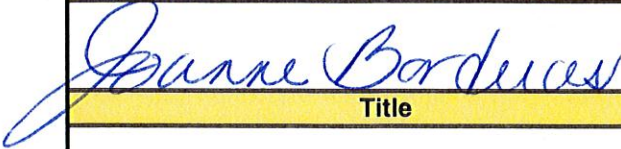


**STATE OF CONNECTICUT**  
**DEPARTMENT OF SOCIAL SERVICES**  
**55 FARMINGTON AVENUE HARTFORD, CONNECTICUT 06105**

**ANNUAL REPORT**  
**FEDERALLY QUALIFIED HEALTH CENTER (FQHC)**

Date Submitted: \_\_\_\_\_ Date Received: \_\_\_\_\_

1.	<b>FQHC Name</b>	Community Health and Wellness Center of Greater Torrington, Inc.		
	<b>Street Address</b>	469 Migeon Avenue		
	<b>City, State, ZIP</b>	Torrington, CT 06790		
	<b>Telephone Number</b>	860-387-0436		
	<b>Contact Person</b>	Joanne Borduas		
	<b>Title</b>	CEO		
2.	<b>FQHC Medicaid Provider Number:</b>	3. <b>Reporting Period:</b>		
	Medical	9247872	From	10/1/2019
	Dental	8024018	To	9/30/2020
	Mental Health	8033022		
	Other (Specify)			
4.	<b>Type of Control (Check One Only)</b>			
	<input checked="" type="checkbox"/> NONPROFIT ORGANIZATION			
	<input type="checkbox"/> GOVERNMENT			
	<input type="checkbox"/> STATE	<input type="checkbox"/> DISTRICT	<input type="checkbox"/> OTHER	
	<input type="checkbox"/> COUNTY	<input type="checkbox"/> CITY		
5.	<b>FQHC Owned By:</b>			
	<b>CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC</b>			
	I Hereby Certify That I Have Examined the Accompanying Worksheets Prepared By Community Health and Wellness Center of Greater Torrington, Inc. 9247872 (FQHC Name)			
	For the Reporting Period Beginning 10/1/2019 and Ending 9/30/2020 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 FQHC In Accordance With Applicable Instructions, Except as Noted:			
6.	<b>Signature (Officer or Administrator of FQHC)</b>		<b>Printed Name</b>	
			Joanne Borduas	
	Title		Date	
	CEO			





STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES  
ANNUAL REPORT  
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Reporting Period: From 10/1/2019 To 9/30/2020

FQHC Name: Community Health and Wellness Center of Greater Torrington, Inc.

**Form A-1 (Direct Health Care Cost)**  
**RECLASSIFICATIONS AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES**

COST CENTER	Salaried Personnel		Other Costs	Total	Reclassifications	Reclassified Trial Balance (Col. 3 & 4)	Adjustments Increase (Decrease)	Net Expenses (Col. 5 & 6)
	I	II						
<b>A. DIRECT HEALTH CARE COST</b>								
<i>(Excluding Dental, Mental Health &amp; Other)</i>								
<b>1. Staff Cost</b>								
a. Physician	576,600	89,536	666,136		(72,579)	593,557		593,557
b. Physician Assistant	0	0	0			0		0
c. Nurse (APRN, Midwife, RN)	538,008	125,543	663,551			663,551		663,551
d. Other - Specify								
LPN, Medical Assistant, Case Manager	446,815	69,382	516,197			516,197		516,197
Dietician	42,819	6,649	49,468			49,468		49,468
Ophthalmologist	7,506	1,166	8,672			8,672		8,672
Chiropractor	82,668	12,837	95,505			95,505		95,505
Podiatrist	9,913	1,539	11,452			11,452		11,452
	0	0	0			0		0
	0	0	0			0		0
	0	0	0			0		0
	0	0	0			0		0
	0	0	0			0		0
	0	0	0			0		0
	0	0	0			0		0
<b>e. Subtotal Direct Health Care Cost</b>	<b>1,704,329</b>	<b>306,652</b>	<b>2,010,981</b>		<b>(72,579)</b>	<b>1,938,402</b>	<b>0</b>	<b>1,938,402</b>
<b>2. Other Direct Health Care Cost</b>								
a. Medical Supplies	0	223,070	223,070			223,070		223,070
b. Transportation	0	1,801	1,801			1,801		1,801
c. Depreciation - Medical Equipment	0	0	0			0		0
d. Professional Liability Insurance	0	25,069	25,069		(3,061)	22,008		22,008
e. Laboratory	0	0	0			0		0
f. Radiology	0	0	0			0		0
g. Physician-Administered Drugs	0	0	0			0		0
h. Other - Specify								
Interpreting Services	0	14,975	14,975		(100)	14,875		14,875
	0	0	0			0		0
	0	0	0			0		0
	0	0	0			0		0
	0	0	0			0		0
<b>i. Subtotal Other Direct Health Care Cost</b>	<b>0</b>	<b>264,915</b>	<b>264,915</b>		<b>(3,161)</b>	<b>261,754</b>	<b>0</b>	<b>261,754</b>
<b>3. TOTAL DIRECT HEALTH CARE COST (1e &amp; 2i)</b>	<b>1,704,329</b>	<b>571,567</b>	<b>2,275,896</b>		<b>(75,740)</b>	<b>2,200,156</b>	<b>0</b>	<b>2,200,156</b>





STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES  
ANNUAL REPORT  
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Reporting Period: From 10/1/2019 To 9/30/2020

FQHC Name: Community Health and Wellness Center of Greater Torrington, Inc.

Form A-3 (Direct Mental Health Care Cost)

**RECLASSIFICATIONS AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES**

COST CENTER	I Salaried Personnel	II Other Costs	III Total	IV Reclass- ifications	V Reclassified Trial Balance (Col 3 & 4)	VI Adjustments Increase (Decrease)	VII Net Expenses (Col 5 & 6)
<b>C. DIRECT MENTAL HEALTH CARE COST</b>							
<b>1. Staff Cost</b>							
a. Psychologist	0	0	0		0		0
b. Social Worker	435,443	67,616	503,059		503,059		503,059
c. Other - Specify	0	0	0		0		0
Contracted Staff	417,425	64,819	482,244		482,244		482,244
Psychiatrist							
<b>d. Subtotal Direct Mental Health Care Cost</b>	<b>852,868</b>	<b>132,435</b>	<b>985,303</b>	<b>0</b>	<b>985,303</b>	<b>0</b>	<b>985,303</b>
<b>2. Other Direct Mental Health Care Cost</b>							
a. Medical Supplies	0	0	0		0		0
b. Transportation	0	49	49		49		49
c. Depreciation - Mental Health Equipment	0	0	0		0		0
d. Professional Liability Insurance	0	0	0		0		0
e. Other - Specify							
<b>f. Subtotal Other Direct Mental Health Care Cost</b>	<b>0</b>	<b>49</b>	<b>49</b>	<b>0</b>	<b>49</b>	<b>0</b>	<b>49</b>
<b>3. TOTAL DIRECT MENTAL HEALTH CARE COST (1d &amp; 2f)</b>							
	852,868	132,484	985,352	0	985,352	0	985,352
<b>D. TOTAL DIRECT COST BEFORE NON-ALLOWABLE SERVICES</b>							
	2,960,228	853,152	3,813,380	(70,891)	3,742,489	-	3,742,489

STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES  
ANNUAL REPORT  
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Reporting Period: From 10/1/2019 To 9/30/2020

FQHC Name: Community Health and Wellness Center of Greater Torrington, Inc.

Form A-4 (Non-Allowable Direct Other Service Cost)

RECLASSIFICATIONS AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES							
COST CENTER	Salaried Personnel	Other Costs	Total	Reclassifications	Reclassified Trial Balance	Adjustments Increase (Decrease)	Net Expenses
E. NON-ALLOWABLE DIRECT OTHER SERVICE COST	I	II	III	IV	V	VI	VII
<b>1. Service</b>							
a. Clinical Diagnostic Lab	0	0	0		0		0
b. Radiology	0	0	0		0		0
c. Prescription Drugs/Pharmacy	0	613,234	613,234		613,234	(613,234)	0
d. Battered Women	0	0	0		0		0
e. Homeless	0	0	0		0		0
f. WIC	0	0	0		0		0
g. Non-FQHC Sites	0	0	0		0		0
h. Other - Specify							
LPN Chronic Care Management	57,211	8,884	66,095		66,095		66,095
Patient Assistance and Travel	0	0	0	0	0		0
340B Contract Admin Expense and Fees	0	457,036	457,036		457,036	(457,036)	0
			0		0		0
			0		0		0
			0		0		0
			0		0		0
			0		0		0
			0		0		0
<b>I. Total Non-Allowable Direct Other Service Cost</b>	<b>57,211</b>	<b>1,079,154</b>	<b>1,136,365</b>	<b>0</b>	<b>1,136,365</b>	<b>(1,070,270)</b>	<b>66,095</b>
<b>F. TOTAL DIRECT COST (D+E1)</b>	<b>3,017,439</b>	<b>1,932,306</b>	<b>4,949,745</b>	<b>(70,891)</b>	<b>4,878,854</b>	<b>(1,070,270)</b>	<b>3,808,584</b>



STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES  
ANNUAL REPORT  
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Reporting Period: From 10/1/2019 To 9/30/2020  
 FQHC Name: Community Health and Wellness Center of Greater Torrington, Inc.

Form A-5 (Overhead Cost)

RECLASSIFICATIONS AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES							
COST CENTER	Salaried Personnel	Other Costs	Total	Reclassifications	Reclassified Trial Balance	Adjustments Increase (Decrease)	Net Expenses
	I	II	III	IV	V	VI	(Col 5 & 6)
VI							VII
<b>G. OVERHEAD - FACILITY COST</b>							
a. Rent	0	265,401	265,401		265,401	(20,909)	244,492
b. Insurance	0	48,759	48,759		48,759		48,759
c. Interest on Mortgage or Loans	0	100,808	100,808		100,808	(94,189)	6,619
d. Utilities	0	91,646	91,646		91,646		91,646
e. Depreciation - Building	0	867	867		867		867
f. Depreciation - Equipment	0	17,087	17,087		17,087		17,087
g. Housekeeping & Maintenance	0	100,140	100,140		100,140		100,140
h. Other (Specify)	0	0	0		0	483,071	483,071
	0	1,968	1,968		1,968		1,968
	0	0	0		0		0
	0	0	0		0		0
	0	0	0		0		0
<b>i. Subtotal Overhead - Facility Cost</b>	<b>0</b>	<b>626,676</b>	<b>626,676</b>	<b>0</b>	<b>626,676</b>	<b>367,973</b>	<b>994,649</b>
<b>H. OVERHEAD - ADMINISTRATIVE COST</b>							
a. Office Salaries	1,794,815	278,702	2,073,517	72,579	2,146,096		2,146,096
b. Depreciation - Office Equipment	0	8,103	8,103		8,103		8,103
c. Office Supplies	0	96,860	96,860	(1,688)	95,172		95,172
d. Legal	0	48,780	48,780		48,780		48,780
e. Accounting	0	48,300	48,300		48,300		48,300
f. Insurance	0	0	0		0		0
g. Telephone	0	55,845	55,845		55,845		55,845
h. Advertising-Help Wanted	0	64	64		64		64
i. Interest - Capital Loans	0	4,470	4,470		4,470		4,470
j. Other (Specify)	0	0	0		0		0
	0	421,142	421,142	0	421,142	(37,775)	383,367
	0	11,023	11,023		11,023	(11,023)	0
	0	2,000	2,000		2,000	(2,000)	0
	0	13,458	13,458		13,458	(13,458)	0
	0	0	0		0		0
<b>k. Subtotal Overhead - Administrative Cost</b>	<b>1,794,815</b>	<b>988,747</b>	<b>2,783,562</b>	<b>70,891</b>	<b>2,854,453</b>	<b>(64,256)</b>	<b>2,790,197</b>
<b>l. TOTAL OVERHEAD COST (GI+HK)</b>	<b>1,794,815</b>	<b>1,615,423</b>	<b>3,410,238</b>	<b>70,891</b>	<b>3,481,129</b>	<b>303,717</b>	<b>3,784,846</b>
<b>J. GRAND TOTAL COSTS<sup>2</sup> (F+I)</b>	<b>4,812,254</b>	<b>3,547,729</b>	<b>8,359,983</b>	<b>-</b>	<b>8,359,983</b>	<b>(766,553)</b>	<b>7,593,430</b>

<sup>2</sup> Reconciliation schedule is required if Line J, Column III does not agree to the Audited Financial Statements

STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES  
ANNUAL REPORT  
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Reporting Period: From 10/1/2019 To 9/30/2020  
 FQHC Name: Community Health and Wellness Center of Greater Torrington, Inc.

