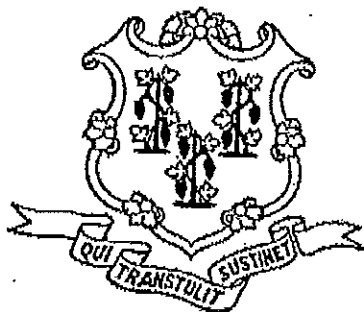


# State of Connecticut



15-79

## Annual Report of Long-Term Care Facility Cost Year 2015

RECEIVED

NOV 17 2016

DEPT. OF SOCIAL SERVICES  
LICENSING AND RATE SETTINGS

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 Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 2025C	RHNS	(Specify)	Medicare Provider No. 07-5312
------------------	---------------	------	-----------	----------------------------------

Medicaid Provider Numbers:	CCNH 2025C	RHNS	ICF-MR
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**For Department Use Only**

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



**MYERS AND  
STAUFFER** LLC  
CERTIFIED PUBLIC ACCOUNTANTS

December 11, 2013

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

Subject: Alternative Annual Report Approval

Dear Mr. Mosier:

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

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

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

Sincerely,

Brittany L. Hester, Administrative Assistant

CC: Claudetta B. Pickens, CPA  
CC: Chris Lavigne

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**General Information**

Name of Facility (as licensed) Wadsworth Glen Health Care and Rehabilitation Center, Inc.	License No. 2025C	Report for Year Ended 9/30/2015	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 Wadsworth Glen Health Care and Rehabilitation Center, Inc. [facility name] for the cost report period beginning October 01, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator) <i>Patricia Hamill</i>	Date 2/10/16	Signed (Owner) <i>[Signature]</i>	Date 2/10/16
Printed Name (Administrator) Patricia Hamill		Printed Name (Owner) Lawrence G. Santilli	
Subscribed and Sworn to before me:	State of Ct	Date 2/10/16	Signed (Notary Public) <i>Maria Lepizzo</i>
Comm. Expires 7/31/18			
Address of Notary Public 30 Boston Rd., Middletown, Ct. 06457			

(Notary Seal)

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

Data Required for Real Wage Adjustment		Page 1A	of 37
Name of Facility <b>Wadsworth Glen Health Care and Rehabilitation Center, Inc</b>		Period Covered: <b>10/1/2014</b>	From To <b>9/30/2015</b>
Address of Facility <b>30 Boston Rd, Middletown, CT 06457</b>			
Report Prepared By <b>Athena Health Care Associates, Inc</b>		Phone Number <b>(860) 751-3900</b>	Date <b>2/10/2016</b>
Item	Total	CCNH	RHNS (Specify)
1. Dietary wages paid..... \$			
2. Laundry wages paid..... \$			
3. Housekeeping wages paid..... \$			
4. Nursing wages paid..... \$			
5. All other wages paid..... \$			
6. <i>Total Wages Paid</i> ..... \$			
7. Total salaries paid..... \$			
8. <i>Total Wages and Salaries Paid</i> (As per page 10 of Report) \$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility <b>860-346-9299</b>		Report for Year Ended <b>09/30/15</b>	Page <b>2</b>	of <b>37</b>
Name of Facility (as shown on license) <b>Wadsworth Glen Health Care and Rehabilitation Center, Inc</b>		Address (No. & Street, City, State, Zip) <b>30 Boston Rd, Middletown, CT 06457</b>		
License Numbers:	CCNH <b>2025C</b>	RHNS	(Specify)	Medicare Provider No. <b>07-5312</b>
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)
Type of Ownership (Check appropriate box)				
<input type="checkbox"/> PROPRIETORSHIP <input type="checkbox"/> LLC <input type="checkbox"/> PARTNERSHIP <input checked="" type="checkbox"/> PROFIT CORP. <input type="checkbox"/> NON-PROFIT CORP. <input type="checkbox"/> GOVERNMENT <input type="checkbox"/> TRUST				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No            If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator <b>Patricia Hamill</b>		Nursing Home Administrator's License No.:	<b>001195</b>	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		
<b>Not Applicable</b>				









### General Information and Questionnaire Related Parties\*

Name of Facility		License No.		Report for Year Ended		Page	of
Wadsworth Glen Health Care and Rehabilitation Center, Inc		2025C		9/30/2015		4	37
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
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="checkbox"/> Yes <input type="checkbox"/> No							
If "Yes," provide the Name/Address and complete the information on Page 11 of the report.							
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				
Shady Knoll Health Care Center	41 Skokorat Street, Seymour, CT 06483	<input checked="" type="checkbox"/>	<input type="checkbox"/>	SWAP Interest Mortgage Payments	P 22, L 9	\$4,910	\$4,910
Athena Captive	135 South Rd, Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Workers Comp Captive	Pg 15 1a1	\$431,203	\$431,203
CT Health Center of Middletown	30 Boston Rd, Middletown, CT 06457	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Rental of Property	Pg 22, Ln 9, 10b, Pg 27 Ln 14	\$689,894	\$689,894
Athena Health Care Assoc 410k Plan	135 South Rd, Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Facility Participates in common 401k plan			
Laurel Ridge HCC	642 Danbury Rd, Ridgefield, CT 06877	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Bank Fees	P16 L m13	\$7,982	\$7,982
Athena Health Care	135 South Rd, Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	See Attached		\$567,262	\$255,568
Athena Health Care	135 South Rd, Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Self Insured Employee Health & Dental Insurance	Pg 15, 1	\$805,138	\$805,138
Litchfield Woods	255 Roberts Street, Torrington, CT 06790	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Legal Fee Reimbursement	Pg 7	\$5,077	\$5,077

\* Use additional sheets if necessary.

