THE CONTINUING CARE AT HOME PROGRAM

SENIOR CHOICE AT HOME®

Disclosure Statement

July, 2020

SPONSORED BY

JEWISH SENIOR SERVICES
4200 Park Avenue
Bridgeport, Connecticut 06604
(203) 365-6491

***Senior Choice at Home*® is registered with the State of Connecticut Department of Social Services pursuant to Sections 17b-520 through 17b-535 of the Connecticut General Statutes.**

Registration with the Department of Social Services does not constitute approval, recommendation or endorsement by the Department or the State of Connecticut, nor does it evidence the accuracy or completeness of the information provided in this Disclosure Statement.

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INDEX OF REQUIRED PROVISIONS

INDEX CROSS REFERENCE
In compliance with Conn. Agencies Regs. § 17b-533-3 (a) (3).

General Information

This Disclosure Statement is provided pursuant to Connecticut law by The Jewish Home for the Elderly of Fairfield County, Inc. d/b/a Jewish Senior Services ("Provider") to a prospective Member ("Member") of The Senior Choice Continuing Care at Home Program ("CCAH Program"). Connecticut law requires the Provider to provide the prospective Member with a disclosure statement before the initial transfer of funds and before the prospective Member enters into any agreement with the Provider.

Description

Name and Type of Organization

The Provider is a not-for-profit corporation organized under the laws of the State of Connecticut and exempt from taxation under Section 501(c) (3) of the Internal Revenue Code. The Provider is the owner of a 9-acre health care complex known as The Jewish Home of Fairfield County ("the Community") located at 4200 Park Avenue in Bridgeport, Connecticut. The Provider has decades of experience in providing services to the elderly, and the Community features one of the largest Skilled Nursing Facilities in the State of Connecticut. The Skilled Nursing Facility accepts most forms of insurance, including Medicare and Medicaid. In addition to the Skilled Nursing Facility, the Community offers Assisted Living, Adult Day Care, Medical and Non-Medical Home Care, Hospice, Physician Services, Outpatient, Sub-Acute, and Long-Term Rehabilitation Therapy, and the Institute on Aging.

Through the on-going management of the Community, Provider provides quality continuing care as described further in this Disclosure Statement, including the attached Member Agreement. The Provider's goal is to allow Members to continue an independent lifestyle and to provide the peace of mind associated with knowing that certain additional attention and care is available if ever needed through the care and services offered by the CCAH Program. The CCAH Program is designed to allow Members to remain in their private homes while enjoying the traditional benefits of a Continuing Care Retirement Facility.

Affiliations

The Provider is the only organization responsible for the CCAH Program, and it has arranged for the Program's start up financing and management. Similarly, the Provider works closely with a separate physician practice, Geriatric Professional Group, LLC ("GPG"). GPG provides physician services to residents of the Community's Skilled Nursing Facility as well as outpatient physician services. GPG has no responsibility for the Provider's financial or contractual obligations.

Benefits/Services Provided

In order to participate in the CCAH Program, Member must execute a Member Agreement. Please refer to a copy of the Provider's standard Member Agreement in Exhibit I. The Provider currently offers three pricing plans. Each plan requires payment of a Membership Fee and a Monthly Service Fee. All plans cover 100% of the cost of care coordination, emergency response system, home inspection and delivered meals if these services are authorized by the Care Coordinator. Some plans require co-pays or payment in full for some of the services delivered, depending on the type of membership selected. Following is a summary description of the three pricing plans. Please refer to Exhibit II for a detailed description of the plans and the current Membership and Monthly Service Fees associated with each plan.

All-Inclusive Plan: No co-pay required and 100% coverage of specified and authorized services, including home health aide, companion, delivered meals, adult day care, assisted living facility and skilled nursing facility services.

Security Plan: 15% co-pay required for specified home health aide, companion and adult day care services and 30% co-pay for assisted living facility and skilled nursing facility.

Co-Pay Plan: 50% co-pay for specified home health aide, companion, adult day care, assisted living facility and skilled nursing facility services.

The Provider will deliver services in a manner consistent with the objective of enabling the Member to maintain his/her own living arrangement at home for as long as is practical and to provide Facility Based Services if and when needed.

The CCAH Program includes the following services and programs, which, unless noted otherwise below, will be provided in exchange for payment of the Membership Fee and Monthly Service Fee discussed below, with no additional charge under the All-Inclusive Plan and applicable co-pays under the Security and Co-Pay Plans:

A. Residence. The Member will remain in his/her existing home (or subsequent residence of the Member's choice).

B. Member Home Inspection. During the first year of Membership, Provider will conduct an inspection of the Member's home to identify any functional or safety problems for Member, and will make recommendations to the Member based on the inspection. This inspection will not identify physical or environmental problems with the premises, such as roof, plumbing, HVAC issues. It will focus only on functional and safety issues for the Member. After the initial inspection, the Provider will conduct an inspection every second year, unless circumstances or the Member's health condition justify more frequent inspections.

C. Annual Physical Examination. The Provider encourages the Member to have an annual physical examination performed by the Member's personal physician or by one of Provider's physicians or nurse practitioners. The Provider encourages the Member to submit a medical report from the Member's personal physician to the Care Coordinator.

D. Care Coordination. A Care Coordinator will be assigned to the Member. The Care Coordinator will lead the Care Coordination Team, consisting of an Authorized Senior Choice at Home Staff Member, the Medical Director, and other clinical professionals as determined appropriate by the Care Coordinator. The Care Coordination Team, in consultation with the Member and/or the Member's designated representative, will prepare a care plan to meet the Member's particular needs. The Care Coordination Team will make all decisions involving the Member's participation in various medical and health care Services or permanent transfer from home to facility based services following consultation with the Member or the Member's Designated Representative.

E. Home Site Service. Home Site Services are available when the Care Coordination Team, in consultation with the Member or the Member's Designated Representative, determines that Home Site Services would be appropriate. The Provider may require an examination by its Medical Director (or his/her designee) to determine eligibility for Home Site Services, and the Member must use an approved provider to be eligible for coverage. Following is a description of Home Site Services offered by the Provider:

1. SKILLED HOME HEALTH CARE
   The Provider will provide non-Medicare covered home care services, including personal care provided by a State licensed Home Health Aide, as determined to be appropriate by the Care Coordination Team and to the extent that this service is covered in the plan selected by the Member.

2. HOMEMAKER SERVICES
   The Provider will provide Homemaker Services, including a companion, light housekeeping and chore services as determined to be appropriate by the Care Coordination Team and to the extent that this service is covered in the plan selected by the Member.

3. COMPANION SERVICES
   The Provider will provide Companion Services as determined to be appropriate by the Care Coordination Team and to the extent that this service is covered in the plan selected by the Member.

4. EMERGENCY RESPONSE SYSTEM
   If determined to be appropriate by the Care Coordination Team and agreed to by the Member, the Provider will provide an emergency response system with 24-hour coverage to the extent this service is covered in the plan selected by the Member.

5. MEALS
   If determined to be appropriate by the Care Coordination Team, the Provider will deliver a maximum of two meals per day to be delivered to the Home Site for a limited amount of time, while the member is recovering from an

illness or recent hospitalization, and if the member is not already receiving aide, companion, or homemaker services.

6. ADULT DAY CARE
The Provider will provide Adult Day Care Services as determined to be appropriate by the Care Coordination Team to the extent this service is covered in the plan selected by the Member.

F. Facility Based Services

1. When Determined To Be Appropriate by the Care Coordination Team and prescribed by a physician, Provider will provide or arrange for Facility Based Services, including Assisted Living in a private accommodation and Nursing Home Services in a semi-private accommodation. Provider may require an examination of the Member by its Medical Director (or his/her designee) to determine eligibility for Facility Based Services.

2. ASSISTED LIVING AND NURSING HOME SERVICES
Assisted Living and Nursing Home Services will be provided either in the Provider's Community Skilled Nursing Facility, or in similar facilities approved by the Provider. The Provider will not be responsible for any ancillary charges (such as laundry, prescription drugs, medical supplies, telephone, or television) that may be incurred for Facility Based Services. The Member will be solely responsible for such charges.

G. CCAH Program Facilities and Programs. The Provider has made and will continue to make arrangements with several organizations to provide CCAH Program Members with access to facilities and programs, including but not limited to, a library, computer center, indoor swimming pool, meeting rooms, and arts and crafts programs.

H. Activities and Leisure Events. The Member will have access to planned and scheduled social, recreational, spiritual, educational and cultural activities and leisure events, as well as, arts and crafts, exercise and health programs, and other special activities designed to meet the needs of the Members.

I. Lifestyle and Wellness Programs. The Provider will offer Lifestyle and Wellness Programs from time to time, free of charge or with an applicable fee for service, including but not limited to, exercise classes, arts and crafts, wellness seminars, speakers and day excursions.

J. Transportation Services. If the Member is unable to drive or instructed by his/her physician not to drive, the Provider will provide transportation to and from medically necessary outpatient surgery or minor procedures such as cataract removal, chemotherapy treatments, and surgical biopsies. The Provider does not provide transportation for regular physician office visits, dialysis, or other routine or on-going specialist appointments. If the Member requires such additional

transportation services, the Provider may assist the Member in arranging for such services. The Member will be responsible for paying any fees associated with such additional transportation services.

K. Other Services and Programs at Additional Charge. Other services and programs will be available to the Member for an additional charge, including but not limited to, private transportation, catering, and other special services performed for the Member beyond the normal scope of services offered by Provider. Availability and charges for these additional services and programs will be determined by Provider.

L. Referral Service for Additional Services. A Referral Service for other services is available with associated additional charges to be paid to a third party vendor who functions as an independent contractor of Provider. These services may include, but not be limited to, landscape maintenance, legal, financial planning, home maintenance and rental of medical equipment.

M. Limitation of Provider Payment for Non-Institutional Health Care Services. Provider may limit payment for Home Site Services (skilled home health care, homemaker, companion, emergency response system, meals and adult day care) if the cost of such Home Site Services for any thirty (30) day period exceeds the cost based on standard published rates for care in the Community's Nursing Home Facility. Member may either transfer to a Plan Participating Facility or pay the difference between the cost of Home Site Services and the cost based on standard published rates for care in the Community's Nursing Home Facility.

Board Members and Officers

The Provider is governed by a voluntary Board of Directors. Directors and Officers serve without compensation, and no Director or Officer has any equitable or beneficial interest in Provider. Within the last five (5) years, neither Provider, nor any of its Officers or Directors, has been a party to any civil or criminal proceeding of any kind described in Section 17b-522(b)(4) of the Connecticut General Statutes. Following is a list of Provider's Directors and Officers:

Jon August (**Secretary**)
Andrew H. Banoff
Russell Beitman
Carl Bennett (**Honorary Director for Life**)
Jim Bennett
Robert Berkowitz
Muriel Brown
Dorothy N. Freedman
Janet Freedman
Roy Friedman (**Honorary Director for Life**)
Roslyn Goldstein (**Honorary Director for Life**)
Eric Hendlin **(Treasurer)**
Debby Hiller (**Women's Auxiliary**)
Eric Katz
Mitchell Kornblit
Mark A. Lapine (**Honorary Director for Life**)
Nancy Magida
Michael Marcus
Emil Meshberg
Brian Miles (**Men's Club**)
Jerry Minsky
Frank Morse
Nate Nevas
Alan Phillips (**Vice Chairperson**)
Jeff Radler
Hal Rosnick
Dr. Scott Serels
Amanda Shapiro
Jeffrey J. Siegel
William Sims
Art Spinner
Carol Spinner
Milton Sutin (**Honorary Director for Life**)
John Vaccaro
Kenneth I. Wirfel (**Chairperson**)
Martin F. Wolf (**Honorary Director for Life**)
Mike Wolfson

Prior Experience

The Provider has extensive prior experience providing services to the elderly across the continuum of care. In particular, the Provider operates a 294-bed Skilled Nursing Facility, 18 Assisted Living Apartments, 14 Memory Care Studios, inpatient and outpatient rehabilitation services, home care, companions, hospice and other community services, including adult day care, geriatric assessment, physician services, etc.

Program Implementation

Program Consultant

The Provider had contracted with Cadbury Senior Services to provide assistance in developing and implementing the CCAH Program.

Cadbury Senior Services, Inc. is a Quaker guided not-for-profit organization that owns and operates Cadbury at Cherry Hill, New Jersey, a continuing care retirement community established in 1978, and Cadbury at Lewes, a continuing care retirement community in Lewes, Delaware that opened in 2007. In addition, Cadbury Senior Services also operates Cadbury Continuing Care at Home, a program established in 1998 to meet the desire of many seniors to stay in their homes and age in place and to complement and expand the mission of Cadbury Senior Services.

The American Association of Homes and Services for the Aging has recognized Cadbury Continuing Care at Home with an Innovation of the Year award. Cadbury Care at Home has been replicated numerous times by other not-for-profit senior care providers across the country.

Management

The Provider will manage the CCAH Program. The Provider's management team consists of Andrew H. Banoff, President and Chief Executive Officer; Larry Condon, Senior Vice President, Administrator; Roger Sliby, Vice President of Finance and Chief Financial Officer; Linda Ciszkowski, Vice President & Chief Administrative Officer; and Erena Fitzgerald, Director of Nursing.

Right to Rescission

A new Member has the right to rescind the Member Agreement within thirty (30) days after signing the Member Agreement ("Rescission Period"). If the Member exercises this right, then the Provider will issue a full refund of the Membership Fee paid less the $250 application fee.

The Application Process

A prospective Member qualifies for the CCAH Program upon satisfaction of the following requirements and admission steps:

A. Age. The CCAH Program is intended for and restricted to persons 55 years of age or older.

B. Personal Interview. A prospective Member must have a personal interview with a representative from the Provider. The Provider may request additional interviews upon review of all information submitted with the application.

C. Confidential Data Application and Personal Health History. The prospective Member must submit for approval by Administration, a Confidential Data Application and a Personal Health History, all on forms furnished by the Provider.

D. Financial Requirements. The prospective Member must have assets and income sufficient under foreseeable circumstances to meet the prospective Member's financial obligations under the CCAH Program and to meet the prospective Member's ordinary living expenses. The Provider may require the prospective Member to furnish additional, current financial information as may be needed.

E. Health Requirements. The prospective Member must submit a report of a physical examination of the prospective Member performed by the prospective Member's physician. The Provider may require the prospective Member to have another physical examination by its Medical Director or by another physician approved by the Provider. The prospective Member shall be responsible for the costs of physical examinations performed for purposes of the application.

F. Notification. The Provider will review the Confidential Data Application and Personal Health History and the results of the personal interview and will notify the prospective Member once a decision has been made on whether the prospective Member is eligible to participate in the CCAH Program.

G. Application Fee. The Provider will charge a $250 non-refundable application fee to cover the administrative costs involved in processing the Member's application.

Termination

The grounds under which the Provider may terminate the Member Agreement and the procedures for termination and issuance of refunds, if any, are described in Section VI of the Member Agreement attached as Exhibit I. As noted in the Member Agreement, any interest earned on Membership Fees or other deposits from the Member will accrue to the Provider's benefit. Any refunds due to the Member upon termination of the Member Agreement will not include interest earned.

Spouses and Multiple Household Members

Each member of a married couple or household must sign a separate Member Agreement for the CCAH Program. As a result, termination of the Member Agreement with one spouse or household member due to death or any other reason will have no impact on the Member Agreement with other spouse or household member.

