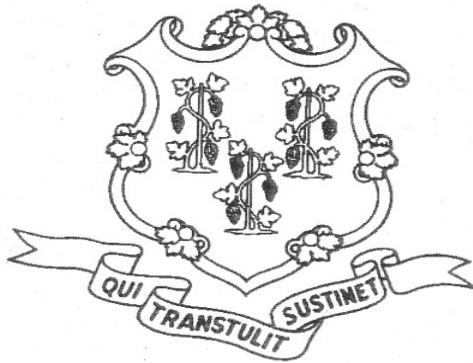


# State of Connecticut



# Annual Report of Long-Term Care Facility

## Cost Year 2022

Name of Facility (as licensed) Wolcott Hall Nursing Center		
Address (No. & Street, City, State, Zip Code) 215 Forest St. Torrington, CT 06790		
Type of Facility		
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS)	<input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022	

License Numbers:	CCNH 1096-C	RHNS	(Specify)	Medicare Provider 07-5111
------------------	----------------	------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 210967	RHNS	ICF-IID
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### **For Department Use Only**

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

**General Information**

Name of Facility (as licensed) Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022	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 Wolcott Hall Nursing Center [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, 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) Melissa Flammia		Printed Name (Owner) Brian Foley		
Subscribed and Sworn to before me:	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 Wolcott Hall Nursing Center	Period Covered:		From 10/1/2021	To 9/30/2022
Address of Facility 215 Forest St. Torrington, CT 06790				
Report Prepared By Apple Health Care, Inc.	Phone Number (860) 678-9755	Date		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
<b>6. Total Wages Paid</b>	<b>\$</b>			
7. Total salaries paid	\$			
<b>8. Total Wages and Salaries Paid (As per page 10 of Report)</b>	<b>\$</b>			

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	Page	of
860-482-8554	9/30/2022	2	37

Name of Facility (as shown on license) Wolcott Hall Nursing Center	Address (No. & Street, City, State, Zip) 215 Forest St. Torrington, CT 06790		
License Numbers:  CCNH 1096-C	RHNS	(Specify)	Medicare Provider No. 07-5111
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:	Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes <input checked="" type="radio"/> No	If "Yes," explain fully.

**Administrator**

Name of Administrator Melissa Flammia	Nursing Home Administrator's License No.: 002130
--	---

Other Operators/Owners who are assistant administrators (full or part time) of this facility.	
Name	License No.:

## **General Information and Questionnaire Partners/Members**

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

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022	Page of 3A   37
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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	
Wolcott Hall Nursing Center	215 Forest St. Torrington, CT 06790	Connecticut	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Brian Foley	21 Waterville Rd. Avon, CT 06001	President	100
Ryan Vess	21 Waterville Rd. Avon, CT 06001	Secretary	
Names of Stockholders Owning at Least 10% of Shares			
Brian Foley	21 Waterville Rd. Avon, CT 06001	President	100

# **General Information and Questionnaire**

## **Individual Proprietorship**

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

## General Information and Questionnaire

### Related Parties\*

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> No				If "Yes," provide the Name/Address and complete the information on Page 11 of the report.				
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the following information:				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Brian J. Foley	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Real Estate Rental	Pg. 22 Line 9	240,000	240,000
Apple Health Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Management & Accounting Services	Pg. 16 Line m12	304,040	304,040
Corporate Employees	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	120,889	120,889
Healthport	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	380	380
Employees @ various Apple Facilities		<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	(33,120)	(33,120)
Apple Health Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Pension Plan (401K)	Pg. 15 Line 1a7	26,027	26,027
Lucent Health Solutions	424 Church St. Nashville, TN 37219	<input checked="" type="radio"/>	<input type="radio"/>		Group Medical	Pg. 15 Line 1a5	293,168	
MetLife	PO Box 360229 Pittsburgh, PA 15251	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 Line 1a5	2,561	
Delta Dental of CT	148 Eastern Blvd Glastonbury, CT 06033	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 Line 1a5	7,472	

\* 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 Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022	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?	<input checked="" type="radio"/> Yes <input type="radio"/> 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.		
The costs incurred by Apple Health Care, Inc. (a related party) to provide accounting and managerial services to each facility owned by Brian J. Foley are allocated on a per bed basis.		
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.)		
<input type="radio"/> Yes <input checked="" type="radio"/> No    If "No," explain fully why such allocation was not made.		
N/A		

