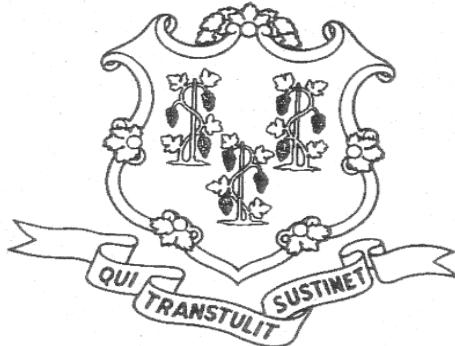


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2019

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	
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input checked="" type="checkbox"/> Other
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 993-C	RHNS	Other	Medicare Provider 07-5293
------------------	---------------	------	-------	------------------------------

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
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### For Department Use Only

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

## General Information

Name of Facility (as licensed) Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019	Page 1	of 37
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### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Hartford Hospital d/b/a Jefferson House [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, 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:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Hartford Hospital d/b/a Jefferson House	Period Covered:		From 10/1/2018	To 9/30/2019
Address of Facility 1 John J. Stewart Drive, Newington, CT 06111				
Report Prepared By Dorothy Robinson	Phone Number 860-696-6438	Date		
Item	Total	CCNH	RHNS	Other
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

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

		Phone No. of Facility 860-667- 4453	Report for Year Ended 9/30/2019	Page 2	of 37
Name of Facility (as shown on license) Hartford Hospital d/b/a Jefferson House		Address (No. & Street, City, State, Zip ) 1 John J. Stewart Drive, Newington, CT 06111			
License Numbers: CCNH 993-C		RHNS	Other	Medicare Provider No. 07-5293	
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Supervision only (RHNS) <input checked="" type="checkbox"/> Other					
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:		Date Opened	Date Closed		
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," explain fully.	
<b>Administrator</b>					
Name of Administrator Susan Vinal				Nursing Home Administrator's License No.:	001692
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name				License No.:	

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

# **General Information and Questionnaire**

## **Corporate Owners**

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

# **General Information and Questionnaire**

## **Individual Proprietorship**

## General Information and Questionnaire

### Related Parties\*

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.				
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the following information:				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			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	%**				
See attached listing		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019	Page 5 of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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.

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

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

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

Yes

⊕ No

Total \*\*\*

11,735

\* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

\*\* Attach copies of newly acquired leases.

\*\*\* Amount should agree to Page 22, Line 6e.

## General Information and Questionnaire

### Accounting Basis

Name of Facility Hartford Hospital d/b/a Jefferson H	License No. 993-C	Report for Year Ended 9/30/2019	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual     Cash     Modified Cash

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

#### **Independent Accounting Firm**

Name of Accounting Firm 1    Ernst & Young 2 3 4	Address (No. & Street, City, State, Zip Code) 225 Asylum St. Hartford, CT
--	--

Services Provided by This Firm (*describe fully*)

1    Audit Fees - part of Hartford Hospital's audit and paid by Hartford Hospital	\$
2	\$
3	\$
4	\$
	Charge for Services Provided \$

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

Yes     No    |p 15 1d

#### **Legal Services Information**

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

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

1 2 3 4 5	
-----------------------	--

Services Provided by This Firm (*describe fully*)

1    Jefferson House legal fees are included in system fees.	\$
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided \$

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

Yes     No

## Schedule of Resident Statistics

Name of Facility Hartford Hospital d/b/a Jefferson House			License No. 993-C				Report for Year Ended 9/30/2019				Page 8 of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Other	Total	CCNH	RHNS	Other
1. Certified Bed Capacity					104	104			104	104		
A. On last day of PREVIOUS report period	104	104							104	104		
B. On last day of THIS report period	104	104			104	104			104	104		
2. Number of Residents					97	97			102	102		
A. As of midnight of PREVIOUS report period	97	97							102	102		
B. As of midnight of THIS report period	99	99			102	102			99	99		
3. Total Number of Days Care Provided During Period					3,367	3,367			1,073	1,073		
A. Medicare	4,440	4,440							1,073	1,073		
B. Medicaid (Conn.)	22,465	22,465			16,792	16,792			5,673	5,673		
C. Medicaid (other states)												
D. Private Pay	5,284	5,284			3,763	3,763			1,521	1,521		
E. State SSI for RCH												
F. Other (Specify) Mgd Care, WC, Mgd Medicare	4,203	4,203			3,269	3,269			934	934		
G. Total Care Days During Period (3A thru F)	36,392	36,392			27,191	27,191			9,201	9,201		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds					57	57			26	26		
A. Medicaid Bed Reserve Days	83	83							26	26		
B. Other Bed Reserve Days	188	188			156	156			32	32		
<b>5. Total Resident Days (3G + 4A + 4B)</b>	<b>36,663</b>	<b>36,663</b>			<b>27,404</b>	<b>27,404</b>			<b>9,259</b>	<b>9,259</b>		

## Schedule of Resident Statistics (Cont'd)

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?  Yes  No

If "YES", provide the following information:

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

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

1st change	Change in Resident Days			CCNH	RHNS	Other
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	Other	R.C.H.	ICF-MR
No. of Residents	10	60		29				
Per Diem Rate								
a. One bed rm.	Rugs	262.47		509.00				
b. Two bed rms.				499.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	Other
		4,533	1,290		3,243
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments		44	44		
C. Other		24,913	23,147		1,766
D. <b>Total Physical Therapy Treatments</b>		29,490	24,481		5,009

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		134	125		9
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments		6	6		
C. Other		711	711		
D. <b>Total Speech Therapy Treatments</b>		851	842		9

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		1,599	1,256		343
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments		28	28		
C. Other		21,275	21,181		94
D. <b>Total Occupational Therapy Treatments</b>		22,902	22,465		437

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2019		10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No			
		Total Cost and Hours			
Item	CCNH	Hours	RHNS	Hours	Other
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	140,966	2,086			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	366,461	15,221			
5. Dietary Service					
a. Head Dietitian	72,332	2,542			
b. Food Service Supervisor					
c. Dietary Workers	518,643	32,330			
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers	246,705	17,857			4,904
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	78,764	2,045			1,566
b. Other Maintenance Workers	76,301	4,688			1,517
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	131,906	2,086			
b. RN					
1. Direct Care	2,620,159	58,970			
2. Administrative**	396,436	9,043			
c. LPN					
1. Direct Care	288,828	8,207			
2. Administrative**					
d. Aides and Attendants	2,145,682	123,957			
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	183,468	6,393			
i. Physicians					
1. Medical Director					
2. Utilization Review					
3. Resident Care***					
4. Other (Specify)					
j. Dentists					
k. Pharmacists	136,689	2,132			
l. Podiatrists					
m. Social Workers/Case Management	287,204	7,168			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	303,453	6,296			2,064,224
A-13. Total Salary Expenditures	7,993,997	301,021			60,670
					2,072,211

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

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

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

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

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

State of Connecticut

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

CSP-11 Rev. 10/2005

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

Name of Facility Hartford Hospital d/b/a Jefferson House				License No. 993-C		Report for Year Ended 9/30/2019			Page 11	of 37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
<b>Section I - Operators/Owners</b>										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

