80,786	80,786					
d. Other (Specify)	\$						
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	\$ 80,786	80,786					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 572,826	572,826					
10. Property Taxes							
a. Real estate taxes paid by owner	\$						
b. Real estate taxes paid by lessor	\$ 123,838	123,838					
c. Personal property taxes	\$ 13,276	13,276					
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	\$ 892,884	892,902	(18)				

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





### General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Glastonbury Health Care Center, Inc.			License No. 2028C	Report for Year Ended 9/30/2023			Page 22b	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
	<input type="radio"/>	<input checked="" type="radio"/>						
Pitney Bowes Credit, PO Box 856460, Louisville, KY 40285	<input type="radio"/>	<input checked="" type="radio"/>	Mail Machine	03/29/18	Annual Renewal	1,844	1,853	
Hewlett Packard / Visual Edge Technology Inc, PO Box 402582, Atlanta, GA 30384	<input type="radio"/>	<input checked="" type="radio"/>	Copier	07/30/21	48 Months	5,803	5,803	
Atria Litchfield Hills / Hallbridge, 300 East Market St. Suite 100, Louisville, KY 40202	<input type="radio"/>	<input checked="" type="radio"/>	Therapy Space Lease	04/01/19	Annual Renewal	35,008	35,008	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input checked="" type="radio"/> No	<b>Total ***</b>
							42,664	

\* 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.

### Depreciation Schedule

Name of Facility Glastonbury Health Care Center, Inc.			License No. 2028C		Report for Year Ended 9/30/2023			Page 23	of 37			
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
<b>A. Land Improvements</b>												
1. Acquired prior to this report period			120,712		120,712	120,396	S/L	Various	211			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal										211		
<b>B. Building and Building Improvements</b>												
1. Acquired prior to this report period			2,854,912		2,854,912	2,450,006	S/L	Various	74,461			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
B-4. Subtotal										74,461		
<b>C. Non-Movable Equipment</b>												
1. Acquired prior to this report period			909,320		909,320	897,883	S/L	Various	1,816			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal										1,816		
		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	2022	1,190,472		1,190,472	S/L	Various	23,212	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative				9	2023	10,000		10,000	S/L	Various	500	
d. Standard Resident				9	2023	33,058		33,058	S/L	Various	1,976	
e. Specialized Resident												
Total Acquired during this report period						43,058		43,058			2,476	
D-3. Subtotal												25,688
<b>E. Total Depreciation</b>												102,176



## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
<b>Additions:</b>					
12/31/2022	patient lift scale	Standard Resident	\$ 1,894	10	\$ 95
2/28/2023	reversing trunnion for washer	Standard Resident	\$ 2,589	5	\$ 259
2/28/2023	dryer motor	Standard Resident	\$ 2,315	5	\$ 232
2/28/2023	scale	Standard Resident	\$ 1,258	10	\$ 63
7/31/2023	ice & water dispenser	Standard Resident	\$ 7,806	10	\$ 390
8/31/2023	condensing unit	Administrative	\$ 10,000	10	\$ 500
8/31/2023	patient station	Standard Resident	\$ 1,539	5	\$ 154
9/30/2023	steam table	Standard Resident	\$ 4,458	10	\$ 223
9/30/2023	refrigeration equipment	Standard Resident	\$ 8,133	10	\$ 407
9/30/2023	20 overbed tables	Standard Resident	\$ 3,066	10	\$ 153
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
<b>Total additions for Movable Equipment</b>			\$ 43,058		\$ 2,476 *
<b>Deletions:</b>					
<b>Total deletions for Movable Equipment</b>			\$ -		\$ - **

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

## Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
12/31/2022		\$ 1,968	10	\$ 98
1/31/2023		\$ 8,013	10	\$ 401
4/30/2023		\$ 4,738	5	\$ 474
4/30/2023		\$ 2,292	5	\$ 229
6/30/2023		\$ 1,235	5	\$ 124
6/30/2023		\$ 5,568	5	\$ 557
9/30/2023		\$ 13,123	10	\$ 656
9/30/2023		\$ 4,015	5	\$ 402
9/30/2023		\$ 5,789	10	\$ 289
9/30/2023		3565	5	357
9/30/2023		1447	5	145
9/30/2023		5224	5	522
9/30/2023		1576	5	158
<b>Total additions for Leasehold Improvement</b>		\$ 58,553		\$ 4,412 *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

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

**Amortization Schedule\***

Name of Facility Glastonbury Health Care Center, Inc.			License No. 2028C		Report for Year Ended 9/30/2023			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							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1. Finance Fees -LOC	9	2018	3	6,395	6,395	SL			
2. Finance Fees	9	2020		10,437					
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period	9	2022	Various	1,908,203	1,019,319	SL	Varior	76,374	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2023	Various	58,553		SL	Varior	4,412	
C-4. Subtotal									80,786
<b>D. Total Amortization</b>									80,786