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

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

### Is a Mileage Log Book Maintained for All Leased Vehicles?

Yes

⊕ No

Total \*\*\*

\* 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 Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022	Page 7	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 Clifton Larson Allen LLP (CLA)	29 South Main Street West Hartford, CT 06127
2 Brazee & Huban	35 Wendell Ave. Pittsfield, MA 10202
3 Clifton Larson Allen LLP (CLA)	29 South Main Street West Hartford, CT 06127
4	

**Services Provided by This Firm (*describe fully*)**

1	Preparation of audited financials (disallow Pg. 28)	\$	7,787
2	Preparation of Tax Returns	\$	2,862
3	Audit 401K	\$	802
4		\$	
			Charge for Services Provided
			\$ 11,451

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

Yes       No      Pg. 15 Line 1d

## Legal Services Information

Name of Legal Firm or Independent Attorney 1 2 3 4 5	Telephone Number
---	------------------

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

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$

4. The Class Described in the Executive portion of this Document IS NOT Specific For Classification Under N

## Are These Charges Reflected in the Expenditure Portion     Pg. 15-12

## Schedule of Resident Statistics

Name of Facility Wolcott Hall Nursing Center			License No. 1096-C			Report for Year Ended 9/30/2022				Page 8 of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					87	87						
A. On last day of PREVIOUS report period	87	87										
B. On last day of THIS report period	87	87							87	87		
2. Number of Residents					39	39						
A. As of midnight of PREVIOUS report period	39	39										
B. As of midnight of THIS report period	41	41							41	41		
3. Total Number of Days Care Provided During Period					2,446	2,446						
A. Medicare	3,373	3,373							927	927		
B. Medicaid (Conn.)	9,751	9,751			7,347	7,347			2,404	2,404		
C. Medicaid (other states)												
D. Private Pay	2,660	2,660			2,122	2,122			538	538		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	15,784	15,784			11,915	11,915			3,869	3,869		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
<b>5. Total Resident Days (3G + 4A + 4B)</b>	<b>15,784</b>	<b>15,784</b>			<b>11,915</b>	<b>11,915</b>			<b>3,869</b>	<b>3,869</b>		

## Schedule of Resident Statistics (Cont'd)

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022	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)	Lost			Gained			CCNH	RHNS	(Specify)		
				(1)	(2)	(3)	(1)	(2)	(3)					

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	5	26		10				
Per Diem Rate								
a. One bed rm.				400.00				
b. Two bed rms.	RUGS III	257.34		350.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		5,912	5,912		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		14,138	14,138		
D. <b>Total Physical Therapy Treatments</b>		20,050	20,050		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		118	118		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		1,368	1,368		
D. <b>Total Speech Therapy Treatments</b>		1,486	1,486		

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		2,557	2,557		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		11,527	11,527		
D. <b>Total Occupational Therapy Treatments</b>		14,084	14,084		

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes		<input type="radio"/> No	
		Total Cost and Hours			
Item		CCNH	Hours	RHNS	Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	107,953	2,080			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	46,489	2,491			
5. Dietary Service					
a. Head Dietitian	6,404	191			
b. Food Service Supervisor	48,989	1,924			
c. Dietary Workers	166,055	9,875			
6. Housekeeping Service					
a. Head Housekeeper	12,852	534			
b. Other Housekeeping Workers	108,705	6,144			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance					
b. Other Maintenance Workers	76,156	2,906			
8. Laundry Service					
a. Supervisor	12,949	537			
b. Other Laundry Workers	27,131	1,472			
9. Barber and Beautician Services					
10. Protective Services					
11. Accounting Services					
a. Head Accountant					
b. Other Accountants	82,589	2,502			
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	123,296	2,050			
b. RN					
1. Direct Care	411,597	8,092			
2. Administrative**	99,759	2,735			
c. LPN					
1. Direct Care	410,616	11,821			
2. Administrative**					
d. Aides and Attendants	626,898	32,353			
e. Physical Therapists	160,049	3,782			
f. Speech Therapists	22,284	491			
g. Occupational Therapists	189,240	4,403			
h. Recreation Workers	57,600	2,282			
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	36,298	1,216			
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
<i>A-13. Total Salary Expenditures</i>	2,833,910	99,879			

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

\*\* Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and

Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

**Schedule of Other Salaries and Wages (Page 10)**

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

State of Connecticut

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

CSP-11 Rev. 10/2005

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

Name of Facility Wolcott Hall Nursing Center			License No. 1096-C		Report for Year Ended 9/30/2022			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
<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.