Form B-1 (Compensation, Encounters, Hours, FTEs - Health Care)

HEALTH CARE COMPENSATION, ENCOUNTERS, HOURS, AND FTEs BY PRACTITIONER					
HEALTH CARE COMPENSATION, ENCOUNTERS, HOURS, & FTEs (Excluding Dental, Mental Health, and Other)	Specialty I	Compensation II	Encounters III	Total Employee Hours and FTEs	
				Employee Total Hours IV	FTEs (2080 hrs = 1 FTE) V
<i>Provide itemized de-identified list (e.g., Physician 1)</i>	<b>General Practitioner</b>	<b>125,000</b>	<b>1,500</b>	<b>1,040</b>	<b>0.50</b>
<b>A. PHYSICIAN</b>					
1. See Form B-4					0.00
2.					0.00
3.					0.00
4.					0.00
5.					0.00
6.					0.00
7.					0.00
8.					0.00
9.					0.00
10.					0.00
<b>Total Physician Encounters, Staff Hours and FTEs</b>				0	0
<b>B. PHYSICIAN ASSISTANT</b>					
1.					0.00
2.					0.00
3.					0.00
4.					0.00
5.					0.00
<b>Total Physician Assistant Encounters, Hours and FTEs</b>				0	0



STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES  
ANNUAL REPORT  
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Reporting Period: From 10/1/2019 To 9/30/2020

FQHC Name: Community Health and Wellness Center of Greater Torrington, Inc.

Form B-1 Continued (Compensation, Encounters, Hours, FTEs - Health Care)

HEALTH CARE COMPENSATION, ENCOUNTERS, HOURS, AND FTEs BY PRACTITIONER					
HEALTH CARE COMPENSATION, ENCOUNTERS, HOURS, & FTEs (Excluding Dental, Mental Health, and Other)	Specialty I	Compensation II	Encounters III	Total Employee Hours and FTEs	
				Employee Total Hours IV	FTEs (2080 hrs = 1 FTE) V
<i>Provide itemized de-identified list (e.g., Physician 1)</i>	General Practitioner	125,000	1,500	1,040	0.50
C. NURSE (APRN, MIDWIFE, RN)					
1. See Form B-4					0.00
2.					0.00
3.					0.00
4.					0.00
5.					0.00
Total Nurse Practitioner				0	0
D. PHYSICIAN SERVICES UNDER CONTRACT					
1.					0.00
2.					0.00
3.					0.00
4.					0.00
5.					0.00
Total Physician Services Under Contract				0	0
E. OTHER HEALTH CARE PRACTITIONER					
1.					0.00
2.					0.00
3.					0.00
Total Other Health Care Practitioner				0	0

STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES  
ANNUAL REPORT  
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Reporting Period: From 10/1/2019 To 9/30/2020  
 FQHC Name: Community Health and Wellness Center of Greater Torrington, Inc.

Form B-2 (Compensation, Encounters, Hours, FTEs - Dental Care)

DENTAL SERVICES COMPENSATION, ENCOUNTERS, HOURS, AND FTEs BY PRACTITIONER				
DENTAL CARE COMPENSATION, ENCOUNTERS, HOURS, & FTEs	Compensation II	Encounters III	Total Employee Hours and FTEs	
			Employee Total Hours IV	FTEs (2080 hrs = 1 FTE) V
<i>Provide itemized de-identified list (e.g., Dentist 1)</i>	125,000	1,500	1,040	0.50
<b>A. DENTIST</b>				
1. See Form B-4				0.00
2.				0.00
3.				0.00
4.				0.00
5.				0.00
<b>Total Dentist Encounters, Staff Hours and FTEs</b>	0	0	0	0.00
<b>B. DENTAL HYGIENIST</b>				
1.				0.00
2.				0.00
3.				0.00
4.				0.00
5.				0.00
<b>Total Dental Hygienist Encounters, Hours and FTEs</b>	0	0	0	0.00
<b>C. OTHER DENTAL PRACTITIONER</b>				
1.				0.00
2.				0.00
3.				0.00
4.				0.00
5.				0.00
<b>Total Other Dental Practitioner Encounters, Hours and FTEs</b>	0	0	0	0.00



STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES  
ANNUAL REPORT  
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Reporting Period: From 10/1/2019 To 9/30/2020

FQHC Name: Community Health and Wellness Center of Greater Torrington, Inc.

