State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) Hartford Hospital d/b/a Jefferson House		
Address (No. & Street, City, State, Zip Code) 1 John J. Stewart Drive, Newington, CT 06111		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	993-C			07-5293

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Hartford Hospital d/b/a Jefferson House [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Hartford Hospital d/b/a Jefferson House	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 1 John J. Stewart Drive, Newington, CT 06111				
Report Prepared By Beth Ann Wetherell	Phone Number 860 696-6255		Date 2/14/2017	

Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid $				
2. Laundry wages paid $				
3. Housekeeping wages paid $				
4. Nursing wages paid $				
5. All other wages paid $				
6. ***Total Wages Paid*** $				
7. Total salaries paid $				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report) $				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
	9/30/2016	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Hartford Hospital d/b/a Jefferson House	1 John J. Stewart Drive, Newington, CT 06111

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	993-C			07-5293

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Susan Vinal		001692

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Hartford Hospital	80 Seymour St., Hartford, CT 06102	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Douglas Eliott	Hartford Hospital 80 seymour St., Hartford, CT 06102	Chair	
Alexia Cruz	Hartford Hospital 80 seymour St., Hartford, CT 06102		
David R. McHale	Hartford Hospital 80 seymour St., Hartford, CT 06102	Vice Chair	
Yvette Melendez	Hartford Hospital 80 seymour St., Hartford, CT 06102		
Jeffry Nestler, MD	Hartford Hospital 80 seymour St., Hartford, CT 06102		
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ◉ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No **Total *****

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period?	⊙ Yes ○ No	If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Ernst & Young	225 Asylum St., Hartford, CT
2 Hartford Hospital Accounting	Newington, CT 06111
3 NYASA	150 State St., Ste 301 Albany, NY 12207
4	

Services Provided by This Firm (*describe fully*)

1	200010-618020 - Audit Fees	$ 3,273
2	130010-612010 - HHC System Fees	$ 9,000
3	207070-540010 - Discounts	$ (567)
4	207070-612050 - General Allocation	$ 12,182
		Charge for Services Provided $ 23,888

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

⊙ Yes ○ No 15.1.d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Shipman and Goodwin LLC	8.6E+09
2	
3	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	review of agreements and collection matters	$ 679
2		$
3		$
4		$
5		$
		Charge for Services Provided $ 679

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

⊙ Yes ○ No 15.1.e Legal Expense

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	104	104			104	104			104	104		
B. On last day of THIS report period	104	104			104	104			104	104		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	98	98			98	98			102	102		
B. As of midnight of THIS report period	102	102			102	102			102	102		
3. Total Number of Days Care Provided During Period												
A. Medicare	6,443	6,443			4,832	4,832			1,611	1,611		
B. Medicaid (Conn.)	22,965	22,965			17,139	17,139			5,826	5,826		
C. Medicaid (other states)												
D. Private Pay	4,885	4,885			3,792	3,792			1,093	1,093		
E. State SSI for RCH												
F. Other (Specify)	2,421	2,421			1,724	1,724			697	697		
G. Total Care Days During Period (3A thru F)	36,714	36,714			27,487	27,487			9,227	9,227		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	36,714	36,714			27,487	27,487			9,227	9,227		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	21	64		17				
Per Diem Rate								
a. One bed rm.	488.00	488.00		488.00				
b. Two bed rms.	459.00	459.00		459.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	28,772	28,772		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Physical Therapy Treatments***	28,772	28,772		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	696	696		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Speech Therapy Treatments***	696	696		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	20,245	20,245		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Occupational Therapy Treatments***	20,245	20,245		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ○ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	189,661	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	345,882	12,965				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	105,500	3,060				
c. Dietary Workers	637,300	34,714				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	230,046	15,351				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	184,790	8,099				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	127,730	2,091				
b. RN						
1. Direct Care	2,735,582	63,960				
2. Administrative**						
c. LPN						
1. Direct Care	308,660	8,424				
2. Administrative**						
d. Aides and Attendants	1,941,782	104,122				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	198,792	6,842				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists	97,123	1,554				
m. Social Workers/Case Management	283,996	7,063				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	43,458	1,521				
A-13. Total Salary Expenditures	7,430,302	271,846				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
HIM	$ 43,458	1,521				
Total	$ 43,458	1,521	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Consulting Other	$ 123,722					
Consulting Other	$ 3,836					
Consulting Primary Research	$ (16,506)					
Total	$ 111,052	-	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Susan Vinal	189,661			same as any other hartford hospital employee		2,080				
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	12,236	231				
3. Pharmacist	48,670	811				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	964,881	16,081				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)						
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	111,052					
B-13 Total Fees Paid in Lieu of Salaries	1,136,839	17,123				

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

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

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

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Report of Expenditures
Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis*