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

Wadsworth Glen  
RELATED PARTIES QUESTIONNAIRE  
PAGE 4

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report - Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No				
Athena Health Care	135 South Road Farmington, CT	<input checked="" type="checkbox"/>	<input type="checkbox"/>	MDS Fill In, Legal, Office Supplies, Employee Relations, Education Expenses, Business Promotion, Lobbying, Payroll Processing Fees, Data Processing Fees, Management Fees, Repairs & Maintenance, Furniture & Equipment.	Pg 13 11a2, Pg 15 1e, 1g; Pg 16 13, 15; Pg 16 m3, m13; Pg 17; Pg 22 6a; Pg 31 6b;	\$667,262	\$255,568

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

Name of Facility Wadsworth Glen Health Care and Rehabilitation Center, Inc	License No. 2025C	Report for Year Ended 9/30/2015	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 (See listing page 13)
Maintenance and operation of plant.....	Square feet
Property costs (depreciation).....	Square feet
Employee health and welfare.....	Gross salaries
Management services.....	Appropriate cost center involved
All other General Administrative expenses.....	Total of Direct and Allocated Costs

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

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

Not Applicable

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

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.

Not Applicable: 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.

Name of Facility		License No.		Report for Year Ended		Page of	
Wadsworth Glen Health Care and Rehabilitation Center, Inc		2025C		9/30/2015		6   37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Leaf, PO Box 644006, Cincinnati, OH 45264	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Copier	06/07/13	33 Months	\$5,001	\$5,001
Pitney Bowes, PO Box 7150M, St Louis, MO 63195	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Postage Machine	01/27/05	66 months	\$1,219	\$1,219
Leaf, PO Box 644006, Cincinnati, OH 45264	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Copier	04/09/12	48 Months	\$8,780	\$8,780
HP Financial, 200 Council Drive, Suite 5000, Berkeley Heights, NJ 07922	<input type="checkbox"/>	<input checked="" type="checkbox"/>	PCC Equipment	08/16/13	60 Months	\$5,994	\$5,994
Graybar Financial, PO Box 644006, Cincinnati, OH 45264	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Boiler Upgrade Lease	11/25/14	60 Months	\$4,178	\$4,178
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
						<b>Total ***</b>	<b>\$25,172</b>

Is a Mileage Log Book Maintained for All Leased Vehicles?  Yes  No  Not Applicable - No Vehicles

\* 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 Rehabilitation Center, Inc	License No. 2025C	Report for Year Ended 9/30/2015	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Cash <input type="checkbox"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "No," explain.				
<b>Independent Accounting Firm</b>				
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)		
1 Dworken, Hillman, LaMorte & Sterczala		Four Corporate Dr, Shelton, CT 06484		
2 Marcum LLP		555 Long Wharf Dr, 12th Floor, New Haven, CT 06511		
3				
4				
Services Provided by This Firm (describe fully)				
1	2015 Audit, Year End Financials & Tax Return		\$	14,000
2	Medicare Cost Report Preparation (Disallow)		\$	2,650
3			\$	-
4			\$	-
			Charge for Services Provided	
			\$16,650	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No    Pg 15, Line1d				
<b>Legal Services Information</b>				
Name of Legal Firm or Independent Attorney			Telephone Number	
1				
2 Schiff Harden			312-258-5500	
3 Murtha Cullina, LLP			860-240-6000	
4 Goldman, Gruder, & Woods, LLC			203-899-8900	
5 State Treasurer/State Marshall fees				
Address (No. & Street, City, State, Zip Code)				
1				
2 6600 Sears Tower, Chicago, IL 60606				
3 185 Asylum St, Hartford, CT 06103				
4 200 Connecticut Avenue, Norwalk, CT 06854				
5				
Services Provided by This Firm (describe fully)				
1			\$	-
2	Line of Credit: Disallowed		\$	5,077
3	Audit Letters & Secretary of State Annual Reports, \$755:Allowed; DPH Matters \$109 & Loan Modification \$7366: Disallowed;		\$	8,230
4	A/R Collections - Disallowed		\$	9,667
5	Conservatorship Fees:Disallow		\$	155
			Charge for Services Provided	
			\$23,129	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No    Pg 15, Line1e				

Schedule of Resident Statistics

Name of Facility	License No.		Report for Year Ended		Page	of
	2025C		09/30/15			
Wadsworth Glen Health Care and Rehabilitation Center, Inc	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30	Period 7/1 Thru 9/30
1. Certified Bed Capacity						
A. On last day of PREVIOUS report period.....	102	102			102	102
B. On last day of THIS report period.....	102	102			102	102
2. Number of Residents						
A. As of midnight of PREVIOUS report period....	96	96			94	96
B. As of midnight of THIS report period.....	99	99			101	99
3. Total Number of Days Care Provided During Period						
A. Medicare.....	6,283	6,283			4,449	1,834
B. Medicaid (Conn.).....	26,079	26,079			19,852	6,227
C. Medicaid (other states).....						
D. Private Pay.....	2,565	2,565			1,792	773
E. State SSI for RCH.....						
F. Other (Specify) Managed Care	446	446			327	119
G. Total Care Days During Period (3A thru F).....	35,373	35,373			26,420	8,953
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds						
A. Medicaid Bed Reserve Days.....	169	169			113	56
B. Other Bed Reserve Days.....	94	94			80	14
5. Total Resident Days (3G + 4A + 4B).....	35,636	35,636			26,613	9,023

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

Name of Facility <b>Wadsworth Glen Health Care and Rehabilitation Center, Inc</b>			License No. <b>2025C</b>			Report for Year Ended <b>9/30/2015</b>			Page <b>9</b>		of <b>37</b>		
4. Were there any changes in the certified bed capacity during the report year? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "YES", provide the following information:													
Date of Change	Place of Change (Specify)			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(3)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)		(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	(Specify)			
1st change.....													
2nd change.....													
3rd change.....													
4th change.....													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid			Self-Pay			Other State Assisted				
	CCNH	RHNS	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR			
No. of Residents	17	66				7			9				
Per Diem Rate													
a. One bed rm.	565.34	226.28				492.00			400.55				
b. Two bed rms.	565.34	226.28				474.00			400.55				
c. Three or more bed rms.	565.34	226.28				462.00			400.55				
7. Total Number of Physical Therapy Treatments						TOTAL	CCNH	RHNS	(Specify)				
A. Medicare - Part B						8,086	8,086						
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments						931	931						
2. Restorative Treatments													
C. Other						16,249	16,249						
D. Total Physical Therapy Treatments						25,266	25,266						
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B						583	583						
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments						67	67						
2. Restorative Treatments													
C. Other						1,844	1,844						
D. Total Speech Therapy Treatments						2,494	2,494						
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B						7,572	7,572						
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments						1,062	1,062						
2. Restorative Treatments													
C. Other						20,446	20,446						
D. Total Occupational Therapy Treatments						29,080	29,080						



Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Wadsworth Glen Health Care and Rehabilitation Center, Inc	2025C	9/30/2015	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	128,826	2,141				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	206,469	9,684				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	62,628	2,073				
c. Dietary Workers	299,137	24,058				
6. Housekeeping Service						
a. Head Housekeeper	45,980	1,957				
b. Other Housekeeping Workers	149,753	13,074				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	62,581	2,107				
b. Other Maintenance Workers	44,617	2,076				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	76,161	6,198				
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	183,630	4,146				
b. RN						
1. Direct Care	563,329	15,938				
2. Administrative**	448,321	19,520				
c. LPN						
1. Direct Care	712,343	26,790				
2. Administrative**						
d. Aides and Attendants	1,205,497	82,154				
e. Physical Therapists	551,804	16,006				
f. Speech Therapists	108,495	2,224				
g. Occupational Therapists	420,706	12,647				
h. Recreation Workers	130,512	5,855				
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	153,591	6,183				
n. Marketing						
o. Other (Specify)						
<i>A-13. Total Salary Expenditures</i>	5,554,380	254,831				

\* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.  
 \*\* Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.  
 \*\*\* This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

Position	\$ CCNH	Hours CCNH	\$ RHNS	Hours RHNS	\$ (Specify)	Hours (Specify)
Total:	\$		\$		\$	

Schedule of Physician: Other Fees (Page 13)

Service	\$ CCNH	Hours CCNH	\$ RHNS	Hours RHNS	\$ (Specify)	Hours (Specify)
Total:	\$		\$		\$	

Schedule of Other Fees (Page 13)

Service	\$ CCNH	Hours CCNH	\$ RHNS	Hours RHNS	\$ (Specify)	Hours (Specify)
Total:	\$		\$		\$	

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	License No.		Report for Year Ended		Page	of	
	2025C	9/30/2015	Line Where Claimed on Page 10	Name and Address of All Other Employment**			
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	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 A.1 - 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		9/30/2015		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***									
Patricia Hamill (10/1/14-9/30/15)	128,826		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,141	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	License No.	Report for Year Ended	Page	of		
Wadsworth Glen Health Care and Rehabilitation Center, Inc	2025C	9/30/2015	13	37		
<b>Total Cost and Hours</b>						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian.....	37,385	947				
2. Dentist.....	11,628	15				
3. Pharmacist.....	6,205	135				
4. Podiatrist.....						
5. Physical Therapy						
a. Resident Care.....	5,000					
b. Other.....						
6. Social Worker.....						
7. Recreation Worker.....						
8. Physicians						
a. Medical Director (entire facility).....	52,084	724				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**.....	5,198					
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.....	5,514	15				
b. Other.....						
10. Occupational Therapist						
a. Resident Care.....						
b. Other.....						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	2,986	96				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides.....						
d. Other.....						
12. Other (Specify) See Attached Schedule						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>126,000</b>	<b>1,932</b>				

\* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

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

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

**Report of Expenditures**  
**Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis\***

Name of Facility		License No.	Report for Year Ended	Page	of
Wadsworth Glen Health Care and Rehabilitation Center, Inc		2025C	9/30/2015	14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Debra Morelli, 440 Old Reservoir Rd, Wethersfield, CT 06109	Dietician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
ABC Recruiting, 2075 Lansing Place, Syosset, NY 11791	Physical Therapist Recruiting Fee	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Prakash Huded MD, 28 Marlborough St, Portland, CT 06480	Medical Director	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Connecticut Oncology, 536 Saybrook Rd, Middletown, CT 06457	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Omnicare Pharmacy, 523 Knotter Drive, Cheshire, CT 06410	Pharmacy Consultant	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Grove Hill Medical Center, 300 Kensington Ave, New Britain, CT 06051	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Healthdrive Audiology, 888 Worcester St, Wellesley, MA 02482	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Middlesex Eye Physician, 400 Saybrook Rd, Middletown, CT 06457	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Joseph Anquillare/CT Multispecialty, 2110 Silas Deane Highway, Rocky Hill, CT 06067	Asst Medical Director	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Southern New England ENT, University Towers, 98 York St, New Haven, CT 06511	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Healthdrive Dental, 888 Worcester Street, Suite 130, Wellesley, MA 02482	Dentist	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Cohen Derma, PO Box 414913, Boston, MA 02241	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Middlesex Hospital, 28 Crescent St, Middletown, CT 06457	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Healthdrive Eye Care Group, 888 Worcester St, Wellesley, MA 06457	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Middlesex Cardiology, 520 Saybrook Road, Middletown, CT 06457	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
SDX Swallowing Diagnostics, P.O. Box 484, Avon, CT 06001	Speech Therapist	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Middlesex Orthopedic Surgery, 410 Saybrook Rd, Middletown, CT 06457	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Yale New Haven Hospital, 20 York St, New Haven, CT 06510	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Cardiology PC, PO Box 848758, Boston, MA 02284	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Hartford Hospital, 80 Seymour St, Hartford, CT 06102	Physician	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Athena Health Care, 135 South Rd, Farmington, CT 06032	MDS Fill In	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Owners	
		<input type="checkbox"/>	<input type="checkbox"/>		

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Wadsworth Glen Health Care and Rehabilitation Center, Inc	2025C	9/30/2015		15	37
Item	Total	CCNH	RHNS	(Specify)	
<b>1. Administrative and General</b>					
<b>a. Employee Health &amp; Welfare Benefits</b>					
1. Workmen's Compensation.....	\$ 431,203	431,203			
2. Disability Insurance.....	\$				
3. Unemployment Insurance.....	\$ 139,164	139,164			
4. Social Security (F.I.C.A.).....	\$ 414,643	414,643			
5. Health Insurance.....	\$ 656,305	656,305			
6. Life Insurance (employees only) (not-owners and not-operators).....	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators).....	\$ 21,133	21,133			
8. Uniform Allowance.....	\$				
9. Other (Specify)..... See Attached Schedule	\$				
<b>b. Personal Retirement Plans, Pensions, and        Profit Sharing Plans for Owners and        Operators (Discriminatory)* .....</b>	\$				
c. Bad Debts*.....	\$ 80,845	80,845			
d. Accounting and Auditing.....	\$ 16,650	16,650			
e. Legal (Services should be fully described on Page 7)	\$ 23,129	23,129			
f. Insurance on Lives of Owners and Operators (Specify)*.....	\$				
g. Office Supplies.....	\$ 49,818	49,818			
h. Telephone and Cellular Phones.....					
1. Telephone & Pagers.....	\$ 30,992	30,992			
2. Cellular Phones.....	\$ 1,129	1,129			
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*.....	\$ 250	250			
2. Other (Specify) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 617,000	617,000			
<b>Subtotal</b>	\$ 2,482,261	2,482,261			