\* 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 Glastonbury Health Care Center, Inc.	License No. 2028C	Report for Year Ended 9/30/2023	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description	Total			
1. Date Land Purchased	05/16/86			
2. Date Structure Completed	01/25/88			
3. If <b>NOT</b> Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	105			
6. Square Footage				
7. Acquisition Cost				
a. Land	544,799			
b. Building	4,193,044			
<b>Part B - Owner and Related Parties</b>	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	03/29/12			
c. Interest Rate for the Cost Year	3.22%			
d. Term of Mortgage (number of years)	35			
e. Amount of Principal Borrowed	7,992			
f. Principal balance outstanding as of _____	6,303,886			
<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
Glastonbury Health Care Center, Inc.		2028C	9/30/2023				26	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
12. Interest								
A. Building, Land Improvement & Non-Movable Equipment								
1. First Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
2. Second Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
3. Third Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
4. Fourth Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
B. CHEFA Loan Information								
1. Original Loan Amount		\$						
2. Loan Origination Date								
3. Interest Rate %								
4. Term								
5. CHEFA Interest Expense								
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$						

*(Carry Subtotals forward to next page)*



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

Name of Facility		License No.		Report for Year Ended				Page	of	
Glastonbury Health Care Center, In		2028C		9/30/2023				27	37	
Item				Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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) Vendor Interest = \$83,128; Interest LOC = \$640,453				\$	723,581	723,581				
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	723,581	723,581				
14. Insurance										
a. Insurance on Property (buildings only)				\$	132,982	132,982				
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)				\$	132,982	132,982				
15. Total All Expenditures (A-13 thru C-14)				\$	13,568,132	15,798,770	(2,230,638)			

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended		Page	of
Glastonbury Health Care Center, Inc.	2028C	9/30/2023		30	37
Item	Total	CCNH / RHNS	(Specify)	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 15,478,370	15,478,370			
b. Medicaid Room and Board Contractual Allowance **	\$ (8,812,772)	(8,812,772)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 2,327,024	2,327,024			
b. Medicare Room and Board Contractual Allowance **	\$ 71,186	71,186			
4. a. Private-Pay Residents and Other	\$ 5,098,453	5,098,453			
b. Private-Pay Room and Board Contractual Allowance **	\$ (1,556,799)	(1,556,799)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 177,646	177,646			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (177,646)	(177,646)			
c. Prescription Drugs - Non-Medicare	\$ 378,478	378,478			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (378,478)	(378,478)			
2. a. Medical Supplies - Medicare	\$ 255	255			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (255)	(255)			
c. Medical Supplies - Non-Medicare	\$ 23,608	23,608			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (23,608)	(23,608)			
3. a. Physical Therapy - Medicare	\$ 600,034	600,034			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (470,166)	(470,166)			
c. Physical Therapy - Non-Medicare	\$ 556,140	556,140			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (556,140)	(556,140)			
4. a. Speech Therapy - Medicare	\$ 94,840	94,840			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (81,050)	(81,050)			
c. Speech Therapy - Non-Medicare	\$ 97,075	97,075			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (97,075)	(97,075)			
5. a. Occupational Therapy - Medicare	\$ 518,142	518,142			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (429,796)	(429,796)			
c. Occupational Therapy - Non-Medicare	\$ 586,600	586,600			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (586,600)	(586,600)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (482,930)	(482,930)			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 12,354,536	12,354,536			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$ 38,646	39,108	(462)		
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 185,821	185,821			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 224,467	224,929	(462)		
<b>VI. Total All Revenue</b> (III +V)	\$ 12,579,003	12,579,465	(462)		

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

## Schedule of Other Non-Medicare Resident Revenue

## Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
N/A	Medicaid rate adjustments	\$ (7,041)		
N/A	Medicare rate adjustments	\$ (475,889)		
<b>Total Other Resident Revenue</b>		\$ (482,930)	\$ -	\$ -

## Interest Income

## Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
31, A2	Interest on A/R		\$ 39,108	\$ (462)	
<b>Total Interest Income</b>			\$ 39,108	\$ (462)	\$ -

## Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
22 6d	Water/Sewer Income	\$ 29,310		
19 3E	Laundry Services	\$ 1,741		
	Bad Debt Recovery	\$ 154,770		
<b>Total Other Revenue</b>		\$ 185,821	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Glastonbury Health Care Center, Inc.	2028C	9/30/2023	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	229,770
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,632,034
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	20,356
5. Prepaid Expenses			\$	295,208
a. Prepaid Insurance	137,091			
b. _____				
c. Prepaid Expenses (itemize)	158,117			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	38,020
Due From Hallbridge	38,020			
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	2,215,388
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	120,712	\$	105
	Accum. Depreciation	120,607		Net
3. Buildings	*Historical Cost	2,854,912	\$	330,445
	Accum. Depreciation	2,524,467		Net
4. Leasehold Improvements	*Historical Cost	1,966,756	\$	866,651
	Accum. Depreciation	1,100,105		Net
5. Non-Movable Equipment	*Historical Cost	909,320	\$	9,621
	Accum. Depreciation	899,699		Net
6. Movable Equipment	*Historical Cost	1,233,455	\$	102,741
	Accum. Depreciation	1,130,714		Net
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation			Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	113,361
Moveable Equipment Carryforward	76			
See Schedule	113,285			
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	1,422,924

\* 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 (itemize) 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	
		Project Development	\$ 113,285
Total Other Other Fixed Assets (Itemize)			\$ 113,285

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Glastonbury Health Care Center, Inc.	2028C	9/30/2023	32	37
<b>Account</b>			<b>Amount</b>	
Total Brought Forward:			\$	3,638,312
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
1. Land			\$	544,799
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	4,193,044		
	Accum. Depreciation	4,193,044	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			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	544,799
<b>D. Investment and Other Assets</b>				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	353,370
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
_____				
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	(6,526,898)
Name and Address		Amount	Loan Date	
Due from Related Party		(6,526,898)		
7. Other Assets ( <i>itemize</i> )			\$	(378,320)
LOC Deposit		10,437		
Solar Panel Project		(388,757)		
See Schedule				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	(6,551,848)
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	(2,368,737)

\* 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
Glastonbury Health Care Center, Inc.	2028C	9/30/2023	33	37
Account			Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable			\$	1,119,940
2. Notes Payable ( <i>itemize</i> )			\$	2,498,782
Medicap Line of Credit				2,498,782
See Schedule				
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )			\$	
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )			\$	279,864
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$	
6. Accrued Payroll Taxes Payable			\$	295,409
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> )			\$	2,033,141
Acc'd Operating Expenses			49,980	Accrued Other - Related 73,931
Acc'd Expense - Sales Tax			278	
Provider Taxes Due			1,908,952	
See Schedule				
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)			\$	6,227,136

\* 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 Glastonbury Health Care Center, Inc.	License No. 2028C	Report for Year Ended 9/30/2023		Page 34	of 37
Account				Amount	
Total Brought Forward:				6,227,136	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> )					
				\$	
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable					
				\$	
3. Loans from Owners or Related Parties ( <i>itemize</i> )					
				\$ 230,381	
Name and Address of Lender	Amount	Loan Date			
Working Capital Reserve	(5,702)	NA			
Notes Payable - Procare Investment	236,083	NA			
4. Other Long-Term Liabilities ( <i>itemize</i> )					
		2,566,106			
		106,291			
		See Schedule			
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 2,902,778	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 9,129,914	



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

Name of Facility	License No.	Report for Year Ended	Page	of
Glastonbury Health Care Center, Inc.	2028C	9/30/2023	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	544,799
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			\$	544,799
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	50,000
3. Paid-in Surplus			\$	300,000
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(9,174,145)
6. Gain or Loss for Period	10/1/2022	thru	9/30/2023	\$ align="right">(3,219,305)
7. Total Net Worth			\$	(12,043,450)
<b>C. Total Reserves and Net Worth</b>			\$	(11,498,651)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	(2,368,737)

### H. Changes in Total Net Worth

Name of Facility Glastonbury Health Care Center, Inc.	License No. 2028C	Report for Year Ended 9/30/2023	Page 36	of 37		
Account			Amount			
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	(10,805,554)		
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	12,579,465		
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	15,798,770		
D. Net Income or Deficit			\$	(3,219,305)		
E. Balance			\$	(14,024,859)		
F. Additions						
1. Additional Capital Contributed <i>(itemize)</i>						
ERC JE	1,981,408					
Rounding	1					
2. Other <i>(itemize)</i>						
F-3. Total Additions					\$	1,981,409
G. Deductions						
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>					\$	
Name and Address <i>(No., City, State, Zip)</i>	Title	Amount				
2. Other Withdrawings <i>(Specify)</i>					\$	
Purpose	Amount					
3. Total Deductions			\$			
H. <b>Balance at End of Period</b>			\$	(12,043,450)		

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

Name of Facility Glastonbury Health Care Center, Inc.	License No. 2028C	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> Home (CCNH) & RHNS <input type="checkbox"/> Combined	<input type="checkbox"/> (Specify)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Athena Health Care Associates, Inc				
Address Address			Phone Number	
135 South Road Farmington CT 06032			(860) 751-3900	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Amanda Doncet			(860) 751-3900	
Contact Email Address				
adoncet@athenahealthcare.com				