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

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

State of Connecticut

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

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)			License No.		Report for Year Ended			Page	of	
Hartford Hospital d/b/a Jefferson House			993-C		9/30/2019			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	Other							
<b>Section III - Administrators***</b>										
Susan Vinal	140,966			Non-discriminatory	Administrator - Management of facility	2,086	A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

**B. Report of Expenditures - Professional Fees**

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019		Page 13	of 37
Item	Total Cost and Hours				
	CCNH	Hours	RHNS	Hours	Other
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>					
1. Dietitian					
2. Dentist	11,294	48			
3. Pharmacist	11,653	185			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	503,320	9,357			102,983
b. Other					1,914
6. Social Worker					
7. Recreation Worker	6,926	56			
8. Physicians					
a. Medical Director (entire facility)	12,150	130			
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	194,719	3,050			2,081
b. Other					33
10. Occupational Therapist					
a. Resident Care	412,527	8,836			8,025
b. Other					172
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					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	1,152,589	21,662			113,089
					2,119

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

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

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

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

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Healthdrive Dental	Dental	<input type="radio"/>	<input checked="" type="radio"/>		
Hartford HealthCare Rehab Network	Therapy	<input checked="" type="radio"/>	<input type="radio"/>		
Jerome Home - Amy Damato	Physical Therapy	<input checked="" type="radio"/>	<input type="radio"/>		
Anna Cairnduff	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
Beverly M Flaherty	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
Bruce Macleod	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
Chai-Lun Yuch	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
Connecticut Audubon Society, Inc.	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
CT Bristol Old Time Fiddlers Club	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
David G Goclowski	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
Douglas Codianni	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
Glastonbury Ukulele Band	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
Jeannette Wheeler	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
John Paolillo	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
John W Bunker	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
Jose Paulo Dos Santos	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
Joseph Giangrasso	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
Lori A Cartwright	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
Louis Ames III	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
Mary Morse	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
Matthew Bennett	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		
Paul Shlien	Recreation Program	<input type="radio"/>	<input checked="" type="radio"/>		

\* Use additional sheets if necessary.

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

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

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019		Page 15	of 37
Item		Total	CCNH	RHNS	Other
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$				
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$	699,266	555,316		143,950
5. Health Insurance	\$	1,334,476	1,016,444		318,032
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	674,692	535,801		138,891
8. Uniform Allowance	\$	2,413	827		1,586
9. Other (Specify ) See Attached Schedule	\$	63,972	49,590		14,382
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$	12,000	12,000		
d. Accounting and Auditing	\$				
e. Legal (Services should be fully described on Page 7)	\$				
f. Insurance on Lives of Owners and Operators (Specify )*	\$				
g. Office Supplies	\$	39,785	23,004		16,781
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	565	565		
2. Cellular Phones	\$	9,372	5,179		4,193
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	\$	602,748	602,748		
<b>Subtotal</b>		<b>3,439,289</b>	<b>2,801,474</b>		<b>637,815</b>

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

**Schedule of Other Employee Benefits**

Description	CCNH	RHNS	Other
BACKGROUND VERIFICATIONS ADMIN & GENERAL	\$ 4,914		\$ 1,274
BACKGROUND VERIFICATIONS EMPLOYEE HEALTH	\$ 381		\$ 99
BACKGROUND VERIFICATIONS HR TALENT ACQUISITION	\$ 858		\$ 222
RECLASS BACKGROUND CHECKS RECREATION THERAPY	\$ 51		\$ -
SYSTEM FEE DIRECT PRYL FRG FRINGE BENEFITS	\$ 43,386		\$ 11,246
HSA ER CONTRIBUTION			\$ 1,541
<b>Total</b>	<b>\$ 49,590</b>	<b>\$ -</b>	<b>\$ 14,382</b>

**Schedule of Other Taxes**

Description	CCNH	RHNS	Other
<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019		Page 16	of 37
Item		Total	CCNH	RHNS	Other
	<b><i>Subtotals Brought Forward:</i></b>	3,439,289	2,801,474		637,815
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 1,146	1,146			
2. Holiday Parties for Staff	\$ 1,200	1,200			
3. Gifts to Staff and Residents	\$ 7,483	7,364			119
4. Employee Travel	\$ 58,742	5,653			53,089
5. Education Expenses Related to Seminars and Conventions	\$ 21,391	14,171			7,220
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$ 1,451	1,451			
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$				
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 15,036				15,036
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 7,689	5,916			1,773
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 11,046	11,046			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 550	550			
9. Subscriptions	\$ 3,550	3,550			
10. Contributions*** See Attached Schedule	\$ 17,500				17,500
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$ 62,271	61,890			381
12. Administrative Management Services**	\$ 1,462,144	1,390,144			72,000
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 978,782	19,058			959,724
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 6,089,270	4,324,613			1,764,657

\* 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	Other
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description	CCNH	RHNS	Other
ADVERTISING- MARKETING & ADVERTISING - DISALLOWED			\$ 6,750
ADVERTISING - ADMIN & GENERAL - DISALLOWED			\$ 400
PROMOTIONAL EVENTS ADMIN & GENERAL - DISALLOWED			\$ 727
PROMOTIONAL EVENTS CENTER FOR HEALTHY AGING - DISALLOWED			\$ 4,985
ADVERTISING - CENTER FOR HEALTHY AGING - DISALLOWED			\$ 74
SIGNS CENTER FOR HEALTHY AGING - DISALLOWED			\$ 975
PRINTING/PRINT SHOP MARKETING & ADVERTISING - DISALLOWED			\$ 1,125
<b>Total Other Advertising</b>	\$ -	\$ -	\$ 15,036

**Schedule of Dues**

Description	CCNH	RHNS	Other
ALTFCM	\$ 255		
LEADING AGE CT	\$ 10,061		
AMDA PHYSICIAN MEMBERSHIP	\$ 380		
CAHCF	\$ 350		
<b>Total Dues</b>	\$ 11,046	\$ -	\$ -

**Schedule of Contributions**

Description	CCNH	RHNS	Other
TOWN OF NEWINGTON GOOD SAMARITAN FUND - DISALLOWED			\$ 17,500
<b>Total Contributions</b>	\$ -	\$ -	\$ 17,500

