

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) Robert C. Geer Memorial Hospital, Inc. D/B/A Geer Nursing and Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 99 South Canaan Road, Canaan, CT 06018	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022

License Numbers:	CCNH 843-C	RHNS	(Specify)	Medicare Provider 07-5202
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Medicaid Provider Numbers:	CCNH 000008433	RHNS	ICF-IID
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### For Department Use Only

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

## General Information

Name of Facility (as licensed) Robert C. Geer Memorial Hospital, Inc. D/B/A Geer	License No. N843-C	Report for Year Ended 9/30/2022	Page 1	of 37
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### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Robert C. Geer Memorial Hospital, Inc. D/B/A Geer Nursing and Rehabilitation Center [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

(a) Subject to Desk Audit review

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Kevin O'Connell			Printed Name (Owner)	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>				Page 1A	of 37
Name of Facility Robert C. Geer Memorial Hospital, Inc. D/B/A Geer Nursing and Rehabilitation Center	Period Covered: From 10/1/2021	To 9/30/2022			
Address of Facility 99 South Canaan Road, Canaan, CT 06018					
Report Prepared By Marcum LLP	Phone Number 203-781-9600	Date 3/29/2023			
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	Report for Year Ended	Page	of
860-824-5137	9/30/2022	2	37

Name of Facility (as shown on license) Robert C. Geer Memorial Hospital, Inc. D/B/A Geer Nursing	Address (No. & Street, City, State, Zip ) 99 South Canaan Road, Canaan, CT 06018		
License Numbers: 843-C	CCNH	RHNS	(Specify)
			Medicare Provider No. 07-5202

Type of Facility (Check appropriate box(es))

Chronic and Convalescent  
 Nursing Home only (CCNH)       Rest Home with Nursing  
 Supervision only (RHNS)       (Specify)

Type of Ownership (Check appropriate box)

Proprietorship     LLC     Partnership     Profit Corp.     Non-Profit Corp.     Government     Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed
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Has there been any change in ownership  
or operation during this report year?       Yes       No      If "Yes," explain fully.

N/A

**Administrator**

Name of Administrator Kevin O'Connell	Nursing Home Administrator's License No.: 1687
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Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name N/A	License No.:

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

# **General Information and Questionnaire**

## **Corporate Owners**

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc. D/B/A	843-C	9/30/2022	3A	37

If this facility is owned or operated as a corporation, provide the following information:

State of Connecticut

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

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**General Information and Questionnaire**  
**Individual Proprietorship**

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc. D/B/A Ged	843-C	9/30/2022	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

N/A

## General Information and Questionnaire

### Related Parties\*

Name of Facility Robert C. Geer Memorial Hospital, Inc. D/B/A Geer N	License No. 843-C	Report for Year Ended 9/30/2022			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.				
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the following information:				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party	
		Yes	No	%**				Description of Goods/Services Provided
Geer Corporation	99 South Canaan Road, North Canaan CT	<input type="radio"/>	<input checked="" type="radio"/>		Management Services	Pg 16 / Line m12	602,041	622,263
Geer Village	77 South Canaan Road, North Canaan CT	<input type="radio"/>	<input checked="" type="radio"/>		Marketing Services	Pg 16 / Line m3	31,248	31,248
Geer Foundation	77 South Canaan Road, North Canaan CT	<input type="radio"/>	<input checked="" type="radio"/>		Strategic Planning and Marketing Services	Pg 16 / Line m13	18,756	18,756
Conquest Consulting	30 Tower Lane, 4th Floor, Avon CT	<input type="radio"/>	<input checked="" type="radio"/>		Internet Marketing Consultant	Pg 16 / Line m13	18,000	18,000
Celtic Consulting	East Main Street, Suite 308, Torrington, CT	<input type="radio"/>	<input checked="" type="radio"/>		Outpatient Services	Pg 20 / Line 5L	225,045	225,045
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Robert C. Geer Memorial Hospital, Inc. D/B/A C	License No. 843-C	Report for Year Ended 9/30/2022	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

Note that due to accounting changes the cost report was prepared with only nursing facility related expenses, which is the cause of many ADH and transportation disallowances no longer being applicable.

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

N/A

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

Yes       No      If "No," explain fully why such allocation was not made.