State of Connecticut

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

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page <span style="float: right;">of</span>	
Wolcott Hall Nursing Center				1096-C		9/30/2022			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Melissa Flammia	107,953				Administrator 10/1/21 - 9/30/22	2,080	A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
	1096-C	9/30/2022		13	37
	Total Cost and Hours				
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist	8,554	93			
3. Pharmacist	8,468	50			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	30,000	227			
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	3,600	16			
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care					
2. Administrative***					
b. LPN					
1. Direct Care					
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify)					
See Attached Schedule	2,355	44			
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	52,978	430			

\* 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\*

\* 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
	1096-C	9/30/2022		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 92,942	92,942			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 41,351	41,351			
4. Social Security (F.I.C.A.)	\$ 206,503	206,503			
5. Health Insurance	\$ 264,478	264,478			
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 13,103	13,103			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 26,027	26,027			
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 9,186	9,186			
d. Accounting and Auditing	\$ 11,451	11,451			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$				
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 8,531	8,531			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 18,359	18,359			
2. Cellular Phones	\$				
i. Appraisal ( <i>Specify purpose and attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$				
k. Other Taxes ( <i>Not related to property - See Page 22</i> )					
1. Income*	\$ 38,250	38,250			
2. Other ( <i>Specify</i> ) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 260,984	260,984			
<b>Subtotal</b>	\$ 991,165	991,165			

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

**Schedule of Other Employee Benefits**

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 Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022	Page 16	of 37
Item	Total	CCNH	RHNS	(Specify)
<b><i>Subtotals Brought Forward:</i></b>	991,165	991,165		
I. Travel and Entertainment				
1. Resident Travel and Entertainment	\$ 218	218		
2. Holiday Parties for Staff	\$ 1,419	1,419		
3. Gifts to Staff and Residents	\$ 8,112	8,112		
4. Employee Travel	\$ 16,538	16,538		
5. Education Expenses Related to Seminars and Conventions	\$ 1,327	1,327		
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$			
7. Other ( <i>Specify</i> ) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$			
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$			
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 2,842	2,842		
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	\$ 2,384	2,384		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 6,287	6,287		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$ 432	432		
10. Contributions*** See Attached Schedule	\$ 35	35		
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$			
12. Administrative Management Services**	\$ 304,040	304,040		
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 142,368	142,368		
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	<b>\$ 1,477,167</b>	<b>1,477,167</b>		

\* 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)
Advertising - Public Relations	\$ 2,842		
<b>Total Other Advertising</b>	\$ 2,842	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 6,287		
<b>Total Dues</b>	\$ 6,287	\$ -	\$ -

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
The Litchfield Hills Elderly Nutrition Program Thanksgiving Campaign	\$ 35		
<b>Total Contributions</b>	\$ 35	\$ -	\$ -

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Corporate Fees - Non Reimbursable	\$ 59,666		
Licenses & Fees	\$ 560		
Pre Employment Screenings	\$ 11,204		
System License & Subscription Fees	\$ 27,652		
Bank Service Charges	\$ 2,439		
Legal Fees - Collection/Probate	\$ 89		
IT Service Fees	\$ 834		
Internet & Cable/Satellite TV	\$ 13,286		
Survey Fines & Citations	\$ 21,125		
Healthport Indirect	\$ 63		
Resident Expenses	\$ 448		
Account Write Off	\$ 5,002		
	\$ 142,368	\$ -	\$ -

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

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022	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 #
Apple Health Care, Inc.	304,040	Accounting and Management Services	Pg. 16 Line m12