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	Other
MERCHANT FEES - DISALLOWED	\$ -		\$ 3,033
CASH DISCOUNTS ACCOUNTING GENERAL	\$ (953)		\$ -
LATE FEES FINANCE ADMIN - DISALLOWED	\$ -		\$ 239
MISCELLANEOUS EXPENSE FUND DEPT - DISALLOWED	\$ -		\$ 30
MISCELLANEOUS EXPENSE ADMIN & GENERAL - DISALLOWED	\$ -		\$ (79)
MISCELLANEOUS EXPENSE ACCOUNTING GENERAL - DISALLOWED	\$ (240)		\$ -
MISCELLANEOUS EXPENSE NURSING DIRECT MGMT - DISALLOWED	\$ -		\$ 361
MISCELLANEOUS EXPENSE NURSING RN ADMIN - DISALLOWED	\$ 189		\$ -
MISCELLANEOUS EXPENSE CENTER FOR HEALTHY AGING - DISALLOWED	\$ -		\$ 152
MISCELLANEOUS EXPENSE GOOD LIFE FITNESS - DISALLOWED	\$ -		\$ 1,843
FACILITY RENT/LEASE (SPACE) CENTER FOR HEALTHY AGING - DISALLOWED	\$ -		\$ -
PURCHASED SERVICES - AFFILIATE GRANT ADMINISTRATION - DISALLOWED	\$ -		\$ 1,645
PURCHASED SERVICES - OTHER GRANT ADMIN - DISALLOWED	\$ -		\$ (1,645)
STORAGE RENT/LEASE HEALTH INFO MGMT	\$ 9,193		\$ -
RECLASS CT CONTROLLED SUBSTANCE REGISTRATION FROM DUES	\$ 40		\$ -
DUES AND LICENSES CENTER FOR HEALTHY AGING - DISALLOWED	\$ -		\$ 195
RECLASS MOTION PICTURE LICENSE FROM DUES	\$ 377		\$ -
RECLASS NOTARY RENEWAL FROM DUES	\$ 60		\$ -
RECLASS FOOD SERVICE LICENSE FROM DUES	\$ 200		\$ -
BAD DEBT-NON PATIENT CENTER FOR HEALTHY AGING - DISALLOWED	\$ -		\$ 100
RECLASS CREDIT FROM LEGAL P 15	\$ (600)		\$ -
PURCHASE SERVICES - OTHER ADMIN & GENERAL - DISALLOWED			\$ 2,934
PURCHASED SERVICES - OTHER FUND DEPT - DISALLOWED			\$ 35,470
NON-OPERATING BANK FEES FUND DEPT - DISALLOWED	\$ -		\$ 153,513
SPONSORSHIPS FUND DEPARTMENT - DISALLOWED	\$ -		\$ 671,933
INTERNAL SPONSOR EXP AFFILIATE FUND DEPT - DISALLOWED	\$ -		\$ 90,000
INTERNAL SPONSOR EXP AFFILIATE GRANT ADMIN	\$ -		\$ 241,579
SPONSORSHIPS GRANT ADMINISTRATION	\$ -		\$ (241,579)
CABLE TV - DISALLOWED	\$ 10,792		
<b>Total Other Administrative and General</b>	\$ 19,058	\$ -	\$ 959,724

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

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Hartford HealthCare & Hartford HealthCare Senior Services	1,462,144	Contracting and Management	p 16 1m12
Morrison Community Living	625,049	Dietary Staff Management, Support, Food Purchase, Quantity Discount	p 18 2a1,2a2, 2a3,& 2b
Crothall Healthcare	107,769	Environmental Services Staff Management, Support, Supplies Purchase, Quantity Discount	p 20 4a1 & 4b
Hartford Hospital	108,144	Laundry Services	p 19 3b

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

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

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019		Page 18 of 37
Item	Total	CCNH	RHNS	Other
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 298,624	298,624		
2. Non-Food Supplies	\$ 73,572	55,043		18,529
3. Other (Specify) _____ In House food for depts and non-residents - disallowed	\$ 76,233	6,971		69,262
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 186,545	186,545		
c. Other (Specify) _____	\$			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 634,974</b>	<b>547,183</b>		<b>87,791</b>
2E. Dietary Questionnaire	Total	CCNH	RHNS	Other
F. Resident Meals: Total no. of meals served per day:*	298	298		
G. Is cost of employee meals included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No				
H. Did you receive revenue from employees? <input checked="" type="radio"/> Yes <input type="radio"/> No			If yes, specify amt.	included below
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				30 IV1
Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input checked="" type="radio"/> Yes <input type="radio"/> No			If yes, specify cost.
K. Is any revenue collected from these people? <input checked="" type="radio"/> Yes <input type="radio"/> No			If yes, specify amt.	\$11,360
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				30 IV1
Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input checked="" type="radio"/> Yes <input type="radio"/> No			If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019		Page 19	of 37
Item	Total	CCNH	RHNS	Other	
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$				
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$	108,144	108,144		
c. Other (Specify)	\$				
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	108,144	108,144		
<b>3E. Laundry Questionnaire</b>					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
<b>K. Where is the revenue received reported in the Cost Report?</b>	(Page/Line Item)				

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019		Page 20	of 37
Item		Total	CCNH	RHNS	Other
4. Housekeeping	Sq. Ft. Serviced by Personnel	62,900	61,674		1,226
a. In-House Care	Amt. \$	46,182	45,282		900
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel	62,900	61,674		1,226
	Amt. \$	67,978	66,653		1,325
C. Other (Specify)	\$	637	625		12
Maintenance & Repair Equipment - Environmental Services					
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>114,797</b>	<b>112,560</b>		<b>2,237</b>
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Neighborcare Pharmacy Services Inc.	\$	273,603	273,603		
b. Medicine Cabinet Drugs	\$	18,135	18,135		
c. Medical and Therapeutic Supplies	\$	391,290	387,328		3,962
d. Ambulance/Limousine***	\$	8,239	8,239		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	43,979	43,979		
f. X-rays and Related Radiological Procedures***	\$	14,834	14,834		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	89,176	89,176		
i. Recreation	\$	7,615	4,643		2,972
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)****	\$	21,435	71		21,364
See Attached Schedule					
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>868,306</b>	<b>840,008</b>		<b>28,298</b>

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

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

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

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

**Schedule of Other Resident Care**

Description	CCNH	RHNS	Other
Reclass Mobile Audiology from p 13 B2 - disallowed	\$ 71		
PT Optima software fees 690090-409050 from p 13 line B5 - disallowed			\$ 1,364
HHCRN PT Mgmt fees 690090-409050 and 611020-409510 from p 13 line B5 - disallowed			\$ 20,000
<b>Total Other Resident Care</b>	<b>\$ 71</b>	<b>\$ -</b>	<b>\$ 21,364</b>

## Report of Expenditures

### Schedule C-2 - Individuals or Firms Providing Services by Contract \*

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

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

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

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

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019			Page 22   37
Item		Total	CCNH	RHNS	Other
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 247,916	242,571			5,345
b. Heat	\$ 52,095	51,080			1,015
c. Light & Power	\$ 174,850	171,442			3,408
d. Water	\$ 70,409	69,037			1,372
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 11,735	11,735			
f. Other ( <i>itemize</i> )	\$ 141,141	138,389			2,752
See Attached Schedule					
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 698,146	684,254			13,892
7. Depreciation ( <i>complete schedule page 23*</i> )					
a. Land Improvements	\$ 8,813	8,641			172
b. Building & Building Improvements	\$ 354,944	348,026			6,918
c. Non-Movable Equipment	\$ 5,032	4,934			98
d. Movable Equipment	\$ 123,040	119,905			3,135
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 491,829	481,506			10,323
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$				
d. Other ( <i>Specify</i> )	\$				
*8e. <b>Total Amortization Costs</b> (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	\$ 226				226
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 492,055	481,506			10,549

\* 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	Other
MAINTENANCE - GROUNDS/LANDSCAPING OPERATION OF PLANT - OUTPATIENT PORTION DISALLOWED	\$ 42,986		\$ 855
WASTE REMOVAL OPERATION OF PLANT - OUTPATIENT PORTION DISALLOWED	\$ 66,774		\$ 1,327
STORAGE RENT/LEASE OPERATION OF PLANT - OUTPATIENT PORTION DISALLOWED	\$ 8,234		\$ 164
PURCHASED SERVICES - AFFILIATE OPERATION OF PLANT - OUTPATIENT PORTION DISALLOWED	\$ 4,164		\$ 83
OTHER NON-BILLABLE MED/SURG OPERATION OF PLANT - OUTPATIENT PORTION DISALLOWED	\$ 16,231		\$ 323
<b>Total Other Repairs and Maintenance</b>	<b>\$ 138,389</b>	<b>\$ -</b>	<b>\$ 2,752</b>