N/A

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

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

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

Yes

○ No

**Total \*\*\*** 29,015

\* 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 Robert C. Geer Memorial Hospital,	License No. 843-C	Report for Year Ended 9/30/2022	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual     Cash     Modified Cash

Is the accounting basis for this

period the same as for the     Yes    If "No," explain.  
previous period?     No

N/A

#### Independent Accounting Firm

Name of Accounting Firm 1    Marcum LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 555 Long Wharf Drive, New Haven CT 06511
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Services Provided by This Firm (*describe fully*)

1    Accounting, audit and cost report preparation	\$    83,436
2	\$
3	\$
4	\$
	Charge for Services Provided \$    83,436

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

Yes     No    |Page 15, Line 1d

#### Legal Services Information

Name of Legal Firm or Independent Attorney 1    Various Probate Fees 2    DMC Law 3    Kainen, Escalera, & Michale 4    Various Legal Fees 5	Telephone Number N/A 203-687-6683 860-493-0870 N/A
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Address (No. & Street, City, State, Zip Code)

1    N/A 2    P.O. Box 817 North Haven CT 06473 3    21 Oak St # 601, Hartford, CT 06106 4    N/A 5	
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Services Provided by This Firm (*describe fully*)

1    Probate court (Disallowed on Pg. 28)	\$    4,646
2    Collections (Disallowed on Pg. 28)	\$    1,122
3    Employee relations	\$    9,675
4    Various - Will provide further detail in RFI	\$    987
5	\$
	Charge for Services Provided \$    16,430

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

Yes     No    |Page 15, Line 1e

## Schedule of Resident Statistics

Name of Facility Robert C. Geer Memorial Hospital, Inc. D/B/A Geer Nursing and Rehab			License No. 843-C				Report for Year Ended 9/30/2022				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					120	120						
A. On last day of PREVIOUS report period	120	120										
B. On last day of THIS report period	120	120							120	120		
2. Number of Residents					85	85						
A. As of midnight of PREVIOUS report period	85	85										
B. As of midnight of THIS report period	82	82							82	82		
3. Total Number of Days Care Provided During Period					2,031	2,031			597	597		
A. Medicare	2,628	2,628										
B. Medicaid (Conn.)	17,986	17,986			12,970	12,970			5,016	5,016		
C. Medicaid (other states)												
D. Private Pay	5,800	5,800			4,078	4,078			1,722	1,722		
E. State SSI for RCH												
F. Other (Specify) Managed Care	1,374	1,374			1,020	1,020			354	354		
G. Total Care Days During Period (3A thru F)	27,788	27,788			20,099	20,099			7,689	7,689		
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>	<b>27,788</b>	<b>27,788</b>			<b>20,099</b>	<b>20,099</b>			<b>7,689</b>	<b>7,689</b>		

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

Name of Facility Robert C. Geer Memorial Hospital, Inc. D/B/A	License No. 843-C	Report for Year Ended 9/30/2022	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?

 Yes No

If "YES", provide the following information:

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

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.

1st change	Change in Resident Days			CCNH	RHNS	(Specify)
	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)
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	8	56		18				
Per Diem Rate								
a. One bed rm.	Various	291.69		535.00				
b. Two bed rms.	Various	291.69		480.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		12,227	12,227		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		1,146	1,146		
2. Restorative Treatments					
C. Other		24,837	24,837		
D. <b>Total Physical Therapy Treatments</b>		38,210	38,210		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		5,748	5,748		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		539	539		
2. Restorative Treatments					
C. Other		11,675	11,675		
D. <b>Total Speech Therapy Treatments</b>		17,962	17,962		

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		20,445	20,445		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		1,426	1,426		
2. Restorative Treatments					
C. Other		25,675	25,675		
D. <b>Total Occupational Therapy Treatments</b>		47,546	47,546		

## Report of Expenditures - Salaries &amp; Wages

Name of Facility Robert C. Geer Memorial Hospital, Inc. D/B/A Geer Nursing	License No. 843-C	Report for Year Ended 9/30/2022		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
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	176,821	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	56,552	1,880				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	127,855	6,635				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	496,096	24,007				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	188,865	8,021				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	277,968	4,160				
b. RN						
1. Direct Care	833,959	13,980				
2. Administrative**	312,112	6,481				
c. LPN						
1. Direct Care	810,862	20,457				
2. Administrative**						
d. Aides and Attendants	1,602,334	75,486				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	188,461	8,151				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists	253,973	5,424				
l. Podiatrists						
m. Social Workers/Case Management	51,547	1,463				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	581,682	14,420				
<i>A-13. Total Salary Expenditures</i>	5,959,087	192,645				

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

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

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

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

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

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

State of Connecticut

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

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

Name of Facility Robert C. Geer Memorial Hospital, Inc. D/B/A Geer Nursing and Rehab			License No. 843-C		Report for Year Ended 9/30/2022			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

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

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

State of Connecticut

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

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Robert C. Geer Memorial Hospital, Inc. D/B/A Geer Nursing and Reha				843-C		9/30/2022			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Kevin O'Connell	176,821			Non Discriminatory	Administrator	2,080	A2			
<b>Section IV - Assistant Administrators</b>										
Dan Rupenski	56,552			Non Discriminatory	Assistant Administrator	1,880	A3			