\* 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 Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022		Page 18   37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 114,574	114,574		
2. Non-Food Supplies	\$ 10,857	10,857		
3. Other (Specify) _____	\$			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 4,102	4,102		
c. Other (Specify) _____	\$			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 129,534</b>	<b>129,534</b>		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	130	130		
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" 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 Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022		Page 19	of 37
Item	Total	CCNH	RHNS	(Specify)	
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	1,894	1,894		
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. \$	2,384	2,384		
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$	57,103	57,103		
c. Other ( <i>Specify</i> )	\$				
<b>3D. Total Laundry Expenditures (3a + b + c )</b>	<b>\$</b>	<b>61,380</b>	<b>61,380</b>		
3E. Laundry Questionnaire					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 15,822	15,822		
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel				
	Amt.	\$			
C. Other ( <i>Specify</i> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>15,822</b>	<b>15,822</b>		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Neighborcare	\$	85,846	85,846		
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	130,099	130,099		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	14,338	14,338		
f. X-rays and Related Radiological Procedures***	\$	20,165	20,165		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	9,738	9,738		
i. Recreation	\$	11,497	11,497		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other ( <i>Specify</i> )**** See Attached Schedule	\$	13,385	13,385		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>285,067</b>	<b>285,067</b>		

\* 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**

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

\* 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 Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 113,479	113,479				
b. Heat	\$ 38,390	38,390				
c. Light & Power	\$ 31,787	31,787				
d. Water	\$ 11,494	11,494				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$					
f. Other ( <i>itemize</i> )	\$ 17,161	17,161				
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 212,311	212,311				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$ 277	277				
d. Movable Equipment	\$ 4,341	4,341				
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 4,617	4,617				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 27,899	27,899				
d. Other ( <i>Specify</i> )	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$ 27,899	27,899				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 240,000	240,000				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 38,548	38,548				
c. Personal property taxes	\$ 16,311	16,311				
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 327,376	327,376				

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

## **Schedule of Other Repairs and Maintenance**

## Depreciation Schedule

**Schedule of Land Improvements Acquired during this report period**

\*Ties to Page 23, Line A3

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

**Schedule of Building Improvements Acquired during this report period**

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

**Schedule of Non-Movable Equipment Acquired during this report period**

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

\*\*Ties to Page 23, Line C2

## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
<b>Additions:</b>					
11/25/2021	POC Bundle W10- White-Us 17	Administrative	\$ 2,552	ME-3	\$ 1,064
4/29/2022	Thermal Scanner for 2nd Entrance	Administrative	\$ 1,648	ME-5	\$ 104
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
<b>Total additions for Movable Equipment</b>			\$ 4,200		\$ 1,167 *
<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
<b>Additions:</b>					
3/11/2022	Replace mixing valve cartridge	\$ 2,114	LHI-10	\$ 73	
3/29/2022	Removal of 2 - 1000 gallon storage tanks	\$ 5,129	LHI-10	\$ 172	
3/29/2022	Replace circulator pump on water heater	\$ 1,230	LHI-10	\$ 41	
3/29/2022	Replace circulator pump on water heater	\$ 1,230	LHI-10	\$ 41	
3/29/2022	Removal of 2 underground fuel tanks	\$ 5,129	LHI-10	\$ 172	
3/29/2022	Removal of 2 underground fuel tanks	\$ 1,276	LHI-10	\$ 43	
<b>Total additions for Leasehold Improvement</b>		\$ 16,108		\$ 542 *	
<b>Deletions:</b>					
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ -	**

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility Wolcott Hall Nursing Center			License No. 1096-C		Report for Year Ended 9/30/2022			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.									
<b>A-4. Subtotal</b>									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
<b>B-4. Subtotal</b>									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period				1,547,522	1,371,469	A		27,357	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				16,108				542	
<b>C-4. Subtotal</b>									27,899
<b>D. Total Amortization</b>									27,899