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

(Carry Subtotals forward to next page)

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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



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

Name of Facility	License No.	Report for Year Ended		Page	of
Wadsworth Glen Health Care and Rehabilitation Center, Inc	2025C	9/30/2015		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>	2,482,261	2,482,261			
<b>I. Travel and Entertainment</b>					
1. Resident Travel and Entertainment.....	\$				
2. Holiday Parties for Staff.....	\$ 5,845	5,845			
3. Gifts to Staff and Residents.....	\$ 12,851	12,851			
4. Employee Travel.....	\$ 2,623	2,623			
5. Education Expenses Related to Seminars and Conventions	\$ 8,521	8,521			
6. Automobile Expense (not purchase or depreciation).....	\$				
7. Other (Specify)..... See Attached Schedule	\$				
<b>m. Other Administrative and General Expenses</b>					
1. Advertising Help Wanted (all such expenses).....	\$ 900	900			
2. Advertising Telephone Directory (all such expenses)***	\$ 858	858			
3. Advertising Other (Specify)***:..... See Attached Schedule	\$ 41,448	41,448			
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.....	\$ 10,919	10,919			
* 8. Dues and Membership Fees to Professional Associations (Specify) See Attached Schedule	\$ 6,960	6,960			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 280	280			
9. Subscriptions.....	\$				
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (Specify and Complete Schedule C-2, Page 21 for each firm or individual)	\$				
12. Administrative Management Services**.....	\$ 350,228	350,228			
13. Other (Specify) See Attached Schedule	\$ 126,846	126,846			
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 3,050,540	3,050,540			

\* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 41,448		
<b>Total Other Advertising</b>	\$ 41,448	\$	\$

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCP	\$ 6,960		
<b>Total Dues</b>	\$ 6,960	\$	\$

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Lobbying Fees	\$ 3,416		
Employee Physicals/Background Checks	\$ 22,820		
Bank Charges	\$ 7,729		
Payroll Processing Fees	\$ 19,509		
Licenses	\$ 1,960		
Compliance Consulting	\$ 38,683		
Data Processing	\$ 13,730		
<b>Total Other Administrative and General</b>	\$ 126,846	\$	\$

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

Name of Facility	License No.	Report for Year Ended	Page of
Wadsworth Glen Health Care and Rehabilitation Center, Inc	2025C	9/30/2015	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	\$481,337	Contract Attached to a Prior Year	See Below
Allocation of the above	\$317,682 \$77,014 \$86,641	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 18, Line 2C Pg 20, Line 5J
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	\$32,546	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
Wadsworth Glen Health Care and Rehabilitation Center, Inc	2025C	9/30/2015		18	37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food.....	\$ 215,109	215,109			
2. Non-Food Supplies.....	\$ 27,837	27,837			
3. Other (Specify) _____ Dishes = \$2,744	\$ 2,744	2,744			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Management Services**.....	\$ 77,014	77,014			
d. Other (Specify) _____	\$				
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 322,704</b>	<b>322,704</b>			
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)	
G. Resident Meals: Total no. of meals served per day:*	291	291			
H. Is cost of employee meals included in 2E?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No			
I. Did you receive revenue from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.		
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, specify cost. = \$1187		
L. Is any revenue collected from these people?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, specify amount. = \$641		
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)	Pg 18 in 2a1				
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.		
O. Is any revenue collected from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.		
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

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

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Wadsworth Glen Health Care and Rehabilitation Center, Inc	2025C	9/30/2015		19	37
Item	Total	CCNH	RHNS	(Specify)	
<b>3. Laundry</b>					
<b>a. In-House Processing*</b>	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. \$	10,999	10,999		
<b>b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)</b>	\$				
<b>c. Management Services**</b> .....	\$				
<b>d. Other (Specify)</b> Supplies = \$8,210	\$	8,210	8,210		
<b>3E. Total Laundry Expenditures (3a + b + c + d)</b>	\$	19,209	19,209		
<b>3F. Laundry Questionnaire</b>					
G. Is cost of employee laundry included in 3E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.		
I. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.		
L. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

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

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

Name of Facility Wadsworth Glen Health Care and Rehabilitation Center, Inc		License No. 2025C	Report for Year Ended 9/30/2015		Page 20	of 37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	28,737	28,737		
b.	Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	Sq. Ft. Serviced by Personnel				
		Amt. \$				
c.	Management Services*	\$				
d.	Other ( <i>Specify</i> )	\$				
4E.	<b>Total Housekeeping Expenditures (4a + b + c + d)....</b>	\$	28,737	28,737		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy.....	\$				
2.	Purchased from Omnit Care	\$	316,079	316,079		
b.	Medicine Cabinet Drugs.....	\$	4,008	4,008		
c.	Medical and Therapeutic Supplies.....	\$	230,609	230,609		
d.	Ambulance/Limousine***	\$	10,116	10,116		
e.	Oxygen					
1.	For Emergency Use.....	\$				
2.	Other***	\$	26,010	26,010		
f.	X-rays and Related Radiological Procedures***	\$	30,984	30,984		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> ) .....	\$				
h.	Laboratory***	\$	21,855	21,855		
i.	Recreation.....	\$	14,125	14,125		
j.	Other (Specify)**** See Attached Schedule	\$	192,572	192,572		
5K.	<b>Total Resident Care Expenditures (5a - 5j).....</b>	\$	846,358	846,358		