\*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
	843-C	9/30/2022		13	37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)					
1. Dietitian	40,050	801			
2. Dentist	14,118	96			
3. Pharmacist					
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	247,171	3,076			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	78,900	315			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**					
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
9. Speech Therapist					
a. Resident Care	61,398	2,678			
b. Other					
10. Occupational Therapist					
a. Resident Care	175,444	1,617			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	90,843	792			
2. Administrative***					
b. LPN					
1. Direct Care	62,502	850			
2. Administrative***					
c. Aides	286,771	7,027			
d. Other					
12. Other (Specify)					
See Attached Schedule	500	10			
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	1,057,697	17,262			

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

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

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

## Report of Expenditures

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Laura W. Koski, RD, 339 Washington Rd, Terryville, CT 06786	Dietician	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Healthdrive Dental Group, PO Box 22010, New York, NY 10087	Dentist	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Preferred Therapy Solutions; 850 Silas Deane Hwy, 2nd Floor, Wethersfield, CT 06109	PT ST OT	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
InHouse Care LLC, 276 Highland Ave., Suite 2A, Waterbury, CT 06708	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Amor Lomibao, 6 Frey Road, Canton, CT 06019	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Geron Nursing & Respite Care, Inc 42 Main St New Milford	RN Staffing	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
MAS Medical Staffing, 1 Federal St bldg 101, Springfield, MA 01105	LPN & Aides Staffing	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Karen Cornell, LCSW, 220 Cider Crossing, Torrington, CT 06790	Clinical Services	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Fusion Staffing, 47 Maple St # L10, Summit, NJ 07901	RN Staffing	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
CareStaff Partners, 4279 Spring Run Rd, Mechanicsville, VA 23116	Aides Staffing	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
SVNA Home Assistance; 342 Main St, PO Box 406, Lakeville, CT 06039	Aides Staffing	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" 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
Robert C. Geer Memorial Hospital, Inc. D/B/A G	843-C	9/30/2022	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 172,748	172,748		
2. Disability Insurance	\$ 30,549	30,549		
3. Unemployment Insurance	\$ 29,714	29,714		
4. Social Security (F.I.C.A.)	\$ 459,957	459,957		
5. Health Insurance	\$ 658,141	658,141		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$			
9. Other (Specify) See Attached Schedule	\$ 23,283	23,283		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 740,000	740,000		
d. Accounting and Auditing	\$ 83,436	83,436		
e. Legal (Services should be fully described on Page 7)	\$ 16,430	16,430		
f. Insurance on Lives of Owners and Operators (Specify)*	\$			
g. Office Supplies	\$ 13,279	13,279		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 46,450	46,450		
2. Cellular Phones	\$ 3,188	3,188		
i. Appraisal (Specify purpose and attach copy)*	\$			
j. Corporation Business Taxes (franchise tax)	\$			
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$			
2. Other (Specify) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 535,085	535,085		
<b>Subtotal</b>	\$ 2,812,260	2,812,260		

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

**Schedule of Other Employee Benefits**

Description	CCNH	RHNS	(Specify)
EMPLOYEE TESTS - TB, OSHA, ETC	\$ 9,402		
INFECTION CONTROL	400		
403b Employer Match	12,934		
PHARM-EMPLOYEE OTC (Disallowed on Pg 28a)	547		
<b>Total</b>	<b>\$ 23,283</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Taxes**

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		16	37
Item		Total	CCNH	RHNS	(Specify)
	<b><i>Subtotals Brought Forward:</i></b>	2,812,260	2,812,260		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 30,170	30,170			
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 2,068	2,068			
5. Education Expenses Related to Seminars and Conventions	\$ 2,719	2,719			
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$ 8,974	8,974			
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 16,806	16,806			
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 31,248	31,248			
4. Fund-Raising***	\$				
5. Medical Records	\$ 152	152			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$ 10,228	10,228			
7. Postage	\$ 5,364	5,364			
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 8,516	8,516			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 500	500			
9. Subscriptions	\$ 6,361	6,361			
10. Contributions*** See Attached Schedule	\$ 652	652			
11. Services Provided by Contract ( <i>Specify and Complete     Schedule C-2, Page 21 for each firm or individual</i> )	\$ 317,962	317,962			
12. Administrative Management Services**	\$ 602,041	602,041			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 75,371	75,371			
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$ 3,931,392	3,931,392			