Financial Hardship

As a not-for-profit organization, the Provider has established a policy whereby it will not terminate membership in the CCAH Program solely by reason of a Member's inability to pay the total Monthly Fee. When a Member establishes facts to justify the need for financial assistance as determined by Provider in its sole discretion, the Provider will advance funds to help the Member pay his/her Monthly Fee. Such advances, plus interest at 1% above the prime rate computed monthly noted on the first day of each month in the Wall Street Journal, shall be charged against the refundable portion, if any, of the Membership Fee. If such advances exceed the refundable portion, if any, of the Membership Fee, the Provider may waive some or all of the Member's Monthly Fee if the Member has not intentionally depleted assets needed to pay his/her Monthly Fee.

Interest on Deposit

Senior Choice at Home is not required to hold any amounts in escrow on behalf of members and, therefore, no interest is paid to members based on any amounts paid for Senior Choice at Home.

Tax Consequences

Payment of a Membership Fee pursuing to a continuing care contract may have tax implications, including benefits. Any person considering such a payment may wish to consult a qualified advisor.

Financial Information

Membership Fees

The Membership and Monthly Fees for the CCAH Program are attached as Exhibit II.

CCAH Projected Income Statements

The projected income statements of the CCAH Program are attached as Exhibit III.

Financial Statements of The Jewish Home of Fairfield County

The latest available audited annual financial statements for The Jewish Home for the Elderly of Fairfield County, Inc. are attached as Exhibit IV.

Prepaid Obligations, Actuarial Value

Provider, through the execution of Member Agreements for the CCAH Program, will incur prepaid health obligations for its Members. The actuarial present value of Member prepaid health obligations is $2,637,094 as of 9/30/19 based on a study conducted by Continuing Care Actuaries. The Provider will review and update prepaid health obligations on an annual basis.

Reserve Funding

Connecticut law does not require reserve funding for the CCAH Program.

DOCUMENTS FILED WITH THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

The Provider has filed all materials required to be filed with the Connecticut Department of Social Services are on file. These materials include:

1. A current Disclosure Statement.

2. An index identifying the location of information required by law and listed in Section 17b-533-3 (a) (3) of Social Services regulations (Page ii).

3. Supplemental financial information.

All documents filed will be a matter of public record and may be reviewed at the Department's Offices located at 25 Sigourney Street, Hartford, CT 06106. Telephone: (860) 424-5250.

EXHIBIT I

THE CONTINUING CARE AT HOME PROGRAM

SENIOR CHOICE AT HOME®

SPONSORED BY

JEWISH SENIOR SERVICES

MEMBER AGREEMENT

THE CONTINUING CARE AT HOME PROGRAM

SENIOR CHOICE AT HOME®

SPONSORED BY

JEWISH SENIOR SERVICES

Member Agreement

THIS SENIOR CHOICE AT HOME® MEMBER AGREEMENT ("Agreement") is made this _____day of _____ 202___, between The Jewish Home for the Elderly of Fairfield County, Inc. d/b/a Jewish Senior Services, a Connecticut not-for-profit Corporation, hereinafter, called the "Provider," and _____, hereinafter called "Member."

Recitals:

Provider is the owner of a 9-acre health care complex known as The Jewish Home of Fairfield County ("the Community"), located at 4200 Park Avenue in Bridgeport, Connecticut. Provider has established and wishes to offer to Member "Senior Choice at Home®," a Continuing Care at Home Program ("CCAH Program") that allows a Member to remain in his/her private residence while enjoying the traditional benefits of a Continuing Care Retirement Facility. The goal of the CCAH Program is to allow Member to continue an independent lifestyle and to provide the peace of mind associated with knowing that certain additional attention and care is available if ever needed.

Member desires to participate in the CCAH Program and to use and enjoy the facilities, programs and services provided by the Provider under such Program;

This Agreement is made and entered into between Provider and Member as a commitment to the terms and conditions set forth below.

NOW, THEREFORE, Provider and Member agree as follows:

I. DEFINITIONS

All terms not defined in this Section shall have the meanings ascribed to them in the Agreement, or their common meaning.

The Act means Public Act No. 86-252, an Act Concerning Management of Continuing Care Facilities (Conn. Gen. Stat. § 17b-520 et seq.) as amended, including amendments of Public Act No. 08-36 addressing continuing care at home.

ADL (Activities of Daily Living) Deficiencies means deficiencies, as determined by the Care Coordination Team, in activities of daily living such as bathing, dressing, eating, transferring, walking, mobility, grooming and continence. Those persons deemed to have ADL Deficiencies may include, but may not be limited to, those who need personal assistance, those with Alzheimer's

Disease or any type of dementia disorder, those who are bed bound or homebound, or those who need special equipment to ambulate (i.e. wheelchair, walker).

Adult Day Care Services means a facility that offers a program of services in a group setting for a scheduled number of hours per week. Elements of an adult day care program usually include transportation, meals and activities (both health related and social).

Assisted Living Facility means a registered Managed Residential Facility where nursing and personal care services are provided by an Assisted Living Services Agency licensed by the State of Connecticut. Assisted Living Services are provided, in accordance with Connecticut assisted living licensure requirements, exclusively for residents who require substantial assistance with at least two ADL's, twenty-four (24) hour supervision for safety, and who are Determined To Be Appropriate for assisted living services.

Care Coordination Team means the persons appointed by Provider for Member, comprised of the Care Coordinator assigned to the Member, an Authorized Senior Choice at Home Staff Member, the Medical Director, and other clinical professionals as determined appropriate by the Care Coordinator, in consultation with the Member and/or Member's designee. The Provider, in its sole discretion, may change from time to time titles and personnel of the Care Coordination Team.

Care Coordinator means the person appointed by Provider to be responsible for handling needs of Member for Services and for conducting specific needs assessments and for making recommendations for Services subject to review and final determination of Member's eligibility for Services by the Care Coordination Team.

Care Plan means the written plan of Services (including type of Service, start date, quantity, frequency, duration of Service, name of Plan Participating Provider or Facility and any special considerations) that the Care Coordination Team develops and approves for Member based on a comprehensive needs assessment. The Care Plan is agreed to and signed by Member.

Companion means a person designated by the Provider to provide Companion Services to a Member at the Member's Home Site, when the Member lives alone or when the Member's family is temporarily away from home.

Companion Services means those services provided by a Companion, which may include visiting a Member for conversation and social time, including playing cards, games or going for a walk, supervision of and assistance with activities of daily living, medication reminders, and regular telephone calls.

Designated Service Area means Provider's area of coverage for Services (currently Fairfield and New Haven Counties), as defined by Provider. The Designated Service Area may be altered from time to time at the sole discretion of Provider. No change in the Designated Service Area by Provider will adversely affect this Agreement.

Determined To Be Appropriate means that the Care Coordination Team, utilizing industry standards and accepted standards of health care practice, has assessed a Member's medical and functional status and concluded that Services are necessary and will be provided by the Provider or another provider as specified in this Agreement.

Disclosure Statement means the Disclosure Statement of Provider available to Member, pursuant to the Act.

Effective Date means the date by which all parties have executed this Agreement and the Membership Fee has been paid in full or in part per other financial arrangements. The Provider will assume none of the responsibilities of this Agreement until the Effective Date.

Emergency Response System means an in-home 24-hour electronic alarm system activated by a signal to a central switchboard. This system allows Members who are deemed to be at high risk to secure immediate help in the event of a medical, physical, emotional or environmental emergency.

Facility Based Services means Services provided in a facility outside the Home Site; including Assisted Living and Nursing Home Facilities.

Home Health Aide means certified home health aide who has successfully completed a training and/or competency evaluation program approved by the Connecticut Department of Public Health and designated by the Provider to provide Home Health Aide Services to a Member at the Member's Home Site.

Home Health Aide Services means services provided by a Home Health Aide, which may include assistance with bathing and dressing, an established activity regimen such as range of motion exercises, nutritional needs such as feeding assistance and simple maintenance of the Member's environment.

Homemaker is a person designated by the Provider to provide Homemaker Services to the Member at the Member's Home Site.

Homemaker Services are services provided by a Homemaker, which may include assistance with day-to-day chore activities in the Home Site such as cooking, dishwashing, laundry, light housekeeping and errands.

Home Site is the residence of the Member which is not on or at the site of the Provider's campus or facility.

Home Site Services means Services provided at the Member's Home Site.

Medical Director means a physician appointed from time to time by Provider to oversee the provision of medical and health care Services provided to Members.

Medical Record means all records relating to Member's medical history and condition, which may be maintained by Provider or by a Plan Participating Facility or a Plan Approved Provider.

Medicare means the Health Insurance for the Aging Act, Title XVIII of the Social Security Amendment of 1965, as amended and Regulations promulgated thereunder in effect from time to time.

Medicare Covered Services means all hospital, skilled nursing, home care and medical services covered and paid for by Medicare Parts A and B and Member's MediGap or Secondary Insurance.

Member's Designated Representative means any person appointed by Member to represent Member's interests, including but not limited to a health care representative, an attorney-in-fact or conservator.

Medicare Supplemental Coverage means a private health insurance plan, which is certified by the Secretary of Health and Human Services as meeting federal requirements for Medicare supplemental policies. In general, Medicare Supplemental Coverage, also referred to as MediGap Insurance or Secondary Insurance, pays for certain deductibles and co-payments and for some of the balance of the costs of care covered by Medicare Parts A and B when full costs are not paid by Medicare.

Nursing Home Facility means a facility licensed by the State of Connecticut to provide various levels of nursing care.

Permanent Member means a Member who has resided in an Assisted Living or Nursing Home Facility for 100 consecutive days, and has been determined to be a Permanent Member with respect to such Facility by the Care Coordination Team.

Plan means the CCAH Program Plan selected by Member.

Plan Approved Provider means a health care services facility or agency having an agreement with the Provider to supply Services to Members.

Plan Participating Facility means an Assisted Living or Nursing Home Facility having an agreement with Provider to supply Facility Based Services according to the definition of Facility Based Services to Member.

Prevailing Rate for a Plan Participating Facility means the current per diem rate charged by a particular Plan Participating Facility.

Referral Service means a service provided under the Plan whereby Provider, acting as an intermediary between Member and third party vendors of such services, makes referrals to Member for such services as he/she may choose, at costs payable in full by Member.

Services mean any assistance, including care coordination, Member home inspection, annual physical examination, Home Site Services (including Skilled Home Health Care, Homemaker Services, Companion Services, Emergency Response System, Meals and Adult Day Care), Facility Based Services (including Assisted Living and Nursing Home Facility), transportation services, Referral Services and lifestyle and wellness programs, that is provided to Member as described in this Agreement, subject to applicable co-payments.

II. ACCOMMODATIONS AND SERVICES

Provider will provide the following Services to Member, subject to the terms and conditions of this Agreement for the lifetime of the Member in a manner consistent with the objective of enabling Member to remain at the Home Site for as long as is practical and to provide Facility Based Services if needed:

A. Residence. Member shall remain in the Home Site (or subsequent residence if Member moves to another location within the Designated Service Area).

Member currently lives at _____
and shall remain within the Designated Service Area to remain eligible for the Services.

B. Member Home Inspection. During the first year of Member's participation in the CCAH Program and every second year thereafter (unless circumstances or Member's health condition justify more frequent inspections), Provider will provide a functional inspection of the Home Site for the purpose of attempting to identify any functional and safety problems, and will make recommendations to Member based on such inspection. The Home Site inspection will focus solely on functional and safety issues for Member. The Home Site inspection will not identify physical, structural or environmental problems with the Home Site, such as problems involving the roof, structure, HVAC, plumbing, electric, leaks or dampness, mold, termites, carpenter ants or other wood destroying insects, asbestos, radon, leaking underground storage tanks and other environmental conditions. Provider may require, based on circumstances of previous inspections or Member's health condition, that Member permit Provider to provide a functional inspection of the Home Site on a more frequent basis. Provider does not represent that it will undertake steps necessary to effectuate any of recommendations that may result from its Home Site inspection. Implementation of any recommended changes or corrections and payment of any costs involved are the sole responsibility of Member.

C. Annual Physical Examination. Provider encourages Member to undergo an annual physical examination performed by Member's personal physician or by one of Provider's physicians or nurse practitioners. Provider also encourages Member to submit, or arrange for Member's personal physician to submit, a medical report from Member's personal physician to Member's Care Coordinator.

D. Care Coordination. Provider shall assign a Care Coordinator to Member. The Care Coordination Team, in consultation with Member and/or Member's Designated Representative, shall prepare a care plan to meet Member's particular needs from time to time during the term of the Agreement. The Care Coordination Team will make all decisions involving Member's participation in various medical and health care Services or permanent transfer from the Home Site to Facility Based Services following consultation with Member or Member's Designated Representative.

E. Home Site Service. Consistent with the benefit level and required co-payments for the Plan selected by Member, Provider shall provide Home Site Services, as Determined To Be Appropriate by the Care Coordination Team. Member must exhibit at least one or more ADL Deficiencies to be eligible for the following Home Site Services, and Member must use a Plan Approved Provider and sign the relevant agreement to be eligible for coverage. Provider may

require an examination by its Medical Director (or his/her designee) to determine eligibility for Services:

1. SKILLED HOME HEALTH CARE
   Provider will provide non-Medicare covered skilled Home Health Care Services, including personal care provided by a Home Health Aide as Determined To Be Appropriate by the Care Coordination Team.

2. HOMEMAKER SERVICES
   Provider will provide Homemaker Services as Determined To Be Appropriate by the Care Coordination Team.

3. COMPANION SERVICES
   Provider will provide Companion Services as Determined To Be Appropriate by the Care Coordination Team.

4. EMERGENCY RESPONSE SYSTEM
   If Determined To Be Appropriate by the Care Coordination Team and agreed to by the Member or Member's Designated Representative, Provider will provide an Emergency Response System.

5. MEALS
   If Determined To Be Appropriate by the Care Coordination Team, the Provider will deliver a maximum of two meals per day to be delivered to the Home Site for a limited amount of time, while the member is recovering from an illness or recent hospitalization, and if the member is not already receiving aide, companion, or homemaker services.

6. ADULT DAY CARE
   Provider will provide Adult Day Care Services as Determined To Be Appropriate by the Care Coordination Team.

F. Facility Based Services

1. When Determined To Be Appropriate by the Care Coordination Team and prescribed by a physician, Provider will provide or cause to be provided, Facility Based Services, including Assisted Living in a private accommodation and Nursing Home Services in a semi-private accommodation. Provider may require an examination of Member by its Medical Director (or his/her designee) to determine eligibility for Facility Based Services.

2. ASSISTED LIVING AND NURSING HOME SERVICES
   As Determined To Be Appropriate by the Care Coordination Team, Facility Based Services will be provided either in the Community's Skilled Nursing Home or in similar Plan Participating Facilities approved by Provider. Provider will not be responsible for any ancillary charges such as laundry, prescription drugs, medical supplies, telephone, or television. Such charges shall be Member's sole responsibility.

G. CCAH Program Facilities. Member shall have access to facilities and programs for the use and benefit of all Members of the CCAH Program. Such facilities and programs may include a library,

computer center, indoor swimming pool, meeting rooms, arts and crafts programs, and other facilities and programs described in CCAH Program materials.