Form B-3 (Compensation, Encounters, Hours, FTEs - Mental Health Care)

MENTAL HEALTH SERVICES COMPENSATION, ENCOUNTERS, HOURS, AND FTEs BY PRACTITIONER				
MENTAL HEALTH SERVICES COMPENSATION, ENCOUNTERS, HOURS, & FTEs	Compensation	Encounters	Total Employee Hours and FTEs	
			Employee Total Hours	FTEs (2080 hrs = 1 FTE)
<i>Provide itemized de-identified list (e.g., Psychologist 1)</i>	125,000	1,500	1,040	0.50
<b>A. PSYCHOLOGIST</b>				
1. See Form B-4				0.00
2.				0.00
3.				0.00
4.				0.00
5.				0.00
<b>Total Psychologist Encounters, Staff Hours and FTEs</b>	0	0	0	0.00
<b>B. SOCIAL WORKER</b>				
1.				0.00
2.				0.00
3.				0.00
4.				0.00
5.				0.00
<b>Total Social Worker Encounters, Hours and FTEs</b>	0	0	0	0.00
<b>C. OTHER MENTAL HEALTH PRACTITIONER</b>				
1.				0.00
2.				0.00
3.				0.00
4.				0.00
5.				0.00
<b>Total Other Mental Health Practitioner Encounters, Hours and FTEs</b>	0	0	0	0.00

STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES  
ANNUAL REPORT  
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Reporting Period: From 10/1/2019 To 9/30/2020

FQHC Name: Community Health and Wellness Center of Greater Torrington, Inc.

Form B-4 (Summary Compensation, Encounters, Hours, FTEs)

SUMMARY COMPENSATION, ENCOUNTERS, HOURS, AND FTEs BY PRACTITIONER TYPE											
SUMMARY COMPENSATION, ENCOUNTERS, HOURS, AND FTEs BY PRACTITIONER TYPE	Number of Practitioners	Total Compensation	Compensation Range			Turnover		Encounters	Employee Hours and FTEs		
			High	Low	Hires	Departures	Employee Total Hours		FTEs (2,080 hrs = 1 FTE)		
<b>A. HEALTH CARE PRACTITIONERS</b>	<b>4</b>	<b>500,000</b>	<b>150,000</b>	<b>100,000</b>	<b>2</b>	<b>1</b>	<b>10,000</b>	<b>8,320</b>	<b>4.00</b>		
1. PHYSICIAN	6	576,600	251,148	201,760	3	1	6,634	5,432	2.61		
2. PHYSICIAN ASSISTANT	0	0	0	0	0	0	0	0	0.00		
3. NURSE (APRN, MIDWIFE, RN)	7	538,008	152,131	73,326	1	0	6,896	10,655	5.12		
4. PHYSICIAN SERVICES UNDER CONTRACT	0	0	0	0	0	0	0	0	0.00		
5. OTHER HEALTH PROFESSIONALS	3	100,087	245,465	162,638	0	0	1,077	1,200	0.58		
6. OTHER ALLIED HEALTH PROFESSIONALS	2	42,819	67,433	37,440	0	0	138	1,400	0.67		
7. OTHER HEALTH CARE PRACTITIONERS	11	446,815	63,172	48,538	1	1	0	16,694	8.03		
<b>Total Health Care</b>	<b>29</b>	<b>1,704,329</b>			<b>5</b>	<b>2</b>	<b>14,745</b>	<b>35,381</b>	<b>17.01</b>		
<b>B. DENTAL PRACTITIONERS</b>											
1. DENTIST	3	249,421	151,376	135,000	0	2	3,468	3,568	1.72		
2. DENTAL HYGIENIST	2	49,985	76,687	74,984	0	1	867	1,340	0.64		
3. OTHER DENTAL PRACTITIONERS	4	103,625	45,849	33,218	0	3	0	5,460	2.63		
<b>Total Dental</b>	<b>9</b>	<b>403,031</b>			<b>0</b>	<b>6</b>	<b>4,335</b>	<b>10,368</b>	<b>4.99</b>		
<b>C. MENTAL HEALTH PRACTITIONERS</b>											
1. PSYCHIATRIST	3	417,425	431,043	378,412	1	0	2,127	2,242	1.08		
2. PSYCHOLOGIST					0	0	0	0	0.00		
3. LICENSED CLINICAL SOCIAL WORKER	7	435,443	89,143	54,877	2	0	5,860	12,137	5.84		
4. PSYCHIATRIC APRN									0.00		
5. OTHER MENTAL HEALTH PRACTITIONERS									0.00		
<b>Total Mental Health</b>	<b>10</b>	<b>852,868</b>			<b>3</b>	<b>0</b>	<b>7,987</b>	<b>14,379</b>	<b>6.92</b>		



STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES  
ANNUAL REPORT  
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Reporting Period:	From	10/1/2019	To	9/30/2020
FQHC Name:	Community Health and Wellness Center of Greater Torrington, Inc.			

Form C (Cost Adjustment & Allocation)

COST ADJUSTMENT AND ALLOCATION		
A.	Direct Cost Title XIX Services (P5 - Form A-3, Line D, Col. VII)	3,742,489
B.	Direct Cost Other Services (P6 - Form A-4, Line E.1.i, Col. VII)	66,095
C.	Total Direct Costs (A+B)	3,808,584
D.	Portion of Title XIX Services (A/C)	98.26%
E.	Total Overhead Cost (P7 - Form A-5, Line I, Col. VII)	3,784,846
F.	Overhead Cost Applicable to Title XIX Services (DxE)	3,718,990
G.	Total Title XIX Services Cost (A+F)	7,461,479
H.	Thirty Percent (30%) of Total Title XIX Svc Cost (Gx.30)	2,238,444
I.	Cost Adjustment (Lower of H-F or Zero)	(1,480,546)
J.	Allowable Title XIX Overhead Cost (F+I)	2,238,444
K.	Direct Costs	
	1. Health Care Services (P3 - Form A-1, Line A3, Col. VII)	2,200,156
	2. Dental Services (P4 - Form A-2, Line B3, Col. VII)	556,981
	3. Mental Health Services (P5 - Form A-3, Line C3, Col. VII)	985,352
	4. Total Direct Costs (K1 thru K3)	3,742,489
L.	Direct Costs as a % of Total	
	1. Health Care Services (K1/K4)	58.79%
	2. Dental Services (K2/K4)	14.88%
	3. Mental Health Services (K3/K4)	26.33%
M.	Allocated Allowable Overhead Cost	
	1. Health Care Services (JxL1)	1,315,981
	2. Dental Services (JxL2)	333,080
	3. Mental Health Services (JxL3)	589,382
	4. Total Allowable Title XIX Overhead Cost (M1 thru M3)	2,238,443

STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES  
ANNUAL REPORT  
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Reporting Period:	From <u>10/1/2019</u>	To <u>9/30/2020</u>
FQHC Name:	Community Health and Wellness Center of Greater Torrington, Inc.	

Form D (Allowable Cost per Encounter)

ALLOWABLE COST PER ENCOUNTER	
<b>I. Health Care Cost (Excluding Dental and Mental Health)</b>	
A. Direct Health Care Cost (P3 - Form A-1, Line A3, Col. VII)	2,200,156
B. Allowable Overhead Cost (P13 - Form C, Line M1)	1,315,981
C. Total Allowable Health Care Cost (A+B)	3,516,137
D. Encounters (P12 - Form B-4, Health Care Total)	14,745
E. Allowable Health Care Cost Per Encounter (C/D)	238.46
<b>II. Dental</b>	
A. Direct Dental Care Cost (P4 - Form A-2, Line B3, Col. VII)	556,981
B. Allowable Overhead Cost (P13 - Form C, Line M2)	333,080
C. Total Allowable Dental Cost (A+B)	890,061
D. Encounters (P12 - Form B-4, Dental Total)	4,335
E. Allowable Dental Cost Per Encounter (C/D)	205.32
<b>III. Mental Health</b>	
A. Direct Mental Health Care Cost (P5 - Form A-3, Line C3, Col. VII)	985,352
B. Allowable Overhead Cost (P13 - Form C, Line M3)	589,382
C. Total Allowable Mental Health Cost (A+B)	1,574,734
D. Encounters (P12 - Form B-4, Mental Health Total)	7,987
E. Allowable Mental Health Cost Per Encounter (C/D)	197.16



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 FQHC Name: Community Health and Wellness Center of Greater Torrington, Inc.

Form E (Revenues)						
REVENUES		I	II	III	IV	V
		Services Excluding Dental, Mental Health &	Dental	Mental Health	Other	Total (Col. I thru IV)
<b>A.</b>	<b>Operating Revenue</b>					
1.	Medicaid	1,272,736	299,680	833,368		2,405,784
2.	Private	290,361	73,555	160,036		523,952
3.	Medicare	324,493	0	147,397		471,890
4.	Patient Cash/Self Pay	18,004	50,218	(1,660)		66,562
5.	Other - Specify				0	0
6.	Total (1 thru 5)	1,905,594	423,453	1,139,141	0	3,468,188
<b>B.</b>	<b>Other Revenue</b>					
1.	Contributions				158,894	158,894
2.	Grants				2,899,775	2,899,775
3.	Interest				94,189	94,189
4.	Donations				0	0
5.	Other - Specify				139,961	139,961
6.	Other - Specify Contract 340B Pharmacy				1,977,206	1,977,206
7.	Other - Specify				0	0
8.	Other - Specify				0	0
9.	Other - Specify				0	0
10.	Other - Specify				0	0
11.	Total (1 thru 10)	0	0	0	5,270,025	5,270,025
<b>C.</b>	<b>Other Revenue (Include revenue generated by non-approved FQHC sites)</b>					
1.	Other - Specify					0
2.	Other - Specify					0
3.	Other - Specify					0
4.	Other - Specify					0
5.	Other - Specify					0
6.	Other - Specify					0
7.	Total (1 thru 7)	0	0	0	0	0
<b>D.</b>	<b>Total Revenue (A6+B11+C7)</b>	1,905,594	423,453	1,139,141	5,270,025	8,738,213

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FQHC Name:	Community Health and Wellness Center of Greater Torrington, Inc.			

Form F (Grants and Contributions)

**GRANTS AND CONTRIBUTIONS (EXCLUDING THE PUBLIC HEALTH SERVICES GRANTS)**

A.	Contributions	ACTUAL
	1. Services ( <i>Excluding Dental, Mental Health and Other</i> )	
	2. Dental	
	3. Mental Health	
	4. Other - Specify _____	
	Other - Specify _____	
	Other - Specify _____	
	Other - Specify _____	
	Other - Specify _____	
	5. Total (1 thru 4)	0

B.	Grants ( <i>Excluding PHS</i> )	
	1. Services ( <i>Excluding Dental, Mental Health and Other</i> )	
	2. Dental	
	3. Mental Health	
	4. Other - Specify _____	
	Other - Specify _____	
	Other - Specify _____	
	Other - Specify _____	
	Other - Specify _____	
	5. Total (1 thru 4)	0



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Form G (Cost Disallowance and Offset)

**COST DISALLOWANCE AND OFFSET**

COST DISALLOWANCE AND OFFSET		
<b>A.</b>	<b>Cost Disallowance</b>	
	1. Entertainment	
	2. Fines and penalties	
	3. Bad debt	
	4. Cost of actions to collect receivables	
	5. Advertising, except for recruitment of personnel	11,023
	6. Contingent reserves	
	7. Legal, Accounting and professional services incurred in connection with rehearing, arbitration, or judicial proceedings pertaining to the reimbursement approved by the Commissioner	
	8. Fundraising	13,458
	9. Amortization of goodwill	
	10. Directors fees	
	11. Contributions	2,000
	12. Membership dues for public relations	
	13. Cost not related to patient care	1,070,270
	14. Interest	94,189
	15. Pass through expenses	
	16. Total (1 thru 15)	<b>1,190,940</b>
<b>B.</b>	<b>Cost Offset (Expense Recovery)</b>	
	1. Refunds - Medicaid Outreach	
	2. Rent Income	20,909
	3. In-Kind Medical Supplies	
	4. In-Kind Dental Supplies	
	5. In-Kind Computer Supplies	
	6. In-Kind Advertising	
	7. Total (1 thru 6)	<b>20,909</b>
<b>C.</b>	<b>Total Cost Disallowance and Offset (A16+B7)</b>	<b>1,211,849</b>