\* 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)
Management Fee Direct	\$ 86,641		
Physical Therapy Supplies	\$ 38,938		
Medical Equip Rentals-Medicare	\$ 26,673		
Cable-IV Services	\$ 17,254		
Oxygen Rental	\$ 1,197		
Medical Equip Rentals-Other	\$ 22,147		
Occupational Therapy Supplies	\$ 122		
<b>Total Other Resident Care</b>	\$ 192,572	\$	\$

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

Name of Facility	License No.	Report for Year Ended	Related ** to Owners, Operators, Officers		Full Explanation of Service Provided*	CCNH	RHNS	Total Cost/Page Ref.***	Pg	Page of
			Yes	No						
Wadsworth Glen Health Care and Rehabilitation Center, Inc	2025C	9/30/2015							21	37
Name of Individual or Company	Address									
Ct Waste Processing	PO Box 99, Plainville, CT 06062		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Rubbish Removal	18,714			22	6f
ADP	100 Corporate Drive, Windsor, CT 06095		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Payroll Processing	15,473			16	m13
Allen Lawn Care	16 Sunset Drive, Rookfall, CT 06481		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Snow Removal & Landscaping	15,138			22	6f
Winterberry Landscape Management	2070 West St, Southington, CT 06489		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Groundsweeping	13,883			22	6f
Value Health Care	PO Box 31513, Hartford, CT 06150		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pharmacy	314,561			20	5&2
Otis Elevator	PO Box 905454, Charlotte, NC 28290		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Elevator Maintenance	15,281			22	6a
Harmony Healthcare	430 Boston Street, Ste 104, Topsfield, MA 01983		<input type="checkbox"/>	<input checked="" type="checkbox"/>	Compliance Consulting	58,683			16	m13
			<input type="checkbox"/>	<input type="checkbox"/>						
			<input type="checkbox"/>	<input type="checkbox"/>						
			<input type="checkbox"/>	<input type="checkbox"/>						
			<input type="checkbox"/>	<input type="checkbox"/>						
			<input type="checkbox"/>	<input type="checkbox"/>						
			<input type="checkbox"/>	<input type="checkbox"/>						
			<input type="checkbox"/>	<input type="checkbox"/>						
			<input type="checkbox"/>	<input type="checkbox"/>						
			<input type="checkbox"/>	<input type="checkbox"/>						

\* 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 Wadsworth Glen Health Care and Rehabilitation Center, Inc	License No. 2025C	Report for Year Ended 9/30/2015			Page 22	of 37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance..... \$	87,928	87,928				
b. Heat..... \$	68,650	68,650				
c. Light & Power..... \$	119,191	119,191				
d. Water..... \$	62,679	62,679				
e. Equipment Lease (Provide detail on page 6)..... \$	25,172	25,172				
f. Other (itemize)..... \$	77,064	77,064				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)..... \$	440,684	440,684				
7. Depreciation (complete schedule page 23*)						
a. Land Improvements..... \$						
b. Building & Building Improvements..... \$						
c. Non-Movable Equipment..... \$	28,687	28,687				
d. Movable Equipment..... \$	70,470	70,470				
*7e. Total Depreciation Costs (7a + b + c + d)..... \$	99,157	99,157				
8. Amortization (Complete att. Schedule Page 24*)						
a. Organization Expense..... \$						
b. Mortgage Expense..... \$						
c. Leasehold Improvements..... \$	95,960	95,960				
d. Other (Specify)..... \$						
*8e. Total Amortization Costs (8a + b + c + d)..... \$	95,960	95,960				
9. Rental payments on leased real property less real estate taxes included in item 10b..... \$	490,534	490,534				
10. Property Taxes						
a. Real estate taxes paid by owner..... \$						
b. Real estate taxes paid by lessor..... \$	157,852	157,852				
c. Personal property taxes..... \$	14,051	14,051				
11. Total Property Expenses (7e + 8e + 9 + 10)..... \$	857,554	857,554				

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	\$ 17,243		
Rubbish Removal	\$ 18,714		
Supplies	\$ 29,329		
Snow Removal	\$ 11,778		
<b>Total Other Repairs and Maintenance</b>	\$ 77,064	\$	\$



Schedule of Land Improvements Acquired during this report period

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

\*Ties to Page 23, Line A3  
 \*\*Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Building Improvements</b>		\$		\$
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$		\$

\*Ties to Page 23, Line B3  
 \*\*Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$		\$
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$		\$

\*Ties to Page 23, Line C3  
 \*\*Ties to Page 23, Line C2



Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
Oct 14	Carpetworks Vinyl Flooring	\$ 9,518	10	\$ 476
Oct 14	Carpetworks Vinyl Flooring	\$ 9,518	10	\$ 476
Oct 14	Weld Power Block Heater	\$ 1,841	10	\$ 92
Dec 14	Middletown Plate Glass Panels	\$ 1,055	10	\$ 63
Jun 15	Modern Mechanical Condenser Fan Motor	\$ 2,035	10	\$ 102
Sep 15	Modern Mechanical Kitchen Exhaust Hood	\$ 2,732	10	\$ 137
Sep 15	Graybar Electrical Lighting	\$ 5,021	10	\$ 290
May 15	Legacy Fire Protection Rebarate 2 1/2" Flood Drain	\$ 2,146	15	\$ 122
Aug 15	Modern Mechanical Condensing Unit	\$ 5,469	15	\$ 182
Jun 15	Weld Power AFS Open Trans Generator	\$ 12,233	20	\$ 306
Sep 15	Graybar Electrical Boiler	\$ 143,763	20	\$ 5,590
<b>Total additions for Leasehold Improvements</b>		\$ 248,333		\$ 8,390
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvements</b>		\$		\$

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

Amortization Schedule\*

Name of Facility	License No.		Report for Year Ended		Page	of
	2025C		9/30/2015			
Wadsworth Glen Health Care and Rehabilitation Center, Inc	Date of Acquisition		Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate Amortization % for This Year	Totals
Item	Month	Year				
A. Organization Expense						
1.						
2.						
3.						
A-4. Subtotal.....						
B. Mortgage Expense						
1. Deferred Finance Fees						
2. Finance Fees						
3. Finance Fees						
B-4. Subtotal.....						
C. Leasehold Improvements and Other (Specify)						
1. Acquired prior to this report period	9	2014	927,204	SL	Var	87,570
2. Disposals (attach schedule)						
3. Acquired during this report period (attach schedule)	9	2015	248,333	SL	Var	8,390
C-4. Subtotal.....						
D. Total Amortization .....						95,960
						95,960