\* 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 Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022	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.																																					
<p>*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.</p>																																									
<table border="1"> <tr> <th>Description</th> <th>Total</th> </tr> <tr> <td>1. Date Land Purchased</td> <td></td> </tr> <tr> <td>2. Date Structure Completed</td> <td></td> </tr> <tr> <td>3. If NOT Original Owner, Date of Purchase</td> <td></td> </tr> <tr> <td>4. Date of Initial Licensure</td> <td></td> </tr> <tr> <td>5. Total Licensed Bed Capacity</td> <td>87</td> </tr> <tr> <td>6. Square Footage</td> <td></td> </tr> <tr> <td>7. Acquisition Cost</td> <td></td> </tr> <tr> <td>    a. Land</td> <td></td> </tr> <tr> <td>    b. Building</td> <td></td> </tr> </table>		Description	Total	1. Date Land Purchased		2. Date Structure Completed		3. If NOT Original Owner, Date of Purchase		4. Date of Initial Licensure		5. Total Licensed Bed Capacity	87	6. Square Footage		7. Acquisition Cost		a. Land		b. Building																					
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7. Acquisition Cost																																									
a. Land																																									
b. Building																																									
<b>Part B - Owner and Related Parties</b> <table border="1"> <tr> <th></th> <th>1st Mortgage</th> <th>2nd Mortgage</th> <th>3rd Mortgage</th> <th>4th Mortgage</th> </tr> <tr> <td>1. Financing</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>    a. Type of Financing (e.g., fixed, variable)</td> <td>Fixed</td> <td></td> <td></td> <td></td> </tr> <tr> <td>    b. Date Mortgage Obtained</td> <td>04/21/22</td> <td></td> <td></td> <td></td> </tr> <tr> <td>    c. Interest Rate for the Cost Year</td> <td>4.50%</td> <td></td> <td></td> <td></td> </tr> <tr> <td>    d. Term of Mortgage (number of years)</td> <td>25</td> <td></td> <td></td> <td></td> </tr> <tr> <td>    e. Amount of Principal Borrowed</td> <td>2,765,625</td> <td></td> <td></td> <td></td> </tr> <tr> <td>    f. Principal balance outstanding as of</td> <td>2,742,166</td> <td></td> <td></td> <td></td> </tr> </table>			1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage	1. Financing					a. Type of Financing (e.g., fixed, variable)	Fixed				b. Date Mortgage Obtained	04/21/22				c. Interest Rate for the Cost Year	4.50%				d. Term of Mortgage (number of years)	25				e. Amount of Principal Borrowed	2,765,625				f. Principal balance outstanding as of	2,742,166			
	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage																																					
1. Financing																																									
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f. Principal balance outstanding as of	2,742,166																																								
<b>Complete if Mortgage was Refinanced During Current Cost Year</b> <table border="1"> <tr> <td>g. Type of Financing (e.g., fixed, variable)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>h. Date of Refinancing</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>i. New Interest Rate</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>j. Term of Mortgage (number of years)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>k. Amount of Principal Borrowed</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>l. Principal Outstanding on Note Paid-Off</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		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														
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> <table border="1"> <thead> <tr> <th>Name and Address of Lessor</th> <th>Property Leased</th> <th>Date of Lease</th> <th>Term of Lease</th> <th>Annual Amount of Lease</th> </tr> </thead> <tbody> <tr><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>					Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease																																
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease																																					

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

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			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						
<b>12 B7. Total Building Interest Expense (A1 - A4 + B5)</b>	\$					

(Carry Subtotals forward to next page )

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$				
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)		\$				
14. Insurance						
a. Insurance on Property (buildings only)		\$	137,035	137,035		
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella ( <i>Blanket Coverage</i> )		\$				
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$				
14d. <b>Total Insurance Expenditures</b> (14a + b + c)		\$	137,035	137,035		
15. <b>Total All Expenditures</b> (A-13 thru C-14)		\$	5,532,581	5,532,581		

## **D. Adjustments to Statement of Expenditures**

Name of Facility Wolcott Hall Nursing Center				License No. 1096-C	Report for Year Ended 9/30/2022		Page of 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	\$ 189,240	189,240		
4.			Other - See attached Schedule	\$ 4,467	4,467		
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 9,186	9,186		
10.	15	1d	Accounting	\$ 7,787	7,787		
10a.			Legal	\$ 89	89		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
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	m 2/3	Unallowable Advertising *	\$ 2,842	2,842		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$ 35	35		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 96,897	96,897		
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 310,544	310,544		

\* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

**Schedule of Other Salaries Adjustment**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A12m	Social Service - Marketing	\$ 4,467		
<b>Total Other Salaries Adjustment</b>			\$ 4,467	\$ -	\$ -

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**Schedule of Fees Adjustments**