H. Activities and Leisure Events. Member shall have access to planned and scheduled social, recreational, spiritual, educational and cultural activities and leisure events as well as arts and crafts, exercise and health programs, and other special activities designed to meet the needs of Member.

I. Lifestyle and Wellness Programs. Provider shall offer lifestyle and wellness programs from time to time, either free of charge or for a fee. Such services may include but not be limited to, exercise classes, arts and crafts, wellness seminars, speakers and day excursions. Provider shall advise Member of the schedules and the cost of these programs on an as offered basis.

J. Transportation Services. If Member is unable to drive or instructed by his/her physician not to drive, Provider will provide transportation to and from medically necessary outpatient surgery or minor procedures which may include, but not be limited to, cataract removal, chemotherapy treatments, and surgical biopsies. Provider shall not provide transportation for regular physician office visits, dialysis, and routine or specialist appointments. If Member requires assistance in obtaining such transportation services, Provider may assist Member in arranging for such services, but Provider shall not be responsible for any fees involved in such additional transportation services. Payment of any fees associated with additional transportation services will be the sole responsibility of Member.

K. Other Services and Programs at Additional Charge. Other services and programs will be available to Member at Member's expense, including but not limited to, private transportation, catering, and other special services beyond the normal scope of services offered by Provider. Provider shall determine the availability and charges for such additional services.

L. Referral Service for Additional Services. Provider shall provide a Referral Service so that Member may obtain additional services not provided under this Agreement such as landscape, maintenance, legal, financial planning, home maintenance and rental of medical equipment. Member shall be responsible for paying any charges for such additional services directly to the third party vendor selected.

M. Limitation of Provider Payment for Non-Institutional Health Care Services. Provider may limit payment for Home Site Services (skilled home health care, homemaker, companion, emergency response system, meals and adult day care) if the cost of such Home Site Services for any thirty (30) day period exceeds the cost based on standard published rates for care in the Community's Nursing Home Facility. Member may either transfer to a Plan Participating Facility or pay the difference between the cost of Home Site Services and the cost based on standard published rates for care in the Community's Nursing Home Facility.

III. FEES, TERMS AND CONDITIONS

A. Membership Fee. Member agrees to pay the Provider a nontransferable, non-interest bearing Membership Fee of $_____upon signing this Agreement as a condition of becoming a Member participant in the CCAH Program. The Membership Fee is a one-time fee and shall not be increased or changed during the duration of this Agreement. This Membership Fee is in payment for the _____ **PLAN**.

B. Monthly Service Fee. In addition to the Membership Fee, Member agrees to pay a Monthly Service Fee for the term of this Agreement which shall be payable in advance by the 1st day of each month. As of the date of this Agreement, the Monthly Service Fee associated with the _____ **PLAN** will be $_____ per month. Provider may adjust the Monthly Service Fee during the term of this Agreement as described in Paragraph III. C. below.

C. Adjustments in the Monthly Service Fee. Provider charges a Monthly Service Fee in order to provide the programs and services described in this Agreement and to cover the costs of debt service, insurance, maintenance, depreciation, administration, staffing, and other expenses associated with the operation and management of the CCAH Program. Provider shall have the authority to adjust the Monthly Service Fee from time to time during the term of this Agreement as Provider deems necessary in order to reflect changes in costs of providing the facilities, programs and services described herein consistent with operating on a sound financial basis and maintaining the quality of services. The Provider will make any such increases in the Monthly Service Fee or other charges upon sixty (60) days prior written notice to Member.

D. Additional Service Fees. Provider may charge additional service fees to cover costs of programs and services that are not included in the Monthly Service Fee, as approved or requested by Member.

E. Monthly Statements. Provider will furnish Member with monthly statements for payment of the Monthly Service Fee and Additional Service Fees owed by Member. Member shall pay all fees reflected on the monthly statement by the 10th day of the month. Provider may charge interest at a rate of One and One-half Percent (1.5%) per month on any unpaid balance owed by Member thirty (30) days after the monthly statement is furnished. In the event Member does not make payment on a timely basis, Member agrees to pay all costs and attorney fees, if any, in the collection of such indebtedness.

F. Care in Other Facilities. Should Member need a level of care beyond that which the Community is licensed to provide (i.e., Acute Care or Psychiatric Hospital, etc.) or beyond Services covered under this Agreement and Member requires transfer to another facility, all expenses that will result from such transfer and care shall be borne entirely by Member.

G. Care in Other Assisted Living or Nursing Home Facilities. Should Member be transferred to another Assisted Living or Skilled Nursing Facility because an appropriate bed is not available in the Provider's Community, Member will continue to pay the Monthly Service Fee. Provider will be responsible for charges incurred at the other facility for the level of services defined within this Agreement.

H. Third Party Reimbursement. The Provider reserves the right to bill Medicare and other third party payers such as insurance and long-term care insurance companies. Member shall be responsible

for all fees and charges incurred while this Agreement remains in force and Member will pay any disputed or denied claims within ninety (90) days.

I. New Spouse/Partner. In the event Member is or becomes single and then desires to get married or have a partner live with Member at the Home Site, Member may do so.

However, that additional person will not be subject to nor receive any benefits of this Agreement. The additional potential Member must meet both of the following conditions:

1. The additional potential Member qualifies under the same conditions as the initial Member under this Agreement and

2. The additional potential Member agrees to pay the Membership Fee and the Monthly Service Fee then in effect and to execute a separate Member Agreement.

J. Excess Costs. Except as specifically provided by this Agreement, Member shall be solely responsible for services not covered by Medicare Parts A and B and Medicare Supplemental Coverage and for payments exceeding Medicare and Member's Supplemental Coverage limits including but not limited to: audiology tests and hearing aids; eye glasses and refractions; dentistry; dentures; dental inlays; organ transplants; orthopedic appliances; occupational, physical and speech therapy; podiatry; hospitalization and professional care for psychiatric disorders; treatment for alcohol or drug abuse medications; chiropractors; renal dialysis; extraordinary treatments; and experimental treatments as reasonably determined by its Medical Director.

K. Illness or Accident While Traveling. If Member is involved in an accident or suffers an illness while traveling or while living at a temporary or second residence outside the Designated Service Area, Member shall make every reasonable effort to notify Provider as soon as possible. If continued medical care is required, Member shall arrange to return to Home Site or, if applicable, to a Plan Participating Facility as soon as reasonably possible. Provider will have no responsibility for costs resulting from such accident or illness until Member returns to Home Site or to a Plan Participating Facility and Provider or a Plan Participating Facility becomes responsible for Member's care.

L. Financial Hardship. As a not-for-profit organization, the Provider has established a policy whereby it will not terminate membership in the CCAH Program solely by reason of a Member's inability to pay the total Monthly Fee. When a Member establishes facts to justify the need for financial assistance as determined by Provider in its sole discretion, the Provider will advance funds to help the Member pay his/her Monthly Fee. Such advances, plus interest at 1% above the prime rate computed monthly noted on the first day of each month in the Wall Street Journal, shall be charged against the refundable portion, if any, of the Membership Fee. If such advances exceed the refundable portion, if any, of the Membership Fee, Provider may waive some or all of the Member's Monthly Fee if Member has not intentionally depleted assets needed to pay his/her Monthly Fee.

IV. AGREEMENT REQUIREMENTS AND PROCEDURES

Member qualified for services under this Agreement upon satisfaction of the following provisions:

A. Condition of Membership in CCAH Program. The CCAH Program is available to persons who are 55 years of age or older and who meet all eligibility requirements established by Provider. Through the application process, Member submitted a Confidential Data Application and Personal Health History, as well as other information required by Provider, participated in one or more interviews with Provider and arranged for Member's physician to furnish a physical examination report to Provider. As a condition of membership in the CCAH Program, Member must continue to meet all eligibility requirements established by Provider, including but not limited to financial qualifications and qualifications to ensure that Provider can accommodate Member's health needs through the CCAH Program. Member agrees to provide such additional information that Provider may require from time to time to supplement the Confidential Data Application, Personal Health History and other information provided in the application.

B. Representations. Member's application, including the Confidential Data Application and Personal Health History, is incorporated by reference into this Agreement. Member affirms that the representations made in the application, including the Confidential Data Application and Personal Health History, are true and correct as of the date made and that there have been no material changes in the information provided since such date. Member understands that any material misstatements or omissions may result in termination of this Agreement.

C. Medical Insurance. Member shall procure and maintain in force, at Member's own expense, maximum coverage available to Member under any applicable program of Federal Social Security, commonly known as Medicare A and B (basic and supplemental coverage), if eligible, or under similar programs as may be offered in the future and at least one Medicare supplemental health insurance commonly called ("MediGap") policy satisfactory to Provider. If Member is not eligible for Medicare A and B, Member will be required to obtain a health insurance policy equivalent to Medicare (both A and B) and at least one other Medicare supplementary health insurance (commonly called "MediGap") policy, both satisfactory to the Provider. Member must also procure and maintain maximum coverage under Medicare Part D. If Member is not eligible to participate in Medicare Part D, Member agrees to maintain a health insurance policy that provides creditable prescription drug coverage. If Member fails or neglects to arrange for such medical insurance coverage, Provider, in Provider's sole discretion, may terminate this Agreement. Alternatively, Provider may, in Provider's sole discretion, make application on Member's behalf, pay Member's premium for the insurance and bill the costs to Member on the Monthly Service Fee statement. Member is responsible for procuring as well as maintaining such medical insurance coverage and Provider, while authorized to do so, shall have no obligation to do so. Should Member incur a medical expense during a period of time for which such medical insurance was required by Provider but was not procured and/or maintained either by Member or by Provider, Member shall be responsible for any portion of such expense that would have been covered had such a medical insurance policy been procured and maintained. All changes in information regarding Member's insurance coverage whether adding or canceling a policy, must be submitted in writing to Provider within ten (10) calendar days.

D. Transfer of Property. Member agrees not to make any gift or other transfer of assets for less than adequate consideration if such gift or other transfer is made for the purpose of avoiding Member's

obligations under this Agreement, or if such gift or transfer would render Member unable to meet Member's financial obligations under this Agreement.

V. TRANSFERS OR CHANGES IN LEVELS OF CARE

A. Transfer to Assisted Living or Nursing Home Facility. Member agrees that Provider shall have authority to determine that Member should be transferred from the Home Site to an Assisted Living or Nursing Home Facility or from one level of care to another level of care within Provider. Such determination shall be based on the Care Coordination Team's assessment, based on its professional judgment, to determine the appropriate level of care for Member. Any decision to transfer Member or change levels of care for Member shall be made only after consultation, to the extent practicable under the circumstances at that time, with Member or, in the case of incapacity, Member's Designated Representative; a representative of Member's family; and Member's attending physician.

B. Transfer to Hospital or Other Facility. Once Member moves to an Assisted Living or Nursing Home Facility under this Agreement, if Provider determines that Member needs care beyond that which Provider can provide, Provider may transfer Member to a hospital or other facility equipped to provide such care, and Member shall be responsible for the cost of any care or services provided by the hospital or other facility. Such transfer of Member will be made only after consultation, to the extent practicable under the circumstances at the time, with Member or, in the case of incapacity, Member's Designated Representative; or a representative of Member's family; and Member's attending physician.

C. Decisions Involving Permanent Transfer from Living Accommodation. All decisions involving permanent transfer from Member's current living accommodation (including Home Site, Assisted Living Facility, Nursing Home Facility or hospital/other facility), to another accommodation will be made by the Care Coordination Team in consultation with Member or, in case of incapacity, with Member's Designated Representative. If Provider determines that any transfer is permanent, Member may dispose (or keep) his/her Home Site as Member sees fit; however, all services provided for under this Agreement pertaining to such Home Site will terminate unless separate arrangements are made between the parties.

VI. TERMINATION AND REFUND PROVISIONS

A. Member's Termination of Agreement During Thirty (30) Day Rescission Period. Member shall have the right to rescind this Agreement within thirty (30) days of the Effective Date ("Rescission Period"). If Member wishes to terminate this Agreement within the Rescission Period, Member must notify Provider in writing by registered or certified mail within such Rescission Period of Member's decision to rescind the Agreement. In the event of such rescission, Provider shall refund all money transferred by Member to Provider less the application fee within thirty (30) days of receipt by Provider of the notice of termination. Member, or Member's Designated Representative, must sign a receipt supplied by Provider, releasing Provider from any and all further obligations before a refund can be issued.

B. Member's Voluntary Termination After Effective Date. At any time after the Rescission Period, Member may terminate this Agreement for any reason by giving the Provider at least thirty (30) days prior written notice of such termination. If a refund is due to Member, Provider will make the refund in accordance with subsections E and F of this Paragraph.

C. Termination Upon Member's Death After Commencement of CCAH Program Services. In the event that Member dies at any time after commencement of CCAH Program Services, this Agreement shall terminate automatically; and any Refund due consistent with Paragraph E and F, below shall be payable to the Member's Estate.

D. Termination by the Provider. Provider may terminate this Agreement at any time for any cause that Provider, in its discretion, deems good and sufficient. Good or sufficient cause shall include, but is not limited to the following: (1) there has been a material misrepresentation or omission made by Member in Member's Confidential Data Application or Personal Health History forms; (2) Member fails to make payment to Provider of any fees or charges due to Provider within sixty (60) days of the date when due; (3) Member permanently relocates outside the Designated Service Area or enters a continuing care retirement community at the residential level; or (4) Member breaches any of the terms and conditions of this Agreement. If a refund is due to Member following such termination, Provider will make the refund in accordance with subsection E and F, of this Paragraph.

E. Refund. If this Agreement is terminated under Paragraph VI. B, C or D above, during the first forty-eight (48) months following the Effective Date, Provider will pay Member a refund, less an administration fee equal to four percent (4%) of the Membership Fee and less two percent (2%) of the Membership Fee for each month (full or partial without prorating) of Membership. If, however, the Member has transferred into Assisted Living or a Nursing Home Facility, the Refund will be reduced by four percent (4%) per month. If services are provided during this period the refund will be distributed as stated above less the cost of services rendered. If either party terminates this Agreement after forty-eight (48) months following the Effective Date, Member will not be entitled to any refund of the Membership Fee.

F. Right of Set-Off; Other Rights. Provider will have the right to set-off against any refund payable to Member or Member's estate under Paragraph VI. E above, any accrued Monthly Service Fees that may have been deferred, any fees or amounts payable to Provider under this Agreement and under any other Agreement between Member and Provider or any affiliate of Provider and any costs or expenses that might be due, payable or incurred by Member due to Member's violation of this Agreement.

VII. GENERAL

A. Assignment. The rights and privileges of Member under this Agreement to the facilities, services, and programs of Provider are personal to Member and may not be transferred or assigned by Member. Provider reserves the right to assign this Agreement in the event of a corporate reorganization, sale or other event requiring assignment.

B. Provider's Rights of Management. The absolute rights of management are reserved by Provider, its Board of Directors and its administrators. Provider reserves the right to accept or reject any person for Membership. Members do not have the right to determine admissions or terms of admission of any other Member.

C. Entire Agreement. This Agreement, including all exhibits, constitutes the entire Agreement between Provider and Member. Provider shall not be liable for or bound in any manner by any statements, representations or promises made by any person representing or assuming to represent

Provider, unless such statements, representations or promises are set forth in this Agreement. Any modification or amendment to this Agreement must be in writing and signed by Provider and Member.