\* 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>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Marketing Expenses (Disallowed on Pg 28)	\$ 31,248		
<b>Total Other Advertising</b>	<b>\$ 31,248</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
CAHCF Dues	\$ 8,206		
ACHCA Dues	310		
<b>Total Dues</b>	<b>\$ 8,516</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
Donations (Disallowed on Pg 28)	\$ 652		
<b>Total Contributions</b>	<b>\$ 652</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Fundraising Expenses (Disallowed on Pg 28a)	\$ 18,756		
PERMITS	180		
EMPLOYEE RECOGNITION (Disallowed on Pg 28a)	12,323		
TUITION REIMBURSEMENT (Disallowed on Pg 28a)	5,440		
BANK AND CREDIT CARD FEES	3,051		
FINANCE CHARGES (Disallowed on Pg 28a)	8,487		
Civil Penalty (Disallowed on Pg 28a)	6,120		
Fine (Disallowed on Pg 28a)	1,310		
Marketing Expense (Disallowed on Pg 28a)	19,704		
<b>Total Other Administrative and General</b>	<b>\$ 75,371</b>	<b>\$ -</b>	<b>\$ -</b>

State of Connecticut

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

CSP-17 Rev. 10/97

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

Name of Facility	License No.	Report for Year Ended	Page of
Robert C. Geer Memorial Hospital, Inc. D	843-C	9/30/2022	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 #
Geer Corporation- Canaan CT	602,041	Mgmt of Facility, HR, Maintenance, AP, AR and Benefits	Page 16 / Line m12

**\* In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.**

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

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc. D/B/A Geer N	843-C	9/30/2022	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 219,574	219,574		
2. Non-Food Supplies	\$ 40,706	40,706		
3. Other (Specify) _____	\$ _____			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ _____			
c. Other (Specify) _____	\$ _____			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 260,280</b>	<b>260,280</b>		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
H. Did you receive revenue from employees? <input checked="" type="radio"/> Yes <input type="radio"/> No			If yes, specify amt.	\$924
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg 30 Line IV 1
Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.	
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.	
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility Robert C. Geer Memorial Hospital, Inc. D/B/A Geer Nur	License No. 843-C	Report for Year Ended 9/30/2022	Page of 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. \$			
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. \$			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$	72,552	72,552	
c. Other (Specify) Soap / Supplies	\$	2,643	2,643	
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	<b>75,195</b>	<b>75,195</b>	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H. Where is the revenue received reported in the Cost Report?			(Page/Line Item)	
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K. Where is the revenue received reported in the Cost Report?			(Page/Line Item)	

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 32,677	32,677		
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 342,400	342,400		
C. Other ( <i>Specify</i> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>375,077</b>	<b>375,077</b>		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$	772,524	772,524		
2. Purchased from	\$				
b. Medicine Cabinet Drugs	\$	166,042	166,042		
c. Medical and Therapeutic Supplies	\$	25,512	25,512		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	36,238	36,238		
f. X-rays and Related Radiological Procedures***	\$				
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$				
i. Recreation	\$	51,338	51,338		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other ( <i>Specify</i> )**** <i>See Attached Schedule</i>	\$	346,350	346,350		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>1,398,004</b>	<b>1,398,004</b>		

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

\*\* Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

\*\*\* Facility should self-disallow the expense on Page 29 of the Cost Report.

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

**Schedule of Other Resident Care**

Description	CCNH	RHNS	(Specify)
MEDICAL SERVICES - OTHER	\$ 7,061		
PATIENT SUPPLIES - REHAB (Disallowed on Pg 29a)	7,953		
Lost Resident Items (Disallowed on Pg 29a)	770		
MEDICARE ADD-ON EXPENSES (Disallowed on Pg 29a)	28,545		
Outpatient Supplies & Expenses (Disallowed on Pg 29a)	271,665		
ST Supplies	13,205		
PHARMACY CONTRACTED SERVICES	11,168		
PHARM-SOFTWEAR EXPENSE	370		
Inpatient Therapy	5,613		
<b>Total Other Resident Care</b>	<b>\$ 346,350</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility Robert C. Geer Memorial Hospital, Inc. D/B/A Geer Nursing and Rehabilita				License No. 843-C	Report for Year Ended 9/30/2022				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
Ability Network Inc.	Minneapolis, MN 55485-6015	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Medicare services	17,228			16	m11
Datahal, LLC	730 Hayden Hill Road, Torrington, CT 06790	<input type="radio"/>	<input checked="" type="radio"/>	N/A	IT Support	78,676			16	m11
PointClickCare Technologies Inc.	PO Box 674802, Detroit, MI 48267-4802	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Software Services	39,579			16	m11
Paycom	Oklahoma City, OK 73142	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Payroll services	62,193			16	m11
Conquest	PO Box 416, Avon CT 06001	<input checked="" type="radio"/>	<input type="radio"/>	Related party	Internet marketing consultant	18,000			16	m13
Unitex Textile Rental Services	Pkwy, Mount Vernon, NY 10550-1700	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Laundry purchased services	72,552			19	3b
EMS, LLC	245 Main St, Suite 204, Chester, NJ 07930	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Housekeeping purchased services	342,400			20	4b
Kone Brooklyn, PO Box 22251	New York, NY 10087-2251	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Elevator services	17,113			22	6f
USA Waste and Recycling, Inc.	P.O. Box 1000, East Windsor, 06088	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Trash removal	33,029			22	6f
Celtic Consulting	Plaza, 507 E Main St #308, Torrington, CT	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Outpatient services	225,045			20	5L
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

\* List all contracted services over \$10,000. Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

\*\*\* Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended		Page of
		9/30/2022		22   37
Item		Total	CCNH	RHNS
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance	\$	15,850	15,850	
b. Heat	\$	103,490	103,490	
c. Light & Power	\$	73,067	73,067	
d. Water	\$	29,639	29,639	
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	29,015	29,015	
f. Other <i>(itemize)</i>	\$	147,557	147,557	
See Attached Schedule				
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$	398,618	398,618	
7. Depreciation <i>(complete schedule page 23*)</i>				
a. Land Improvements	\$	2,756	2,756	
b. Building & Building Improvements	\$	79,058	79,058	
c. Non-Movable Equipment	\$	8,012	8,012	
d. Movable Equipment	\$	58,130	58,130	
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$	147,956	147,956	
8. Amortization <i>(Complete att. Schedule Page 24*)</i>				
a. Organization Expense	\$			
b. Mortgage Expense	\$	344	344	
c. Leasehold Improvements	\$			
d. Other <i>(Specify)</i>	\$			
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$	344	344	
9. Rental payments on leased real property less real estate taxes included in item 10b	\$			
10. Property Taxes				
a. Real estate taxes paid by owner	\$			
b. Real estate taxes paid by lessor	\$			
c. Personal property taxes	\$			
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$	148,300	148,300	

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

**Schedule of Other Repairs and Maintenance**

Description	CCNH	RHNS	(Specify)
CONTRACT MAINT SERVICES	\$ -		
O/S Plum,Heat, Refrig	10,112		
O/S Elevators	11,624		
O/S State Required	17,857		
O/S Miscellaneous	21,863		
TRASH REMOVAL	6,134		
Supplies-State Required	33,029		
Supplies-Miscellaneous	1,495		
LANDSCAPING/SNOW REMOVAL	5,649		
Landscaping	4,825		
Snow Removal	615		
INTERNET SERVICES	195		
	34,159		
<b>Total Other Repairs and Maintenance</b>	<b>\$ 147,557</b>	<b>\$ -</b>	<b>\$ -</b>

## Depreciation Schedule

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

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

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

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

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

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

\*\*Ties to Page 23, Line C3

## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
FY2022	Accushield	Administrative	\$ 6,883	5	\$ 1,377
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
<b>Total additions for Movable Equipment</b>			<b>\$ 6,883</b>		<b>\$ 1,377</b>
Deletions:					
<b>Total deletions for Movable Equipment</b>			<b>\$ -</b>		<b>\$ -</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
Additions:				
<b>Total additions for Leasehold Improvements</b>		<b>\$ -</b>		<b>\$ -</b>
Deletions:				
<b>Total deletions for Leasehold Improvements</b>		<b>\$ -</b>		<b>\$ -</b>

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

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## Amortization Schedule\*

Name of Facility Robert C. Geer Memorial Hospital, Inc. D/B/A Geer Nursing			License No. 843-C		Report for Year Ended 9/30/2022			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Mortgage Expense	Var	Var		91,230	45,661	S/L		344	
2.									
3.									
B-4. Subtotal									344
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									344

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

- Minimum of 5 years or 60 months.
- Life of mortgage; OR
- Remaining Life of Lease; OR
- Actual Life if owned by Related Party.

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

Name of Facility Robert C. Geer Memorial Hospital, Inc	License No. 843-C	Report for Year Ended 9/30/2022	Page 25	of 37
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#### 11. Property Questionnaire

##### Part A

Is the property either owned by the Facility  
or leased from a Related Party?

Yes

No

If "Yes," complete Part B.  
If "No," complete Part C.

\*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	120			
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				

##### Part B - Owner and Related Parties

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed	Fixed		
b. Date Mortgage Obtained	03/01/18	01/28/21		
c. Interest Rate for the Cost Year	3.63%	2.88%		
d. Term of Mortgage (number of years)	35	35		
e. Amount of Principal Borrowed	21,946,900	21,946,000		
f. Principal balance outstanding as of 9/30/2022		2,134,713	***	

##### Complete if Mortgage was Refinanced

###### During Current Cost Year

g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

##### Part C - Arms-Length Leases for Real Property Improvements Only

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.

\*\*\* Balance outstanding only includes amount for Geer Nursing

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage		\$ 63,000	63,000			
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)		\$ 63,000	63,000			

(Carry Subtotals forward to next page )

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:			63,000	63,000		
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)		\$				
<b>13. Total All Interest Expense (12B7 + 12C3 + 12D)</b>		\$	63,000	63,000		
14. Insurance						
a. Insurance on Property (buildings only)		\$	42,958	42,958		
b. Insurance on Automobiles		\$	2,906	2,906		
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$				
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$	26,854	26,854		
D&O Insurance						
<b>14d. Total Insurance Expenditures (14a + b + c)</b>		\$	72,718	72,718		
<b>15. Total All Expenditures (A-13 thru C-14)</b>		\$	13,739,368	13,739,368		

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

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		843-C	9/30/2022	28   37	
			Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b><i>Page 10 - Salaries and Wages</i></b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 752,363	752,363		
<b><i>Page 13 - Professional Fees</i></b>							
5.			Resident Care Physicians **	\$			
6.	13	b10a	Occupational Therapy	\$ 175,444	175,444		
7.			Other - See attached Schedule	\$ 500	500		
<b><i>Pages 15 &amp; 16 - Administrative and General</i></b>							
8.	15	1a9	Discriminatory Benefits	\$ 547	547		
9.	15	1c	Bad Debts	\$ 740,000	740,000		
10.			Accounting	\$			
10a.			Legal	\$ 5,768	5,768		
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 388	388		
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 *	\$ 31,248	31,248		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$ 652	652		
21.	16	m12	Unallowable Management Fees	\$ 23,560	23,560		
22.	16	m6	Barber and Beauty	\$ 10,228	10,228		
23.			Other - See attached Schedule	\$ 72,640	72,640		
<b><i>Page 18 - Dietary Expenditures</i></b>							
24.	30	IV1	Meals to employees, guests and others who are not residents	\$ 924	924		
<b><i>Page 19 - Laundry Expenditures</i></b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b><i>Page 20 - Housekeeping Expenditures</i></b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 1,814,262	1,814,262			

\* All except "Help Wanted".

(Carry Subtotal forward to next page )

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

**Schedule of Other Salaries Adjustment**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12o	Outpatient Rehab	\$ 498,390		
10	A12o	Pharmacist	253,973		
<b>Total Other Salaries Adjustment</b>			\$ 752,363	\$ -	\$ -

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	b12o	Outside Clinical Services	\$ 500		
<b>Total Other Fees Adjustments</b>			\$ 500	\$ -	\$ -

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Fundraising Expenses	\$ 18,756		
16	m13	EMPLOYEE RECOGNITION	12,323		
16	m13	TUITION REIMBURSEMENT	5,440		
16	m13	FINANCE CHARGES	8,487		
16	m13	Civil Penalty	6,120		
16	m13	Fine	1,310		
16	m13	Marketing Expense	19,704		
16	m8a	Chamber Dues	500		
<b>Total Other A&amp;G Adjustments</b>			\$ 72,640	\$ -	\$ -

State of Connecticut

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

Name of Facility			License No.	Report for Year Ended		Page of	
Robert C. Geer Memorial Hospital, Inc. D/B/A Geer Nursing			843-C	9/30/2022		29   37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 1,814,262	1,814,262		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 772,524	772,524		
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$			
30.			Laboratory	\$			
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 36,238	36,238		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 343,755	343,755		
<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	\$ 344	344		
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$ 206,060	206,060		
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 51,247	51,247		
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation				
			Unallowable Building Interest -				
			See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 3,224,430	3,224,430		

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

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	51	Therapy Supplies (See Attached)	\$ 3,646		
20	51	Lost Resident Items	770		
20	51	MEDICARE ADD-ON EXPENSES	28,545		
20	51	Outpatient Supplies & Expenses (See Attached)	271,665		
20	5c	Patient Specific Beds (See Attached)	2,557		
20	5i	Cable Television Disallowance (See Attached)	36,572		
<b>Total Other Ancillary Costs</b>			<b>\$ 343,755</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Excess Movable Equipment Depreciation**

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

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	8b	Mortgage Amortization	\$ 344		
<b>Total Other Property Adjustments</b>			<b>\$ 344</b>	<b>\$ -</b>	<b>\$ -</b>

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

Attachment Page 29

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

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

### **Schedule of Unallowable Building Interest**

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended		Page of	
		9/30/2022		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> )	\$ 8,331,792	8,331,792			
b. Medicaid Room and Board Contractual Allowance **	\$ (3,229,400)	(3,229,400)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,271,647	1,271,647			
b. Medicare Room and Board Contractual Allowance **	\$ (316,399)	(316,399)			
4. a. Private-Pay Residents and Other	\$ 3,620,502	3,620,502			
b. Private-Pay Room and Board Contractual Allowance **	\$ (584,872)	(584,872)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 84,518	84,518			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$ 987,445	987,445			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
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	\$ 314,785	314,785			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 963,261	963,261			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 93,960	93,960			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 59,760	59,760			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 282,800	282,800			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 122,270	122,270			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 14,457	14,457			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 4,204	4,204			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 12,020,730	12,020,730			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$ 924	924			
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$ 32	32			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$ 6,569	6,569			
8. Other ( <i>Specify</i> )	\$ 417,006	417,006			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 424,531	424,531			
<b>VI. Total All Revenue</b> (III +V)	\$ 12,445,261	12,445,261			

\* 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)
30 II 6a	LAB REV/MED A	\$ 9,130		
30 II 6a	X-RAY REV/MED A	5,327		
<b>Total Other Resident Revenue - Medicare</b>		<b>\$ 14,457</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Non-Medicare Resident Revenue****Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30 II 6b	LAB REVENUE - PRIVATE PAY	\$ 21		
30 II 6b	LAB REVENUE - MEDICAID	83		
30 II 6b	LAB REVENUE - MANAGED CARE	1,505		
30 II 6b	X-RAY MEDICAID	268		
30 II 6b	X-RAY MANAGED CARE	2,327		
<b>Total Other Resident Revenue</b>		<b>\$ 4,204</b>	<b>\$ -</b>	<b>\$ -</b>

**Interest Income****Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30 IV 5	Interest Income on Cash Accounts	N/A	\$ 32		
<b>Total Interest Income</b>		<b>\$ 32</b>	<b>\$ -</b>	<b>\$ -</b>	

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV 8	ADMINISTRATIVE INCOME (Disallowed on Pg 29a)	\$ 31,921		
30 IV 8	GRANT INCOME	370,834		
30 IV 8	TRANSPORTATION INCOME (Disallowed on Pg 29a)	14,251		
<b>Total Other Revenue</b>		<b>\$ 417,006</b>	<b>\$ -</b>	<b>\$ -</b>

**G. Balance Sheet**

Name of Facility	License No.	Report for Year Ended	Page of
Robert C. Geer Memorial Hospital, Inc.	843-C	9/30/2022	31   37
Account			Amount
<b>Assets</b>			
A. Current Assets			
1. Cash ( <i>on hand and in banks</i> )			\$ 136,319
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 2,841,641
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$
4. Inventories			\$
5. Prepaid Expenses			\$ 95,050
a. _____			
b. _____			
c. _____			
d. See Schedule			95,050
6. Interest Receivable			\$
7. Medicare Final Settlement Receivable			\$
8. Other Current Assets ( <i>itemize</i> )			\$
_____			
_____			
See Schedule			
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 3,073,010
B. Fixed Assets			
1. Land			\$ 137,129
2. Land Improvements	*Historical Cost	144,976	\$ 8,972
	Accum. Depreciation	136,004	Net
3. Buildings	*Historical Cost	3,129,858	\$ 676,914
	Accum. Depreciation	2,452,944	Net
4. Leasehold Improvements	*Historical Cost	_____	\$
	Accum. Depreciation	_____	Net
5. Non-Movable Equipment	*Historical Cost	80,118	\$ 64,094
	Accum. Depreciation	16,024	Net
6. Movable Equipment	*Historical Cost	876,798	\$ 186,314
	Accum. Depreciation	690,484	Net
7. Motor Vehicles	*Historical Cost	62,148	\$
	Accum. Depreciation	62,148	Net
8. Minor Equipment-Not Depreciable			\$
9. Other Fixed Assets ( <i>itemize</i> )			\$ 1,581,855
See Schedule			1,581,855
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$ 2,655,278

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

(Carry Total forward to next page)

**Schedule of Prepaid Expenses Page 31 Line A5**

Page Ref	Line Ref	Description	
	31 A5	PREPAID INS-COMM/PROP/LIAB	\$ 20,278
	31 A5	PREPAID INS-AUTO PACKAGE	1,485
	31 A5	PREPAID INS-D & O LIAB	14,328
	31 A5	Prepaid Water & Sewer	4,559
	31 A5	PREPAID FINANCING FEES	54,400
<b>Total Prepaid Expenses</b>			\$ 95,050

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

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

Page Ref	Line Ref	Description	
	31 B9	F/S vs C/R NBV	\$ (4,243)
	31 B9	CONSTRUCTION IN PROGRESS	20,949
	31 B9	CIP - 12 IL Apt Addition	10,000
	31 B9	CIP - NURSING ADDITION	1,555,148
	31 B9	Rounding	1
<b>Total Other Other Fixed Assets (Itemize)</b>			\$ 1,581,855

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

Page Ref	Line Ref	Description	
<b>Total Other Assets</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			\$ -

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

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

## G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Robert C. Geer Memorial Hospital, Inc.	843-C	9/30/2022	32   37
Account			Amount
Total Brought Forward:			\$ 5,728,288
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			\$
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$
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> )			\$ 2,962,364
Name and Address	Amount	Loan Date	
Due from Related Parties	2,962,364		
7. Other Assets ( <i>itemize</i> )			\$ 82,817
PATIENT TRUST FUNDS	62,394		
SUSPENSE	20,423		
See Schedule			
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$ 3,045,181
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$ 8,773,469

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

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

Name of Facility	License No.	Report for Year Ended	Page
Robert C. Geer Memorial Hospital, Inc. D/B/A	843-C	9/30/2022	33   37
Account			Amount
<b>Liabilities</b>			
A. Current Liabilities			
1. Trade Accounts Payable			\$ 2,088,307
2. Notes Payable ( <i>itemize</i> )			\$ 38,595
<u>CURRENT PORTION - HUD</u>			38,595
<hr/>			
<hr/>			
See Schedule			
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )			\$
Name of Lender		Purpose	Amount
			Date Due
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )			\$ 389,512
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$
6. Accrued Payroll Taxes Payable			\$
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> )			\$ 1,088,706
<u>CT USER TAX PAYABLE</u>			136,932 HRA DEDUCTIBLE 29,868
<u>PATIENT FUNDS PAYABLE</u>			62,454 ACCRUED LEGAL/PRC 22,367
<u>DEFERRED INCOME</u>			822,000
<u>FLEX SPENDING PAYABLE</u>			15,085 See Schedule
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)			<b>\$ 3,605,120</b>

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

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

Name of Facility Robert C. Geer Memorial Hospital, Inc. D/B	License No. 843-C	Report for Year Ended 9/30/2022	Page 34	of 37
Account			Amount	
Total Brought Forward:			3,605,120	
<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				\$ 2,134,713
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ (11,461)
HUD FINANCING COSTS				(12,034)
AMORIZATION-FINANCE COSTS				573
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 2,123,252
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 5,728,372

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

Name of Facility	License No.	Report for Year Ended	Page	of
Robert C. Geer Memorial Hospital, Inc	843-C	9/30/2022	35	37
Account				Amount
<b>A. Reserves</b>				
1. Reserve for value of leased land				\$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				\$
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )				\$
4. Reserve for leasehold real properties on which fair rental value is based				\$
5. Reserve for funds set aside as donor restricted				\$
6. Total Reserves				\$
<b>B. Net Worth</b>				
1. Owner's Capital				\$
2. Capital Stock				\$
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ 4,359,730
6. Gain or Loss for Period 10/1/2021 thru 9/30/2022				\$ (1,314,633)
7. Total Net Worth				\$ 3,045,097
<b>C. Total Reserves and Net Worth</b>				\$ 3,045,097
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 8,773,469

## **H. Changes in Total Net Worth**

Name of Facility Robert C. Geer Memorial Hospital, Inc.	License No. 843-C	Report for Year Ended 9/30/2022	Page 36	of 37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ 4,079,750
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 12,445,261
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 13,759,894
D. Net Income or Deficit				\$ (1,314,633)
E. Balance				\$ 2,765,117
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
Total Expenses per Page 27	\$13,739,368			
F/S vs C/R Depreciation	20,526			
Total Expenses per FS	\$13,759,894			
2. Other ( <i>itemize</i> )				
Prior Period Adjustment	279,980			
F-3. Total Additions				\$ 279,980
G. Deductions				
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )				\$
Name and Address (No., City, State, Zip )		Title	Amount	
2. Other Withdrawals ( <i>Specify</i> )				\$
Purpose		Amount		
3. Total Deductions				\$
H. <b>Balance at End of Period</b>	09/30/22			\$ 3,045,097

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

Name of Facility Robert C. Geer Memorial Hospital, Inc.	License No. 843-C	Report for Year Ended 9/30/2022	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

### Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer  Matthew S. Bavolack		
Address 555 Long Wharf Drive, New Haven, CT 06511		Phone Number 203-781-9600
Contacted Person Regarding Additional Information Needed Regarding This Report Shaun Powell		Phone Number 860-824-3860
Contact Email Address  spowell@geercares.org		