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

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**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fees Non Reimbursable	\$ 59,666		
16	1.3	Employee Recognition/Gifts/Parties	\$ 8,112		
16	m13	Bank Charges	\$ 2,439		
16	8a	Chamber of Commerce	\$ -		
16	m13	Survey Fines & Citations	\$ 21,125		
16	m13	Resident Expenses	\$ 448		
16	m13	Account Write Off	\$ 5,002		
30	IV 8	Settlement	\$ 105		
<b>Total Other A&amp;G Adjustments</b>			\$ 96,897	\$ -	\$ -

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State of Connecticut

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

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

Name of Facility Wolcott Hall Nursing Center				License No. 1096-C	Report for Year Ended 9/30/2022		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)	
Subtotals Brought Forward				\$ 310,544	310,544			
<b>Page 20 - Resident Care Supplies***</b>								
27.	20	5a2	Prescription Drugs	\$ 83,006	83,006			
28.	16	L1	Ambulance/Limousine	\$ 218	218			
29.	20	h	X-rays, etc	\$ 20,165	20,165			
30.	20	f	Laboratory	\$ 9,738	9,738			
31.			Medical Supplies	\$				
32.	20	5e	Oxygen (non emergency)	\$ 7,397	7,397			
33.			Occupational Therapy	\$				
34.			Other - See Attached Schedule	\$ 12,575	12,575			
<b>Page 22 - Maintenance and Property</b>								
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$				
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.			Other - Indirect	\$				
43.	30	IV5	Interest Income on Account Rec.	\$ 177	177			
44.			Other - Miscellaneous Administrative	\$				
45.			Management Fees Direct	\$				
46.			Management Fees Indirect	\$				
47.			Other - Direct	\$				
<b>Not For Profit Providers Only</b>								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$				
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 443,819	443,819			

\*\*\* 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**

## **Schedule of Excess Movable Equipment Depreciation**

### **Schedule of Other Property Adjustments**

## **Schedule of Other - Indirect Adjustments**

Attachment Page 29

### **Schedule of Other - Miscellaneous Administrative Adjustments**

### **Schedule of Other - Direct Adjustments**

## **Schedule of Unallowable Building Interest**

**F. Statement of Revenue**

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022			Page 30   37
Item		Total	CCNH	RHNS	(Specify)
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 2,649,273	2,649,273			
b. Medicaid Room and Board Contractual Allowance **	\$				
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,262,818	1,262,818			
b. Medicare Room and Board Contractual Allowance **	\$ 710,070	710,070			
4. a. Private-Pay Residents and Other	\$ 1,051,004	1,051,004			
b. Private-Pay Room and Board Contractual Allowance **	\$				
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 82,943	82,943			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (81,478)	(81,478)			
c. Prescription Drugs - Non-Medicare	\$ 2,825	2,825			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (2,825)	(2,825)			
2. a. Medical Supplies - Medicare	\$ 576	576			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (576)	(576)			
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 653,250	653,250			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (571,329)	(571,329)			
c. Physical Therapy - Non-Medicare	\$ 48,460	48,460			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (47,915)	(47,915)			
4. a. Speech Therapy - Medicare	\$ 61,440	61,440			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (59,336)	(59,336)			
c. Speech Therapy - Non-Medicare	\$ 5,460	5,460			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (4,960)	(4,960)			
5. a. Occupational Therapy - Medicare	\$ 571,740	571,740			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (526,191)	(526,191)			
c. Occupational Therapy - Non-Medicare	\$ 62,020	62,020			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (50,275)	(50,275)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 5,816,995	5,816,995			
<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> )	\$ 177	177			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 250,706	250,706			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 250,884	250,884			
<b>VI. Total All Revenue</b> (III +V)	\$ 6,067,879	6,067,879			

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

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

**Schedule of Other Resident Revenue - Medicare**

## Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Resident Revenue - Medicare</b>		\$ -	\$ -	\$ -

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

## Related Exp

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

## Interest Income

## Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 30 IV5	Interest Income	341,061	\$ 177		
<b>Total Interest Income</b>			\$ 177	\$ -	\$ -