D. Successors and Assigns. This Agreement shall bind and inure to the benefit of Member's heirs, executors and administrators only in accordance with its terms.

E. Right of Entry. Member authorizes employees and agents of Provider to enter the Home Site for the purpose of providing services, inspection, and in the event of perceived medical or other emergency.

F. Subordination. Member will not be liable for any indebtedness of Provider. Member agrees, however, that, except as provided under applicable law, Member's rights under this Agreement are subordinate and inferior to all bond indentures, mortgages or other documents creating liens encumbering real or personal property of Provider.

G. Right to Confidentiality. Except as may be required by law or by the order of court, Provider will hold all medical records and other information concerning Member's health condition confidential and will not disclose such information or records except for purposes of treatment, payment or Provider's health care operations. Member agrees that Provider may provide protected health information to health care professionals, third-party payers and others that have a need, in Provider's judgment, or right to know such information under applicable federal or state laws. In addition, Provider will hold Member's Confidential Financial Statement and associated materials confidential. This right to confidentiality shall continue in effect upon termination of this Agreement.

H. Rules Adopted by Provider. Provider reserves the right to adopt or amend policies, procedures and rules regarding membership consistent with the provisions of this Agreement, and Member agrees to observe such policies, procedures and rules.

I. Required Notice of Relocation from Home Site. Member shall not relocate from the Home Site without notifying Provider in writing. Provider has the right to do a functional Home Site Inspection. Member understands that Provider has the right to terminate the Agreement upon Member's relocation outside the Designated Service Area.

J. Power of Attorney and Designation of Health Care Representative. Member agrees to execute and maintain in effect a Durable Power of Attorney and Designation of Health Care Representative valid under Connecticut law. This Power of Attorney shall designate as Member's attorney-in-fact, a bank, lawyer, relative, or other responsible person or persons of Member's choice, to act for Member in managing Member's financial affairs, and filing for insurance and other benefits as fully and completely as Member would if acting personally. The Designation of Health Care Representative shall designate a family member or other representative to serve as Member's Designated Representative to make health care decisions on Member's behalf in the event of incapacity. The Durable Power of Attorney and Designation of Health Care Representative each shall be in a form that survives Member's incapacity or disability, and be otherwise satisfactory to Provider.

K. Governing Laws. The laws of the State of Connecticut shall govern this Agreement.

L. Partial Illegality. The invalidity of any restriction, condition or other provision of this Agreement or any part of the same, shall not impair or affect in any way the validity or enforceability of or otherwise affect the rest of this Agreement, and the Agreement shall be valid and enforced to the fullest extent permitted by law.

M. Appeal Process. For purposes of this subsection, absent unusual circumstances, "prompt" or "promptly" shall mean no more than seven (7) days from the date Member or Provider is informed in writing of the decision related to appeal.

1. MEMBER'S RIGHT TO APPEAL
   Member has the right to appeal decisions in connection with Section II. Accommodations and Services and Section V. Transfers or Changes in Levels of Care.

2. WHO MAY APPEAL
   Member or Member's Designated Representative has the right to appeal. The family of a Member may advocate for or may encourage Member to appeal, but cannot themselves appeal, except in the case where the family member has been appointed Member's Designated Representative and Member is deemed incapacitated. The Care Coordinator may act as an advocate for Member or may facilitate the appeal, but cannot appeal him/herself.

3. APPEAL PROCESS - LEVEL I
   a. Care Coordinator shall record all requests for appeal.

   b. Member shall promptly initiate appeal procedures by (1) telephoning Member's Care Coordinator; or (2) informing Provider, in writing, of his/her desire to appeal.

   c. Director of Care Coordination shall perform a prompt, independent review of the case, and shall notify Member of review decision promptly thereafter.

4. APPEAL PROCESS - LEVEL II
   If Member promptly notifies Provider in writing of desire to appeal to the next level, the case will be reviewed promptly by the Care Coordination Team. The Director of Care Coordination shall notify Member of review decision promptly thereafter.

5. APPEAL PROCESS - LEVEL III
   If Member promptly notifies Provider, in writing, of Member's desire to appeal to the next level, the case will be reviewed promptly by the Appeal Committee, consisting of the Medical Director, President and Chief Executive Officer, Clinical Representative, and a representative designated by Member. The Director of Care Coordination shall notify Member of review decision promptly thereafter.

6. NO FURTHER APPEAL
   Member shall have no right to appeal a Level III decision.

N. Arbitration. Any dispute, claim or controversy of any kind between the parties, arising out of, or in connection with, this Agreement or any amendment thereto, or the breach hereof, shall be submitted to and determined by arbitration in Fairfield, Connecticut in accordance with the commercial arbitration rules of the American Arbitration Association. Both parties shall be bound be the

decision of the arbitrator, and judgment upon such disposition may be entered in any state or federal court having jurisdiction over the matter unless the arbitration is fraudulent or so grossly erroneous as to necessarily imply bad faith. If the parties are unable to agree in good faith and within a reasonable time on the selection of an arbitrator, either party may request appointment of an arbitrator by the American Arbitration Association. The parties shall make a reasonable attempt to select an arbitrator with experience in retirement communities, long-term care or health care operations generally. Costs of arbitration shall be shared by both parties equally.

O. Statement of Nondiscrimination. Provider complies with all applicable federal and state laws that prohibit discrimination based on race, color, sex, religious beliefs, national origin, sexual orientation, veteran's status, and other protected classes of persons.

P. Member acknowledges receipt of a *Disclosure Statement* not more than sixty (60) nor less than ten (10) days before signing this Agreement.

Member has read and understood the *Disclosure Statement*, including this Agreement. Member acknowledges having read these documents and having had the opportunity to review them with an attorney, financial advisor or other representative of Member's choice.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year above written.

JEWISH SENIOR SERVICES

WITNESS:

_____ By: _____

Print Name:_____ President & CEO or Authorized Representative

WITNESS: **MEMBER**

_____ _____

Print Name:_____ Print Name:_____

_____
Current Address: Street

_____
City, State, Zip Code

_____
Telephone Number

EXHIBIT II

PLAN OPTIONS AND MEMBERSHIP/MONTHLY FEES

(Effective through June 30, 2021)

PLAN OPTIONS

TYPE OF SERVICE	ALL INCLUSIVE	SECURITY	CO-PAY
Care Coordination	100%	100%	100%
Health Support Services			
Home Health Aide	100%	85%	50%
Companion/Homemaker	100%	85%	50%
Live-In Companion	100%	85%	50%
Adult Day Care	100%	85%	50%
Delivered Meals	100%	100%	100%
Emergency Response System	100%	100%	100%
Home Inspections	100%	100%	100%
Transportation	100%	100%	100%
Residential Healthcare or Assisted Living Care	100%	70%	50%
Nursing Home Care	100%	70%	50%

All-Inclusive

Age	Single Membership Fee	Single Monthly Fee	Couple Membership Fee**	Couple Monthly Fee**
55	$ 31,565	$ 500	$ 30,916	$ 485
56	$ 32,509	$ 500	$ 31,841	$ 485
57	$ 33,453	$ 500	$ 32,765	$ 485
58	$ 34,971	$ 500	$ 34,253	$ 485
59	$ 36,491	$ 500	$ 35,740	$ 485
60	$ 38,009	$ 500	$ 37,228	$ 485
61	$ 39,528	$ 500	$ 38,715	$ 485
62	$ 41,046	$ 500	$ 40,203	$ 485
63	$ 42,402	$ 500	$ 41,524	$ 485
64	$ 43,757	$ 500	$ 42,845	$ 485
65	$ 45,112	$ 500	$ 44,167	$ 485
66	$ 46,190	$ 500	$ 45,218	$ 485
67	$ 47,270	$ 500	$ 46,270	$ 485
68	$ 48,348	$ 500	$ 47,321	$ 485
69	$ 49,426	$ 500	$ 48,373	$ 485
70	$ 50,444	$ 500	$ 49,393	$ 485
71	$ 51,386	$ 500	$ 50,283	$ 485
72	$ 52,267	$ 500	$ 51,142	$ 485
73	$ 53,149	$ 500	$ 52,002	$ 485
74	$ 54,030	$ 500	$ 52,862	$ 485
75	$ 54,912	$ 500	$ 53,721	$ 485
76	$ 55,720	$ 500	$ 54,510	$ 485
77	$ 56,528	$ 500	$ 55,298	$ 485
78	$ 57,338	$ 500	$ 56,086	$ 485
79	$ 58,146	$ 500	$ 56,875	$ 485
80	$ 58,954	$ 500	$ 57,663	$ 485
81	$ 60,038	$ 500	$ 58,719	$ 485
82	$ 61,121	$ 500	$ 59,775	$ 485
83	$ 62,204	$ 500	$ 60,830	$ 485
84	$ 63,287	$ 500	$ 61,886	$ 485
85	$ 64,370	$ 500	$ 62,942	$ 485
86	$ 65,894	$ 500	$ 64,429	$ 485
87	$ 67,419	$ 500	$ 65,916	$ 485
88	$ 68,944	$ 500	$ 67,402	$ 485
89	$ 70,469	$ 500	$ 68,889	$ 485
90	$ 71,994	$ 500	$ 70,377	$ 485
91	$ 73,323	$ 500	$ 71,671	$ 485
92	$ 74,650	$ 500	$ 72,967	$ 485
93	$ 75,979	$ 500	$ 74,262	$ 485
94	$ 77,307	$ 500	$ 75,557	$ 485
95	$ 78,636	$ 500	$ 76,852	$ 485

** Fee per person per age

Security

Age	Single Membershp Fee	Single Monthly Fee	Couple Membership Fee**	Couple Monthly Fee**
55	$ 24,439	$ 440	$ 23,969	$ 427
56	$ 25,170	$ 440	$ 24,686	$ 427
57	$ 25,901	$ 440	$ 25,403	$ 427
58	$ 27,076	$ 440	$ 26,556	$ 427
59	$ 28,252	$ 440	$ 27,709	$ 427
60	$ 29,428	$ 440	$ 28,862	$ 427
61	$ 30,604	$ 440	$ 30,015	$ 427
62	$ 31,781	$ 440	$ 31,169	$ 427
63	$ 32,816	$ 440	$ 32,178	$ 427
64	$ 33,851	$ 440	$ 33,187	$ 427
65	$ 34,885	$ 440	$ 34,195	$ 427
66	$ 35,714	$ 440	$ 35,003	$ 427
67	$ 36,543	$ 440	$ 35,812	$ 427
68	$ 37,372	$ 440	$ 36,620	$ 427
69	$ 38,201	$ 440	$ 37,428	$ 427
70	$ 39,030	$ 440	$ 38,236	$ 427
71	$ 39,711	$ 440	$ 38,900	$ 427
72	$ 40,391	$ 440	$ 39,564	$ 427
73	$ 41,073	$ 440	$ 40,228	$ 427
74	$ 41,754	$ 440	$ 40,892	$ 427
75	$ 42,435	$ 440	$ 41,556	$ 427
76	$ 43,057	$ 440	$ 42,163	$ 427
77	$ 43,678	$ 440	$ 42,768	$ 427
78	$ 44,299	$ 440	$ 43,374	$ 427
79	$ 44,921	$ 440	$ 43,980	$ 427
80	$ 45,543	$ 440	$ 44,586	$ 427
81	$ 46,362	$ 440	$ 45,385	$ 427
82	$ 47,182	$ 440	$ 46,185	$ 427
83	$ 48,002	$ 440	$ 46,984	$ 427
84	$ 48,821	$ 440	$ 47,783	$ 427
85	$ 49,641	$ 440	$ 48,582	$ 427
86	$ 50,781	$ 440	$ 49,694	$ 427
87	$ 51,922	$ 440	$ 50,806	$ 427
88	$ 53,060	$ 440	$ 51,917	$ 427
89	$ 54,201	$ 440	$ 53,029	$ 427
90	$ 55,341	$ 440	$ 54,140	$ 427
91	$ 56,330	$ 440	$ 55,105	$ 427
92	$ 57,320	$ 440	$ 56,069	$ 427
93	$ 58,309	$ 440	$ 57,033	$ 427
94	$ 59,298	$ 440	$ 57,998	$ 427
95	$ 60,288	$ 440	$ 58,963	$ 427

** Fee per person per age

Co-Pay

Age	Single Membership Fee	Single Monthly Fee	Couple Membership Fee**	Couple Monthly Fee**
55	$ 18,152	$ 375	$ 17,839	$ 364
56	$ 18,695	$ 375	$ 18,372	$ 364
57	$ 19,238	$ 375	$ 18,906	$ 364
58	$ 20,112	$ 375	$ 19,764	$ 364
59	$ 20,985	$ 375	$ 20,622	$ 364
60	$ 21,858	$ 375	$ 21,481	$ 364
61	$ 22,731	$ 375	$ 22,339	$ 364
62	$ 23,605	$ 375	$ 23,197	$ 364
63	$ 24,294	$ 375	$ 23,869	$ 364
64	$ 24,984	$ 375	$ 24,542	$ 364
65	$ 25,673	$ 375	$ 25,213	$ 364
66	$ 26,226	$ 375	$ 25,752	$ 364
67	$ 26,778	$ 375	$ 26,290	$ 364
68	$ 27,329	$ 375	$ 26,829	$ 364
69	$ 27,881	$ 375	$ 27,367	$ 364
70	$ 28,433	$ 375	$ 27,905	$ 364
71	$ 28,885	$ 375	$ 28,346	$ 364
72	$ 29,337	$ 375	$ 28,787	$ 364
73	$ 29,791	$ 375	$ 29,228	$ 364
74	$ 30,243	$ 375	$ 29,669	$ 364
75	$ 30,695	$ 375	$ 30,110	$ 364
76	$ 31,102	$ 375	$ 30,507	$ 364
77	$ 31,510	$ 375	$ 30,904	$ 364
78	$ 31,917	$ 375	$ 31,301	$ 364
79	$ 32,324	$ 375	$ 31,699	$ 364
80	$ 32,732	$ 375	$ 32,096	$ 364
81	$ 33,265	$ 375	$ 32,616	$ 364
82	$ 33,797	$ 375	$ 33,135	$ 364
83	$ 34,331	$ 375	$ 33,655	$ 364
84	$ 34,863	$ 375	$ 34,174	$ 364
85	$ 35,397	$ 375	$ 34,694	$ 364
86	$ 35,929	$ 375	$ 35,213	$ 364
87	$ 36,463	$ 375	$ 35,733	$ 364
88	$ 36,995	$ 375	$ 36,252	$ 364
89	$ 37,529	$ 375	$ 36,773	$ 364
90	$ 39,082	$ 375	$ 38,287	$ 364
91	$ 39,615	$ 375	$ 38,806	$ 364
92	$ 40,147	$ 375	$ 39,326	$ 364
93	$ 40,681	$ 375	$ 39,846	$ 364
94	$ 41,213	$ 375	$ 40,365	$ 364
95	$ 42,266	$ 375	$ 41,391	$ 364

** Fee per person per age

EXHIBIT III

CCAH PROGRAM PROJECTED INCOME STATEMENTS

Senior Choice at Home
Projected Income Statement

Jewish Senior Services
Senior Choice at Home

FISCAL YEAR	2020	2021	2022	2023	2024
Revenue: (in thousands)					
Earned Membership Fees	$558	$646	$733	$821	$909
Monthly Fees	696	805	915	1,024	1,133
Other Revenue - Application Fees	5	5	5	5	5
Total Revenues	$1,259	$1,456	$1,653	$1,850	$2,047
Expenses: (in thousands)					
Salaries & Benefits	$202	$206	$260	$265	$321
Benefits	61	62	78	80	96
Marketing	75	79	83	87	91
General & Administrative	55	58	61	64	67
Assisted Living	94	80	83	85	88
Companion Services	730	803	883	972	1,069
Total Expenses	$1,217	$1,288	$1,448	$1,552	$1,731
Net Income	$42	$168	$205	$298	$316

step forward →

JEWISH HOME FOR THE ELDERLY OF FAIRFIELD COUNTY, INC. D/B/A JEWISH SENIOR SERVICES

FINANCIAL STATEMENTS
SEPTEMBER 30, 2019 AND 2018

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JEWISH HOME FOR THE ELDERLY OF FAIRFIELD COUNTY, INC. D/B/A JEWISH SENIOR SERVICES

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Independent Auditors' Report

To the Board of Directors
Jewish Home for the Elderly of Fairfield County, Inc.
d/b/a Jewish Senior Services
Fairfield, Connecticut

We have audited the accompanying financial statements of Jewish Home for the Elderly of Fairfield County, Inc. d/b/a Jewish Senior Services, which comprise the statements of financial position as of September 30, 2019 and 2018, and the related statements of activities and changes in net assets and cash flows for the years then ended, and the related statement of functional expenses for the year ended September 30, 2019 (with comparative totals for 2018) and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Jewish Home for the Elderly of Fairfield County, Inc. d/b/a Jewish Senior Services as of September 30, 2019 and 2018, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Change in Accounting Principle

As discussed in Note 2, during the year ended September 30, 2019, Jewish Home for the Elderly of Fairfield County, Inc. d/b/a Jewish Senior Services adopted Accounting Standards Update No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*, Accounting Standards Update No. 2018-08, *Not-for-Profit Entities (Topic 958): Clarifying the Scope and Accounting Guidance for Contributions Received and Contributions Made*, and Accounting Standards Update No. 2014-09*, Revenue from Contracts with Customers (Topic 606).* Our opinion is not modified with respect to this matter.