## Depreciation Schedule

Name of Facility Hartford Hospital d/b/a Jefferson House				License No. 993-C			Report for Year Ended 9/30/2019				Page 23	of 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	
<b>A. Land Improvements</b>												
1. Acquired prior to this report period				66,550		66,550	(403)			6,795		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)				32,284		32,284				2,018		
<b>A-4. Subtotal</b>											8,813	
<b>B. Building and Building Improvements</b>												
1. Acquired prior to this report period				8,508,947		8,508,947	5,802,571		various	352,409		
2. Disposals (attach schedule)				(485,805)		(485,805)						
3. Acquired during this report period (attach schedule)				50,710		50,710				2,535		
<b>B-4. Subtotal</b>											354,944	
<b>C. Non-Movable Equipment</b>												
1. Acquired prior to this report period				1,960,501		1,960,501	1,420,889		various	2,917		
2. Disposals (attach schedule)				(521,002)		(521,002)						
3. Acquired during this report period (attach schedule)				21,150		21,150				2,115		
<b>C-4. Subtotal</b>											5,032	
	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								
<b>D. Movable Equipment</b>												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. Ram Quad Cab 2500 Truck 4x4	x		9	2004	34,166		34,166	34,166		4 years		
b. 2017 Ford E-350 Cutaway	x		1	2017	49,988		49,988	18,746		4 years	12,497	
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					2,799,962		2,799,962	1,723,493		various	101,572	
b. Disposals (attach schedule)					(589,744)		(589,744)					
c. Acquired during this report period (attach schedule)					106,879		106,879				8,971	
<b>D-3. Subtotal</b>											123,040	
<b>E. Total Depreciation</b>											491,829	

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
4/30/2019	PARKING LOT ASPHALT	\$ 32,284	8	\$ 2,018
<b>Total additions for Land Improvements</b>		\$ 32,284		\$ 2,018 *
<b>Deletions:</b>				
<b>Total deletions for Land Improvements</b>		\$ -		\$ - **

\*Ties to Page 23, Line A3

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

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
5/31/2019	INSULATED FIRE GLASS REPLACEMENT	\$ 6,037	10	\$ 302
6/30/2019	JH DATA CABLING	\$ 44,673	10	\$ 2,233
<b>Total additions for Building Improvements</b>		\$ 50,710		\$ 2,535 *
<b>Deletions:</b>				
	SEE ATTACHED SCHEDULE	\$ (485,805)	various	
<b>Total deletions for Building Improvements</b>		\$ (485,805)		\$ - **

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

\*\*Ties to Page 23, Line B2

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

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
2/28/2019	MAXI MOVE PATIENT LIFTER	\$ 5,934	10	\$ 297
2/28/2019	NURSE CALL SYSTEM HITCHCOCK	\$ 74,395	5	\$ 7,439
5/31/2019	HILO BARIATRIC TREATMENT TABLE	3002	15	100
5/31/2019	CARENDO SHOWER CHAIR KIT	5995	10	300
5/31/2019	HILO ELECTRIC MAT TABLE	2558	15	85
8/31/2019	TOTAL BODY RECUMBENT STEPPER	14995	10	750
<b>Total additions for Movable Equipment</b>		<b>\$ 106,879</b>		<b>\$ 8,971</b>
<b>Deletions:</b>				
	SEE ATTACHED SCHEDULE	\$ (589,744)	various	
<b>Total deletions for Movable Equipment</b>		<b>\$ (589,744)</b>		<b>\$ -</b>

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Leasehold Improvement</b>		<b>\$ -</b>		<b>\$ -</b>
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		<b>\$ -</b>		<b>\$ -</b>

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

\$ (1,596,551)

**Amortization Schedule\***

Name of Facility Hartford Hospital d/b/a Jefferson House			License No. 993-C		Report for Year Ended 9/30/2019			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
<b>A-4. Subtotal</b>									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
<b>B-4. Subtotal</b>									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
<b>C-4. Subtotal</b>									
<b>D. Total Amortization</b>									

\* Straight-line method must be used.

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

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

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

Name of Facility Hartford Hospital d/b/a Jefferson Hous	License No. 993-C	Report for Year Ended 9/30/2019	Page 25	of 37
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#### 11. Property Questionnaire

##### Part A

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

Yes

No

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

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

Description	Total			
1. Date Land Purchased	10/24/78			
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase	N/A			
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	104			
6. Square Footage	75,000			
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.

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

Name of Facility	License No.	Report for Year Ended 9/30/2019			Page 26	of 37
Item		Total	CCNH	RHNS	Other	
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						
<b>12 B7. Total Building Interest Expense (A1 - A4 + B5)</b>	\$					

(Carry Subtotals forward to next page )

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

Name of Facility	License No.	Report for Year Ended 9/30/2019			Page 27	of 37
Item			Total	CCNH	RHNS	Other
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. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)		\$				
14. Insurance						
a. Insurance on Property (buildings only)		\$ 8,001	7,845			156
b. Insurance on Automobiles		\$ 7,518	7,518			
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$ 21,608	21,608			
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$ 1,566	1,566			
Crime Insurance						
14d. <b>Total Insurance Expenditures</b> (14a + b + c)		\$ 38,693	38,537			156
15. <b>Total All Expenditures</b> (A-13 thru C-14)		\$ 20,376,271	16,283,391			4,092,880

## **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	9/30/2019		28   37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
			<b>Page 10 - Salaries and Wages</b>				
1.	10	A12e	Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 2,089,467	17,256		2,072,211
			<b>Page 13 - Professional Fees</b>				
5.			Resident Care Physicians **	\$			
6.	10	B10a	Occupational Therapy	\$ 420,552	412,527		8,025
7.			Other - See attached Schedule	\$ 814,397	709,333		105,064
			<b>Pages 15 &amp; 16 - Administrative and General</b>				
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 12,000	12,000		
10.			Accounting	\$			
10a.			Legal	\$			
11.	15	1h1	Telephone	\$ 565	565		
12.	15	1h2	Cellular Telephone	\$ 6,500	2,307		4,193
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.	16	1L5	Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	1m3	Unallowable Advertising *	\$ 15,036			15,036
19.			Income Tax / Corporate Business Tax	\$			
20.	16	1m10	Fund Raising / Contributions	\$ 17,500			17,500
21.	16	1m12	Unallowable Management Fees	\$ 1,462,144	1,390,144		72,000
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 1,755,981	81,524		1,674,457
			<b>Page 18 - Dietary Expenditures</b>				
24.	18	2a3	Meals to employees, guests and others who are not residents	\$ 76,233	6,971		69,262
			<b>Page 19 - Laundry Expenditures</b>				
25.			Laundry services to employees, guests and others who are not residents	\$			
			<b>Page 20 - Housekeeping Expenditures</b>				
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 6,670,375	2,632,627		4,037,748