\* Straight-line method must be used.  
 \*\* Specify which of the following bases were used:  
 A. Minimum of 5 years or 60 months.  
 B. Life of mortgage; OR  
 C. Remaining Life of Lease; OR  
 D. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Wadsworth Glen Health Care and Rehabilitation Center, Inc	2025C	9/30/2015	24A	37
<b>C. Leasehold Improvements</b>				
(Specify)				
1. Acquired prior to this report period	9 2014 Various	884,040 SL	87,570	
2. Disposals (attach schedule)				
3. Acquired during this report period	9 2015 Various		8,390	
C-4. Subtotal.....				95,960
<b>C. Other (Specify)</b>				
1. Intangible Asset-Bed Purchase	9 1998 15 yrs	43,164 SL	0	
2.				
C-4. Subtotal.....				
Total Acquired prior to this report period	9 2014 Various	927,204 SL	87,570	
Total Disposals				
Total Acquired during this report period	9 2015 Various		8,390	



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

Name of Facility Wadsworth Glen Health Care and Rehabilitation Center, Inc	License No. 2025C	Report for Year Ended 9/30/2015	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
Is the property either owned by the Facility or leased from a Related Party*? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description	Total			
1. Date Land Purchased				
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			
<b>Part B - Owner and Related Parties</b>	<b>1st Mortgage</b>	<b>2nd Mortgage</b>	<b>3rd Mortgage</b>	<b>4th Mortgage</b>
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	03/29/12			
c. Interest Rate for the Cost Year	3.22%			
d. Term of Mortgage (number of years)	31			
e. Amount of Principal Borrowed	5,400,000			
f. Principal balance outstanding as of 9/30/2015	5,033,217			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
<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 Wadsworth Glen Health Care and Rehabilitation Center, Inc		License No. 2025C	Report for Year Ended 9/30/2015			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			Page	of
Wadsworth Glen Health Care and Rehabilitation Center, Inc		2025C		9/30/2015			27	37
Item				Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:								
12. C. Movable Equipment								
1. Automotive Equipment..... \$								
A. Item		Rate	Amount					
Lender								
Address of Lender								
2. Other (Specify)..... \$				11,688	11,688			
A. Item		Rate	Amount					
Boiler/Lighting Capital Lease		7.42%	201,784					
Lender								
Graybar Financial Services								
Address of Lender								
PO Box 644006, Cincinnati, OH 45264								
B. Item		Rate	Amount					
Lender								
Address of Lender								
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)..... \$				11,688	11,688			
12. D. Other Interest Expense (Specify)..... \$				29,573	29,573			
Vender Interest = \$2,686; Line of Credit Interest = \$434; KeyBank Term Loan Int & Fees = \$26,453								
13. Total All Interest Expense (12B7 + 12C3 + 12D).....\$				41,261	41,261			
14. Insurance								
a. Insurance on Property (buildings only)..... \$				75,514	75,514			
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).... \$				75,514	75,514			
15. Total All Expenditures (A-13 thru C-14)..... \$				11,362,941	11,362,941			

**D. Adjustments to Statement of Expenditures**

Name of Facility			License No.	Report for Year Ended	Page	of	
Wadsworth Glen Health Care and Rehabilitation Center, Inc			2025C	9/30/2015	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs.....	\$			
2.			Salaries not related to Resident Care....	\$			
3.	10	A12g	Occupational Therapy.....	\$ 420,706	420,706		
4.	Var	Var	Other - See attached Schedule.....	\$ 3,436	3,436		
<b>Page 13 - Professional Fees</b>							
5.	13	B8c	Resident Care Physicians **.....	\$ 5,198	5,198		
6.			Occupational Therapy.....	\$			
7.			Other - See attached Schedule.....	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.	15	1a9	Discriminatory Benefits.....	\$			
9.	15	1c	Bad Debts.....	\$ 80,845	80,845		
10.	15	1d&e	Accounting & Legal.....	\$ 25,024	25,024		
11.			Telephone.....	\$			
12.	15	1h2	Cellular Telephone.....	\$ 409	409		
13.			Life insurance premiums on the life of Owners, Partners, Operators.....	\$			
14.	16	13	Gifts, flowers and coffee shops.....	\$ 12,851	12,851		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees.....	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative....	\$			
17.			Automobile Expense (e.g. personal use).	\$			
18.	16	m2&3	Unallowable Advertising *.....	\$ 42,306	42,306		
19.	15	1j&k1 & 2	Income Tax / Corporate Business Tax...	\$ 250	250		
20.			Fund Raising / Contributions.....	\$			
21.	16	m12	Unallowable Management Fees.....	\$ 209,726	209,726		
	18	2c		\$ 50,843	50,843		
	20	5j		\$ 57,198	57,198		
22.			Barber and Beauty.....	\$			
23.	Var	Var	Other - See attached Schedule.....	\$ 70,108	70,108		
<b>Page 18 - Dietary Expenditures</b>							
24.	18	2a1	Meals to employees, guests and others who are not residents.....	\$ 546	546		
<b>Page 19 - Laundry Expenditures</b>							
25.	19	3d	Laundry services to employees, guests and others who are not residents.....	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.	20	4d	Housekeeping services to employees and others who are not residents.....	\$			
Subtotal (Items 1 - 26)				\$ 979,446	979,446		

\* All except "Help Wanted".