Blum, Shapiro & Company, P.C.

West Hartford, Connecticut
January 30, 2020

JEWISH HOME FOR THE ELDERLY OF FAIRFIELD COUNTY, INC.
D/B/A JEWISH SENIOR SERVICES

STATEMENTS OF FINANCIAL POSITION
SEPTEMBER 30, 2019 AND 2018

	2019	2018
ASSETS		
Current Assets		
Cash and cash equivalents (Note 2)	$ 2,578,278	$ 1,481,934
Accounts receivable, net (Notes 2, 10)	4,345,261	4,864,007
Current portion of contributions receivable, net (Notes 2, 4)	196,631	411,698
Prepaid expenses and other assets	453,027	412,695
Entrance fee receivables	375,294	110,407
Agency assets - residents' trust funds (Note 2)	156,139	151,304
Total current assets	8,104,630	7,432,045
Property and Equipment		
Land	5,000,000	5,000,000
Buildings and improvements	92,359,465	92,238,875
Equipment	3,965,040	3,897,654
Computers and software	1,370,696	1,317,709
Vehicles	379,859	379,859
Construction in process	159,463	-
	103,234,523	102,834,097
Less accumulated depreciation	13,516,695	9,643,854
Property and equipment, net	89,717,828	93,190,243
Other Assets		
Investments	12,126,760	12,356,533
Contributions receivable, net (Notes 2, 4)	68,794	430,349
Charitable remainder trust	268,090	268,090
Total other assets	12,463,644	3,054,972
Total Assets	$ 110,286,102	$ 113,677,260

The accompanying notes are an integral part of the financial statements

JEWISH HOME FOR THE ELDERLY OF FAIRFIELD COUNTY, INC.
D/B/A JEWISH SENIOR SERVICES

STATEMENTS OF FINANCIAL POSITION (CONTINUED)
SEPTEMBER 30, 2019 AND 2018

	2019	2018
LIABILITIES AND NET ASSETS		
Current Liabilities		
Accounts payable	$ 607,281	$ 772,287
Accrued taxes, expenses and other liabilities	2,725,130	3,320,547
Current portion of deferred compensation obligation (Note 5)	84,309	84,309
Contract liabilities (Note 2)	499,593	548,748
Current portion of notes payable (Note 6)	442,301	598,997
Current portion of bonds payable, net (Note 7)	2,055,000	1,968,333
Unearned entrance fees	375,294	110,407
Agency liabilities - funds held for residents (Note 2)	156,139	151,304
Total current liabilities	6,945,047	7,554,932
Other Liabilities		
Notes payable (Note 6)	110,159	825,378
Bonds payable, net (Note 7)	52,869,547	54,882,397
Liability under split-interest agreements	251,192	266,921
Deferred revenue from entrance fees, net (Note 2)	3,445,754	3,384,591
Deferred compensation obligation (Note 5)	19,885	45,933
Interest rate swap agreements (Note 7)	54,623	56,331
Accrued pension cost (Note 9)	1,946,013	2,114,981
Total other liabilities	58,697,173	61,576,532
Total liabilities	65,642,220	69,131,464
Net Assets		
Without donor restrictions	32,453,465	31,538,912
With donor restrictions (Note 12)	12,190,417	13,006,884
Total net assets	44,643,882	44,545,796
Total Liabilities and Net Assets	$ 110,286,102	$ 113,677,260

The accompanying notes are an integral part of the financial statements

JEWISH HOME FOR THE ELDERLY OF FAIRFIELD COUNTY, INC.
D/B/A JEWISH SENIOR SERVICES

STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS
FOR THE YEAR ENDED SEPTEMBER 30, 2019

	Without Donor Restrictions	With Donor Restrictions	Total
Revenues and Other Support			
Resident care and services (Note 2)	$ 43,846,495	$ -	$ 43,846,495
Community services (Note 2)	11,734,016	-	11,734,016
Other income	1,764,812	-	1,764,812
Provision for bad debts	(27,856)	-	(27,856)
Net assets released from restrictions	803,189	(803,189)	-
Total revenues and other support	58,120,656	(803,189)	57,317,467
Expenses			
Program services	52,117,697	-	52,117,697
Management and general	6,499,332	-	6,499,332
Fundraising	437,231	-	437,231
Total expenses	59,054,260	-	59,054,260
Operating Loss	(933,604)	(803,189)	(1,736,793)
Nonoperating Income (Expense)			
Contributions	486,872	437,876	924,748
Change in liability under split-interest agreements	(38,760)		- (38,760)
Net realized and unrealized losses on investments	(6,290)	(3,926)	(10,216)
Investment income, net	45,282	360,791	406,073
Change in pension liability (Note 9)	551,326		- 551,326
Unrealized gain on interest rate swap agreements (Note 7)	1,708		- 1,708
Net assets released from restrictions - capital	808,019	(808,019)	-
Net nonoperating income	1,848,157	(13,278)	1,834,879
Change in Net Assets	914,553	(816,467)	98,086
Net Assets - Beginning of Year	31,538,912	13,006,884	44,545,796
Net Assets - End of Year	$ 32,453,465	$ 12,190,417	$ 44,643,882

The accompanying notes are an integral part of the financial statements

JEWISH HOME FOR THE ELDERLY OF FAIRFIELD COUNTY, INC.
D/B/A JEWISH SENIOR SERVICES

STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS
FOR THE YEAR ENDED SEPTEMBER 30, 2018

	Without Donor Restrictions	With Donor Restrictions	Total
Revenues and Other Support			
Resident care and services (Note 2)	$ 42,670,811	$ -	$ 42,670,811
Community services (Note 2)	10,767,172	-	10,767,172
Other income	1,919,215	-	1,919,215
Provision for bad debts	(514,600)	-	(514,600)
Net assets released from restrictions	972,432	(972,432)	-
Total revenues and other support	55,815,030	(972,432)	54,842,598
Expenses			
Program services	51,081,980	-	51,081,980
Management and general	6,020,126	-	6,020,126
Fundraising	441,162	-	441,162
Total expenses	57,543,268	-	57,543,268
Operating Loss	(1,728,238)	(972,432)	(2,700,670)
Nonoperating Income (Expense)			
Contributions	1,470,295	486,046	1,956,341
Change in liability under split-interest agreements	(29,776)	-	(29,776)
Net realized and unrealized gains on investments	36,541	263,327	299,868
Investment income, net	39,270	348,555	387,825
Change in pension liability (Note 9)	36,745	-	36,745
Unrealized gain on interest rate swap agreements (Note 7)	31,870	-	31,870
Loss on disposal of property and equipment	(9,849)	-	(9,849)
Net assets released from restrictions - capital	1,094,058	(1,094,058)	-
Net nonoperating income	2,669,154	3,870	2,673,024
Change in Net Assets	940,916	(968,562)	(27,646)
Net Assets - Beginning of Year, as Previously Reported	31,155,391	13,975,446	45,130,837
Cumulative Adjustment - Adoption of New Accounting Standard (Note 2)	(557,395)	-	(557,395)
Net Assets - Beginning of Year, as Adjusted	30,597,996	13,975,446	44,573,442
Net Assets - End of Year	$ 31,538,912	$ 13,006,884	$ 44,545,796

The accompanying notes are an integral part of the financial statements

JEWISH HOME FOR THE ELDERLY OF FAIRFIELD COUNTY, INC.
D/B/A JEWISH SENIOR SERVICES

STATEMENT OF FUNCTIONAL EXPENSES
FOR THE YEAR ENDED SEPTEMBER 30, 2019
(WITH COMPARATIVE TOTALS FOR 2018)

	2019				2018
		Supporting Services			
	Program Services	Management and General	Fundraising	Total	Total
Salaries and wages	$ 27,638,149	$ 3,163,777	$ 253,343	$ 31,055,269	$ 30,401,589
Employee benefits	6,581,216	1,041,962	38,307	7,661,485	7,500,401
Purchased services	2,454,510	97,318	4,933	2,556,761	2,099,194
Interest expense	2,331,899	160,647	17,571	2,510,117	2,646,670
Occupancy	1,806,770	124,471	13,614	1,944,855	2,013,914
Food expense	1,391,960	236,710	12,610	1,641,280	1,647,819
Consulting and management fees	1,036,154	758,755	144	1,795,053	1,575,692
Medical supplies and expenses	1,588,747	1,481	-	1,590,228	1,544,921
Taxes	1,438,394	72,840	-	1,511,234	1,578,302
Office supplies	1,160,792	220,160	42,059	1,423,011	1,435,006
Depreciation expense	3,630,144	250,085	27,353	3,907,582	3,886,972
Information technology	457,981	29,372	24,638	511,991	401,437
Miscellaneous	600,981	341,754	2,659	945,394	811,351
Total Expenses	$ 52,117,697	$ 6,499,332	$ 437,231	$ 59,054,260	$ 57,543,268

The accompanying notes are an integral part of the financial statements

JEWISH HOME FOR THE ELDERLY OF FAIRFIELD COUNTY, INC.
D/B/A JEWISH SENIOR SERVICES

STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED SEPTEMBER 30, 2019 AND 2018

	2019	2018
Cash Flows from Operating Activities		
Change in net assets	$ 98,086	$ (27,646)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation	3,907,582	3,886,972
Bad debt expense	27,856	514,600
Interest for debt issuance costs	42,151	42,002
Net realized and unrealized (gains) losses on investments	10,216	(299,868)
Loss on disposal of property and equipment	-	9,849
Proceeds from entrance fees	(519,638)	(242,136)
Amortization of entrance fees	580,801	495,558
Unrealized gain on interest rate swap agreements	(1,708)	(31,870)
Contributions restricted for long-term investment purposes	(21,350)	(32,740)
Contributions restricted for capital purposes	-	(27,548)
(Increase) decrease in operating assets:		
Assets held by bond trustee	-	508,216
Accounts receivable	490,890	(417,794)
Contributions receivable	(76,950)	(14,993)
Prepaid expenses and other assets	(40,332)	(228,556)
Agency assets - residents' trust funds	(4,835)	(6,659)
Increase (decrease) in operating liabilities:		
Accounts payable	(165,006)	313,394
Accrued taxes, expenses and other liabilities	(738,742)	(1,082,635)
Accrued pension cost	(168,968)	126,772
Agency liabilities - funds held for residents	4,835	6,659
Liability under split-interest agreements	(15,729)	64,238
Contract liabilities	(49,155)	137,434
Deferred compensation obligation	(26,048)	(26,049)
Net cash provided by operating activities	3,333,956	3,667,200
Cash Flows from Investing Activities		
Cash outlays for property and equipment	(435,167)	(2,075,543)
Purchases of investments and reinvested income	(2,738,167)	(3,862,038)
Proceeds from sale of investments	2,957,724	3,791,170
Net cash used in investing activities	(215,610)	(2,146,411)
Cash Flows from Financing Activities		
Proceeds from notes payable and line of credit	-	585,000
Principal payments on notes payable and line of credit	(728,590)	(427,759)
Principal payments on bonds payable	(1,968,334)	(1,883,185)
Proceeds from contributions restricted for long-term investment purposes	25,560	9,753
Proceeds from contributions restricted for capital purposes	649,362	1,094,058
Net cash used in financing activities	(2,022,002)	(622,133)
Net Increase in Cash and Cash Equivalents	1,096,344	898,656
Cash and Cash Equivalents - Beginning of Year	1,481,934	583,278
Cash and Cash Equivalents - End of Year	$ 2,578,278	$ 1,481,934

The accompanying notes are an integral part of the financial statements

NOTES TO FINANCIAL STATEMENTS

NOTE 1 - NATURE OF OPERATIONS

Jewish Home for the Elderly of Fairfield County, Inc. d/b/a Jewish Senior Services (the Home) is a nonstock corporation under Connecticut law and a not-for-profit health care facility providing rest home and skilled nursing care, adult day care, licensed medical home care services and nonmedical home care services to the aged and infirm. As of September 30, 2019 and 2018, the Home was licensed for 294 skilled nursing beds. A substantial portion of the Home's revenue and related receivables is provided by Medicaid and Medicare programs.

The Auxiliary Organizations include the Women's Auxiliary of the Jewish Home for the Elderly and the Men's Club of the Jewish Home for the Elderly (the Auxiliaries). The Auxiliaries are incorporated separately; however, the principal function is fundraising for the Home. The Auxiliaries do not have agreements with the Home and, therefore, their activities are not included in the accompanying financial statements. However, they continue to have a financial interrelationship with the Home. Related party transactions are included in Note 14.