\* 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	Other
10	A6b	Outpatient portion Housekeeper Wages			\$ 4,904
10	A7a	Outpatient portion Chief of Maintenance Wages			\$ 1,566
10	A7b	Outpatient portion Maintenance Wages			\$ 1,517
10	A12o	SALARY AND WAGES FINANCE DECISION SUPPORT			\$ 32,556
10	A12o	SALARY AND WAGES COMMUNITY NETWORK ADMIN			\$ 107,833
10	A12o	SALARY AND WAGES CENTER FOR HEALTHY AGING			\$ 1,318,511
10	A12o	SALARY RECLASS CENTER FOR HEALTHY AGING			\$ 75,237
10	A12o	SALARY AND WAGES GOOD LIFE FITNESS			\$ 371,548
10	A12o	PTO ACCRUAL - FRINGE BENEFITS DEPT			\$ 15,326
10	A12o	HOLIDAY ACCRUAL - FRINGE BENEFITS DEPT			\$ (1,092)
10	A12o	SALARY RECLASS GRANT ADMIN			\$ 144,305
10	A12o	DR MONTI, PHYSIATRIST	\$ 17,256		\$ -
<b>Total Other Salaries Adjustment</b>			\$ 17,256	\$ -	\$ 2,072,211

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
13	B2	CONTRACT LABOR-CLINICAL - ADMIN AND GENERAL - DENTAL	\$ 11,294		
13	B5A	PURCHASED SERVICES AFFILIATE - PHYSICAL THERAPIST	\$ 503,320		\$ 102,983
13	b9	PURCHASED SERVICES AFFILIATE - SPEECH THERAPIST	\$ 194,719		\$ 2,081
<b>Total Other Fees Adjustments</b>			\$ 709,333	\$ -	\$ 105,064

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
15	1A4	BENEFITS RELATED TO OUTPATIENT THERAPY, CHA, GRANT ADMIN FICA			\$ 143,950
15	1A5	BENEFITS RELATED TO OUTPATIENT THERAPY, CHA, GRANT ADMIN			\$ 318,032
15	1A5	BENEFITS RELATED TO PHYSIATRIST	\$ 4,308		
15	1A7	BENEFITS RELATED TO OUTPATIENT - PENSION			\$ 138,891
15	1A8	BENEFITS RELATED TO OUTPATIENT - UNIFORMS			\$ 1,586
15	1A9	OTHER EMPLOYEE BENEFITS RELATED TO OUTPATIENT			\$ 14,382

Page Ref	Line Ref	Description	CCNH	RHNS	Other
15	1G	OFFICE SUPPLIES, PRINTING RELATED TO OUTPATIENT			\$ 10,175
15	1G	GENERAL OFFICE SUPPLIES REHAB GENERAL	\$ 460		
15	1G	MINOR EQUIPMENT, MINOR IT EQUIPMENT AND FURNISHINGS RELATED TO OUTPATIENT			\$ 6,606
16	1L3	GIFTS IN EXCESS OF \$25 OR DISCRIMINATORY IN NATURE	\$ 7,364		\$ 119
16	1L4	TRAVEL, AIRFARE, MEALS & ENTERTAINMENT, LODGING, PARKING - CENTER FOR HEALTHY AGING			\$ 51,474
16	1L4	TRAVEL - GOOD LIFE FITNESS			\$ 1,615
16	1L5	STAFF DEVELOPMENT CENTER FOR HEALTHY AGING AND FUND DEPT			\$ 7,220
16	1M7	POSTAGE - CENTER FOR HEALTHY AGING			\$ 1,735
16	1M7	POSTAGE - MARKETING			\$ 38
16	1M8A	DUES TO CIVIC ORGANIZATIONS - NEWINGTON CHAMBER OF COMMERCE	\$ 550		
16	1M111	MAINT & REPAIR - IT EQUIP/GOOD LIFE FITNESS			\$ 381
16	1M111	MAINT & REPAIR - IT EQUIP/SOFT ADMIN AND GENERAL - SALINA	\$ 13,627		
16	1M111	CONSULTING ADMIN AND GENERAL - HARMONY HEALTHCARE	\$ 48,263		
16	1M13	MERCHANT FEES			\$ 3,033
16	1M13	LATE FEES FINANCE ADMIN			\$ 239
16	1M13	MISCELLANEOUS EXPENSE FUND DEPT			\$ 30
16	1M13	MISCELLANEOUS EXPENSE ADMIN & GENERAL			\$ (79)
16	1M13	MISCELLANEOUS EXPENSE ACCOUNTING GENERAL	\$ (240)		\$ -
16	1M13	MISCELLANEOUS EXPENSE NURSING DIRECT MGMT			\$ 361
16	1M13	MISCELLANEOUS EXPENSE NURSING RN ADMIN			\$ -
16	1M13	MISCELLANEOUS EXPENSE CENTER FOR HEALTHY AGING			\$ 152
16	1M13	MISCELLANEOUS EXPENSE GOOD LIFE FITNESS			\$ 1,843
16	1M13	DUES AND LICENSES CENTER FOR HEALTHY AGING			\$ 195
16	1M13	BAD DEBT-NON PATIENT CENTER FOR HEALTHY AGING			\$ 100
16	1M13	PURCHASED SERVICES - OTHER ADMIN & GENERAL - RESIDENT SURVEY AND HAIRCUT			\$ 2,934
16	1M13	PURCHASED SERVICES - OTHER FUND DEPT			\$ 35,470
16	1M13	NON-OPERATING BANK FEES FUND DEPT			\$ 153,513
16	1M13	SPONSORSHIPS FUND DEPARTMENT			\$ 671,933
16	1M13	INTERNAL SPONSOR EXP AFFILIATE FUND DEPT			\$ 90,000
16	1M13	CABLE TV NET OF \$3,600 ALLOWANCE	\$ 7,192		
18	2A2	DIETARY SUPPLIES FOR NON-RESIDENTS			\$ 18,529
<b>Total Other A&amp;G Adjustments</b>			\$ 81,524	\$ -	\$ 1,674,457

State of Connecticut

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

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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	9/30/2019		29   37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
			Subtotals Brought Forward	\$ 6,670,375	2,632,627		4,037,748
			<b>Page 20 - Resident Care Supplies***</b>				
27.	20	5a2	Prescription Drugs	\$ 273,603	273,603		
28.	20	5d	Ambulance/Limousine	\$ 8,239	8,239		
29.	20	5f	X-rays, etc	\$ 14,834	14,834		
30.	20	5h	Laboratory	\$ 89,176	89,176		
31.	20	5c	Medical Supplies	\$ 30,080	26,118		3,962
32.	20	500	Oxygen (non emergency)	\$ 43,979	43,979		
33.	20	5L	Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 26,644	71		26,573
			<b>Page 22 - Maintenance and Property</b>				
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 3,744	609		3,135
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.	22	10c	Unallowable Property and Real Estate Taxes	\$ 226			226
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 14,357	293		14,064
			<b>Page 27 - Insurance</b>				
40.			Mortgage Insurance	\$			
41.	27	14a	Property Insurance	\$ 156			156
			<b>Other - Miscellaneous</b>				
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 1,859,934	3,232,883		(1,372,949)
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
			<b>Not For Profit Providers Only</b>				
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$ 7,016			7,016
49.	<b>Total Amount of Decrease (Items 1 - 48)</b>			\$ 9,042,363	6,322,432		2,719,931