(Carry Subtotal forward to next page)

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



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

Name of Facility			License No.	Report for Year Ended	Page	of	
Wadsworth Glen Health Care and Rehabilitation Center, Inc			2025C	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 979,446	979,446		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a1,2	Prescription Drugs.....	\$ 316,079	316,079		
28.	20	5d	Ambulance/Limousine.....	\$ 10,116	10,116		
29.	20	5f	X-rays, etc.....	\$ 30,984	30,984		
30.	20	5h	Laboratory.....	\$ 21,855	21,855		
31.	20	5c	Medical Supplies.....	\$ 10,200	10,200		
32.	20	5e2	Oxygen (non emergency).....	\$ 26,010	26,010		
33.	20	5j	Occupational Therapy.....	\$ 122	122		
34.	Var	Var	Other - See Attached Schedule.....	\$ 22,147	22,147		
<b>Page 22 - Maintenance and Property</b>							
35.	Var	Var	Excess Movable Equipment Depreciation See Attached Schedule.....	\$ 2,612	2,612		
36.			Depreciation on Unallowable Motor Vehicles.....	\$			
37.			Unallowable Property and Real Estate Taxes.....	\$			
38.			Rental of Building Space or Rooms.....	\$			
39.			Other - See Attached Schedule.....	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance.....	\$			
41.			Property Insurance.....	\$			
<b>Other - Miscellaneous</b>							
42.			Research or Experimental Activities.....	\$			
43.	20	5j	Radio and Television Revenue.....	\$ 13,654	13,654		
44.			Vending Machine Revenue.....	\$			
45.			Purchase Discounts and Allowances.....	\$			
46.			Duplications of functions or services....	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest.....	\$			
48.	30	IV5	Interest Income on Accounts Rec.....	\$ 123	123		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule.....	\$			
<b>Not For Profit Providers Only</b>							
50.	Var	Var	Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule.....	\$			
51.	<b>Total Amount of Decrease (Items 1 - 50)</b> .....			\$ 1,433,348	1,433,348		

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	51	Medical Equipment Rental	22,147		
Total Other Ancillary Costs			\$ 22,147	\$	\$

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Moveable Equip Carry Forward	2,612		
Total Excess Movable Equipment Depreciation			2,612		

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

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

Schedule of Unallowable Building Interest

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



**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended			Page of
Wadsworth Glen Health Care and Rehabilitation Center, Inc	2025C	9/30/2015			30   37
Item	Total	CCNH	RHNS	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents (CT only).....	\$ 12,453,284	12,453,284			
b. Medicaid Room and Board Contractual Allowance **.....	\$ (6,523,495)	(6,523,495)			
2. a. Medicaid (All other states).....	\$				
b. Other States Room and Board Contractual Allowance **.....	\$				
3. a. Medicare Residents (all inclusive) .....	\$ 2,589,786	2,589,786			
b. Medicare Room and Board Contractual Allowance **.....	\$ 610,482	610,482			
4. a. Private-Pay Residents and Other.....	\$ 1,790,927	1,790,927			
b. Private-Pay Room and Board Contractual Allowance **.....	\$ (55,584)	(55,584)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare.....	\$ 317,908	317,908			
b. Prescription Drugs - Medicare Contractual Allowance **.....	\$ (317,908)	(317,908)			
c. Prescription Drugs - Non-Medicare.....	\$ 67,767	67,767			
d. Prescription Drugs - Non-Medicare Contractual Allowance **.....	\$ (67,767)	(67,767)			
2. a. Medical Supplies - Medicare.....	\$				
b. Medical Supplies - Medicare Contractual Allowance **.....	\$				
c. Medical Supplies - Non-Medicare.....	\$ 447	447			
d. Medical Supplies - Non-Medicare Contractual Allowance **.....	\$ (447)	(447)			
3. a. Physical Therapy - Medicare.....	\$ 951,115	951,115			
b. Physical Therapy - Medicare Contractual Allowance **.....	\$ (738,533)	(738,533)			
c. Physical Therapy - Non-Medicare.....	\$ 162,638	162,638			
d. Physical Therapy - Non-Medicare Contractual Allowance **.....	\$ (162,533)	(162,533)			
4. a. Speech Therapy - Medicare.....	\$ 220,905	220,905			
b. Speech Therapy - Medicare Contractual Allowance **.....	\$ (191,386)	(191,386)			
c. Speech Therapy - Non-Medicare.....	\$ 45,963	45,963			
d. Speech Therapy - Non-Medicare Contractual Allowance **.....	\$ (45,963)	(45,963)			
5. a. Occupational Therapy - Medicare.....	\$ 1,157,602	1,157,602			
b. Occupational Therapy - Medicare Contractual Allowance **.....	\$ (954,182)	(954,182)			
c. Occupational Therapy - Non-Medicare.....	\$ 194,284	194,284			
d. Occupational Therapy - Non-Medicare Contractual Allowance **.....	\$ (194,165)	(194,165)			
6. a. Other (Specify) - Medicare.....	\$				
b. Other (Specify) - Non-Medicare.....	\$ 3,779	3,779			
<b>III Total Resident Revenue (Section I thru Section II.).....</b>	<b>\$ 11,314,924</b>	<b>11,314,924</b>			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others.....	\$				
2. Rental of rooms to non-residents.....	\$				
3. Telephone .....	\$				
4. Rental of Television and Cable Services.....	\$				
5. Interest Income (Specify) .....	\$ 29,626	29,626			
6. Private Duty Nurses' Fees.....	\$				
7. Barber, Coffee, Beauty and Gift shops.....	\$				
8. Other (Specify) .....	\$ 36,250	36,250			
<b>V. Total Other Revenue (1 thru 8).....</b>	<b>\$ 65,876</b>	<b>65,876</b>			
<b>VI. Total All Revenue (III + V).....</b>	<b>\$ 11,380,800</b>	<b>11,380,800</b>			