TJH Senior Living, LLC, and TJH Holding, LLC, were incorporated in 2009 as holding companies for potential business activities outside of the health care facility. The Home is the manager of these companies. Since incorporation, these companies have not had any business activity.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Change in Accounting Principle

In August 2016, the Financial Accounting Standards Board issued Accounting Standards Update (ASU) No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*. The amendment changes the previous reporting model for nonprofit organizations and enhances the disclosure requirements. The major changes include: (a) requiring the presentation of only two classes of net assets rather than three, (b) modifying the presentation of underwater endowment funds and related disclosures, (c) requiring the use of the placed in service approach to recognize the expirations of restrictions on gifts used to acquire or construct long-lived assets absent explicit donor stipulations otherwise, (d) requiring that all nonprofits present an analysis of expenses by function and nature in either the statement of activities, a separate statement, or in the notes and disclose a summary of the allocation methods used to allocate costs, (e) requiring the disclosure of quantitative and qualitative information regarding liquidity and availability of resources, (f) presenting investment return net of external and direct internal investments expenses, and (g) modifying other financial statement reporting requirements and disclosures intended to increase the usefulness of nonprofit financial statements. This ASU is effective for annual periods beginning after December 15, 2017. Management has adopted ASU 2016-14 for the year ended September 30, 2019. The amendments have been retrospectively applied, with the exception of a statement of functional expenses and disclosures on liquidity and availability of resources for the year ended September 30, 2018.

NOTES TO FINANCIAL STATEMENTS

In June 2018, the Financial Accounting Standards Board issued ASU No. 2018-08, *Not-for-Profit Entities (Topic 958): Clarifying the Scope and Accounting Guidance for Contributions Received and Contributions Made*. The amendment clarifies guidance on how an entity determines whether a transfer of assets is a contribution or exchange transaction. The two permitted transition methods under the new standard are the full retrospective method, in which case the standard would be applied to each prior reporting period presented, and the cumulative effect of applying the standard would be recognized at the earliest period shown, or the modified prospective method, in which case the effect of applying the standard would be recognized for any agreements not completed and any new agreements entered into at the date of initial application. The new standard is effective for annual reporting periods beginning after December 15, 2018. Management has adopted ASU2018-08 for the year ended September 30, 2019. The amendments have been applied using the full retrospective method.

There was no cumulative effect of applying ASU 2018-08.

In May 2014, the Financial Accounting Standards Board issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*, which replaces numerous requirements in accordance with accounting principles generally accepted in the United States of America, including industry-specific requirements, and provides companies with a single revenue recognition model for recognizing revenue from contracts with customers. The core principle of the new standard is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The two permitted transition methods under the new standard are the full retrospective method, in which case the standard would be applied to each prior reporting period presented and the cumulative effect of applying the standard would be recognized at the earliest period shown, or the modified retrospective method, in which case the cumulative effect of applying the standard would be recognized at the date of initial application. The new standard is effective for annual reporting periods beginning after December 15, 2017. Management has adopted ASU 2014-09 for the year ended September 30, 2019. The amendments have been applied using the full retrospective method.

The cumulative effect of applying ASU 2014-09 resulted in the following adjustments at September 30, 2018.

Financial Statement Line	As Previously Reported	Cumulative Adjustment	As Adjusted
On the statement of activities:			
Beginning net assets - October 1, 2017	$ 45,130,837	$ (557,395)	$ 44,573,442
Community services revenue	11,403,639	(636,467)	10,767,172
Ending net assets - September 30, 2018	45,739,658	(1,193,862)	44,545,796
On the statement of financial position:			
Entrance fee receivable	-	110,407	110,407
Unearned entrance fee	-	110,407	110,407
Deferred revenue from entrance fees	2,190,729	1,193,862	3,384,591

NOTES TO FINANCIAL STATEMENTS

Basis of Presentation

In order to ensure observance of limitations and restrictions placed on the use of the resources available to the Home, the accounts are maintained on the accrual basis of accounting, in conformity with accounting principles generally accepted in the United States of America (GAAP), and, accordingly, the accounts are recorded in the following net asset categories:

Net Assets Without Donor Restrictions
Net assets without donor restrictions consist of net assets over which the governing Board has control to use in carrying out the operations of the Home in accordance with its charter and by-laws and are neither required to be held in perpetuity or purpose restricted by donor-imposed restrictions. Board-designated endowment funds within net assets without donor restrictions were $210,773 and $177,518 as of September 30, 2019 and 2018, respectively.

Net Assets With Donor Restrictions
Net assets with donor restrictions represent contributions that are restricted by the donor as to purpose or time of expenditure and also include accumulated investment income and gains on donor- restricted endowment assets that have not been appropriated for expenditure. Net assets with donor restrictions also represent resources that have donor-imposed restrictions requiring that the principal be maintained in perpetuity but permit the Home to expend the income earned thereon for general purposes or purposes specified by the donor.

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions affecting the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash equivalents include cash and highly liquid investments purchased with an original maturity of three months or less. The Home maintains deposits in financial institutions that may, at times, exceed federal depository insurance limits. Management believes that the Home's deposits are not subject to significant credit risk.

Accounts Receivable

Accounts receivable are considered delinquent and written off when all attempts to collect from individuals or other payor sources have been exhausted. Management maintains an allowance for doubtful accounts of $195,112 and $437,821 at September 30, 2019 and 2018, respectively, which is based on a review of significant balances and past experience.

Investment Valuation and Income Recognition

Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 3 for a discussion of fair value measurements.

NOTES TO FINANCIAL STATEMENTS

Purchases and sales of securities are recorded on the trade date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Investment income (loss) includes the gains and losses on investments bought and sold as well as held during the year. Realized and unrealized gains and losses on these investments are reported in the statements of activities as increases or decreases in unrestricted net assets unless their use is temporarily or permanently restricted by explicit donor stipulations or by law. Realized and unrealized gains and losses and other investment income, net of related fees, are reflected in the accompanying statements of activities as investment income, net. These amounts are reported in the statements of activities as increases or decreases in net assets without donor restrictions or net assets with donor restrictions as appropriate based on any donor stipulations or law.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation of property and equipment is provided using the straight-line method over the estimated useful lives of the assets as follows:

Buildings and improvements	10-40 years
Furniture, fixtures and equipment	3-25 years
Computers and software	3-5 years
Vehicles	4 years

Expenditures for maintenance and repairs are charged to operations as incurred. Expenditures in excess of $1,000 for renewals and betterments are capitalized.

Contributions, Including Government Grants and Contracts

In accordance with ASU 2018-08, certain governmental grants and contracts received by a not-for- profit, including certain awards to fund capital expenditures, are generally considered to be contributions rather than exchange transactions since there was not commensurate value transferred between the resource provider and the Home. Promises to give that are subject to donor-imposed conditions (i.e., a donor stipulation that includes a barrier that must be overcome and a right of release from obligation) are recognized when the conditions on which they depend are substantially met, that is, when the conditional promise becomes unconditional. Unconditional contributions are recognized when promised or received, as applicable, and are considered to be available for unrestricted use unless specifically restricted by the donor.

The Home reports contributions of cash and other assets as donor-restricted support if they are received with donor stipulations that limit their use. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the accompanying statements of activities and changes in net assets as net assets released from restrictions. Transfers of assets from a resource provider received before the barriers are overcome are reported as deferred revenue on the accompanying consolidated statements of financial position. Contributions receivable expected to be collected in more than one year are discounted to their present value.

There were no conditional government grants and contracts not recognized as revenue as of September 30, 2019 and 2018.

NOTES TO FINANCIAL STATEMENTS

Contributed services are recognized in the financial statements if they enhance nonfinancial assets or require specialized skills, are provided by individuals possessing those skills and would typically need to be purchased if not provided by donation. General volunteer services do not meet these criteria for recognition. No contributed services requiring recognition were received during the years ended September 30, 2019 and 2018. However, services have been provided by various organizations, and a number of unpaid volunteers have contributed their time to the Home.

Contributions Receivable

Contributions receivable are stated net of discounts and allowance for uncollectible amounts, which are based upon estimates of collectability by the Home's management. The allowance for uncollectible amounts is evaluated periodically for adequacy based upon management's evaluation of past loss experience, known and inherent risks in its accounts, plus other factors that could affect collectability.

Split-Interest Agreements

The Home is a party to the following types of split-interest agreements:

Charitable Gift Annuities
The Home has entered into several charitable gift annuities whereby assets were transferred to the Home and invested. Under the terms of the program, contributions are received from donors in exchange for a promise by the Home to pay a fixed amount for a specified period of time to a donor or individuals designated by the donor. Annuity contracts may be established for either one or two lives and provide that fixed payments be made to the annuitants for the remainder of their lives. Upon termination of the annuity contract, any remaining assets revert to the Home for purposes as specified in the charitable gift annuity contracts. On an annual basis, the Home revalues the liability to make distributions to the designated beneficiaries based on actuarial assumptions. The present value of principal amounts due on these annuities was $268,090 as of September 30, 2019 and 2018.

Charitable Remainder Trust
The Home is the beneficiary of a charitable remainder trust managed by an unrelated trustee. A charitable remainder trust provides for the payment of distributions to the grantor or other designated beneficiaries over the trust's term (usually the designated beneficiary's lifetime). At the end of the trust's term, the remaining assets are available for the Home's use. The trust is carried at the fair value of the underlying investments. The portion of the trust attributable to the present value of the future benefits to be received by the Home is recognized in the statements of activities as a donor- restricted contribution in the period the trust is established. On an annual basis, the Home revalues the liability to make distributions to the designated beneficiaries based on actuarial assumptions.

Debt Issuance Costs

Debt issuance costs are fees and other costs incurred in obtaining financing, amortized on a straight- line basis, over the term of the related debt. Debt issuance costs are presented as a direct deduction of the carrying amount of the debt. Amortization of debt issuance costs is included in interest expense.

NOTES TO FINANCIAL STATEMENTS

Interest Rate Swap Agreements

The Home has entered into two interest rate swap agreements associated with its bonds payable. The agreements effectively change the interest rate exposure of the bonds payable from variable rate to fixed rate. The swap agreements became effective on May 1, 2016, which was one month prior to the first principal payment. The termination date of the swap agreements is May 1, 2026. See Note 7 for further information.

Agency Transactions

The Home provides residents with a service by which residents' funds are maintained in a separate account, the use of which is directed by the resident. Such funds are maintained in a separate bank account and are reflected in the accompanying statements of financial position as agency assets - residents' trust funds with a corresponding liability as agency liabilities - funds held for residents.

Revenue Recognition

The Home recognizes revenue at an amount reflecting the consideration to which the Home expects to be entitled in exchange for transferring goods or services to its customers using the following five-step process:

1. Identify the contract(s) with the customer
2. Identify the performance obligation(s) in the contract
3. Determine the transaction price
4. Allocate the transaction price to performance obligations in the contract
5. Recognize revenue when (or as) the company satisfies a performance obligation

See below for details on how the above five-step process is applied to the Home's contracts with customers.

Revenues from Contracts with Customers

Resident care and services and community services revenue is reported at the amount reflecting the consideration the Home expects to receive in exchange for the services provided. These amounts are due from residents, patients or third-party payors (including health insurers and government payors). Performance obligations are determined based on the nature of the services provided. Resident care and services and community services revenue is recognized as performance obligations are satisfied. The Home recognizes revenue in accordance with the provisions of ASC 606, *Revenue from Contracts with Customers* (ASC 606).

NOTES TO FINANCIAL STATEMENTS

Performance Obligations

At contract inception, the Home assesses the goods and services promised in its contracts with customers and identifies a performance obligation for each promise to transfer to the customer a distinct good or service (or bundle of goods or services). To identify the performance obligations, the Home considers all of the goods or services promised in the contract regardless of whether they are explicitly stated or implied by customary business practices. The Home determines the following distinct goods and services represent separate performance obligations:

- Skilled nursing facility services
- Assisted living services
- Continuing care at home services
- Home care services
- Hospice services
- Outpatient services
- Other services

The Home satisfies its performance obligations for skilled nursing facility services, hospice and assisted living services upon completion of each day's service or as ancillary services are provided. Patients receive care and room and board on a per diem basis and can also receive various ancillary services. Residents are charged a daily fee for bed stay and services provided. Fees for ancillary services performed are payable upon receipt. Private room charges are due one month in advance.

The Home satisfies its performance obligations for continuing care at home services over time as benefits are transferred to the resident. Because a member has the ability to discontinue paying the monthly service fee at any time, the agreement is viewed as a monthly contract with an option to renew. Payment terms for the entrance fee are a fixed amount paid at the time the contract is signed and the member begins in the program. The nonrefundable entrance fee is recorded as a contract liability and amortized over the estimated actuarial life of the member, which is re-evaluated on an annual basis. The monthly service fee is set at the time of the contract signing and is fixed except for annual inflationary increases.

The Home satisfies its performance obligations for home care services upon completion of each session of service provided. Medicare pays the Home a predetermined base payment for each patient, adjusted for the health condition and care needs of the beneficiary. The payment covers a 60-day episode of care. The Home receives half of the estimated base payment upon filing of the initial claim. The second half of the payment is received at the close of the 60-day episode. Once an episode is approved by Medicare, payment is expected for the services provided.

The Home satisfies its performance obligations for outpatient services upon completion of each service provided.

Performance obligations are determined based on the nature of the services provided by the Home. Revenue for performance obligations satisfied over time is recognized based on the estimated realizable amount earned for services provided. The Home believes this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation.

NOTES TO FINANCIAL STATEMENTS

Transaction Price

The Home determines the transaction price based on standard charges for room and board and services provided, reduced by contractual adjustments provided to applicable third-party payors or discounts provided to uninsured patients in accordance with the Home's policy. The Home determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies and historical experience. The Home determines its estimate of implicit price concessions based on its historical collection experience with this class of patients. Agreements with third-party payors provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

- Medicare - Certain skilled nursing facility services are paid at prospectively determined rates per discharge based on clinical, diagnostic and other factors.
- Medicaid - Reimbursements for Medicaid services are generally paid at prospectively determined rates on a per diem basis.
- Other - Payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations provide for payment using prospectively determined daily rates or discounts from established charges.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various healthcare organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the Home's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Home. In addition, the contracts the Home has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive revenue adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Home's historical settlement activity, including an assessment to ensure the probability of a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews and investigations.

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts and implicit price concessions based on historical collection experience. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Subsequent changes determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense.

NOTES TO FINANCIAL STATEMENTS

The Home has determined that the nature, amount, timing and uncertainty of revenue and cash flows are affected by the following factors:

- Payors (for example, Medicare, Medicaid, managed care or other insurance, patient) have different reimbursement and payment methodologies
- Length of the patient's service or episode of care
- Line of business providing the service

Other operating revenue includes food and service revenue, child care, fitness center and other nonpatient revenue. This revenue is recognized on a monthly basis upon the provision of the respective service.

The difference between the opening and closing balances of the Home's contract liabilities from entrance fees primarily result from the timing difference between the Home's performance and nonrefundable entrance fees received and/or amortized during the period.