### **Schedule of Other Revenue**

**G. Balance Sheet**

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$ 400	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 341,061	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$ 21,602	
5. Prepaid Expenses			\$ 10,749	
a. _____				
b. _____				
c. _____				
d. See Schedule		10,749		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$ 540,513	
_____				
_____				
See Schedule		540,513		
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 914,325	
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Depreciation	_____	Net	
3. Buildings	*Historical Cost		\$	
	Accum. Depreciation	_____	Net	
4. Leasehold Improvements	*Historical Cost	1,563,630	\$	164,262
	Accum. Depreciation	1,399,368	Net	
5. Non-Movable Equipment	*Historical Cost	38,097	\$	3,003
	Accum. Depreciation	35,093	Net	
6. Movable Equipment	*Historical Cost	302,307	\$	8,703
	Accum. Depreciation	293,604	Net	
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation	_____	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$ 175,969	

\* 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	
31	A5	Prepaid Insurance	\$ -
31	A5	Prepaid Property Tax	\$ 10,749
31	A5	Other Prepaid Expenses	\$ -
31	A5	Prepaid Income Tax	\$ -
<b>Total Prepaid Expenses</b>			\$ 10,749

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

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

**Schedule of Other Assets Page 32 Line D7**

**Schedule of Notes Payable (Itemize) Page 33 Line A2**

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

Page Ref	Line Ref	Description	
		Due Affiliate (Credit Balance)	
33	A12	Exchange Accounts (10401-10403) (Credit Balance)	\$ 4,359
33	A12	Accrued PTO	\$ 113,704
33	A12	Payroll W/H	\$ 11,193
33	A12	Accrued Professional Fees	\$ 13,244
33	A12	AP Patient Exchange	\$ (23,932)
33	A12	Accrued Worker's Comp	\$ 62,858
33	A12	Accrued Group Insurance	\$ 35,165
33	A12	Accrued Other Expense	\$ 236,982
<b>Total Other Current Liabilities (Itemize)</b>			\$ 453,573

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

## G. Balance Sheet (cont'd)

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022	Page 32	of 37
Account		Amount		
		Total Brought Forward:		\$ 1,090,294
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements	*Historical Cost Accum. Depreciation	Net	\$	
3. Buildings	*Historical Cost Accum. Depreciation	Net	\$	
4. Non-Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
5. Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
6. Motor Vehicles	*Historical Cost Accum. Depreciation	Net	\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense	*Historical Cost Accum. Depreciation	Net	\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )			\$	
See Schedule				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	1,090,294

\* 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
		9/30/2022	33	37
		Account	Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 170,743
2. Notes Payable ( <i>itemize</i> )				\$
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> )				\$ 44,246
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$
6. Accrued Payroll Taxes Payable				\$ 10,336
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> )				\$ 453,573
See Schedule				453,573
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)				\$ 678,898

\* 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 Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022	Page 34	of 37
Account				Amount
Total Brought Forward:				678,898
<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> )				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 1,085,444
See Schedule				1,085,444
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 1,085,444
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 1,764,342

## G. Balance Sheet (cont'd)

### Reserves and Net Worth

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022	Page 35	of 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				\$ 2,955,029
2. Capital Stock				\$ 1,000
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ (4,165,374)
6. Gain or Loss for Period		10/1/2021 thru 9/30/2022	\$ 535,298	
7. Total Net Worth				\$ (674,047)
<b>C. Total Reserves and Net Worth</b>				\$ (674,047)
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 1,090,294

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Wolcott Hall Nursing Center	1096-C	9/30/2022	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ (1,204,764)		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 6,067,879		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 5,532,581		
D. Net Income or Deficit				\$ 535,298		
E. Balance				\$ (669,466)		
F. Additions						
1. Additional Capital Contributed ( <i>itemize</i> )						
2. Other ( <i>itemize</i> )						
F-3. Total Additions				\$		
G. Deductions						
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )				\$ 4,581		
Name and Address (No., City, State, Zip)		Title	Amount			
Brian Foley		President	4,581			
2. Other Withdrawings ( <i>Specify</i> )				\$		
Purpose		Amount				
3. Total Deductions				\$ 4,581		
H. <b>Balance at End of Period</b>				\$ (674,047)		

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

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2022	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

### Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Robert Gwizdak		
Address Address 21 Waterville Road Avon, CT 06001		Phone Number (860) 678-9755
Contacted Person Regarding Additional Information Needed Regarding This Report Susan Southey		Phone Number (860) 470-7542
Contact Email Address ssouthey@apple-rehab.com		