State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as licensed)								
Jerome Home								
Address (No. & Street, City, State, Zip Code)								
975 Corbin Avenue, New Britain, CT 06051								
Type of Facility								
☑ Chronic and Convalescent Nursing Home only (CCNH)		Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home					
Report for Year Beginning 10/1/2018		Report for Year Ending 9/30/2019						

License Numbers:	CCNH 2065C	RHNS	Residential Care I 1427	Home Medicare Provider 07-5343					

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	20652		

For Department Use Only

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

Jerome Home)	License N		Report for Year Ended	Page	0
		2065C	9	9/30/2019	1	37
	CATION OR FALSII MAY BE PUNISHA	FICATION OF		ion Ion contained in Onment under s		
Cost Report and so period beginning (and belief, it is a t	upporting schedules October 1, 2018 and	prepared for Jer ending Septem pplete statement	rome Home [facility per 30, 2019, and the prepared from the	re examined the accomy y name], for the cost re hat to the best of my kr books and records of t	eport nowledge	
Schedule of Resider	nt Statistics, Statemen is Facility in accordan	ts of Reported E	xpenditures, Stateme	ormation and Questionna nts of Revenues and the of the State of Connectic	related	
my knowledge un presented in this R	der the penalty of pe Report as a basis for s urred to provide resi	rjury. I also cen securing reimbu dent care in this	tify that all salary a rsement for Title X Facility. All supp	s true and correct to the and non-salary expense IX and/or other State a orting records for the e nade available to audit	es assisted expenses	
recorded have bee request.		Date	Signed (Owner	·)	Date	
recorded have bee		Date	Signed (Owner)	Date	
recorded have bee request. Signed (Administrator) Printed Name (Administrator	·)	Date	Signed (Owner Printed Name	, 	Date	
recorded have bee request.) State of	Date		(Owner)	Date Comm. Expi	res

General Information

(Notary Seal)

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State of Connecticut Department of Social Services

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	Page	of		
			1Å	37
Name of Facility	Period Cov	ered:	From	То
Jerome Home			10/1/2018	9/30/2019
Address of Facility 975 Corbin Avenue, New Britain, CT 06051				
Report Prepared By	Phone Num	nber	Date	
Dorothy Robinson	860-696-64	38		-
				Residential Care
Item	Total	CCNH	RHNS	Home
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.

General Information and Questionnaire Type of Facility - Organization Structure

			ne No. of Fa -229-3707	cility	Report for Ye 9/30/2019	ar Ended	Page 2		of 37
Name of Facility (as shown on license)				0 f (Street, City, Sta	uto 7in)	2		37
Jerome Home					ue, New Brita	· ·	051		
	CCNH		RHNS		dential Care H		Medicare I	Provid	der No.
License Numbers:	2065C					427	07-5343		
Type of Facility (Check appropriate box(e	s))						1		
Chronic and Convalescent Nursing Home only (CCNH)			t Home with ervision only			Resident	ial Care Hor	ne	
Type of Ownership (Check appropriate bo	x)								
O Proprietorship O LLC O	Partnership	0	Profit Corp.	0	Non-Profit Cor	p. O	Government	\odot	Trust
If this facility opened or closed during rep	ort year provid	e:		Date	e Opened	Date Clo	sed		
Has there been any change in ownership				•					
or operation during this report year?		0	Yes	\odot	No	If "Yes,"	explain full	y.	
Administrator									
Name of Administrator					Nursing Ho				
Lori Toombs					Administrat		001985		
	1	(6-1		. 64	License M	No.:			
Other Operators/Owners who are assistant Name	administrators	s (ful	f or part time) of th	License I	No			
Ivallie					License	NU			

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General Information and Questionnaire Partners/Members

Name of Facility Jerome Home	License No. 2065C	Report for Y 9/30/2019	ear Ended	Page of 3 37			
Legal Name of Part	nership/LLC	Business 4	Address		/or Town(s) in Registered		
Name of Partners/Members	Business Ac	ddress	,	Title	% Owned		

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Yea	r Ended	Page of
Jerome Home	2065C	9/30/2019		3A 37
If this facility is owned or operated as a corpo	ration, provide th	he following infor	mation:	
Legal Name of Corporation	Busin	ess Address	State(s) in W	hich Incorporated
Name of Directors, Officers	Busin	less Address	Title	No. Shares Held by Each
See attached list of Trustees				
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	f						
Jerome Home	2065C	9/30/2019	3B 37	7						
If this facility is owned or operated as an individua	al proprietorship, j	provide the following informat	ion:							
Owner(s) of Facility										

General Information and Questionnaire Related Parties*

Name of Facility		License	e No.		Report for Year Ended		Page	of
Jerome Home			2065C		9/30/2019		4	37
5	ving compensation from the fa			U		If "Yes," provide th		
marriage, ability to control	ol, ownership, family or busin	ess asso	ciation?	0	Yes O No	complete the inform	nation on Pa	age 11 of the report.
	mpanies which provide goods							
	operty or the loaning of funds		-					
	sociation, common ownership				⊙ Yes O No			
association to any of the	owners, operators, or officials	of this f	facility?			If "Yes," provide th	ne following	information:
						1	1	1
			so Provi			Indicate Where		
			ls/Servi			Costs are Included		
Name of Related	Business		Related		Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	No	%**	Provided	Page # / Line #	Reported	Related Party
See attached listing		0	\odot					
		0	۲					
		0	۲					
		0	۲					
		0	۲					
		0	٥					
		0	٥					
		0	•					
		0	٥					

* 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	License No.		Report for Year Ended	Page	of							
Jerome Home	2065C		9/30/2019	5	37							
If the facility is licensed as CDH and/or RCH or	provides AI	DS or TBI :	services with special Medicaid r	ates, cost	ts							
must be allocated to CCNH and RHNS as follow	•		1	,								
Item			Method of Allocation									
Dietary		Number of meals served to residents										
Laundry		Number of pounds processed										
Housekeeping		Number of square feet serviced										
		Number of	hours of routine care provided b	y EACH	[
Nursing		employee classification, i.e., Director (or Charg										
		•	Nurses, Licensed Practical Nurs	es, Aides	s and							
		Attendants										
Direct Resident Care Consultants			hours of resident care provided	by EACI	Н							
		-	See listing page 13)									
Maintenance and operation of plant		Square feet										
Property costs (depreciation)		Square feet										
Employee health and welfare		Gross salar										
Management services		Appropriate cost center involved										
All other General Administrative expenses			rect and Allocated Costs									
The preparer of this report must answer the follo	wing question	ons applicat	ble to the cost information provide	ded.								
1. In the preparation of this Report, were all	• Yes	O No	If "No," explain fully why such	allocatio	on was not							
costs allocated as required?			made.									
Note: General & Administrative Expenses are al	llocated base	d on patient	t days which is consistent with	prior year	rs which							
have been audited by DSS.												
2. Explain the allocation of related company exp	penses and at	ttach copy o	of appropriate supporting data.									
3. Did the Facility appropriately allocate and set			e	e cost cer	nters?							
(e.g., Assisted Living, Home Health, Outpatie	ent Services,	Adult Day	Care Services, etc.)									
	• Yes	O No	If "No," explain fully why such made.	allocatio	on was not							

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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 Y	ear Ended		Page	of
Jerome Home			2065C	9/30/2019)		6	37
	Relate	ed * to						
	Ow	ners,						
	_	ators,				Annual		
	-	icers		Date of	Term of	Amount		ount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Clai	imed
Short term leases only	0	۲						
	0	۲						
	0	۲						
	0	۲						
	0	۲						
	0	۲						
	0	۲						
	0	۲						
	0	۲						
	0	۲						
Is a Mileage Log Book Maintained for All	Leased V	ehicles	? O Yes	s •	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.