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

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



### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Wadsworth Glen Health Care and Rehabilitation Center, Inc	2025C	9/30/2015	31	37
Account			Amount	
<b>Assets</b>				
<b>A. Current Assets</b>				
1. Cash ( <i>on hand and in banks</i> ).....			\$	129,660
2. Resident Accounts Receivable (Less Allowance for Bad Debts).....			\$	761,080
3. Other Accounts Receivable (Excluding Owners or Related Parties).....			\$	
4 Inventories.....			\$	20,503
5. Prepaid Expenses.....			\$	145,545
a. Prepaid Insurance	145,545			
b. _____				
c. _____				
d. _____				
6. Interest Receivable.....			\$	18,078
7. Medicare Final Settlement Receivable.....			\$	
8. Other Current Assets ( <i>itemize</i> ).....			\$	171,044
A/R Related Parties	170,562			
A/R Non Related Parties	482			
<b>A-9. Total Current Assets (Lines A1 thru 8)</b>			<b>\$</b>	<b>1,245,910</b>
<b>B. Fixed Assets</b>				
1. Land.....			\$	
2. Land Improvements	*Historical Cost.....		\$	
	Accum. Depreciation	Net.....		
3. Buildings	*Historical Cost.....		\$	
	Accum. Depreciation	Net.....		
4. Leasehold Improvements	*Historical Cost.....	1,536,647	\$	556,647
	Accum. Depreciation	(980,000) Net.....		
5. Non-Movable Equipment	*Historical Cost.....	498,482	\$	162,396
	Accum. Depreciation	(336,086) Net.....		
6. Movable Equipment	*Historical Cost.....	1,125,432	\$	302,657
	Accum. Depreciation	(822,775) Net.....		
7. Motor Vehicles	*Historical Cost.....		\$	
	Accum. Depreciation	Net.....		
8. Minor Equipment-Not Depreciable.....			\$	
9. Other Fixed Assets ( <i>itemize</i> ).....			\$	15,706
Moveable Equip Carry Forward Adj	15,706			
<b>B-10. Total Fixed Assets (Lines B1 thru 9)</b>			<b>\$</b>	<b>1,037,406</b>

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

(Carry Total forward to next page)



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

Name of Facility	License No.	Report for Year Ended	Page	of
Wadsworth Glen Health Care and Rehabilitation Center, Inc	2025C	9/30/2015	32	37
Account			Amount	
Total Brought Forward:			\$	2,283,316
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
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.....			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	
<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).....			\$	26,836
5. Investments Related to Resident Care ( <i>itemize</i> ).....			\$	
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	733,279
Name and Address		Amount	Loan Date	
Related Party Note		733,279	3/29/2012	
7. Other Assets ( <i>itemize</i> ).....			\$	34,010
Deposit IRS			9,960	
Project Development			24,050	
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b> .....			\$	794,125
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b> .....			\$	3,077,441

\* 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 Rehabilitation Center, Inc		2025C	9/30/2015	33	37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable.....				\$	658,704
2. Notes Payable ( <i>itemize</i> ).....				\$	100,000
Line of Credit					100,000
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> ).....				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> ).....				\$	197,241
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> ).....				\$	
6. Accrued Payroll Taxes Payable.....				\$	3,553
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> ).....				\$	1,894
11. Accrued Income Taxes*.....				\$	
12. Other Current Liabilities ( <i>itemize</i> ).....				\$	192,467
Acc'd Operating Expenses					39,839
Acc'd Expense - CT Sales Tax					1,515
Provider Taxes Due					151,113
<b>A-13. Total Current Liabilities (Lines A1 thru 12).....</b>				<b>\$</b>	<b>1,153,859</b>

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

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

(Carry Total forward to next page)



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

Name of Facility Wadsworth Glen Health Care and Rehabilitation Center, Inc		License No. 2025C	Report for Year Ended 9/30/2015	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,153,859	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> ).....					
				\$	173,116
Name of Lender	Purpose	Amount	Date Due		
		173,116			
2. Mortgages Payable.....				\$	
3. Loans from Owners or Related Parties ( <i>itemize</i> ).....				\$	1,134,640
Name and Address of Lender	Amount	Loan Date			
Due to Partnership	1,134,640				
4. Other Long-Term Liabilities ( <i>itemize</i> ).....				\$	496,940
Key Bank Term Loan		489,938			
Swap-Valuation		7,002			
B-5. Total Long-Term Liabilities (Lines B1 thru 4).....				\$	1,804,696
C. Total All Liabilities (Lines A-13 + B-5).....				\$	2,958,555



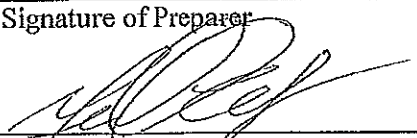
**G. Balance Sheet (cont'd)**  
**Reserves and Net Worth**

Name of Facility	License No.	Report for Year Ended	Page	of
Wadsworth Glen Health Care and Rehabilitation Center, Inc	2025C	9/30/2015	35	37
Account			Amount	
<b>A. Reserves</b>				
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>B. Net Worth</b>				
1. Owner's Capital.....			\$	
2. Capital Stock.....			\$	
3. Paid-in Surplus.....			\$	(7,002)
4. Treasury Stock.....			\$	
5. Cumulated Earnings.....			\$	108,029
6. Gain or Loss for Period			\$	17,859
7. Total Net Worth.....			\$	118,886
<b>C. Total Reserves and Net Worth .....</b>			\$	118,886
<b>D. Total Liabilities, Reserves, and Net Worth .....</b>			\$	3,077,441

### H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year Ended	Page	of
Wadsworth Glen Health Care and Rehabilitation Center, Inc		2025C	9/30/2015	36	37
Account				Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014				\$	284,783
B. Total Revenue (From Statement of Revenue Page 30 ) .....				\$	11,380,800
C. Total Expenditures (From Statement of Expenditures Page 27 ) .....				\$	11,362,941
D. Net Income or Deficit.....				\$	17,859
E. Balance.....				\$	302,642
F. Additions					
1. Additional Capital Contributed (itemize )					
			(172,275)		
	Change in Swap		(5,997)		
	Prior Year AP Void Error		(5,483)		
	Rounding		(1)		
2. Other (itemize )					
F-3. Total Additions.....				\$	(183,756)
G. Deductions					
1. Drawings of Owners/Operators/Partners (Specify).....				\$	
Name and Address (No., City, State, Zip)		Title	Amount		
2. Other Withdrawings (Specify).....				\$	
Purpose		Amount			
3. Total Deductions.....				\$	
H. Balance at End of Period				\$	118,886
					09/30/15

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

Name of Facility Wadsworth Glen Health Care and Rehabilitation Center, Inc	License No.  2025C	Report for Year Ended  9/30/2015	Page 37	of 37
<i>Check appropriate category</i>				
CCNH	RHNS	Other ( <i>Specify</i> )		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer 	Title  CFO	Date Signed  2/12/10		
Printed Name of Preparer  Athena Health Care Associates, Inc				
Address 135 South Road Farmington, CT 06032		Phone Number  (860) 751-3900		