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

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
20	4A	HOUSEKEEPING SUPPLIES OUTPATIENT			\$ 900
20	4B	HOUSEKEEPING PURCHASED SERVICES OUTPATENT			\$ 1,325
20	4C	HOUSEKEEPING OTHER REPAIR & MAINTENANCE OUTPATIENT			\$ 12
20	5I	MINOR EQUIPMENT AND FURNISHING FUND DEPT			\$ 1,744
20	5I	RECREATION SUPPLIES FUND DEPT			\$ 418
		MAINTENANCE GROUNDS LANDSCAPING FUND DEPT FOR RECREATION			\$ 810
20	5I	MOBIL AUDIOLOGY - DISALLOWED	\$ 71		
20	5L	PT OPTIMA SOFTWARE FEES - DISALLOWED			\$ 1,364
20	5L	HHC REHAB NETWORK MANAGEMENT FEES - DISALLOWED			\$ 20,000
<b>Total Other Ancillary Costs</b>			\$ 71	\$ -	\$ 26,573

**Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
22	7D	DEP EXP - EQUIPMENT ADMIN & GENERAL			\$ 33
22	7D	DEP EXP - EQUIPMENT HHC FOOD & NUTRITION			\$ 322
22	7D	DEP EXP - EQUIPMENT SYSTEM FEE GEN ALLOCATION			\$ 20
22	7D	DEP EXP - EQUIPMENT LAUNDRY			\$ 3
22	7D	DEP EXP - EQUIPMENT FACILITIES DEV SAFETY			\$ 10
22	7D	DEP EXP - EQUIPMENT NURSING SERVICE OFFICE			\$ 6
22	7D	DEP EXP - EQUIPMENT NURSING RN ADMIN			\$ 878
22	7D	DEP EXP - EQUIPMENT NURSING RN DIRECT CARE			\$ 6
22	7D	DEP EXP - EQUIPMENT SOCIAL WORK			\$ 2
22	7D	DEP EXP - EQUIPMENT RECREATIONAL THERAPY			\$ 6
22	7D	DEP EXP - EQUIPMENT CENTER FOR HEALTHY AGING			\$ 750
22	7D	DEP EXP - EQUIPMENT ENVIRONMENTAL SERVICES GENERAL			\$ 30
22	7D	DEP EXP - EQUIPMENT OPERATION OF PLANT			\$ 1,046
22	7D	DEP EXP - EQUIPMENT REHAB GENERAL	\$ 609		\$ 12
22	7D	DEP EXP - CAP LEASE EQUIP ENVIRONMENTAL SERVICES GEN			\$ 11
<b>Total Excess Movable Equipment Depreciation</b>			\$ 609	\$ -	\$ 3,135

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
22	6A	MAINT & REPAIR BUILDING OPERATION OF PLANT			\$ 729
22	6A	CLEANING & MAINT SUPPLIES OPERATION OF PLANT			\$ 520
22	6A	CLEANING & MAINT SUPPLIES NURSING SERVICE OFFICE			\$ 3
22	6A	CLEANING & MAINT SUPPLIES REHAB GENERAL	\$ 293		\$ 60
22	6A	CONTRACT LABOR - NON CLINICAL OPERATION OF PLANT			\$ 442
22	6A	MAINT & REPAIR - EQUIPMENT OPERATION OF PLANT			\$ 2,498
22	6A	MAINT & REPAIR - AUTO/LOGISTIC OPERATION OF PLANT			\$ 25
22	6A	MAINT & REPAIR - AUTO/LOGISTIC GOOD LIFE FITNESS			\$ 467
22	6A	PURCHASED SERVICES - OTHER OPERATION OF PLANT			\$ 338
22	6A	MEDICAL SUPPLY OPERATION OF PLANT			\$ 4
22	6A	DUES AND LICENSES OPERATION OF PLANT			\$ 30

22	6A	MINOR EQUIPMENT & FURNISHINGS OPERATION OF PLANT			\$ 229	29
22	6B	NATURAL GAS/PROPANE/THERMAL OPERATION OF PLANT			\$ 1,015	
22	6C	ELECTRIC OPERATION OF PLANT			\$ 3,408	
22	6D	WATER OPERATION OF PLANT			\$ 1,372	
22	6F	MAINTENANCE - GROUNDS/LANDSCAPING OPERATION OF PLANT			\$ 855	
22	6F	WASTE REMOVAL OPERATION OF PLANT			\$ 1,327	
22	6F	STORAGE RENT/LEASE OPERATION OF PLANT			\$ 164	
22	6F	PURCHASED SERVICES - AFFILIATE OPERATION OF PLANT			\$ 83	
22	6F	OTHER NON-BILLABLE MED/SURG OPERATION OF PLANT			\$ 323	
22	7A	DEP EXP - LAND IMPROVEMENTS OPERATION OF PLANT			\$ 172	
<b>Total Other Property Adjustments</b>			\$ 293	\$ -	\$ 14,064	

**Schedule of Other - Indirect Adjustments**

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

**Schedule of Other - Miscellaneous Administrative Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
30	IV8	MISC OTHER OPERATING INCOME GRANT ADMIN			\$ 177,789
30	IV8	MISC OTHER OPERATING INCOME FINANCE ADMIN	\$ 6,879,190		\$ 3,133
30	IV8	MISC OTHER OPERATING INCOME CENTER FOR HEALTHY AGING			\$ 4,100
30	IV8	INCOME FROM RESTRICTED FUNDS FUND DEPT	\$ 59,145		
30	IV8	INVESTMENT INC - FUNDS HELD IN TRUST FINANCE ACCRUALS	\$ 1,555,169		
30	IV8	INVESTMENT INCOME FUND DEPT			\$ (1,558,301)
30	IV8	INVESTMENT INCOME ADMIN AND GENERAL	\$ 41		
30	IV8	INVESTMENT INCOME FINANCE ADMIN	\$ (6,879,190)		
30	IV8	INVESTMENT INCOME FINANCE ACCRUALS	\$ 1,558,301		
30	IV8	DIVIDEND INCOME FINANCE CORP TREASURY	\$ 59,240		
30	IV8	RESTRICTED FUNDS - SNF SELF PAY FUND DEPT	\$ (103,909)		
30	IV8	FREE BED INCOME	\$ 104,988		
30	IV8	EQUIPMENT RENTAL	\$ (92)		
30	IV8	CONTRIBUTIONS OPERATIONAL CENTER FOR HEALTHY AGING			\$ 330
<b>Total Other Adjustments</b>			\$ 3,232,883	\$ -	\$ (1,372,949)

**Schedule of Other - Direct Adjustments**

Attachment Page 29

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

**Schedule of Unallowable Building Interest**

Page Ref	Line Ref	Description	CCNH	RHNS	Other
22	7B	DEP EXP - BUILDING ADMIN & GENERAL			\$ 6,557
22	7B	DEP EXP - BUILDING OPERATION OF PLANT			\$ 361
22	7C	DEP EXP - NON MOVABLE EQUIPMENT			\$ 98
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ 7,016