General Information and Questionnaire Accounting Basis

P		-		
Name of Facility	License No.	Report for Year Ended		Page of
Jerome Home	2065C	9/30/2019		7 37
The records of this facility for the	e period covered by this report	were maintained on the following basis:		
	D Modified Cash			
Is the accounting basis for this				
period the same as for the	• Yes	If "No," explain.		
previous period? C	D No			
Independent Accounting Firm				
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code))	
1 Crowe, LLP		320 E. Jefferson Blvd., South Bend, IN 4	6024	
2 Jordan Actuarial Services		29440 Bertrand Dr., Agoura Hill, CA 913	301	
3 SGF Accounting LLC		PO Box 7, Indian Valley, VA 24105		
4				
Services Provided by This Firm (a	describe fully)	·		
1 Year End Audit, 401k/403b Audit			\$	52,800
2 Workers Compensation Study			\$	3,300
3 Medicaid Cost Report Preparation C	Consultation		\$	100
4			\$	
			Charge for S	ervices Provided
			\$	56,200
Are These Charges Reflected in the Expe	enditure Portion of This Report? If Ve	es, Specify Expense Classification and Line No.	Ψ	50,200
\odot Yes \bigcirc No	Page 15 line 1d			
Legal Services Information				
Name of Legal Firm or Independe	ent Attorney		Telephone N	umber
1 Michalik, Bauer, Silvia & Cie			860-225-840	
2 Wiggin & Dana			203-498-440	
3 Metzger Lazarek & Plumb Ll	IC		860-549-502	
	Metzger Lazarek & Plumb LI	C	800-333-208	
5 Barry T. Pontillo Law Office	-		203-238-767	
Address (No. & Street, City, State			203-238-707	0
1 35 Pearl St. Suite 300, New E				
	1832 New Haven, CT 06508			
3 56 Arbor St., Hartford, CT 06				
4 PO Box 6180, Hermitage, PA				
5 PO Box 943 Meriden, CT 06				
Services Provided by This Firm (a				
1 Collections - disallow	uescribe juity)		¢	1.600
	1		\$	1,600
2 Bylaw review, survey consultation,	land record		\$	23,446
3 Collections - disallow			\$	19,325
4 Collections - disallow			\$	1,379
5 Collections - disallow				
			\$	273
				ervices Provided
Are These Charges Reflected in the Expe	enditure Portion of This Report? If Ye Page 15 line 1e	es, Specify Expense Classification and Line No.	Charge for S	ervices Provided

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Schedule of Resident Statistics

Name of Facility			License No. Report for Year Ended						Page	of		
Jerome Home			20)65C			9/30/2019					37
						Period 10/	'1 Thru 6/	30		Period 7/	1 Thru 9/3	30
		Total	Total	Total								
	Total All	CCNH	RHNS	Residential				Residential				Residential
	Levels	Level	Level	Care Home	Total	CCNH	RHNS	Care Home	Total	CCNH	RHNS	Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	120	94		26	120	94		26	120	94		26
B. On last day of THIS report period	120	94		26	120	94		26	120	94		26
2. Number of Residents												
A. As of midnight of PREVIOUS report period	113	87		26	113	87		26	117	91		26
B. As of midnight of THIS report period	119	93		26	117	91		26	119	93		26
3. Total Number of Days Care Provided During Period												
A. Medicare	2,421	2,421			1,816	1,816			605	605		
B. Medicaid (Conn.)	21,195	14,850		6,345	17,584	11,239		6,345	3,611	3,611		
C. Medicaid (other states)	2,208			2,208					2,208			2,208
D. Private Pay	13,146	12,380		766	9,673	9,091		582	3,473	3,289		184
E. State SSI for RCH												
F. Other (Specify)	3,069	3,069			2,282	2,282			787	787		
G. Total Care Days During Period (3A thru F)	42,039	32,720		9,319	31,355	24,428		6,927	10,684	8,292		2,392
Total Number of Days Not Included in Figures in4. 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	60	26		34	53	19		34	7	7		
B. Other Bed Reserve Days	96			79	79			17	17			
5. Total Resident Days (3G + 4A + 4B)	42,195	32,842		9,353	31,487	24,526		6,961	10,708	8,316		2,392

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			Scl	hed	ule of	Re	side	nt S	tatis	stics ((Cont'd)		
Name of Faci	lity			Licer	ise No.				Repor	t for Year	Ended		Page	of
Jerome Home	•			2	065C					9/30/201	9		9	37
	-	-		n the certified bed capacity during the report year? O Yes lowing information:									No	
			f Change		Cl	nange	in Bed	s		Ca	pacity Aft	er Change		
			Residential					-			F			
Date of	CCNH	RHNS	Care Home	Care Home Lost Gained										
Change	(1)	(2)	(3)	(3) (1) (2) (3) (1) (2) (3) CCNH RHNS Care Ho									Reason f	or Change
						(-)			(-)					0
	•	•	in certified bed c 90 days followin	•	• •	the re	eport ye	ar (as	report	ed in item	4 above) j	provide the num	ber of	
1st chan	ge		Change in Ro	esiden	t Days					CC	CNH	RHNS	Residential	l Care Home
2nd char														
3rd chan														
4th chan		1 .	1.0.	1	20 60									
6. Number	of Resid	dents and	d Rates on Septe Medicare	mber	30 of Co Medi		ır	1		S	elf-Pay		Other Sta	te Assisted
			Wedicare		Medi					50	iii-Pay		Other Sta	le Assisted
	Item		CCNH	C	CNH	RI	HNS	СС	CNH	Rŀ	INS	Residential Care Home	R.C.H.	ICF-MR
No. of R		5	7		41				45			2	24	
Per Dien														
a. One b			RUGS		246.00				510.00			215.00	136.00	
b. Two									495.00					
c. Three		e												
bed r	ms.													
7 Total Nu	unber of	f Physic	al Therapy Treat	ments						то	TAL	CCNH	RHNS	Residential Care Home
		are - Par		mento							2,547	965	Iunto	1,582
			lusive of Part B)											
			e Treatments								38	38		
C	2. Res Other	torative	Treatments									10.054		1.070
		Physical	Therapy Treatn	onts							14,948 17,533	13,876 14,879		1,072 2,654
			Therapy Treatm								17,555	14,075		2,034
		are - Par									205	111		94
B.			lusive of Part B)											
			e Treatments											
		torative	Treatments											
	Other Total S	neech T	Therapy Treatme	nte							416 621	413 524		3 97
			ational Therapy		ients						021	524		91
		are - Par		liteatii	lents						976	735		241
			lusive of Part B)											
			e Treatments											
~		torative	Treatments											
	Other	Decunati	ional Therapy T	rontm	onts						13,128 14,104	13,128 13,863		241
D.	1 out C	rcupall	onui 1 nerupy 1	eaim	enis						14,104	13,803		241

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.		Report for Yea	r Ended	Page	of
Jerome Home	2065C		9/30/2019		10	37
Are time records maintained by all individuals receiving con	mpensation?	\odot	Yes	0	No	
			Total Cost a	and Hours		
					Residential	
Item	CCNH	Hours	RHNS	Hours	Care Home	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)	113,705	1,619			32,382	46
3. Assistant Administrator (Complete also Sec. IV		,				-
of Schedule A1)						
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	461,734	15,874			131,496	4,52
5. Dietary Service						
a. Head Dietitian	50.000	1.670			16.004	
b. Food Service Supervisor c. Dietary Workers	59,322 460,654	1,650 28,160			16,894 131,189	47 8,01
6. Housekeeping Service	400,034	28,100			151,189	8,01
a. Head Housekeeper	5,567	210			2,715	10
b. Other Housekeeping Workers	142,270	11,198			69,406	5,46
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	59,917	1,398			29,231	68
b. Other Maintenance Workers	100,714	5,529			49,132	2,69
8. Laundry Service a. Supervisor						
b. Other Laundry Workers	130,035	10,271				
9. Barber and Beautician Services	150,055	10,271				
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants 12. Professional Care of Residents						
	190.025	2 (00			51 520	1.05
a. Directors and Assistant Director of Nurses b. RN	180,935	3,699			51,529	1,05
1. Direct Care	1,610,261	40,180			134,796	3,60
2. Administrative**	298,978	7,056			6,937	16
c. LPN						
1. Direct Care	723,278	22,513				
2. Administrative**		102.010			100.000	
d. Aides and Attendants	2,132,266	123,310			123,662	5,59
e. Physical Therapists f. Speech Therapists	306,735 1,784	<u>9,917</u> 35			54,713 330	1,76
g. Occupational Therapists	286,803	8,342			4,986	14
h. Recreation Workers	132,016	6,345			37,597	1,80
i. Physicians						
1. Medical Director						
2. Utilization Review					↓	
3. Resident Care*** 4. Other (Specify)						
4. Omer (Specify)						
j. Dentists	+ +				<u> </u>	
k. Pharmacists				1		
1. Podiatrists						
m. Social Workers/Case Management	123,322	4,493			35,121	1,27
n. Marketing						
o. Other (Specify)	01 422	2 010			71 527	2.1.
See Attached Schedule A-13. Total Salary Expenditures	81,422 7,411,718	3,010 304,809			71,527 983,643	3,14 40,97