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Alliance Rehab of CT 1520 Kensington, Rd., Oak Brook, IL 60523	Rehab, OT & Speech Therapy	○	⊙	
Health Drive Dental, 85 Barnes Road, Ste 207, Wallingford, CT 06492	Dentistry	○	⊙	
Health Trac, 460 Smith St., Middletown, CT	Medical Diagnostic Testing	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	143,940	143,940		
2. Disability Insurance	$	25,632	25,632		
3. Unemployment Insurance	$	19,646	19,646		
4. Social Security (F.I.C.A.)	$	564,981	564,981		
5. Health Insurance	$	751,983	751,983		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	12,572	12,572		
7. Pensions (Non-Discriminatory)	$	413,182	413,182		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	54,624	54,624		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	23,888	23,888		
e. Legal (*Services should be fully described on Page 7)*	$	679	679		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	65,180	65,180		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	22,176	22,176		
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	592,387	592,387		
Subtotal	$	2,690,870	2,690,870		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
tuition	$ 6,278		
Dental	$ 48,346		
Total	$ 54,624	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Total	$ -	$ -	$ -

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,690,870	2,690,870		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	555	555		
5. Education Expenses Related to Seminars and Conventions	$				
6. Automobile Expense (*not purchase or depreciation*)	$	494	494		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	3,164	3,164		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	798	798		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,753	2,753		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	13,616	13,616		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	1,385,956	1,385,956		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	4,098,206	4,098,206		

* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
advertising	$ 3,164		
Total Other Advertising	$ 3,164	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
dues/licenses	$ 13,616		
Total Dues	$ 13,616	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Total Contributions	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
System Fee/Office Supplies/rental charge/late fees/minor equipment see TB det	$ 1,385,956		
Total Other Administrative and General	$ 1,385,956	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	17	37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Hartford Hospital, Human Resources		Personnel Services	15.1.a.9
Hartford Hospital, Accounting Finance		Financial Services	15.1.d
Michalik, Bauer, Silvia & Ciccarillo, LLP		Legal Matters	15.1.e
E&Y Auditors		Audit Fees	15.1.d
Hartford Hospital		corporate Fee	15.1.d

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	307,116	307,116		
2. Non-Food Supplies	$	48,486	48,486		
3. Other (*Specify*)_____ uniforms/supplies/equipment	$	10,492	10,492		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	255,952	255,952		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	622,046	622,046		

2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*				

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	⊙ Yes	○ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			30IVI
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	33,402	33,402		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	81,946	81,946		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	115,348	115,348		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3E.

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel		45,004	45,004		
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	41,881	41,881		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$	106,941	106,941		
maint contract/windows/exterminator services etc.						
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	148,822	148,822		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$	397,633	397,633		
2. Purchased from		$				
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	338,238	338,238		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$				
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	30,768	30,768		
i. Recreation		$	13,087	13,087		
j. Other (Specify)****		$	1,168,409	1,168,409		
See Attached Schedule						
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,948,135	1,948,135		

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

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

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

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

Schedule of Other Resident Care

Description	**CCNH**	**RHNS**	**(Specify)**
purchases per T/B support	$ 1,168,409		
Total Other Resident Care	$ 1,168,409	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	212,018	212,018		
b. Heat	$	23,539	23,539		
c. Light & Power	$	152,224	152,224		
d. Water	$	57,107	57,107		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	13,064	13,064		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	457,952	457,952		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	383,606	383,606		
c. Non-Movable Equipment	$	3,914	3,914		
d. Movable Equipment	$	110,365	110,365		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	497,885	497,885		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	497,885	497,885		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
uniforms/dues/training materials/storage rent	$ 13,064		
Total Other Repairs and Maintenance	$ 13,064	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	8,414,962			5,182,868	SL	see schedu	383,606	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								383,606
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	1,951,051			1,930,718			3,914	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								3,914

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					2,804,508		2,009,164	2,148,361			110,365	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												110,365
E. ***Total Depreciation***												497,885

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Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Land Improvements		$ -		$ -	*
Deletions:					
Total deletions for Land Improvements		$ -		$ -	**

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Building Improvements		$ -		$ -	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Non-Movable Equipment		$ -		$ -	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Movable Equipment		$ -		$ -	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Leasehold Improvement		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page of
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ No

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

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

Description	Total
1. Date Land Purchased	10/24/78
2. Date Structure Completed	07/16/80
3. If **NOT** Original Owner, Date of Purchase	N/A
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	104
6. Square Footage	75,868
7. Acquisition Cost	
a. Land	262,539
b. Building	2,038,052

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson Hou	993-C	9/30/2016	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage	$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)	$				

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson H	993-C	9/30/2016	27 | 37

Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment 1. Automotive Equipment			$				
A. Item	Rate	Amount					
Lender							
Address of Lender							
2. Other (*Specify*)			$				
A. Item	Rate	Amount					
Lender							
Address of Lender							
B. Item	Rate	Amount					
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			$				
12. D. Other Interest Expense (*Specify*)			$				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$				
14. Insurance							
a. Insurance on Property (buildings only)			$	4,449	4,449		
b. Insurance on Automobiles			$				
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*)			$				
2. Fire and Extended Coverage			$				
3. Other (*Specify*) pro liab/gen liab/auto/director insurance			$	23,893	23,893		
14d. ***Total Insurance Expenditures (14a + b + c)***			$	28,342	28,342		
15. ***Total All Expenditures (A-13 thru C-14)***			$	16,483,877	16,483,877		

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CSP-28 Rev. 9/2002

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.			Accounting & Legal $				
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.			Unallowable Advertising * $				
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $				
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $				

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other A&G Adjustments			$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $				
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $				
28.			Ambulance/Limousine $				
29.			X-rays, etc $				
30.			Laboratory $				
31.			Medical Supplies $				
32.			Oxygen (non emergency) $				
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $				
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.			Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $				
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.	***Total Amount of Decrease (Items 1 - 50)*** $						

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

Attachment Page 29

Hartford Hospital d/b/a Jefferson House
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Ancillary Costs			$ -	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Adjustments			$ -	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	11,232,220	11,232,220		
b. Medicaid Room and Board Contractual Allowance **	$	(5,161,675)	(5,161,675)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	3,088,195	3,088,195		
b. Medicare Room and Board Contractual Allowance **	$	(1,419,154)	(1,419,154)		
4. a. Private-Pay Residents and Other	$	2,905,455	2,905,455		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	264,328	264,328		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	124,965	124,965		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	930,650	930,650		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	620,050	620,050		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$				
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$				
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	12,585,034	12,585,034		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	17,586	17,586		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	85,557	85,557		
V. Total Other Revenue (1 thru 8)	$	103,143	103,143		
VI. Total All Revenue (III +V)	$	12,688,177	12,688,177		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue		$ -	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 116a	laboratory	$ 41,443		
30 116a	radiology	$ 44,114		
Total Other Revenue		$ 85,557	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 5,149,023
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 940,896
4 Inventories				$
5. Prepaid Expenses				$ 72,898
a. Loan receivable from HH		72,898		
b.				
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 87,932
Due to - from affiliates		87,932		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 6,250,749
B. Fixed Assets				
1. Land				$ 262,536
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	8,414,962		$ 2,848,488
	Accum. Depreciation	5,566,474	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	1,951,051		$ 16,419
	Accum. Depreciation	1,934,632	Net	
6. Movable Equipment	*Historical Cost	2,804,508		$ 545,782
	Accum. Depreciation	2,258,726	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 3,673,225

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 9,923,974
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 124,165,080
Board Designated		93,503,842		
Investments for restricted purposes		6,611,997		
funds held in trust by others		24,049,241		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 124,165,080
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 134,089,054

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 124,076
2. Notes Payable (*itemize*)	$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)	$ 548,971
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$
7. Medicare Final Settlement Payable	$
8. Medicare Current Financing Payable	$
9. Mortgage Payable (*Current Portion*)	$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)	$
11. Accrued Income Taxes*	$ 921,711
12. Other Current Liabilities (*itemize*)	$
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 1,594,758

Name of Lender	Purpose	Amount	Date Due

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	34	37

Account	Amount
Total Brought Forward:	1,594,758
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 1,594,758

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson Hous	993-C	9/30/2016	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$ 101,727,022
	2. Capital Stock	$
	3. Paid-in Surplus	$ 4,179,311
	4. Treasury Stock	$ 26,587,963
	5. Cumulated Earnings	$
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$
	7. Total Net Worth	$ 132,494,296
C.	***Total Reserves and Net Worth***	$ 132,494,296
D.	***Total Liabilities, Reserves, and Net Worth***	$ 134,089,054

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	36	37

Account	Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2015	$
B. Total Revenue (*From Statement of Revenue Page 30*)	$
C. Total Expenditures (*From Statement of Expenditures Page 27*)	$
D. Net Income or Deficit	$
E. Balance	$
F. Additions	
1. Additional Capital Contributed (*itemize*)	
2. Other (*itemize*)	
F-3. Total Additions	$
G. Deductions	
1. Drawings of Owners/Operators/Partners (*Specify*)	$

Name and Address (*No., City, State, Zip*)	Title	Amount

2. Other Withdrawings *(Specify)*	$

Purpose	Amount

3. Total Deductions		$
H. ***Balance at End of Period***	09/30/16	$

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2016	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Beth Ann Wetherell

Addres Address	Phone Number
Hartford Hospital	860-696-6255

Level	Item	Reported as