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended 9/30/2019			Page 30	of 37
		Item	Total	CCNH	RHNS	Other
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$	10,972,367	10,972,367			
b. Medicaid Room and Board Contractual Allowance **	\$	(5,316,105)	(5,316,105)			
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents( <i>all inclusive</i> )	\$	2,213,930	2,213,930			
b. Medicare Room and Board Contractual Allowance **	\$	233,440	233,440			
4. a. Private-Pay Residents and Other	\$	5,176,021	5,176,021			
b. Private-Pay Room and Board Contractual Allowance **	\$	78,813	78,813			
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$	183,741	183,741			
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(183,537)	(183,537)			
c. Prescription Drugs - Non-Medicare	\$	148,469	148,469			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(148,469)	(148,469)			
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	\$	701,838	523,364			178,474
b. Physical Therapy - Medicare Contractual Allowance **	\$	(483,946)	(458,914)			(25,032)
c. Physical Therapy - Non-Medicare	\$	432,677	432,677			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$	(429,428)	(429,428)			
4. a. Speech Therapy - Medicare	\$	44,684	43,661			1,023
b. Speech Therapy - Medicare Contractual Allowance **	\$	(27,361)	(27,361)			
c. Speech Therapy - Non-Medicare	\$	30,693	30,693			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	(30,692)	(30,692)			
5. a. Occupational Therapy - Medicare	\$	528,709	512,129			16,580
b. Occupational Therapy - Medicare Contractual Allowance **	\$	(449,385)	(446,997)			(2,388)
c. Occupational Therapy - Non-Medicare	\$	413,189	413,189			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(409,890)	(409,890)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$					
b. Other ( <i>Specify</i> ) - Non-Medicare	\$	54,204	(75,218)			129,422
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)		\$ 13,733,962	13,435,883			298,079
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others	\$	11,360				11,360
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income ( <i>Specify</i> )	\$	3,512,372	3,512,372			
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$	1,859,934	3,232,883			(1,372,949)
<b>V. Total Other Revenue</b> (1 thru 8)		\$ 5,383,666	6,745,255			(1,361,589)
<b>VI. Total All Revenue</b> (III +V)		\$ 19,117,628	20,181,138			(1,063,510)

\* 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	Other
30 II6a	IP LAB SERVICES MEDICARE ANCILLARY SRV	\$ 39,005		
30 II6a	IP RADIOLOGY SERVICES MEDICARE ANCILLARY SRV	\$ 7,832		
30 II6a	IP LAB SERVICES PROF CA MEDICARE ANCILLARY SRV	\$ (39,005)		
30 II6a	IP RADIOLOGY SERV PROF CA MEDICARE ANCILLARY SRV	\$ (7,832)		
30 II6a	IP OXYGEN PROF CA MEDICARE ANCILLARY SRV	\$ (5,121)		
30 II6a	IP OTHER SERVICES MEDICARE ANCILLARY SRV	\$ 5,121		
<b>Total Other Resident Revenue - Medicare</b>		\$ -	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	Other
30 II6b	IP LAB SERVICES MGD MEDICARE ANCILLARY SRV	\$ 30,868		
30 II6b	IP LAB SERVICES MEDICAID ANCILLARY SRV	\$ 80		
30 II6b	IP LAB SERVICES OTHER MANAGED CARE ANCILLARY SRV	\$ 2,575		
30 II6b	IP LAB SERVICES SELF PAY ANCILLARY SRV	\$ 99		
30 II6b	IP OTHER SERVICES MGD MEDICARE ANCILLARY SRV	\$ 5,304		
30 II6b	IP OTHER SERVICES MEDICAID ANCILLARY SRV	\$ 6,132		
30 II6b	IP OTHER SERVICES OTHER MANAGED CARE ANCILLARY SRV	\$ 308		
30 II6b	IP OTHER SERVICES SELF PAY ANCILLARY SRV	\$ 306		
30 II6b	IP RADIOLOGY SERVICES MANAGED MEDICARE ANCILLARY SRV	\$ 4,126		
30 II6b	IP RADIOLOGY SERVICES MEDICAID ANCILLARY SRV	\$ 150		
30 II6b	IP RADIOLOGY SERVICES OTHER MANAGED CARE	\$ 75		
30 II6b	OP OTHER SERVICES SELF PAY CENTER FOR HEALTHY AGING	\$ -		\$ 85,277
30 II6b	OP OTHER SERVICES SELF PAY GOOD LIFE FITNESS			\$ 44,145
30 II6b	IP LAB SERVICES PROF CA MANAGED MEDICARE ANCILLARY SRV	\$ (30,868)		
30 II6b	IP LAB SERVICES PROF CA MEDICAID ANCILLARY SRV	\$ (80)		
30 II6b	IP LAB SERVICES PROF CA OTHER MANAGED CARE ANCILLARY SRV	\$ (2,575)		
30 II6b	IP LAB SERVICES PROF CA SELF PAY ANCILLARY SRV	\$ (99)		
30 II6b	IP RADIOLOGY SERV PROF CA MANAGED MEDICARE ANCILLARY SRV	\$ (4,126)		
30 II6b	IP RADIOLOGY SERV PROF CA MEDICAID ANCILLARY SRV	\$ (150)		
30 II6b	IP RADIOLOGY SERV PROF CA OTHER MANAGED CARE ANCILLARY SRV	\$ (75)		
30 II6b	IP OXYGEN PROF CA MANAGED MEDICARE ANCILLARY SRV	\$ (5,304)		
30 II6b	IP OXYGEN PROF CA MEDICAID B ANCILLARY SRV	\$ (6,132)		
30 II6b	IP OXYGEN PROF CA OTHER MANAGED CARE B ANCILLARY SRV	\$ (308)		
30 II6b	IP OXYGEN PROF CA SELF PAY ANCILLARY SRV	\$ (327)		
30 II6b	OTHER DEDUCTIONS - IP - SELF PAY SENIOR SERVICES REVENUE	\$ (75,197)		
<b>Total Other Resident Revenue</b>		\$ (75,218)	\$ -	\$ 129,422

**Interest Income****Account**

Page Ref	Account	Balance	CCNH	RHNS	Other
30 IV5	INVESTMENT INC - ENDOWMENT LLC FUND DEPT	\$ 3,512,372			
<b>Total Interest Income</b>		\$ 3,512,372	\$ -	\$ -	

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	Other
30 IV8	MISC OTHER OPERATING INCOME GRANT ADMIN			\$ 177,789
30 IV8	MISC OTHER OPERATING INCOME ADMIN AND GENERAL			\$ 3,133
30 IV8	MISC OTHER OPERATING INCOME FINANCE ADMIN	\$ 6,879,190		
30 IV8	MISC OTHER OPERATING INCOME CENTER FOR HEALTHY AGING			\$ 4,100
30 IV8	INCOME FROM RESTRICTED FUNDS FUND DEPT	\$ 59,145		
30 IV8	INVESTMENT INC - FUNDS HELD IN TRUST FINANCE ACCRUALS	\$ 1,555,169		
30 IV8	INVESTMENT INCOME FUND DEPT			\$ (1,558,301)
30 IV8	INVESTMENT INCOME ADMIN AND GENERAL	\$ 41		
30 IV8	INVESTMENT INCOME FINANCE ADMIN	\$ (6,879,190)		
30 IV8	INVESTMENT INCOME FINANCE ACCRUALS	\$ 1,558,301		
30 IV8	DIVIDEND INCOME FINANCE CORP TREASURY	\$ 59,240		
30 IV8	RESTRICTED FUNDS - SNF SELF PAY FUND DEPT	\$ (103,909)		
30 IV8	FREE BED INCOME	\$ 104,988		
30 IV8	EQUIPMENT RENTAL	\$ (92)		
30 IV8	CONTRIBUTIONS OPERATIONAL CENTER FOR HEALTHY AGING			\$ 330
<b>Total Other Revenue</b>		\$ 3,232,883	\$ -	\$ (1,372,949)

**G. Balance Sheet**

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2019	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	3,206,933
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	923,566
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	1,400
4 Inventories			\$	
5. Prepaid Expenses			\$	75,305
a. <u>Prepaid Expenses - General</u>				
b. _____				
c. _____				
d. See Schedule		75,305		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	(1,822,252)
See Schedule		(1,822,252)		
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	2,384,952
B. Fixed Assets				
1. Land			\$	262,536
2. Land Improvements	*Historical Cost	98,834	\$	90,424
	Accum. Depreciation	8,410	Net	
3. Buildings	*Historical Cost	8,073,852	\$	1,916,337
	Accum. Depreciation	6,157,515	Net	
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	1,460,649	\$	34,728
	Accum. Depreciation	1,425,921	Net	
6. Movable Equipment	*Historical Cost	2,317,097	\$	483,061
	Accum. Depreciation	1,834,036	Net	
7. Motor Vehicles	*Historical Cost	84,154	\$	18,745
	Accum. Depreciation	65,409	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	245,543
Capital in Process & Equipment in Process				
See Schedule		245,543		
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	3,051,374

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

(Carry Total forward to next page )

## Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	GAVLAK CONTINGENCY WATER CO	\$ 525
31	A5	LEADING AGE CT	\$ 2,529
31	A5	SALINA OFFICE SERVICES	\$ 3,078
31	A5	JOHNSON CONTROLS	\$ 4,669
31	A5	OTIS ELEVATOR	\$ 746
31	A5	PRIME SELF STORAGE	\$ 5,738
31	A5	MORRISON MANAGEMENT	\$ 41,010
31	A5	CROTHALL HEALTHCARE INC	\$ 17,010
<b>Total Prepaid Expenses</b>			<b>\$ 75,305</b>

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

Page Ref	Line Ref	Description	
31	A8	DUE AFFILIATE GENERAL CONTROL	\$ 125,141
31	A8	DUE AFFILIATE ACCOUNTS PAYABLE CONTROL	\$ (49,247)
31	A8	DUE AFFILIATE PAYROLL CONTROL	\$ (1,863,283)
31	A8	DUE AFFILIATE SYSTEM ALLOCATION CONTROL	\$ (28,307)
31	A8	DUE AFFILIATE INVENTORY CONTROL	\$ (6,556)
<b>Total Other Current Assets (Itemize)</b>			<b>\$ (1,822,252)</b>

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

Page Ref	Line Ref	Description	
31	B9	CAPITAL IN PROCESS	\$ 242,990
31	B9	EQUIPMENT IN PROCESS	\$ 2,553
<b>Total Other Other Fixed Assets (Itemize)</b>			<b>\$ 245,543</b>

## Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	INVESTMENT IN ENDOWMENT LLC	\$ 111,065,225
32	D7	TEMPORARY RESTRICTED CASH	\$ 215,396
32	D7	INVESTMENT IN ENDOWMENT LLC TEMP	\$ 4,613,632
32	D7	INVESTMENT IN ENDOWMENT LLC PERM	\$ 2,538,722
32	D7	ASSETS HELD IN TRUST BY OTHERS	\$ 35,795,177
<b>Total Other Assets</b>			<b>\$ 154,228,152</b>

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

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

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

Page Ref	Line Ref	Description	
33	A12	DEFERRED REVENUES	\$ 892,533
33	A12	DEFERRED MISC INCOME	\$ 6,525
33	A12	ACCRUED STATE PROVIDER TAX	\$ 153,467
33	A12	PENSION TRANSITION	\$ 51,831
33	A12	ER 401K CORE	\$ 138,809
33	A12	ER 401K MATCH TRUE UP	\$ 3,648
33	A12	ER 401K MATCH STATIC ACCRUAL	\$ 19,444
33	A12	RETIREMENT FORFEITURES	\$ (2,439)
33	A12	EE GARNISHMENT WITHHOLDINGS	\$ 186
33	A12	RESIDENT CASH LIABILITY	\$ 21,247
33	A12	DEFER STATE TAX LIABILITY CURRENT	\$ 334
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ 1,285,585</b>

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

Page Ref	Line Ref	Description	
34	B4	LT LEASES - EQUIPMENT	\$ 5,622
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ 5,622</b>

**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	9/30/2019	32	37
Account				Amount
Total Brought Forward:				\$ 5,436,326
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
1. Land				\$
2. Land Improvements	*Historical Cost			\$
	Accum. Depreciation			Net
3. Buildings	*Historical Cost			\$
	Accum. Depreciation			Net
4. Non-Movable Equipment	*Historical Cost			\$
	Accum. Depreciation			Net
5. Movable Equipment	*Historical Cost			\$
	Accum. Depreciation			Net
6. Motor Vehicles	*Historical Cost			\$
	Accum. Depreciation			Net
7. Minor Equipment-Not Depreciable				\$
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>				\$
<b>D. Investment and Other Assets</b>				
1. Deferred Deposits				\$
2. Escrow Deposits				\$
3. Organization Expense	*Historical Cost			\$
	Accum. Depreciation			Net
4. Goodwill (Purchased Only)				\$
5. Investments Related to Resident Care ( <i>itemize</i> )				\$
6. Loans to Owners or Related Parties ( <i>itemize</i> )				\$
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )				\$ 154,228,152
Investment in Endowment, Temp Restricted Cash,				
Assets Held in Trust by Others				
See Schedule	154,228,152			
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>				\$ 154,228,152
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>				\$ 159,664,478

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

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

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

*(Carry Total forward to next page)*

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

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019	Page 34	of 37
Account			Amount	
Total Brought Forward:			2,157,800	
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 5,622
LT Leases - Equipment				
See Schedule		5,622		
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 5,622
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 2,163,422

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

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2019	35	37
		Account	Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	158,759,699
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	
6. Gain or Loss for Period	10/1/2018	thru	9/30/2019	\$ <span style="color: red;">(1,258,643)</span>
7. Total Net Worth			\$	157,501,056
<b>C. Total Reserves and Net Worth</b>				\$ 157,501,056
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 159,664,478

## 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	9/30/2019	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2018				\$ 159,794,167
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 19,117,628
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 20,376,271
D. Net Income or Deficit				\$ (1,258,643)
E. Balance				\$ 158,535,524
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
UR Transfer of Assets				44,673
2. Other ( <i>itemize</i> )				
TR Contributions & TR Investment Held by End				165,907
TR Investment Income				(121,438)
TR NA Released & TR Other				(66,308)
PR Unrealized Gain on Funds Held in Trust				(1,057,302)
F-3. Total Additions				\$ (1,034,468)
G. Deductions				
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )				\$
Name and Address (No., City, State, Zip )				
2. Other Withdrawings ( <i>Specify</i> )				\$
Purpose				Amount
3. Total Deductions				\$
H. <b>Balance at End of Period</b>				\$ 157,501,056
Report for Year Ended 09/30/19				

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

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2019	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Other		

### 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		
Dorothy Robinson		
Address Address Hartford HealthCare 181 Patricia M. Genova Drive, Newington, CT 06111		Phone Number 860-696-6438
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number 860-696-6438
Contact Email Address Dorothy.Robinson@hhchealth.org		