* 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)

	ССИН			R	RHNS	I	Residential C	Care Home
Position		\$	Hours	\$	Hours		\$	Hours
ADMISSIONS-SALARIES - ADMISSIONS SUPERVISOR	\$	58,931	1,650			\$	16,783	470
ADMISSIONS-SALARIES - ADMISSIONS OTHER	\$	22,491	1,360			\$	6,405	387
GOOD LIFE FIT -SENIOR FIT - SALARIES - DISALLOWED	\$	-	-			\$	48,339	2,284
Total	\$	81,422	3,010	\$ -	-	\$	71,527	3,141

Schedule of Other Fees (Page 13)

	CC	NH	RH	NS	Residential Care Home		
Service	\$	Hours	\$	Hours	\$	Hours	
Total	\$ -	-	\$-	-	\$-	-	

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Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other	Related Parties *
------------------------------------	--------------------------

Name of Facility				License No.		1	Year Ended		Page	of
Jerome Home				2065C		9/30/2019			11	37
		Salary Pai	d	Fringe Benefits						
Name	CCNH	RHNS	Residential Care Home	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
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.

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*

		1	Ibbibtuin			Iterated	1 di ties		1	
Name of Facility (as licensed)				License No.		Report for Y	ear Ended		Page	of
Jerome Home				2065C	9/30/2019			12	37	
		Salary Pai	d							
Name	CCNH	RHNS	Residential Care Home		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
Section III - Administrators***										
Lori Toombs	113,705			Non- discriminatory		2,080	A2			
Section IV - Assistant Administrators										

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

** Include <u>all</u> other employment worked during the cost year.

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

State of Connecticut Annual Report of Long-Term Care Facility CSP-13 Rev. 9/2002

Report for Year Ended Name of Facility License No. Page of 9/30/2019 Jerome Home 2065C 13 37 Total Cost and Hours Residential CCNH RHNS Care Home Item Hours Hours 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 32.304 756 9.200 215 2. Dentist 8,190 149 2,332 43 3. Pharmacist 7,259 91 2,067 26 Podiatrist 4. 5. Physical Therapy a. Resident Care 61,464 899 10,964 160 b. Other 6. Social Worker 7. Recreation Worker 8,250 99 2,350 28 8. Physicians a. Medical Director (entire facility) 44,832 300 12,768 85 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 34,888 481 6,458 89 b. Other 10. Occupational Therapist a. Resident Care 4.830 109 84 2 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 **B-13** Total Fees Paid in Lieu of Salaries 202.017 2.884 46.223 648

B. Report of Expenditures - Professional Fees

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

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

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

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

Name of Facility	License No.		Report for Ye	ar Ended	Page	of	
Jerome Home	2065C		9/30/2019		14	37	
Name & Address of Individual	Full Explanation of Service		* to Owners, rs, Officers No	Expla	0		
Catherine Leone	Dietician	0	•				
Mara Davis	Dietician	0	•				
Healthdrive Dental	Dental Services	0	•				
Omni Pharmacy	Pharmacy Consultant	0	•				
Hartford HealthCare - Southington Care Center	Dietician, Physical, Speech & Occupational Therapy	۲	0				
Hartford HealthCare Rehab Network	Physical, Speech & Occupational Therapy	۲	0				
Thomas Alvord	Recreation Entertainment	0	o				
Louis E Ames	Recreation Entertainment	0	•				
Larry Batter	Recreation Entertainment	0	o				
John Bussmann	Recreation Entertainment	0	•				
Margaret W Carchrie	Recreation Entertainment	0	o				
Douglass Codianni	Recreation Entertainment	0	o				
Martha Conway	Recreation Entertainment	0	•				
Richard Dagenais	Recreation Entertainment	0	•				
David Estabrook	Recreation Entertainment	0	o				
Paul Gobell	Recreation Entertainment	0	o				
Kathleen Gregory	Recreation Entertainment	0	•				
Michael Iarusso	Recreation Entertainment	0	•				
Linda Kozlenko	Recreation Entertainment	0	o				
Chris Merwin	Recreation Entertainment	0	o				
Robert Mosebach	Recreation Entertainment	0	o				
Walter Olson	Recreation Entertainment	0	•				

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility Li	cense No.		Report for Ye	ear Ended	Page	of
Jerome Home	2065C		9/30/2019		15	37
						Residential
Item			Total	CCNH	RHNS	Care Home
1. Administrative and General						
a. Employee Health & Welfare Benefits						
1. Workmen's Compensation		\$	128,107	113,097		15,010
2. Disability Insurance		\$	51,325	45,311		6,014
3. Unemployment Insurance		\$	33,429	29,513		3,916
4. Social Security (F.I.C.A.)		\$	620,939	548,187		72,752
5. Health Insurance		\$	1,057,936	933,982		123,954
6. Life Insurance (employees only)						
(not-owners and not-operators)		\$				
7. Pensions (Non-Discriminatory)		\$	157,261	138,836		18,425
(not-owners and not-operators)						
8. Uniform Allowance		\$	563	497		66
9. Other (<i>Specify</i>)		\$	20,104	17,748		2,356
See Attached Schedule						
b. Personal Retirement Plans, Pensions, and		\$				
Profit Sharing Plans forOwners and						
Operators (Discriminatory)*						
c. Bad Debts*		\$	120,000	120,000		
d. Accounting and Auditing		\$	56,200	43,743		12,457
e. Legal (Services should be fully described on	Page 7)	\$	46,023	35,609		10,414
f. Insurance on Lives of Owners and		\$				
Operators (Specify)*						
g. Office Supplies		\$	16,403	12,614		3,789
h. Telephone and Cellular Phones			,	7		
1. Telephone & Pagers		\$	16,596	12,917		3,679
2. Cellular Phones		\$,	,		,
i. Appraisal (Specify purpose and		\$				
attach copy)*						
r, , ,						
j. Corporation Business Taxes (franchise tax)		\$				
k. Other Taxes (<i>Not related to property - See P</i>	Page 22)	Ŧ				
1. Income*	<u> </u>	\$				
2. Other (<i>Specify</i>)		\$				
See Attached Schedule		Ŷ				
3. Resident Day User Fee		\$	583,995	583,995		
Subtotal		\$	2,908,881	2,636,049		272,832

* 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

					idential
Description	(CCNH	RHNS	Car	e Home
EMP BENEFITS-EMP PHYSICALS (& TESTING) -					
PHYSICALS - DISALLOWED	\$	10,896		\$	1,276
EMP BENEFITS-EMP PHYSICALS (& TESTING) -					
PHYSICALS OUTPATIENT - DISALLOWED				\$	170
EMP BENEFITS-EMP PHYSICALS (& TESTING) -					
BACKGROUND CHECKS	\$	5,145		\$	603
EMP BENEFITS-EMP PHYSICALS (& TESTING) -					
BACKGROUND CHECKS OUTPATIENT - DISALLOWED				\$	80
EMP BENEFITS-EMP PHYSICALS (& TESTING) -					
HEALTHSOURCE TESTING TO HIRE	\$	2,528		\$	296
EMP BENEFITS-EMP PHYSICALS (& TESTING) -					
BACKGROUND CHECKS - HEALTHSOURCE TESTING TO					
HIRE OUTPATIENT - DISALLOWED				\$	39
EMP BENEFITS-EMP PHYSICALS (& TESTING) -					
PHYSICALS - IDENTATONICS BADGES	\$	284		\$	33
EMP BENEFITS-EMP PHYSICALS (& TESTING) -					
PHYSICALS - IDENTATONICS BADGES OUTPATIENT -					
DISALLOWED				\$	4
EMP BENEFITS- OTHER	\$	(1,106)		\$	(146)
	-				
Total	\$	17,748	\$-	\$	2,356

Schedule of Other Taxes

		Residential
CCNH	RHNS	Care Home
\$ -	\$ -	\$ -

\$ 20,104

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

Name of Facility	License No.		Report for Y	Year Ended	Page	of
Jerome Home	2065C		9/30/2019		16	37
						Residential
Item			Total	CCNH	RHNS	Care Home
Subtota	ls Brought Forwa	ırd:	2,908,881	2,636,049		272,832
1. Travel and Entertainment						
1. Resident Travel and Entertainment		\$	822	640		182
2. Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$	12,227	9,517		2,710
4. Employee Travel		\$	3,109	1,667		1,442
5. Education Expenses Related to Seminars ar	nd Conventions	\$	20,387	15,868		4,519
6. Automobile Expense (not purchase or depre	eciation)	\$	7,244	5,638		1,606
7. Other (<i>Specify</i>)		\$	300	234		66
See Attached Schedule						
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expenses	s)	\$	9,723	7,568		2,155
2. Advertising Telephone Directory all such e.	xpenses)***	\$				
3. Advertising Other (Specify)***		\$	12,168	9,471		2,697
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service	is supplied	\$				
directly and not by contract or fee for service	ce)***					
7. Postage		\$	4,981	3,877		1,104
* 8. Dues and Membership Fees to Professional		\$	12,340	9,118		3,222
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-A	llowable Org.***	\$	709	552		157
9. Subscriptions		\$	1,875	1,459		416
10. Contributions***		\$				
See Attached Schedule						
11. Services Provided by Contract (Specify and	Complete	\$	131,819	102,600		29,219
Schedule C-2, Page 21 for each firm or ind	ividual)					
12. Administrative Management Services**		\$	340,316			340,316
13. Other (Specify)		\$	879,621	46,045		833,576
See Attached Schedule						
C-14 Total Administrative & General Expenditures		\$	4,346,522	2,850,303		1,496,219

* 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	RH	NS	lential Home
LEADING AGE CARING HANDS EVENT	\$	234			\$ 66
Total Other Travel and Entertainment	\$	234	\$	-	\$ 66

Schedule of Other Advertising

Description	С	CNH	R	HNS	 dential e Home
A & G- BUSINESS PROMOTION-ADVERTISING PROMOTION -					
DISALLOWED	\$	9,471			\$ 2,697
Total Other Advertising	\$	9,471	\$	-	\$ 2,697

Schedule of Dues

c	CONH	RI	INS		idential e Home
\$	58			\$	17
\$	397			\$	113
\$	272			\$	78
\$	8,320			\$	2,369
\$	-			\$	625
\$	71			\$	20
\$	9,118	\$	-	\$	3,222
	\$ \$ \$ \$ \$	\$ 397 \$ 272 \$ 8,320 \$ - \$ 71	\$ 58 \$ 397 \$ 272 \$ 8,320 \$ - \$ 71 	\$ 58 \$ 397 \$ 272 \$ 8,320 \$ - \$ 71	CCNH RHNS Car \$ 58 \$ \$ 397 \$ \$ 397 \$ \$ 272 \$ \$ 8,320 \$ \$ - \$ \$ 71 \$ • • • • • •

Schedule of Contributions

Description	CCNH	RHNS	Residential Care Home
Total Contributions	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	 esidential are Home
EMP BENEFITS-TUITION REIMB - DISALLOWED	\$ 3,19	1	\$ 909
A & G- EQUIPMENT RENTAL	\$ 11,47	3	\$ 3,267
A & G- BANK CHARGES - DISALLOWED	\$ 8,34	6	\$ 2,377
A & G-LICENSES	\$ 1,53	1	\$ 436
A & G- PENALTIES - DISALLOWED	\$ 60	2	\$ 172
NON OPERATING-BHC - BANK FEES - DISALLOWED	\$ -		\$ 70,512
NON OPERATING - OTHER EXPENSE - DISALLOWED	\$ -		\$ 749,951
RECREATION- VOLUNTEER REL EXP - DISALLOWED	\$ 66	0	\$ 188
A & G-RESIDENT RELATIONS	\$ 24	9	\$ 71
A & G-RESIDENT RELATIONS - DISALLOWED	\$ 5,14	6	\$ 1,465
PLANETREE - DISALLOWED	\$ 4,26	6	\$ 1,215
GOOD LIFE FIT-SR FIT - PURCHASED SERVICES - DISALLOWED	\$ (1,50	9)	\$ (430)
MAINTENANCE-EQUIP RENTAL	\$ 5,43	7	\$ 1,548
TRUSTEE FEES FROM 6420-052-000 - DISALLOWED	\$ 6,65	3	\$ 1,895
Total Other Administrative and General	\$ 46,04	5 \$ -	\$ 833,576

Name of Facility	License No.	Report for Year Ended	Page of
Jerome Home	2065C	9/30/2019	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 Senior Services	340,316		Page 16 line 1m12

Schedule C-1 - Management Services*

* 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)

Jerome Home 2065C 9/30/2019 18 37 Image: Instructure Interm Total CCNH RHNS Residential Care Home 2. Dietary a. In-House Preparation & Service 354,511 275,930 78,581 2. Non-Food Supplies \$354,511 275,930 78,581 3. Other (Specify) \$16,224 12,628 3,596 Disallow food for enployees \$16,224 12,628 3,596 b. Purchased Services (by contract other than through Management Services) \$16,024 12,628 3,596 (Complete Schedulte C-2 att, Page 21) \$16,024 30,084 94,003 2D. Total Dietary Expenditures (2a + b + c + d) \$424,087 330,084 94,003 2E. Dietary Questionnaire Total CCNH RHNS Residential Care Home F. Resident Meals [Total no. of meals served per day:* 3 d6 269			IN		Page 5)				-
Item Total CCNH RHNS Residential Care Home 2. Dietary a. In-House Preparation & Service 354.511 275.930 78.581 2. Non-Food Supplies \$354.511 275.930 78.581 2. Non-Food Supplies \$354.511 275.930 78.581 3. Other (Specify) \$16.224 12.628 3.596 Food for residents and for employees at staff meetings 16.224 12.628 3.596 Disallow food for omployees 16.224 12.628 3.596 b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) \$ \$ c. Other (Specify) \$ \$ \$ \$ 2D. Total Dietary Expenditures (2a + b + c + d) \$ \$ \$ 2E. Dietary Questionnaire Total CCNH RHNS Residential Care Home F. Resident Meals; Total no. of meals served per day:* 346 269 77 G. Is cost of employee meals included in 2D? \$ Yes No If yes, specify ant. page 18 21 I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 10:2 2a Is cost of meals provide	Nan	ne of Facility		License	No.	Repor	rt for Y	ear Ended	Page of
ItemTotalCCNHRHNSHome2. Dictary a. In-House Preparation & Service 1. Raw Food\$ 354,511275,930\$ 78,5812. Non-Food Supplies\$ 53,35241,526\$ 11,8263. Other (Specify)\$ 16,22412,6283,596Food for residents and for employees at staff meetings Disallow food for employees\$ 16,22412,6283,596b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)\$ 16,22412,6283,596c. Other (Specify)\$ 424,087330,084\$ 94,0032D. Total Dietary Expenditures (2a + b + c + d)\$ 424,087330,084\$ 94,0032E. Dietary QuestionnaireTotalCCNH RHNSResidential Care HomeF. Resident Meals: Total no. of meals served per day:*34626977G. Is cost of employee meals included in 2D?• YesNoIf yes, specify ant.page 18 21I. Where is the revenue received reported in the Cost Report? (Page/Line Iter)page 18 line 2a18 cost of food (other than meals, e.g., smacks at monthly staff meetings, board meetings) provided to persons other Members, Guests) included in 2D?YesNoIf yes, specify ant.\$ 212,017I. Where is the revenue received reported in the Cost Report? (Page/Line Iter)page 18 line 2a18 cost of food (other than meals, e.g., smacks at monthly staff meetings, board meetings) provided to employees included in 2D?YesNoIf yes, specify ant.\$ 212,017I. Where is the revenue received reported in the C	Jero	me Home			2065C	9/3	0/2019		18 37
2. Dietary a. In-House Preparation & Service 78,581 1. Raw Food \$ 354,511 275,930 78,581 2. Non-Food Supplies \$ 33,352 41,526 11,826 3. Other (Specify) \$ 16,224 12,628 3,596 Food for residents and for employees \$ 16,224 12,628 3,596 b. Purchased Services (by contract other \$ 16,224 12,628 3,596 c. Other (Specify) \$ 20,000 \$ 20,000 \$ 20,000 \$ 20,000 c. Other (Specify) \$ 20,000 \$ 424,087 330,084 94,003 2E. Dietary Questionnaire Total CCNH RHINS Residential Care Home F. Resident Meals. Total no. of meals served per day:* 346 269 77 G. Is cost of employee meals included in 2D? Yes No If yes, specify ant. page 18 21 I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a 1s cost of meals provided to persons other 1f yes, specify cost. \$ 12,017 Members, Guests) included in 2D? Yes No If yes, specify cost. \$ 12,017 Is cost of food (other than meals, e.g., snacks at mon									Residential Care
a. In-House Preparation & Service 334,511 27,5,930 78,581 2. Non-Food Supplies \$354,511 275,930 78,581 2. Non-Food Supplies \$16,224 12,628 3,596 Food for residents and for employees at staff meetings 16,224 12,628 3,596 Disallow food for employees \$16,224 12,628 3,596 b. Purchased Services (by contract other fram through Management Services) \$16,224 12,628 16,224 (Complete Schedule C-2 att. Page 21) \$16,224 330,084 94,003 2D. Total Dietary Expenditures (2a + b + c + d) \$424,087 330,084 94,003 2E. Dietary Questionnaire Total CCNH RHNS Residential Care Home F. Resident Meals: [Total no. of meals served per day:* 346 269 77 G. Is cost of employee meals included in 2D? Yes No If yes, specify ant. page 18 21a 1. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a 18 cost of food (bter than meals, e.g., Members, Guests) included in 2D? Yes No If yes, specify cost. K. Is any revenue collected from these people? Yes		Item			Total	CC	CNH	RHNS	Home
1. Raw Food S 354,511 275,930 78,581 2. Non-Food Supplies S 53,352 41,526 11,826 3. Other (Specify) S 16,224 12,628 3,596 Food for residents and for employees at staff meetings Disallow food for employees 3,596 b. Purchased Services (by contract other fhan through Management Services) S 4 4 (Complete Schedule C-2 att. Page 21) C C 4 4 c. Other (Specify) S 424,087 330,084 94,003 2D. Total Dietary Expenditures (2a + b + c + d) S 424,087 330,084 94,003 ZE. Dietary Questionnaire Total CCNH RHNS Home F. Resident Meals: Total no. of meals served per day:* 346 269 77 G. Is cost of employee meals included in 2D? Yes No If yes, specify amt. page 18 21 I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 21 page 18 21 20 76 J. than employees or residents (i.e., Board Yes No If yes, specify cost. 11, gage 18 1ine 2a 15 cost of food (othe	2.	Dietary							
2. Non-Food Supplies \$ 53,352 41,526 11,826 3. Other (Specify) \$ 16,224 12,628 3,596 Food for residents and for employees \$ 16,224 12,628 3,596 Disallow food for meloyees \$ 16,224 12,628 3,596 b. Purchased Services (by contract other \$ than through Management Services) \$ (Complete Schedule C-2 att. Page 21) \$ 16,224 330,084 94,003 2D. Total Dietary Expenditures (2a + b + c + d) \$ 424,087 330,084 94,003 2E. Dietary Questionnaire Total CCNH RHNS Residential Care Home F. Resident Meals: Total no. of meals served per day.* 346 269 77 G. Is cost of employee meals included in 2D? Yes No If yes, specify amt. page 18 21 I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a 18 cost of food (other than meals, c.g., % mathematical care home food (other than meals, c.g., % mathematical care case of food (other than meals, c.g., % mathematical care case of food (other than meals, c.g., % mathematical care case of food (other than meals, c.g., % mathematical care case of food (other than meals, c.g., % mathematical case case of food (ot		a. In-House Preparation & Service							
3. Other (Specify) Food for residents and for employees at staff meetings Disallow food for employees \$ 16,224 12,628 3,596 b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) \$ 16,224 12,628 12,628 c. Other (Specify) \$ 16,224 12,628 12,628 16,224 c. Other (Specify) \$ 16,224 12,628 12,628 16,224 c. Other (Specify) \$ 16,224 12,628 16,224 12,628 c. Other (Specify) \$ 16,224 12,628 16,224 12,628 c. Other (Specify) \$ 16,224 12,628 16,224 12,628 16,224 c. Other (Specify) \$ 12,017 \$ 12,017 16 16 16 16 16 16 16 16 16 16 16 16 16 16 16 17 17 17 17 17 17 16 <td></td> <td></td> <td></td> <td></td> <td>354,511</td> <td>2</td> <td>75,930</td> <td></td> <td>78,581</td>					354,511	2	75,930		78,581
Food for residents and for employees at staff meetings Disallow food for employees Image: Construct other is the revenue received reported in the Cost Report? (Page/Line Item) Image: Cost of the cost Report? (Page/Line Item) b. Purchased Services (by contract other is not provided to employees at staff meetings) provided to employees? Image: Cost of the cost Report? (Page/Line Item) Image: Cost of the cost Report? (Page/Line Item) c. Other is the revenue received from these people? O Yes No If yes, specify and. 2D. Where is the revenue received from these people? O Yes No If yes, specify and. \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) If yes, specify and. \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a If yes, specify cost. J. Socst of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? Yes No If yes, specify cost. M. is any revenue collected from employees? O Yes No If yes, specify cost.					53,352		41,526		11,826
Disallow food for employees Disallow food for employees b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) S c. Other (Specify) \$ c. Other (Specify) \$ 2D. Total Dietary Expenditures (2a + b + c + d) \$ 424,087 330,084 2E. Dietary Questionnaire Total F. Resident Meals: Total no. of meals served per day:* 346 26. Is cost of employee meals included in 2D? Yes O No If yes, specify amt. I. Where is the revenue from employees? Yes O No If yes, specify cost. J. than employees or residents (i.e., Board Members, Guests) included in 2D? Yes K. Is any revenue collected from these people? Yes No If yes, specify meetings, board meetings, board meetings) provide to employees included in 2D? Yes No N. Is any revenue collected from employees? Yes No If yes, specify cost. Stost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provide to employees included in 2D? Yes No If yes, specify cost. N. Is any revenue collected from employees? Yes No If yes, specify				· · · · ·			12,628		3,596
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) \$			at st	aff mee	tings				
than through Management Services) (Complete Schedule C-2 att. Page 21) Image: Complete Schedule C-2 att. Page 21) c. Other (Specify) \$ Image: Complete Schedule C-2 att. Page 21) c. Other (Specify) \$ 424,087 330,084 94,003 2D. Total Dietary Expenditures (2a + b + c + d) \$ 424,087 330,084 94,003 2E. Dietary Questionnaire Total CCNH RHNS Residential Care Home F. Resident Meals: Total no. of meals served per day:* 346 269 77 G. Is cost of employee meals included in 2D? • Yes O No If yes, specify amt. page 18 21 I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a 18 cost of meals provided to persons other 1 J. than employees or residents (i.e., Board • Yes O No If yes, specify cost. K. Is any revenue collected from these people? O Yes No If yes, specify amt. \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a 18 cost of of (other than meals, e.g., mancks at monthly staff meetings, board meetings) provided to employees included in 2D? • Yes No If yes, specify cost.									
(Complete Schedule C-2 att. Page 21) \$				\$					
c. Other (Specify) \$		e e .							
2D. Total Dietary Expenditures (2a + b + c + d) \$ 424,087 330,084 94,003 2E. Dietary Questionnaire Total CCNH RHNS Residential Care Home F. Resident Meals: Total no. of meals served per day:* 346 269 77 G. Is cost of employee meals included in 2D? Yes No If yes, specify amt. page 18 2I I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of meals provided to persons other J. J. than employees or residents (i.e., Board Members, Guests) included in 2D? Yes No If yes, specify cost. \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 M. saacks at monthly staff meetings, board meetings) provided to employees included in 2D? Yes No If yes, specify cost. N. Is any revenue collected from employees? Yes No									
ZE. Dietary Questionnaire Total CCNH RHNS Residential Care Home F. Resident Meals: Total no. of meals served per day:* 346 269 77 G. Is cost of employee meals included in 2D? Yes O No If yes, specify amt. page 18 2I H. Did you receive revenue from employees? Yes O No If yes, specify amt. page 18 2I I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of meals provided to persons other J. Is any revenue collected from these people? Yes No If yes, specify cost. L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 M. snacks at monthly staff meetings, board meetings) provided to employees included in 2D? Yes No If yes, specify cost. N. Is any revenue collected from employees? Yes		c. Other (<i>Specify</i>)		\$					
ZE. Dietary Questionnaire Total CCNH RHNS Residential Care Home F. Resident Meals: Total no. of meals served per day:* 346 269 77 G. Is cost of employee meals included in 2D? Yes O No If yes, specify amt. page 18 2I H. Did you receive revenue from employees? Yes O No If yes, specify amt. page 18 2I I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of meals provided to persons other J. Is any revenue collected from these people? Yes No If yes, specify cost. L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 M. snacks at monthly staff meetings, board meetings) provided to employees included in 2D? Yes No If yes, specify cost. N. Is any revenue collected from employees? Yes									
ZE. Dietary Questionnaire Total CCNH RHNS Residential Care Home F. Resident Meals: Total no. of meals served per day:* 346 269 77 G. Is cost of employee meals included in 2D? Yes O No If yes, specify amt. page 18 2I H. Did you receive revenue from employees? Yes O No If yes, specify amt. page 18 2I I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of meals provided to persons other J. Is any revenue collected from these people? Yes No If yes, specify cost. L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 M. snacks at monthly staff meetings, board meetings) provided to employees included in 2D? Yes No If yes, specify cost. N. Is any revenue collected from employees? Yes	20	$T_{a,b} = D_{a,b} + D_{a$		¢	101.007	2	20.004		04.002
2E. Dietary Questionnaire Total CCNH RHNS Home F. Resident Meals: Total no. of meals served per day:* 346 269 0 77 G. Is cost of employee meals included in 2D? • Yes • No If yes, specify ant. page 18 2I H. Did you receive revenue from employees? • Yes • No If yes, specify ant. page 18 2I I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of meals provided to persons other Is cost of meals provided to persons other No If yes, specify cost. J. than employees or residents (i.e., Board Members, Guests) included in 2D? • Yes No If yes, specify cost. K. Is any revenue collected from these people? • Yes • No If yes, specify ant. \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? • Yes No If yes, specify cost. If yes, specify cost. N. Is any revenue collected from employees? • Yes </td <td>2D.</td> <td>Total Dielary Expenditures $(2a+b+c+d)$</td> <td></td> <td>\$</td> <td>424,087</td> <td>3.</td> <td>30,084</td> <td></td> <td>94,003</td>	2D.	Total Dielary Expenditures $(2a+b+c+d)$		\$	424,087	3.	30,084		94,003
F. Resident Meals: Total no. of meals served per day:* 346 269 77 G. Is cost of employee meals included in 2D? • Yes • No If yes, specify amt. page 18 2I H. Did you receive revenue from employees? • Yes • No If yes, specify amt. page 18 2I I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of meals provided to persons other page 18 line 2a J. than employees or residents (i.e., Board Members, Guests) included in 2D? • Yes • No If yes, specify cost. If yes, specify cost. K. Is any revenue collected from these people? • Yes • No If yes, specify cost. \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? • Yes • No If yes, specify cost. N. Is any revenue collected from employees? • Yes • No If yes, specify cost. N. Is any									
G. Is cost of employee meals included in 2D? • Yes • No If yes, specify amt. page 18 21 H. Did you receive revenue from employees? • Yes No If yes, specify amt. page 18 21 I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of meals provided to persons other Is cost of meals provided to persons other If yes, specify cost. If yes, specify ant. K. Is any revenue collected from these people? • Yes • No If yes, specify amt. \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? • Yes • No If yes, specify cost. N. Is any revenue collected from employees? • Yes • No If yes, specify cost. N. Is any revenue collected from employees?	2E.	Dietary Questionnaire			Total	CC	CNH	RHNS	Home
H. Did you receive revenue from employees? • Yes • No If yes, specify amt. page 18 21 I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a page 18 line 2a Is cost of meals provided to persons other J. than employees or residents (i.e., Board Members, Guests) included in 2D? • Yes • No If yes, specify cost. K. Is any revenue collected from these people? • Yes • No If yes, specify amt. \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? • Yes • No If yes, specify cost. N. Is any revenue collected from employees? • Yes • No If yes, specify cost. N. Is any revenue collected from employees? • Yes • No If yes, specify amt.	F.	Resident Meals: Total no. of meals served per	day	:*	346		269		77
H. Did you receive revenue from employees? • Yes • No If yes, specify amt. page 18 21 I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a page 18 line 2a Is cost of meals provided to persons other J. than employees or residents (i.e., Board Members, Guests) included in 2D? • Yes • No If yes, specify cost. K. Is any revenue collected from these people? • Yes • No If yes, specify amt. \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? • Yes • No If yes, specify cost. N. Is any revenue collected from employees? • Yes • No If yes, specify cost. N. Is any revenue collected from employees? • Yes • No If yes, specify amt.	G.	Is cost of employee meals included in 2D?	\odot	Yes	0	No			
I. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of meals provided to persons other Is cost of meals provided to persons other If yes, specify cost. J. than employees or residents (i.e., Board Members, Guests) included in 2D? Yes No If yes, specify cost. K. Is any revenue collected from these people? Yes No If yes, specify amt. \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a \$12,017 M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? Yes No If yes, specify cost. N. Is any revenue collected from employees? Yes No If yes, specify amt.	H.	Did you receive revenue from employees?	•	Yes	0	No			page 18 2L
Is cost of meals provided to persons other If yes, specify J. than employees or residents (i.e., Board If yes Members, Guests) included in 2D? No If yes, specify K. Is any revenue collected from these people? Yes No L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board Yes No M. snacks at monthly staff meetings, board Yes No If yes, specify cost. N. Is any revenue collected from employees? Yes No If yes, specify amt.	-	TT 1 1 1 1 1 1	0			T ()		am.	101: 0
J. than employees or residents (i.e., Board Members, Guests) included in 2D? • Yes • No • Yes • No • Society • Society	1.	*	Cos	t Report	? (Page/Line	Item)			page 18 line 2a
J. than employees or residents (i.e., Board Members, Guests) included in 2D? Image: Constant State St		· ·	~	• •	0			If yes, specify	
K. Is any revenue collected from these people? O Yes If yes, specify amt. \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? O No If yes, specify cost. N. Is any revenue collected from employees? O Yes O No	J.	1 · ·	Ο	Yes	0	No			
K. Is any revenue collected from these people? O Yes O No amt. \$12,017 L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a page 18 line 2a Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? O No If yes, specify cost. N. Is any revenue collected from employees? O Yes O No		Members, Guests) included in 2D?						7.0 1.0	
L. Where is the revenue received reported in the Cost Report? (Page/Line Item) page 18 line 2a Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? • Yes • No If yes, specify cost. N. Is any revenue collected from employees? • Yes • No If yes, specify amt.	K.	Is any revenue collected from these people?	0	Yes	\odot	No			\$12,017
Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? N. Is any revenue collected from employees? O Yes If yes, specify cost. If yes, specify amt.	-		~			- \		amt.	
M. snacks at monthly staff meetings, board meetings) provided to employees included in 2D? • Yes • No If yes, specify cost. N. Is any revenue collected from employees? • Yes • No If yes, specify amt.	L.		Cos	t Report	? (Page/Line	ltem)			page 18 line 2a
M. meetings) provided to employees included • Yes • No cost. in 2D? N. Is any revenue collected from employees? • Yes • No If yes, specify amt.								T.C	
in 2D? N. Is any revenue collected from employees? O Yes O No If yes, specify amt.	M.		\odot	Yes	0	No			
N. Is any revenue collected from employees? O Yes O No If yes, specify amt.								cost.	
N. Is any revenue collected from employees? O Yes O No amt.								10 :0	
amt.	N.	Is any revenue collected from employees?	0	Yes	\odot	No			
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)								amt.	
	О.	Where is the revenue received reported in the	Cos	t 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			No.	Report for Y	ear Ended	Page	of
Jerome Home		2	2065C	9/30/2019		19	37
	Item		Total	CCNH	RHNS	Resident Hor	
3. Laundry							
a. In-House Pr	ocessing*	Lbs.					
	ens, cubicle curtains, draperies,						
gowns	and other resident care items	Amt. \$	2,133	2,133			
washed	, ironed, and/or processed.***						
2. Employ	vee items including uniforms,	Lbs.					
U I	etc. washed, ironed and/or						
process	ed.***	Amt. \$					
3. Persona	al clothing of residents	Lbs.					
washed	, ironed, and/or processed.***	Amt. \$					
4. Repair	and/or purchase of linens.***	Lbs.					
		Amt. \$					
b. Purchased S	ervices (by contract other	\$					
	n Management Services)						
0	chedule C-2 att. Page 21)						
c. Other (Speci	fy)	\$	11,012	11,012			
Laundry	Supplies						
3D. Total Laundry	<i>Expenditures</i> (3a + b + c)	\$	13,145	13,145			
3E. Laundry Questi	onnaire						
F. Is cost of emplo	oyee laundry included in 3D?	O Yes	۲	No	If yes, specify cost.		
G. Did you receive	e revenue from employees?	O Yes	۲	No	If yes, specify amt.		
H. Where is the re-	venue received reported in the C	ost Report?		(Page/Line	<u> </u>		
Is Cost of Jaund	lry provided to persons other	•	~		If yes,		
	or residents included in 3D?	O Yes	١	No	specify cost.		
J. Did you receive	e revenue from these people?	O Yes	۲	No	If yes, specify amt.		
K. Where is the re-	venue received reported in the C	ost Report?		(Page/Line	Item)		

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

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

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

Nar	ne of Facility	License No.	Repo	rt for Year E	nded	Page	of
Jerc	ome Home	2065C		9/30/2019		20	37
	Item			Total	CCNH	RHNS	Residential Care Home
4.	Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel	ļ	72,812	48,938		23,874
	1. Supplies - Cleaning (Mops, pails, brooms, etc.)	Amt.	\$	49,692	33,398		16,294
	b. Purchased Services (by contract other than through Management Services)	Sq. Ft. Serviced by Personnel		72,812	48,938		23,874
	(Complete Schedule C-2 att. Page 21)	Amt.	\$				
	C. Other (<i>Specify</i>)		\$				
4D.	Total Housekeeping Expenditures (4a +	b+c)	\$	49,692	33,398		16,294
5.	Resident Care (Supplies)** a. Prescription Drugs***						
	1. Own Pharmacy		\$				
	2. Purchased from Omnicare		\$	213,627	213,627		
	b. Medicine Cabinet Drugs		\$	69,366	53,990		15,376
	c. Medical and Therapeutic Supplies		\$	11,750	9,145		2,605
	d. Ambulance/Limousine***		\$	6,841	6,841		
	e. Oxygen1. For Emergency Use		\$				
	2. Other***		\$	34,823	34,823		
	 f. X-rays and Related Radiological Procedures*** 		\$	33,133	33,133		
	g. Dental (Not dentists who should be inc salaries or fees)	luded under	\$				
	h. Laboratory***		\$	19,804	19,804		
	i. Recreation		\$	7,305	5,686		1,619
	j. Direct Management Services*		\$				
	k. Indirect Management Services*		\$				
	 Other (Specify)**** See Attached Schedule 		\$	173,652	127,014		46,638
5M.	Total Resident Care Expenditures (5a - 5	j)	\$	570,301	504,063		66,238

* 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

				Res	idential
Description	CCNH	RH	NS	Cai	e Home
NURSING-EQUIPMENT RENTAL- FOR INDIVIDUALS -					
DISALLOWED	\$ 9,234			\$	-
NURSING-MEDICAL SUPPLIES	\$ 99,366			\$	28,298
NURSING-PERSONAL CARE	\$ 8,373			\$	2,384
PT-SUPPLIES - DISALLOWED	\$ 2,270			\$	405
OT-SUPPLIES - DISALLOWED	\$ 1,014			\$	18
ANCILLARY-OTHER MEDICARE ANCILLARY(MEDICARE A) -					
DISALLOWED	\$ 6,004			\$	1,710
GOOD LIFE FIT -SENIOR FIT - SUPPLIES - DISALLOWED	\$ -			\$	409
NURSING SUPPLIES	\$ 753			\$	215
HHCRN OPTIMA SOFTWARE FEES - DISALLOWED				\$	4,199
HHC REHAB NETWORK ADMIN FEES - DISALLOWED				\$	9,000
					ŕ
Total Other Resident Care	\$ 127,014	\$	-	\$	46,638

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

Name of Facility Jerome Home				License No. 2065C	Report for Year Ende 9/30/2019		Page 21	of 37		
		Related ** Operators					Total Cost	/Page Ref.**	*	
Name of Individual or Company	Address	Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	Residential Care Home		Line
See attached list		0	o							
		0	o							
		0	o							
		0	o							
		0	o							
		0	o							
		0	o							
		0	o							
		0	o							
		0	o							
		0	o							
		0	o							
		0	o							
		0	o							

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

** Refer to Page 4 for definition of related.

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

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

Name of Facility	License No.	Report for Y	ear Ended		Page of
Jerome Home	2065C	9/30/2019			22 37
					Residential Care
Item		Total	CCNH	RHNS	Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$	168,046	100,453		67,593
b. Heat	\$	100,208	67,352		32,856
c. Light & Power	\$	119,089	80,042		39,047
d. Water	\$	36,349	24,431		11,918
e. Equipment Lease (Provide detail on po	age 6) \$				
f. Other (<i>itemize</i>)	\$	129,935	87,331		42,604
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a -	- 6f) \$	553,627	359,609		194,018
7. Depreciation (complete schedule page 23	*)				
a. Land Improvements	\$	17,274	11,611		5,663
b. Building & Building Improvements	\$	490,870	313,968		176,902
c. Non-Movable Equipment	\$	72,115	48,470		23,645
d. Movable Equipment	\$	171,423	115,215		56,208
*7e. Total Depreciation Costs $(7a + b + c + d)$	l) \$	751,682	489,264		262,418
8. Amortization (Complete att. Schedule Pag	ge 24*)				
a. Organization Expense	\$	•			
b. Mortgage Expense	\$	6,337	4,259		2,078
c. Leasehold Improvements	\$				
d. Other (<i>Specify</i>)	\$	•			
*8e. Total Amortization Costs (8a + b + c + d	l) \$	6,337	4,259		2,078
9. Rental payments on leased real property l	ess				
real estate taxes included in item 10b	\$	5			
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$	•			
c. Personal property taxes	\$	43,198			43,198
11. Total Property Expenses (7e + 8e + 9 +	10) \$	801,217	493,523		307,694

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

Attachment Page 22

1,330 26,365 18,603 376 40,238 419

Schedule of Other Repairs and Maintenance

			Re	esidential
Description	CCNH	RHNS	Ca	are Home
MAINTENANCE-EQUIPMENT-CONTRACT SERVICES	\$ 1,330		\$	649
MAINTENANCE-GROUNDS-CONTRACT SERVICES	\$ 26,365		\$	12,862
MAINTENANCE-RUBBISH REMOVAL	\$ 18,603		\$	9,075
MAINTENANCE-SECURITY-CONTRACT SERVICES	\$ 376		\$	184
MAINTENANCE-BUILDING-CONTRACT SERVICES	\$ 40,238		\$	19,630
	\$ 419		\$	204
Total Other Repairs and Maintenance	\$ 87,331	\$-	\$	42,604

State of Connecticut Annual Report of Long-Term Care Facility CSP-23 Rev. 10/2006

					Deprec	iation Sc	hedule					
Name of Facility					License No.			Report for Year E	nded		Page	of
Jerome Home					2065	C		9/30/2019			23	37
								Accumulated				
					Historical Cost	Less		Depreciation to	Method of			
					Exclusive of	Salvage	Cost to Be	Beginning of Year's		Useful	Depreciation	
Property Item					Land	Value	Depreciated	Operations	Depreciation	Life	for This Year	Totals
A. Land Improvements												
1. Acquired prior to this report period					496,520		496,520	366,834			16,813	
2. Disposals (attach schedule)					(5,727)		(5,727)					
3. Acquired during this report period (attac	ch sche	dule)			7,294		7,294				461	
A-4. Subtotal												17,274
B. Building and Building Improvements												
1. Acquired prior to this report period					13,681,877		13,681,877	8,898,945		various	479,004	
2. Disposals (attach schedule)					(1,320,426)		(1,320,426)					
3. Acquired during this report period (attac	ch sche	dule)			337,773		337,773				11,866	
B-4. Subtotal												490,870
C. Non-Movable Equipment												
1. Acquired prior to this report period					1,717,439		1,717,439	1,332,818		various	70,039	
2. Disposals (attach schedule)												
3. Acquired during this report period (attac	ch sche	dule)			36,651		36,651				2,076	
C-4. Subtotal												72,115
	Is a m	nileage										
		book						Accumulated				
	maint	ained?	Date of A	Acquisition	Historical Cost	Less		Depreciation to	Method of			
	-				Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	
	Yes	No	Month	Year	Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
D. Movable Equipment												
1. Motor Vehicles (Specify name, model												
and year of each vehicle)												
a.	х		7	2000	3,000		3,000	3,000	s/l	5		
b.	Х			2004	46,480		46,480	46,480	s/1	5		
c. Dodge Grand Caravan	х		10	2018	41,630		41,630		s.1	5	4,170	
d.												
2. Movable Equipment												
a. Acquired prior to this report period			L		3,921,267		3,921,267	3,467,757		various	154,655	
b. Disposals (attach schedule)			<u> </u>									
c. Acquired during this report period												
(attach schedule)					154,475						12,598	
D-3. Subtotal												171,423
E. Total Depreciation												751,682

Schedule of Land Improvements Acquired during this report period

				Useful		
Acquisition Date	Description of Item		Cost	Life	Depr	eciation
Additions:						
2/20/2019	EAST PARKING LOT CAMERA	\$	1,918	5	\$	192
11/6/2018	CONCRETE BOLLARDS MAIN ENTRANCE	\$	5,376	10	\$	269
Total additions for 1	and Improvement	\$	7,294		\$	461
Deletions:		Ψ	7,274		Ψ	401
	RENTAL PROPERTY LAND IMPROVEMENT SIDE WALK GORMAN	\$	(4,227)			
9/30/2019	RENTAL PROPERTY LAND IMPROVEMENT	\$	(1,500)			
	(SEE LIST OF RETIREMENTS)					
Total deletions for I	Land Improvement	\$	(5,727)		\$	-

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

			Useful		
cquisition Date	Description of Item	Cost	Life	Depr	eciation
dditions:					
	E-1 DINING ROOM RENOVATION	\$ 24,721	15	\$	826
10/3/2018	EAST ROOF PROJECT	\$ 159,304	20	\$	3,991
11/14/2018	KEYSCAN DO0OR ACCESS SYSTEM	\$ 9,733	8	\$	609
10/11/2018	PROVIDE AND INSTALL PLANK AND BASE	\$ 17,424	10	\$	873
11/6/2018	CARPET SERVICE CORRIDOR/ELEVATOR	\$ 5,843	10	\$	293
10/26/2018	FLOORING RESIDNT ROOMS/OFFICE	\$ 6,293	10	\$	315
3/13/2019	EAST WING CORRIDOR RENOVATION	\$ 46,942	15	\$	1,568
2/26/2019	REPLACEMENT WINDOW #412	\$ 1,290	10	\$	64
1/7/2019	TRANE REPLACEMENT UNIT	\$ 9,776	10	\$	490
2/27/2019	HEALTHCARE COMM SYSTEM NORTH	\$ 47,350	10	\$	2,372
4/26/2019	REC OFFICE REMODEL	\$ 8,547	10	\$	428
7/31/2019	PART OF NORTH DINING ROOM RENOVATION FROM FY18 BI00213	\$ 550	15	\$	37
otal additions for	Building Improvement	\$ 337,773		\$	11,866
Deletions:					
	RETIREMENT OF ALL NON-OPERATING RENTAL PROPERTY				
9/30/2019	BUILDINGS: SEE LIST OF RETIREMENTS	\$ (1,320,426)			
	26-28 HAMILTON STREET				
	30-32 HAMILTON STREET				
	38-40 HAMILTON STREET				
	116-117 BLACK ROCK AVENUE				
	123 BLACK ROCK AVENUE				
	125 BLACK ROCK AVENUE				
	129-131 BLACK ROCK AVENUE				
	130 BLACK ROCK AVENUE				
otal deletions for I	Building Improvement	\$ (1,320,426)		\$	-

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report perio

			Useful		
Acquisition Date	Description of Item	Cost	Life	Depr	eciation
Additions:					
3/31/2019	STEEL DOOR EMPLOYEE BACK ENTRANCE	\$ 6,128	10	\$	307
10/12/2018	ELECTRICAL OUTLETS STAIRWELL & KITCHEN	\$ 1,854	10	\$	93
2/27/2019	JACE REPLACEMENT EAST	9948	10		498
7/8/2019	MIXING VALVES HOT WATER STORAGE TANK	13926	10		698
8/8/2019	STEAM BUNDLE ON STORAGE TANK KITCHEN	4795	5		480

					achm
Total additions for	Non-Movable Equipmen	\$ 36,651	\$	2,076	*
Deletions:					
Total deletions for I	Non-Movable Equipmen	\$ -	\$	-	**
*Ties to Page 23, I	line C3				

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report perio

			Useful		
Acquisition Date	Description of Item	Cost	Life	Deprecia	tion
Additions:		 			
7/31/2019	NORTH, E-1 CAT6 CABLES	\$ 4,699	5	\$	471
2/26/2019	MATRIX CONNECTIVITY LISC BP MACHINES	\$ 8,880	3	\$ 1	,483
9/30/2019	CAT6 CABLE TO E-1 MED ROOM	2299	3		384
10/29/2018	CARPET EXTRACTOR	2606			435
10/23/2018	PROFORCE HEPA VAC (11)	4646			776
	CONNEX BP SPOT MONITORS (5)	19991			2002
10/1/2018	BEVERAGE SVC CART	2012			336
10/25/2018	POTS & PAN REPLACEMENT	3586			599
12/17/2018	FOOD WARMER	1338			223
2/21/2019	ICE MACHINE/DISPENSER	8936			448
4/18/2019	DIGITAL CHAIR SCALE	1749			292
5/1/2019	SARA FLEX SCALE	5166			517
	LOCKING MED CABINET NURSING	1406			141
	(2) WOUND SURFACE MATTRESSES	 2432			244
	ADMISSIONS OFFICE FURNITURE	4395			220
	WHEELCHAIRS - THERAPY	3190			319
8/22/2019	PRIVACY CURTAINS	5705			571
9/11/2019	BED ADVANTAGE FRAMES (32)	\$ 66,661		\$ 2	2,783
8/2/2019	(4) CHAIRS EXEUTIVE DIRECTOR'S OFFICE	\$ 1,446		\$	145
8/1/2019	REACH IN FREEZER	3332			209
	Movable Equipmen	\$ 154,475		\$ 12	,598
Deletions:					
Lotal delations for	Novable Equipmen	\$		\$	
*Ties to Page 23, I	* *	\$ -		φ	-

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report peri-

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
Total additions for Le	asehold Improvemen	\$ -		\$ -
Deletions:				
Total deletions for Lea	asehold Improvemen	\$ -		\$ -
*Ties to Page 24. Lin	e (3		3	

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

Amortization Schedule*

Nam	e of Facility			License No.		Report for Yea	r Ended		Page	of
Jeror	ne Home			206	5C	9/30/2019			24	37
		Date Acqui	e of isition			Accumulated Amort. to Beginning of				
				Length of	Cost to Be	Year's	Computing	Rate	Amortization	
	Item	Month	Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A.	Organization Expense									
	1.									
	2.									
	3.									
A-4.	Subtotal									
B.	Mortgage Expense									
	1. Bond Issue Costs	11	2007	30 years	412,492	79,221	s/l		6,337	
	2.									
	3.									
B-4.	Subtotal									6,337
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									6,337

* 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	License No.	Report for Year Er	ıded		Page	of
Jerome Home	2065C	9/30/2019			25	37
11. