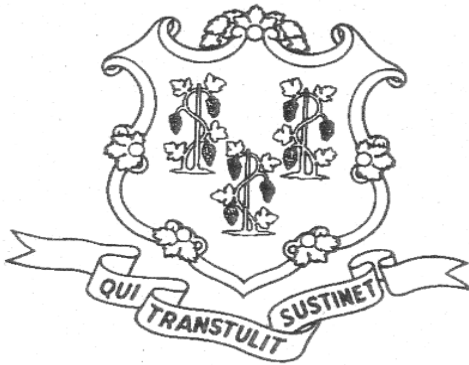


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2016

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 Chronic and Convalescent                      Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH)    (RHNS)	
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016

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

# Table of Contents

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

### General Information

Name of Facility (as licensed) Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2016	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, 2015 and ending September 30, 2016, 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) Gregory Hamley			Printed Name (Owner) Brian J. Foley		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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 10/1/2015	To 9/30/2016
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	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

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

Phone No. of Facility 860-482-8554		Report for Year Ended 9/30/2016		Page 2	of 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 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="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.					
<b>Administrator</b>					
Name of Administrator Gregory Hamley			Nursing Home Administrator's License No.:	00815	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		



**General Information and Questionnaire  
 Corporate Owners**

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2016	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
Wolcott Hall Nursing Center	215 Forest St. Torrington, CT 06790	Connecticut		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Brian J. Foley	21 Waterville Road Avon, CT 06001	President	100	
Ryan Vess	21 Waterville Road Avon, CT 06001	Secretary		
Names of Stockholders Owning at Least 10% of Shares				
Brian J. Foley	21 Waterville Road Avon, CT 06001	President	100	





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

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

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2016	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?  Yes  No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Brian J. Foley	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Real Estate Rental	Pg. 22 Line 9	384,000	384,000
Apple Health Care	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Management & Accounting Services	Pg. 16 Line m12	295,785	295,785
Healthport Services	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10/13 Schedule		
Allstar Therapy	21 Waterville Road Avon, CT	<input checked="" type="radio"/>	<input type="radio"/>	15%	Therapy Services	Pg. 13 B5/B9/B10	204,920	187,911
Corporate Employees	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	9,773	9,773
Employees @ various Apple Facilities		<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	(8,118)	(8,118)
Apple Health Care	21 Waterville Road Avon, CT	<input type="radio"/>	<input checked="" type="radio"/>		Pension Plan (401K)	Pg. 15 1a7	13,244	13,244
Aetna	PO Box 88860 Chicago, IL	<input checked="" type="radio"/>	<input type="radio"/>		Group Medical	Pg. 15 1a5	364,542	
Delta Dental	PO Box 23700 Newark, NJ	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 1a5	22,981	

\* Use additional sheets if necessary.

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

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

Name of Facility Wolcott Hall Nursing Center		License No. 1096-C		Report for Year Ended 9/30/2016		Page 4	of 37	
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?						Yes   x   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?						x Yes   No	If "Yes," provide the following information:	
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Aetna Ancillary	PO Box 88860 Chicago, IL	X			Group Life & Disability	Pg. 15 1a6	22,456	
Marsh	PO Box 19636 Newark, NJ	X			Property, Liability, & Umbrella Insura	Pg. 27 14a	88,165	
AIG	PO Box 10472 Newark, NJ	X			Worker's Compensation	Pg. 15 1a1	46,172	
Swallowing Diagnostics	21 Waterville Rd. Avon, CT	X		83%	Diagnostic Services	Pg. 20 5f	720	679
Brendan Foley	21 Waterville Rd. Avon, CT		X			##		
Ryan Vess	21 Waterville Rd. Avon, CT		X			##		

\* Use additional sheets if necessary.  
 \*\* Provide the percentage amount of revenue received from non-related parties.  
 ## Related expense has been disallowed on Pg. 28 Line 23

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

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2016	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.

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.)

Yes       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.

Name of Facility Wolcott Hall Nursing Center			License No. 1096-C		Report for Year Ended 9/30/2016		Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input checked="" type="radio"/> Yes <input type="radio"/> No	<b>Total ***</b>

\* 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 9/30/2016	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 Blum Shapiro & Co. PC	29 South Main St. West Hartford, CT 06127
2 Brazee & Huban	35 Wendell Avenue Pittsfield, MA 10202
3	
4	

Services Provided by This Firm (*describe fully*)

1 Preparation of audited financials (dissallow Pg. 28)	\$ 4,880
2 Preparation of tax returns	\$ 2,069
3	\$
4	\$
	<b>Charge for Services Provided</b>
	\$ 6,949

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    Pg. 15 1d

**Legal Services Information**

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

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

1  
2  
3  
4  
5

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$
	<b>Charge for Services Provided</b>
	\$

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    Pg. 15 1e

### Schedule of Resident Statistics

Name of Facility Wolcott Hall Nursing Center		License No. 1096-C			Report for Year Ended 9/30/2016				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													
A. On last day of PREVIOUS report period	87	87			87	87			87	87			
B. On last day of THIS report period	87	87			87	87			87	87			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	54	54			54	54			54	54			
B. As of midnight of THIS report period	39	39			39	39			39	39			
3. Total Number of Days Care Provided During Period													
A. Medicare	721	721			637	637			84	84			
B. Medicaid (Conn.)	15,750	15,750			12,341	12,341			3,409	3,409			
C. Medicaid (other states)													
D. Private Pay	1,255	1,255			896	896			359	359			
E. State SSI for RCH													
F. Other (Specify)													
G. Total Care Days During Period (3A thru F)	17,726	17,726			13,874	13,874			3,852	3,852			
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													
5. <b>Total Resident Days (3G + 4A + 4B)</b>	17,726	17,726			13,874	13,874			3,852	3,852			

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

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2016	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)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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

Change in Resident Days	CCNH	RHNS	(Specify)
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	1	35		3				
Per Diem Rate								
a. One bed rm.				443.00				
b. Two bed rms.	RUGS III	221.29		422.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	1,853	1,853		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	2,486	2,486		
<b>D. Total Physical Therapy Treatments</b>	<b>4,339</b>	<b>4,339</b>		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	389	389		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	175	175		
<b>D. Total Speech Therapy Treatments</b>	<b>564</b>	<b>564</b>		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,787	2,787		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	2,274	2,274		
<b>D. Total Occupational Therapy Treatments</b>	<b>5,061</b>	<b>5,061</b>		

### Report of Expenditures - Salaries & Wages

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2016	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	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)	99,718	2,120				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	71,712	3,939				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	57,816	2,188				
c. Dietary Workers	170,719	13,513				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	84,819	6,395				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	93,395	4,519				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	26,891	1,781				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	50,341	2,557				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	136,724	3,681				
b. RN						
1. Direct Care	373,827	10,409				
2. Administrative**	85,945	2,814				
c. LPN						
1. Direct Care	275,001	10,258				
2. Administrative**						
d. Aides and Attendants	607,708	40,858				
e. Physical Therapists	12,666	301				
f. Speech Therapists	3,001	87				
g. Occupational Therapists	2,429	74				
h. Recreation Workers	52,426	2,969				
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	54,409	1,973				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	2,259,548	110,435				

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

Name of Facility				License No.	Report for Year Ended				Page	of
Wolcott Hall Nursing Center				1096-C	9/30/2016				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<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.

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Wolcott Hall Nursing Center				1096-C	9/30/2016			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>										
Gregory Hamley	99,718				Administrator 10/1/2015 - 9/30/2016	2,120	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		
Wolcott Hall Nursing Center	1096-C	9/30/2016	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						
2. Dentist	8,010	87				
3. Pharmacist	9,247	55				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	80,611	1,085				
b. Other						
6. Social Worker	560	18				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	43,200	110				
b. Utilization Review (Title 18 and 19 only) monthly meeting	800	8				
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) Eye Doctor, Orthopedist, Cardiologist	442	4				
9. Speech Therapist						
a. Resident Care	32,289	141				
b. Other						
10. Occupational Therapist						
a. Resident Care	92,020	1,265				
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	3,300	67				
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>270,479</b>	<b>2,840</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 Wolcott Hall Nursing Center		License No. 1096-C	Report for Year Ended 9/30/2016	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Healthdrive Dental 888 Worcester St. Wellesley, MA 02482	Dental	<input type="radio"/>	<input checked="" type="radio"/>		
West River Pharmacy of Connecticut LLC 41 Northwest Drive Plainville, CT 06062	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>		
Allstar Therapy 21 Waterville Rd. Avon, CT	Therapy Services	<input checked="" type="radio"/>	<input type="radio"/>	See Disclosure Pg. 4	
Diane J. Gracewski 32 Rock Hall Rd. Winsted, CT 06098	Social Service	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Jong OH PO Box 150472 Hartford, CT 06115-0472	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Dr, Ethan Nguyen PO Box 150472 Hartford, CT 06115-0472	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Frank Schildgen, MD. 69 Riverside Avenue Torrington, CT 06790	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Litchfield Hills Orthopedic Association 245 Alvord Park Road Torrington, CT 06790	Orthopedist	<input type="radio"/>	<input checked="" type="radio"/>		
The Eye Care Group PC 1201 West Main Street Waterbury, CT 06708	Eye Doctor	<input type="radio"/>	<input checked="" type="radio"/>		
Southern CT Vascular Center 495 Hawley Lane 2A Stratford, CT 06614	Cardiologist	<input type="radio"/>	<input checked="" type="radio"/>		
Pointright, Inc. 150 Cambridge Park Drive Cambridge, MA 02140	Data Integrity Audit	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Wolcott Hall Nursing Center	1096-C	9/30/2016		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 46,172	46,172			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 54,468	54,468			
4. Social Security (F.I.C.A.)	\$ 153,756	153,756			
5. Health Insurance	\$ 268,370	268,370			
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 22,456	22,456			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 13,244	13,244			
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*	\$ 151,403	151,403			
d. Accounting and Auditing	\$ 6,949	6,949			
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	\$ 8,879	8,879			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 17,098	17,098			
2. Cellular Phones	\$				
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$ 250	250			
k. Other Taxes ( <i>Not related to property - See Page 22</i> )					
1. Income*	\$				
2. Other ( <i>Specify</i> ) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 343,825	343,825			
<b>Subtotal</b>	<b>\$ 1,086,870</b>	<b>1,086,870</b>			

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

(Carry Subtotals forward to next page)



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

Name of Facility	License No.	Report for Year Ended	Page	of
Wolcott Hall Nursing Center	1096-C	9/30/2016	16	37
Item	Total	CCNH	RHNS	(Specify)
<b>Subtotals Brought Forward:</b>	1,086,870	1,086,870		
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$ 1,725	1,725		
3. Gifts to Staff and Residents	\$ 9,469	9,469		
4. Employee Travel	\$ 7,570	7,570		
5. Education Expenses Related to Seminars and Conventions	\$ 275	275		
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> )	\$ 40	40		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$			
3. Advertising Other ( <i>Specify</i> )***	\$ 2,831	2,831		
See Attached Schedule				
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	\$ 2,866	2,866		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> )	\$ 6,216	6,216		
See Attached Schedule				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 358	358		
9. Subscriptions	\$ 2,181	2,181		
10. Contributions***	\$ 300	300		
See Attached Schedule				
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$			
12. Administrative Management Services**	\$ 295,785	295,785		
13. Other ( <i>Specify</i> )	\$ 40,348	40,348		
See Attached Schedule				
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 1,456,835	1,456,835		

\* 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	\$ 2,831		
<b>Total Other Advertising</b>	\$ 2,831	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 5,937		
AANAC - RAC-CT Recertification; Individual Membership	\$ 279		
<b>Total Dues</b>	\$ 6,216	\$ -	\$ -

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
Oliver Wolcott Technical High School	\$ 300		
<b>Total Contributions</b>	\$ 300	\$ -	\$ -

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Corporate Fees - Non Reimbursable	\$ 26,206		
Licenses & Fees	\$ 1,931		
Pre Employment Screening	\$ 4,799		
Point Click Care Fees	\$ 8,325		
Bank Charges	\$ -		
Resident Expenses	\$ -		
Account Write Off	\$ 808		
Prior Period Adjustment	\$ (3,028)		
Use Tax Audit Payment	\$ 1,205		
SUTA Payment	\$ 77		
Business Entity Tax Payment	\$ 25		
Healthport Indirect	\$ -		
<b>Total Other Administrative and General</b>	\$ 40,348	\$ -	\$ -

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

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2016	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.	295,785	Accounting & Managerial Services	Pg. 16 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 9/30/2016	Page 18	of 37
<b>Item</b>	<b>Total</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 114,931	114,931		
2. Non-Food Supplies	\$ 16,886	16,886		
3. Other (Specify) _____	\$ _____			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 1,346	1,346		
c. Management Services**	\$ _____			
d. Other (Specify) _____	\$ _____			
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 133,163</b>	<b>133,163</b>		
<b>2F. Dietary Questionnaire</b>	<b>Total</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
G. Resident Meals: Total no. of meals served per day:*	146	146		
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.				
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 type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify cost.				
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.				
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
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="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify cost.				
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.				
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
Wolcott Hall Nursing Center		1096-C	9/30/2016	19	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. \$	3,503	3,503		
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. \$	2,064	2,064		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	65,227	65,227		
c. Management Services**	\$				
d. Other (Specify)	\$				
<b>3E. Total Laundry Expenditures (3a + b + c + d)</b>	<b>\$</b>	<b>70,794</b>	<b>70,794</b>		
<b>3F. Laundry Questionnaire</b>					
G. Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
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 laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue 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)				

\* 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		License No.	Report for Year Ended		Page	of
Wolcott Hall Nursing Center		1096-C	9/30/2016		20	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. \$	16,929	16,929		
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</b> (4a + b + c + d)	\$	16,929	16,929		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from West River Pharmacy	\$	50,757	50,757		
b.	Medicine Cabinet Drugs	\$				
c.	Medical and Therapeutic Supplies	\$	153,098	153,098		
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	6,739	6,739		
f.	X-rays and Related Radiological Procedures***	\$	3,845	3,845		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h.	Laboratory***	\$	2,894	2,894		
i.	Recreation	\$	12,833	12,833		
j.	Other (Specify)**** See Attached Schedule	\$	14,292	14,292		
5K.	<b>Total Resident Care Expenditures</b> (5a - 5j)	\$	244,459	244,459		

\* 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.



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

Name of Facility Wolcott Hall Nursing Center			License No. 1096-C		Report for Year Ended 9/30/2016				Page of 21   37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Cablevision of Litchfield	PO Box 9256 Chelsea, MA 02150-9256	<input type="radio"/>	<input checked="" type="radio"/>		Cable & Internet.	16,394			22	6A
Kenneth J. Zajac, Jr.	139 Turner Ave. Torrington, CT	<input type="radio"/>	<input checked="" type="radio"/>		Ground Maintenance.	14,421			22	6A
CWPM, LLC	PO Box 415 Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Refuse Removal.	10,707			22	6F
Unitex Textile Rental, SVC	PKWY Mt. Vernon, NY	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Services.	65,227			19	3B
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Wolcott Hall Nursing Center	1096-C	9/30/2016			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 108,700	108,700				
b. Heat	\$ 32,924	32,924				
c. Light & Power	\$ 36,526	36,526				
d. Water	\$ 10,339	10,339				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$					
f. Other ( <i>itemize</i> )	\$ 13,495	13,495				
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 201,984</b>	<b>201,984</b>				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 10,581	10,581				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 10,581</b>	<b>10,581</b>				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 29,973	29,973				
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 29,973</b>	<b>29,973</b>				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 384,000	384,000				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 42,968	42,968				
c. Personal property taxes	\$ 10,247	10,247				
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 477,769</b>	<b>477,769</b>				

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







Wolcott Hall Nursing Center  
9/30/2016

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 Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
6/27/2016	11 Kiosks for POC Implementation	\$ 16,319	ME-5	\$ 814
<b>Total additions for Movable Equipment</b>		\$ 16,319		\$ 814
<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>				
3/16/2016	Install Boiler Hot Water Mixing Valve	\$ 3,487	LHI-10	\$ 119
3/22/2016	Sink and Faucet Install - Storage Closet	\$ 3,762	LHI-20	\$ 64
3/22/2016	Sink and Faucet Supplies-Storage Closet	\$ 1,474	LHI-20	\$ 25
3/22/2016	Sink and Faucet Install - Dining Room	\$ 1,052	LHI-20	\$ 18
3/22/2016	Hot Water Recirculation Line Install	\$ 1,276	LHI-25	\$ 17
4/19/2016	Installed 100 Sprinkler Upright Pendants	\$ 2,675	LHI-10	\$ 86
5/2/2016	Install of 8 Dry Pendant Sprinkler Heads	\$ 2,250	LHI-10	\$ 70
7/19/2016	Installation of 49 Fire Sprinkler Heads	\$ 6,350	LHI-10	\$ 142
8/30/2016	Compressor & Filter Install-A/C Unit	\$ 2,944	LHI-15	\$ 26
8/30/2016	Compressor & Filter Install-A/C Unit	\$ 1,861	LHI-15	\$ 16
<b>Total additions for Leasehold Improvement</b>		\$ 27,131		\$ 583
<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 9/30/2016			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period				1,470,412	1,187,040	A		29,390	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				27,131				583	
C-4. Subtotal									29,973
<b>D. Total Amortization</b>									29,973

\* 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 9/30/2016	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 type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description	Total			
1. Date Land Purchased				
2. Date Structure Completed				
3. If <b>NOT</b> 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				
<b>Part B - Owner and Related Parties</b>	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)	See Attached			
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

**CT Medicaid Cost Report Attachment Page 25**

	Original Mortgage	
A. Type of Financing (e.g. fixed, variable)	Fixed	6 Month extension extension to 10/13/15 2.08% 6 month
B. Date of Mortgage Obtained	4/11/2008	
C. Interest Rate For the Cost Year	6.44%	
D. Term of Mortgage (number of years)	7 Yrs.	
E. Amount of Principal Borrowed	119,500,000	
F. Principal Balance Outstanding as of 9/30/	100,562,320	

12 month extension extension to 10/13/16 2.75% 12 months
---

Note: The following facilities are collateralized by this mortgage.

Connecticut Facilities

- Brightview Nursing & Retirement Center, Ltd.
- Rose Haven, Ltd.
- Mary Elizabeth Nursing Center, Inc.
- Fowler Nursing Center, Inc.
- Waterbury Extended Care Facility, Inc.
- Harbor View Nursing Center, Inc.
- Liberty Hall Nursing Center
- Orchard Grove Specialty Care
- Wolcott Hall Nursing Center, Inc.
- Hewitt Health and Rehabilitation Center, Inc.
- Watrous Nursing Center
- Elm Hill Nursing Center, Inc.
- Gardner Heights Health Care Center, Inc.
- Shelton lakes Health Care Center, Inc.
- Highview Health Care Center, Inc.
- Westfield Manor Health Care Center, Inc.
- TA Coccomo Memorial
- Plainville Health Care Center, Inc.
- Ledgecrest Health Care Center, Inc.
- Ridgeview Health Care Center, Inc.
- The Kent, Ltd.
- Chesterfields, Ltd.

Out of State Facilities

- Watch Hill Manor, Ltd.
- The Clipper Home, Inc.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Wolcott Hall Nursing Center	1096-C	9/30/2016	26	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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)	\$			

(Carry Subtotals forward to next page)



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

Name of Facility Wolcott Hall Nursing Center		License No. 1096-C		Report for Year Ended 9/30/2016		Page of 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)				\$			
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) Interest on Value Settlement, City Taxes, Capital Lease, a				\$	9,534	9,534	
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$	9,534	9,534	
14. Insurance							
a. Insurance on Property (buildings only)				\$	88,165	88,165	
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. <b>Total Insurance Expenditures (14a + b + c)</b>				\$	88,165	88,165	
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$	5,229,658	5,229,658	

### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Wolcott Hall Nursing Center				1096-C	9/30/2016	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	\$ 2,429	2,429		
4.			Other - See attached Schedule	\$			
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 92,020	92,020		
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 151,403	151,403		
10.	15	1d/e	Accounting & Legal	\$ 4,880	4,880		
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	m2/3	Unallowable Advertising *	\$ 2,831	2,831		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$ 300	300		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 33,915	33,915		
<b>Page 18 - Dietary Expenditures</b>							
24.	30	IV1	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)				\$ 287,778	287,778		

\* 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)
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

**Schedule of Fees Adjustments**

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

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fee - Non Reimbursable	\$ 26,206		
16	1.3	Employee Recognition/Gift/Parties	\$ 9,469		
16	m8a	Chamber of Commerce	\$ 358		
16	m13	SUTA Payment	\$ 77.02		
16	m13	Business Entity Tax Payment	\$ 25.00		
16	m13	Prior Period Adjustment	\$ (3,028.00)		
30	IV8	Account Write Off	\$ 0.10		
16	m13	Account Write Off	\$ 808.19		
<b>Total Other A&amp;G Adjustments</b>			\$ 33,915	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Wolcott Hall Nursing Center			1096-C	9/30/2016	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 287,778	287,778		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 50,757	50,757		
28.	16	L1	Ambulance/Limousine	\$			
29.	20	h	X-rays, etc	\$ 3,845	3,845		
30.	20	f	Laboratory	\$ 2,894	2,894		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 1,299	1,299		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 10,290	10,290		
<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.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.	30	IV 8	Purchase Discounts and Allowances	\$ 4,725	4,725		
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$ 8,368	8,368		
<b>Not For Profit Providers Only</b>							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	<b>Total Amount of Decrease (Items 1 - 50)</b>			\$ 369,957	369,957		

\*\*\* 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.

Wolcott Hall Nursing Center  
9/30/2016

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy Supplies	\$ 6,395		
20	5j	Rehab Service Supplies	\$ 3,895		
<b>Total Other Ancillary Costs</b>			\$ 10,290	\$ -	\$ -

**Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ -

**Schedule of Other Property Adjustments**

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12D	Value Settlement Interest	\$ 704		
27	12D	City Taxes Interest	\$ 7,621		
27	12D	2014 Business Entity Tax Interest	\$ 43		
<b>Total Other Adjustments</b>			\$ 8,368	\$ -	\$ -

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
Wolcott Hall Nursing Center	1096-C	9/30/2016	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> )	\$ 3,474,338	3,474,338		
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> )	\$ 299,375	299,375		
b. Medicare Room and Board Contractual Allowance **	\$ 88,526	88,526		
4. a. Private-Pay Residents and Other	\$ 514,375	514,375		
b. Private-Pay Room and Board Contractual Allowance **	\$			
<b>II. Other Resident Revenue</b>				
1. a. Prescription Drugs - Medicare	\$ 32,437	32,437		
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (32,437)	(32,437)		
c. Prescription Drugs - Non-Medicare	\$ 18,541	18,541		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (18,541)	(18,541)		
2. a. Medical Supplies - Medicare	\$			
b. Medical Supplies - Medicare Contractual Allowance **	\$			
c. Medical Supplies - Non-Medicare	\$			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$			
3. a. Physical Therapy - Medicare	\$ 128,521	128,521		
b. Physical Therapy - Medicare Contractual Allowance **	\$ (73,500)	(73,500)		
c. Physical Therapy - Non-Medicare	\$ 23,345	23,345		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (19,810)	(19,810)		
4. a. Speech Therapy - Medicare	\$ 23,626	23,626		
b. Speech Therapy - Medicare Contractual Allowance **	\$ (8,775)	(8,775)		
c. Speech Therapy - Non-Medicare	\$ 1,755	1,755		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (1,755)	(1,755)		
5. a. Occupational Therapy - Medicare	\$ 200,432	200,432		
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (94,034)	(94,034)		
c. Occupational Therapy - Non-Medicare	\$ 27,315	27,315		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (23,580)	(23,580)		
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.)	\$ 4,560,155	4,560,155		
<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> )	\$			
6. Private Duty Nurses' Fees	\$			
7. Barber, Coffee, Beauty and Gift shops	\$			
8. Other ( <i>Specify</i> )	\$ 4,725	4,725		
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 4,725	4,725		
<b>VI. Total All Revenue</b> (III +V)	\$ 4,564,880	4,564,880		