The composition of revenues by primary payor for the years ended September 30, 2019 and 2018 is as follows:

	2019		2018	
	Resident Services and Care	Community Services	Resident Services and Care	Community Services
Medicaid	$ 23,361,232	$ 279,765	$ 23,821,631	$ 251,842
Private	12,028,423	6,023,298	11,472,876	5,513,877
Medicare	6,455,279	3,358,182	5,662,807	3,144,707
Continuing care members	-	1,178,381	-	1,108,060
Other third-party payors	2,001,561	894,390	1,713,497	748,686
Total	$ 43,846,495	$ 11,734,016	$ 42,670,811	$ 10,767,172

Contract Liabilities

The Home recognizes contract liabilities in relation to its private payor long-term care, assisted living businesses and adult day services. The opening and closing balances of the Home's contract liabilities are as follows:

	Contract Liabilities
Opening (October 1, 2017)	$ 467,427
Closing (September 30, 2018)	548,748
Increase	81,321
Opening (October 1, 2018)	548,748
Closing (September 30, 2019)	499,593
Decrease	(49,155)

NOTES TO FINANCIAL STATEMENTS

Patient Mix

Revenues per patient mix as of and for the years ended September 30, 2019 and 2018 was as follows:

	As of September 30, 2019	As of September 30, 2018	For the Year Ended September 30, 2019	For the Year Ended September 30, 2018
Medicaid	67%	70%	68%	70%
Medicare and managed care	15	12	15	13
Private*	18	18	17	17
	100%	100%	100%	100%

*including pending Medicaid patients

Average occupancy was 97% and 99% for the years ended September 30, 2019 and 2018, respectively.

Income Taxes

The Home is tax exempt under Section 501(c)(3) of the Internal Revenue Code and is not subject to federal or state income taxes.

Functional Allocation of Expenses

The costs of providing various programs and other activities have been summarized on a functional basis in the statement of functional expenses. Accordingly, certain costs have been allocated among the programs and supporting services benefited. Such allocations are determined by management on an equitable basis. Expenses related to more than one function have been allocated based on time and effort, salaries and wages, square footage occupied and other reasonable measures of relative benefit. All other costs are directly charged to the programs and supporting services they benefit.

Subsequent Events

In preparing these financial statements, management has evaluated subsequent events through January 30, 2020, which represents the date the financial statements were available to be issued.

NOTES TO FINANCIAL STATEMENTS

NOTE 3 - FAIR VALUE MEASUREMENTS

Generally accepted accounting principles establish a framework for measuring fair value. That framework provides a fair value hierarchy prioritizing the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are described below:

Level 1
Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets the Home has the ability to access.

Level 2

Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices observable for the asset or liability;
- Inputs derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3
Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs. As a practical expedient, certain investments are measured at fair value on the basis of net asset value. The fair value of these investments is not included in the fair value hierarchy.

Financial Instruments Measured at Fair Value

The following is a description of the valuation methodologies used for financial instruments measured at fair value:

Money Markets
This investment class is meant to provide safety when money managers are unable to find investments with appropriate returns consistent with their strategy. It tends to be very short term with a very low return.

Corporate Bonds
Certain corporate bonds are valued at the closing price reported in the active market in which the individual securities are traded. Other corporate bonds are valued based on yields currently available on comparable securities of issuers with similar durations and credit ratings.

NOTES TO FINANCIAL STATEMENTS

Municipal Bonds
This investment class is meant to provide a low risk component to the Home's portfolio and provides an asset class that has a low correlation to the equity investments.

Common and Preferred Stocks
Common and preferred stocks are valued at the closing price reported in the active market in which the individual securities are traded.

Mutual Funds
Mutual funds are valued at the quoted net asset value of shares held by the Home at year end.

Exchange Traded Funds
Exchange traded funds are valued at the closing price reported in the active market in which the individual securities are traded.

U.S. Governmental Securities
U.S. governmental securities are valued at the closing price reported in the active market in which the individual securities are traded.

Contributions Receivable
Contributions receivable are values based on discounted cash flows, reduced by an allowance for collectability.

Interest Rate Swap Agreements
Interest rate swap agreements are valued using both observable and unobservable inputs, such as quotations received from the counterparty, dealers or brokers, whenever available and considered reliable. In instances where models are used, the value of the interest rate swap depends upon the contractual terms of, and specific risks inherent in, the instrument as well as the availability and reliability of observable inputs. Such inputs include market prices for reference securities, yield curves, credit curves, measures of volatility, prepayment rates, assumptions for nonperformance risk and correlations of such inputs. Interest rate swap agreements have inputs which can generally be corroborated by market data and are therefore classified as Level 2.

There have been no changes in the methodologies used at September 30, 2019 and 2018.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Home believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

NOTES TO FINANCIAL STATEMENTS

The following tables set forth by level, within the fair value hierarchy, the Home's assets and liabilities subject to fair value reporting at fair value as of September 30, 2019 and 2018:

		2019		
		Fair Value Measurements Using		
Description	Total	Level 1	Level 2	Level 3
Money market funds	$ 1,266,066	$ 1,266,066	$ -	$ -
Fixed income:				
Corporate bonds	313,039	-	313,039	-
Municipal bonds	199,179	199,179	-	-
Equity securities:				
Common stocks	503,719	503,719	-	-
Preferred stocks	187,230	187,230	-	-
Mutual funds:				
Fixed income	2,752,766	2,752,766	-	-
Equities	5,989,835	5,989,835	-	-
U.S. government bonds	80,996	80,996	-	-
Exchange traded funds	833,930	833,930	-	-
Total investments at fair value	12,126,760	11,813,721	313,039	-
Contributions receivable, net	265,425	-	-	265,425
Total Assets at Fair Value	$ 12,392,185	$ 11,813,721	$ 313,039	$ 265,425
Total Liabilities at Fair Value:				
Interest rate swap agreements	$ 54,623	$ -	$ 54,623	$ -

		2018		
		Fair Value Measurements Using		
Description	Total	Level 1	Level 2	Level 3
Money market funds	$ 273,459	$ 273,459	$ -	$ -
Fixed income:				
Corporate bonds	273,193	-	273,193	-
Municipal bonds	209,854	209,854	-	-
Equity securities:				
Common stocks	488,443	488,443	-	-
Preferred stocks	145,345	145,345	-	-
Mutual funds:				
Fixed income	2,629,581	2,629,581	-	-
Equities	7,200,019	7,200,019	-	-
U.S. government bonds	79,362	79,362	-	-
Exchange traded funds	1,057,277	1,057,277	-	-
Total investments at fair value	12,356,533	12,083,340	273,193	-
Contributions receivable, net	842,047	-	-	842,047
Total Assets at Fair Value	$ 13,198,580	$ 12,083,340	$ 273,193	$ 842,047
Total Liabilities at Fair Value:				
Interest rate swap agreements	$ 56,331	$ -	$ 56,331	$ -

NOTES TO FINANCIAL STATEMENTS

The table below sets forth a summary of changes in the fair value of the Home's Level 3 assets for the years ended September 30, 2019 and 2018:

	Contributions Receivable, Net
Balance - September 30, 2017	$ 1,870,577
New contributions receivable	60,288
Collections on contributions receivable	(1,103,811)
Change in discount on contributions receivable	25,699
Write offs for uncollectible accounts	(10,706)
Balance - September 30, 2018	842,047
New contributions receivable	41,350
Collections on contributions receivable	(672,887)
Change in discount on contributions receivable	54,920
Write offs for uncollectible accounts	(5)
Balance - September 30, 2019	$ 265,425

Financial Instruments Not Measured at Fair Value

The carrying amounts of cash and cash equivalents, assets held by trustee, accounts receivable, prepaid expenses and other current assets, agency assets, bond proceeds held in escrow, accounts payable, accrued taxes, expenses and other liabilities, and line of credit approximate their fair value because of the short-term nature of these instruments.

The fair value of bonds payable as of September 30, 2019 and 2018 approximates the total outstanding principal balance. The method used to determine the fair value of bonds payable is quoted prices for similar debt instruments. The fair value of notes payable as of September 30, 2019 and 2018 was $293,566 and $720,404, respectively. The method used to determine the fair value of notes payable is quoted prices for similar debt instruments.

There have been no changes in the methodologies used at September 30, 2019 and 2018.

NOTES TO FINANCIAL STATEMENTS

NOTE 4 - CONTRIBUTIONS RECEIVABLE

Contributions receivable as of September 30, 2019 and 2018 are expected to be collected as follows:

	2019		
	Restricted for Time or Purpose	Restricted in Perpetuity	Total
Within one year	$ 294,656	$ 2,000	$ 296,656
Within one to five years	100,000	8,000	108,000
More than five years	-	19,005	19,005
Total contributions receivable	394,656	29,005	423,661
Allowance for uncollectible	(142,894)	-	(142,894)
Less discount to net present value	(8,000)	(7,342)	(15,342)
Net Contributions Receivable	$ 243,762	$ 21,663	$ 265,425

	2018		
	Restricted for Time or Purpose	Restricted in Perpetuity	Total
Within one year	$ 409,698	$ 2,000	$ 411,698
Within one to five years	616,500	8,000	624,500
More than five years	-	19,005	19,005
Total contributions receivable	1,026,198	29,005	1,055,203
Allowance for uncollectible	(142,897)	-	(142,897)
Less discount to net present value	(62,917)	(7,342)	(70,259)
Net Contributions Receivable	$ 820,384	$ 21,663	$ 842,047

Contributions receivable in more than one year at September 30, 2019 and 2018 are discounted at 4.5%.

Conditional Promises to Give

The Home has been advised that it is named as a beneficiary in other charitable trusts and wills. No amounts have been recognized in the accompanying financial statements, inasmuch as these instruments are conditional and subject to change.

NOTE 5 - DEFERRED COMPENSATION OBLIGATION

The Home's deferred compensation obligation is based on a discount rate of 6-1/2% of payments to be made to the former President over a 15-year period, beginning in fiscal year 2008. As of September 30, 2019 and 2018, the obligation amounted to $104,194 and $130,242, respectively.

NOTES TO FINANCIAL STATEMENTS

NOTE 6 - NOTES PAYABLE

Notes payable as of September 30, 2019 and 2018 consist of the following:

	2019	2018
Term loan in the amount of $2,000,000, payable in monthly installments of $36,881, including interest at 3.99%, compounded monthly through May 2020, secured by specific equipment.	$ 291,622	$ 712,946
Unsecured subordinate loans in the amount of $585,000, payable to related parties monthly in the amount of $17,800, including interest at 5%, compounded monthly commencing on December 1, 2018 through March 1, 2023. The loans will also accrue payment-in-kind (PIK) interest at 5% through December 2018, and the PIK interest will be added to the outstanding balance. During the year ended September 30, 2019, the loans accrued PIK interest of $20,093. The loans are subordinate to the bonds and notes payable.	187,464	613,609
Equipment loans in the amount of $110,493, payable in monthly installments of $1,271 and $766, including one noninterest-bearing loan and one at 2.9%, compounded monthly through April 2022 and March 2023, secured by the financed equipment.	73,374	97,820
	552,460	1,424,375
Less current portion	442,301	598,997
Total Notes Payable - Long Term	$ 110,159	$ 825,378

The following is a schedule of future maturities of notes payable at September 30, 2019:

Year Ending September 30	
2020	$ 442,301
2021	85,697
2022	19,860
2023	4,602
	$ 552,460

Letter of Credit

The Home has a standby letter of credit for $850,000 that renews annually each fiscal year. The letter expires on April 30, 2020.

NOTES TO FINANCIAL STATEMENTS

NOTE 7 - BONDS PAYABLE

On April 29, 2014, the Home obtained $62,000,000 from the issuance of City of Bridgeport tax-exempt bonds through People's United Bank to develop and construct a new campus on Park Avenue. The new campus was substantially completed on July 1, 2016 and houses all operations of the Home. The bonds consist of Senior Living Facility Revenue Bonds, Series 2014A (Series A) in the principal amount of $55,500,000 and Senior Living Facility Revenue Bonds, Series 2014B (Series B) in the principal amount of $6,500,000. The Series A bonds mature on May 1, 2041 and the Series B bonds mature on May 1, 2026. Quarterly interest payments commenced May 29, 2014 at the Bank Rate as defined in the agreement and quarterly principal payments commenced June 1, 2016. The bonds are secured by all tangible assets, contributions receivable, leases and revenues of the Home.

As discussed in Note 2, the Home has interest rate swap agreements with People's United Bank. The original notional values of the swaps were $55,500,000 and $6,500,000, from the issuance of the City of Bridgeport tax-exempt bonds. The swap agreements provide the Home with interest rate protection for its City of Bridgeport tax-exempt variable rate bonds. The Home agrees to pay People's United Bank fixed rates of 2.67% for the Series A bonds and 2.38% for the Series B bonds in exchange for receiving a floating variable rate. The fixed rates include a termination fee equal to 0.145% for the Series A bonds and 0.05% for the Series B bonds, which will enable the Home to terminate the swaps at any time on or after May 1, 2023 without making termination payments.

Bonds payable on the statements of financial position are net of unamortized debt issuance costs of $825,453 and $867,603 at September 30, 2019 and 2018, respectively.

Principal payments due on the bonds payable are expected to be as follows:

Year Ending September 30	
2020	$ 2,055,000
2021	2,148,333
2022	2,246,667
2023	2,343,333
2024	2,446,667
Thereafter	44,510,000
	$ 55,750,000

The bonds payable are subject to certain financial covenants to be tested on an annual basis. The Home entered into a forbearance agreement with People's United Bank on December 13, 2017, which was effective through December 31, 2018. Under this agreement, the Home was required to meet certain requirements throughout the forbearance period, and the original financial covenants became applicable again at the end of the forbearance period. The Home was in compliance with its financial covenants as of September 30, 2019.

NOTES TO FINANCIAL STATEMENTS

NOTE 8 - COMMITMENTS

The Home leased property for its Adult Daycare and Outpatient Programs under an operating lease which expired on August 31, 2019. Rent expense under this lease totaled $74,016 and $201,059 for the years ended September 30, 2019 and 2018, respectively.

The Home leases office equipment and an automobile under operating leases that expire at various times through 2022. The Home also leased office and medical space under a lease which expired on July 31, 2019. Rental expense under these leases totaled $71,652 and $73,452 for the years ended September 30, 2019 and 2018, respectively.

Future minimum lease payments under operating leases that have remaining terms in excess of one year are as follows:

Year Ending September 30		
2020	$	60,559
2021		59,064
2022		59,064
Total Minimum Lease Payments		$ 178,687

NOTE 9 - BENEFIT PLANS

Pension Plan

The Home has a noncontributory defined benefit pension plan covering all eligible employees as of September 30, 2004, the date the plan was frozen and all benefit accruals ceased. The benefits are based upon years of service, and employees were fully vested in the company match and contribution after five years of service.

GAAP requires companies to record a liability on the statements of financial position for the underfunded portion of postretirement plans, defined as the amount by which the projected benefit obligation exceeds the fair value of plan assets.

The Home's funding policy is to make the minimum annual contributions required by applicable regulations. Contributions are intended to provide not only for benefits attributable to service to date, but also for those expected to be earned in the future.

During March 2019, the Home changed trustees. All assets of the plan, totaling approximately $3.3 million, were transferred from Morgan Stanley to Principal Life Insurance Company.

NOTES TO FINANCIAL STATEMENTS

The following table sets forth further information about the Home's defined benefit pension plan as of and for the years ended September 30, 2019 and 2018:

	2019	2018
Funded status	$ (1,946,013)	$ (2,114,981)
Benefits paid	(65,606)	(454,245)
Settlements	(332,878)	-
Employer contributions	200,000	200,000

Amounts recognized in the statements of financial position at September 30, 2019 and 2018 consist of the following:

	2019	2018
Pension Liability	$ (1,946,013)	$ (2,114,981)

Amounts previously recognized in changes in unrestricted net assets consist of the following:

	2019	2018
Net Gain	$ 244,087	$ 159,313

The accumulated benefit obligation was $5,373,726 and $5,497,191 at September 30, 2019 and 2018, respectively.