\* 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)
30 IV 5	Interest Income	562,602	\$ -		
<b>Total Interest Income</b>			\$ -	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV 8	Rebates	\$ 4,725		
30 IV 8	Account Write Off	\$ 0		
<b>Total Other Revenue</b>		\$ 4,725	\$ -	\$ -



### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Wolcott Hall Nursing Center	1096-C	9/30/2016	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	(2,937)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	562,602
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	17,494
5. Prepaid Expenses			\$	14,009
a. Prepaid Insurance				
b. Prepaid Property Tax		14,009		
c. Other Prepaid Expenses				
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
Due Affiliate (Debit Balance)				
A-9. <b>Total Current Assets</b> (Lines A1 thru 8)			\$	591,169
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 <u>1,497,543</u>		\$	280,530
	Accum. Depreciation <u>1,217,012</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>33,947</u>		\$	
	Accum. Depreciation <u>33,947</u>	Net		
6. Movable Equipment	*Historical Cost <u>285,436</u>		\$	33,810
	Accum. Depreciation <u>251,626</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	103
Fixed Asset Clearing Account				
Construction in Progress		103		
B-10. <b>Total Fixed Assets</b> (Lines B1 thru 9)			\$	314,443

\* 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
Wolcott Hall Nursing Center	1096-C	9/30/2016	32	37
Account			Amount	
Total Brought Forward:			\$	905,612
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> )			\$	
Loans Rec. - Officers/Owner				
Capitalized Refinance Expense				
Leasehold Deposits				
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)			\$	905,612

\* 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 Wolcott Hall Nursing Center		License No. 1096-C	Report for Year Ended 9/30/2016	Page 33	of 37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	153,213
2. Notes Payable ( <i>itemize</i> )				\$	
_____					
_____					
_____					
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> )				\$	59,575
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	5,270
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable ( <i>Current Portion</i> )				\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities ( <i>itemize</i> )				\$	1,114,787
Accrued PTO		108,941	Accrued Professional Fee	5,774	
Accrued Pension		2,936	Payroll W/H	3,828	
Accrued Worker's Comp		75,418	Due Affiliate (Credit Bal.	846,686	
Accrued Expense Other		71,205			
A-13. <b>Total Current Liabilities</b> (Lines A1 thru 12)				\$	1,332,845

\* 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 9/30/2016	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,332,845	
<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> )				\$ 1,157,988	
Name and Address of Lender	Amount	Loan Date			
Brian J. Foley	1,157,988	Demand			
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$	
Security Deposits					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 1,157,988	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 2,490,833	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Wolcott Hall Nursing Center	1096-C	9/30/2016	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			\$	1,355,029
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(2,276,472)
6. Gain or Loss for Period			\$	(664,777)
	10/1/2015	thru	9/30/2016	
7. Total Net Worth			\$	(1,585,220)
<b>C. Total Reserves and Net Worth</b>			\$	(1,585,220)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	905,612

### H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year Ended	Page	of
Wolcott Hall Nursing Center		1096-C	9/30/2016	36	37
Account				Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2015				\$	(1,617,284)
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$	4,564,880
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$	5,229,658
D. Net Income or Deficit				\$	(664,777)
E. Balance				\$	(2,282,061)
F. Additions					
1. Additional Capital Contributed ( <i>itemize</i> )					
Brian Foley		700,000			
2. Other ( <i>itemize</i> )					
F-3. Total Additions				\$	700,000
G. Deductions					
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )				\$	3,159
Name and Address ( <i>No., City, State, Zip</i> )		Title	Amount		
Brian Foley		President	3,159		
2. Other Withdrawings ( <i>Specify</i> )					
Purpose		Amount			
3. Total Deductions				\$	3,159
H. <b>Balance at End of Period</b>		09/30/16		\$	(1,585,220)

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

Name of Facility Wolcott Hall Nursing Center	License No. 1096-C	Report for Year Ended 9/30/2016	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)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
Robert Gwizdak				
Address Address			Phone Number	
21 Waterville Road Avon, CT 06001			(860) 678-9755	

Error Check

Level	Item	Reported as	
-	Page 35 - Total Liabilities, Reserves and Net Worth	905,612	Total Assets 905,612