The following table details information for pension plans with an accumulated benefit obligation in excess of plan assets at September 30, 2019 and 2018:

	2019	2018
Projected benefit obligation	$ 5,373,726	$ 5,497,191
Accumulated benefit obligation	5,373,726	5,497,191
Fair value of plan assets	3,427,813	3,382,210

NOTES TO FINANCIAL STATEMENTS

Other changes in plan assets and benefit obligations recognized in the statements of activities and changes in net assets consisted of the following for the years ended September 30, 2019 and 2018:

	2019	2018
Net periodic benefit cost	$ 582,258	$ 363,517
Net (gain) loss	(18,523)	289,677
Settlement	(200,746)	-
Amortization of net gain	(332,057)	(326,422)
Change in pension liability	(551,326)	(36,745)
Total Recognized in Net Periodic Benefit Cost (Salaries and Benefits) and Change in Pension Liability	$ 30,932	$ 326,772

The estimated net loss to be amortized from changes in net assets without donor restrictions into net periodic benefit cost in 2019 has not yet been determined.

Assumptions used in determining the obligation and the net periodic costs of the defined benefit plan were as follows:

	2019	2018
Weighted-average assumptions:		
Discount rate as of end of year	4.21%	3.78%
Expected return on plan assets for the year	6.50%	5.00%

The Home's pension plan weighted-average asset allocations at September 30, 2019 and 2018 by asset category are as follows:

	2019	2018
Separate accounts	100%	0%
Cash	0	5
Equity securities	0	11
Mutual funds	0	79
Debt securities	0	5
Total	100%	100%

The expected rate of return on pension plan assets is determined by those assets' historical long-term investment performance, current asset allocation and estimates of future long-term returns by asset class.

NOTES TO FINANCIAL STATEMENTS

The Home's investment strategy is based on an expectation that equity securities and mutual funds will outperform debt securities over the long term. Accordingly, the asset allocation strategy target allocation is 55% equity, 30% fixed income and 15% other. The strategy utilizes actively managed U.S. equity securities and investment grade debt securities (which constitute 80% or more of debt securities) with lesser allocations to high-yield and international debt securities benchmarked against indices.

The Home attempts to mitigate investment risk by rebalancing between debt and equity classes as the Home's contributions and monthly benefit payments are made. Although changes in interest rates may affect the fair value of a portion of the investment portfolio and cause unrealized gains and losses, such gains or losses would not be realized unless the investments are sold.

Estimated Future Benefit Payments

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid:

Year Ending September 30	
2020	$ 1,130,000
2021	590,000
2022	270,000
2023	250,000
2024	270,000
2025-2029	1,450,000

Expected Cash Flow

The minimum funding requirement for fiscal 2019 is expected to be approximately $145,000.

The following tables set forth by level, within the fair value hierarchy, the Home's defined benefit plan assets at fair value as of September 30, 2019 and 2018:

Fair Value Measurements at September 30, 2019

Asset Class	Total	Level 1	Level 2	Level 3
Separate accounts	$ 3,427,813	$ -	$ 3,427,813	$ -
Total	$ 3,427,813	$ -	$ 3,427,813	$ -

NOTES TO FINANCIAL STATEMENTS

Fair Value Measurements at September 30, 2018				
Asset Class	**Total**	**Level 1**	**Level 2**	**Level 3**
Cash equivalents	$ 187,139	$ 187,139	$ -	$ -
Equities - preferred stocks	38,795	38,795	-	-
Exchange traded funds	321,244	321,244	-	
Mutual funds	2,661,010	2,661,010	-	-
Fixed income:				
Government	125,284	125,284	-	-
Corporate	48,738	-	48,738	-
Total	$ 3,382,210	$ 3,333,472	$ 48,738	$ -

Employee 401k Plan

The Home maintains a defined contribution plan. Employee contributions under the plan are determined by the participating employees, subject to certain Internal Revenue Service limitations, and the Home matches employee contributions at a rate of 50%, up to a maximum of 4% of compensation. The Home also offers a discretionary profit-sharing contribution. The Home's contribution expense totaled $376,680 and $332,720 for the years ended September 30, 2019 and 2018, respectively.

NOTE 10 - CONCENTRATION OF CREDIT RISK

The Home grants credit without collateral to its residents, most of whom are local residents, and some are funded under third-party payor agreements. The mix of gross receivables at September 30, 2019 and 2018 was as follows:

	2019	2018
Medicare	17%	14%
Medicaid	41	43
Private pay and other*	42	43
	100%	100%

*including pending Medicaid patients

NOTE 11 - LIQUIDITY AND AVAILABILITY OF RESOURCES

The Home's financial assets available within one year of the statements of financial position date for general expenditure are as follows:

Cash and cash equivalents	$ 2,578,278
Accounts receivable, net	4,345,261
Current portion of contributions receivable, net, without donor restrictions	29,450
Entrance fee receivables	375,294
Total Financial Assets Available Within One Year for General Expenditure	$ 7,328,283

NOTES TO FINANCIAL STATEMENTS

Liquidity Management

The Home maintains a policy of structuring its financial assets to be available as its general expenditures, liabilities and other obligations come due.

NOTE 12 - NET ASSETS WITH DONOR RESTRICTIONS

The following is the composition of the Home's net assets with donor restrictions at September 30, 2019 and 2018:

	2019	2018
Restricted in perpetuity:		
General purpose	$ 8,878,200	$ 8,792,242
Income use restricted:		
Specific programs	2,129,394	2,129,399
Total restricted in perpetuity	11,007,594	10,921,641
Restricted by time or purpose:		
Accumulated earnings on endowment funds held in perpetuity	939,061	1,264,858
Specific programs	13,182	17,920
Capital	201,130	795,065
Future periods	29,450	7,400
Total purpose and time restricted	1,182,823	2,085,243
Total Net Assets With Donor Restrictions	$ 12,190,417	$ 13,006,884

Net assets with donor restrictions were released from restrictions by incurring expenses satisfying the restricted purposes or by the occurrence of other events specified by donors are as follows for the years ended September 30, 2019 and 2018:

	2019	2018
Purpose restrictions:		
Accumulated earnings on permanent endowment funds	$ 779,154	$ 962,679
Specific programs	17,235	2,873
Capital	808,019	1,094,058
Passage of time	6,800	6,880
Net Assets Released from Restrictions	$ 1,611,208	$ 2,066,490

NOTES TO FINANCIAL STATEMENTS

NOTE 13 - ENDOWMENT

The Home's endowment consists of approximately 69 individual funds established for a variety of purposes. Its endowment includes both donor-restricted endowment funds and funds designated by the Board of Directors to function as endowments. As required by accounting principles generally accepted in the United States of America, net assets associated with endowment funds, including funds designated by the Board of Directors to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

Interpretation of Relevant Law

The Board of Directors of the Home has interpreted the Connecticut Prudent Management of Institutional Funds Act (CTPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Foundation classifies as net assets with donor restrictions (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund not classified in permanently endowment is classified as donor-restricted net assets until those amounts are appropriated for expenditure by the organization in a manner consistent with the standard of prudence prescribed by CTPMIFA.

In accordance with CTPMIFA, the Home considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

- The duration and preservation of the fund
- The purposes of the organization and the donor-restricted endowment fund
- General economic conditions
- The possible effect of inflation and deflation
- The expected total return from income and the appreciation of investments
- Other resources of the organization
- The investment policies of the organization

NOTES TO FINANCIAL STATEMENTS

Endowment net asset composition as of September 30, 2019 is as follows:

	Without Donor Restrictions	With Donor Restrictions	Total Endowment Assets
Board-designated endowment funds	$ 210,773	$ -	$ 210,773
Donor-restricted endowment funds:			
Original donor-restricted gift amount and amounts required to be maintained in perpetuity by donor	-	10,716,566	10,716,566
Accumulated gains and income on donor-restricted endowment assets not yet appropriated	-	151,074	151,074
Term endowment	-	787,986	787,986
Total Funds	$ 210,773	$ 11,655,626	$ 11,866,399

Changes in endowment net assets for the year ended September 30, 2019 are as follows:

	Without Donor Restrictions	With Donor Restrictions	Total
Endowment net assets - October 1, 2018	$ 177,518	$ 11,895,467	$ 12,072,985
Investment return:			
Investment income, net	33,930	360,791	394,721
Net investment losses	(4,747)	(3,926)	(8,673)
Total investment return	29,183	356,865	386,048
Contributions	4,072	182,445	186,517
Appropriation of endowment assets for expenditure	-	(779,151)	(779,151)
Endowment net assets - September 30, 2019	$ 210,773	$ 11,655,626	$ 11,866,399

NOTES TO FINANCIAL STATEMENTS

Endowment net asset composition as of September 30, 2018 is as follows:

	Without Donor Restrictions	With Donor Restrictions	Total Endowment Assets
Board-designated endowment funds	$ 177,518	$ -	$ 177,518
Donor-restricted endowment funds:			
Original donor-restricted gift amount and amounts required to be maintained in perpetuity by donor	-	10,630,609	10,630,609
Accumulated gains and income on donor-restricted endowment assets not yet appropriated	-	476,872	476,872
Term endowment	-	787,986	787,986
Total Funds	$ 177,518	$ 11,895,467	$ 12,072,985

Changes in endowment net assets for the year ended September 30, 2018 are as follows:

	Without Donor Restrictions	With Donor Restrictions	Total
Endowment net assets - October 1, 2017	$ 124,905	$ 11,835,500	$ 11,960,405
Investment return:			
Investment income, net	29,740	348,555	378,295
Net investment gains	22,873	263,327	286,200
Total investment return	52,613	611,882	664,495
Contributions	-	410,764	410,764
Appropriation of endowment assets for expenditure	-	(962,679)	(962,679)
Endowment net assets - September 30, 2018	$ 177,518	$ 11,895,467	$ 12,072,985

Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or CTPMIFA requires the Home to retain as a fund of perpetual duration. As of September 30, 2019, funds with original gift values of $9,112,980, fair values of $8,841,815 and deficiencies of $271,165 were reported in net assets with donor restrictions. There were no such deficiencies as of September 30, 2018.

NOTES TO FINANCIAL STATEMENTS

Return Objectives and Risk Parameters

The Home has adopted investment and spending policies for endowment assets attempting to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor- restricted funds the Home must hold in perpetuity or for a donor-specified period(s) as well as board- designated funds. Under this policy, as approved by the Board of Directors, the endowment assets are invested in a manner intending to produce results exceeding the price and yield results of the Home's custom index while assuming a moderate level of investment risk. The Home expects its endowment funds, over time, to provide an average rate of return of approximately 6.5% annually. Actual returns in any given year may vary from this amount.

Strategies Employed for Achieving Objectives

To satisfy its long-term rate-of-return objectives, the Home relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Home targets a diversified asset allocation placing an emphasis on equity-based and fixed income investments to achieve its long-term return objectives within prudent risk constraints.

Spending Policy and How the Investment Objectives Relate to Spending Policy

The Home has a policy of appropriating for distribution each year 4% of the total endowment investment value. The Home increased the distribution from 4% to 5.5% of the total endowment investment value for the years ended September 30, 2018 and 2019. In establishing this policy, the Home considered the long-term expected return on its endowment. Accordingly, over the long term, the Home expects the current spending policy to allow its endowment to grow at an average of 6.5% annually. This is consistent with the Home's objective to maintain the purchasing power of the endowment assets held in perpetuity or for a specified term as well as to provide additional real growth through new gifts and investment return. The Home has a policy that does not permit spending from underwater endowment funds, unless otherwise precluded by donor intent or relevant laws and regulations.

NOTE 14 - RELATED PARTY TRANSACTIONS

The Auxiliaries made contributions to the Home of $221,227 and $329,500 for the years ended September 30, 2019 and 2018, respectively.

The Home receives a fee for providing billing services for Geriatric Professional Group, LLC (GPG), which provides physicians' services to residents of the Home. The Home had revenues from GPG of approximately $22,800 and $26,000 during the years ended September 30, 2019 and 2018, respectively. Amounts due to the Home from GPG at September 30, 2019 and 2018 are reflected in prepaid expenses and other assets in the accompanying statements of financial position and amounted to approximately $1,500 and $1,900, respectively.

During 2018, the Home received $148,500 from the Women's Auxiliary and $436,500 from various board members in the form of subordinate loans to fund the construction of the Adult Day Care Center. During 2019, payments were made in the amount of $282,820. Additionally, $143,325 was forgiven by the board members. See Note 6 for further information.

NOTES TO FINANCIAL STATEMENTS

NOTE 15 - CASH FLOWS

Additional Cash Flow Information

The Home paid cash for interest of $2,447,873 and $2,576,059 during the years ended September 30, 2019 and 2018, respectively.

Noncash Financing and Investing Activities

During the year ended September 30, 2018, the Home financed the purchase of equipment in the amount of $121,000.

During the years ended September 30, 2019 and 2018, the Home disposed of property and equipment totaling $34,739 and $51,126, respectively.

NOTE 16 - HEALTH CARE INDUSTRY

Regulatory Environment

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes the Home is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. While no material regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Medicare

The Centers for Medicare and Medicaid Services have changed the Medicare reimbursement system for Skilled Nursing Facilities as of October 1, 2019. The new reimbursement system is the Patient Driven Payment Model (PDPM) which replaces the Resource Utilization Grouping (RUG) methodology. The intent of PDPM is to better match reimbursement payments amounts to patients' medical acuity needs. The financial impact to the Home based on this reimbursement change is currently unknown, but it could have a material impact on its operating results.

Medicaid

The State of Connecticut Department of Social Services (the Department) has announced plans to potentially change the Medicaid reimbursement system for Skilled Nursing and Intermediate Care Facilities as of July 1, 2020. This new system (as currently proposed) will be based on a case mix methodology for direct care costs; it will include an add-on related to value-based purchasing, modify the current administrative and general cost center, and continue to incorporate the indirect care, capital and fair rental cost centers during phase one. The base year for the costs and minimum data set information to be used for this new system will be the period October 1, 2017 through September 30, 2018 and the case mix will be determined using the RUG-IV 48 grouper. The implementation of the specifics of the new system are currently being developed and modifications are expected through June 2020. A future phase two of the analysis is expected to update the capital and fair rental cost centers and make modifications to the value-based purchasing add on. The financial impact to the Home from this reimbursement change is currently unknown, but it could have a material impact on its operating results.

MEMBER ACKNOWLEDGEMENT

In compliance with § 17b-522 of Connecticut General Statutes, a person signing a continuing care contract must be informed that:

- **such a contract is a financial investment and such investment may be at risk;**
- **the Provider's ability to meet its contractual obligations under such contract depends upon its financial performance;**
- **it is advisable to consult an attorney or other professional experienced in matters relating to investments regarding continuing care facilities prior to signing a continuing care contract;**
- **the Department of Social Services does not guarantee the security of such investments**

I have received and reviewed a copy of the Disclosure Statement and a copy of the Member Agreement for The SENIOR CHOICE CONTINUING CARE AT HOME Program prior to execution of the contract or the transfer of any money or other property to the Provider.

_____	_____	
Prospective Member Name (Print)	Prospective Member Signature	Date
_____	_____	
Legal Representative, if applicable (Print)	Legal Representative Signature	Date

_____

_____

_____

_____

Legal Firm or Legal Representative Name, Address, Phone (Print)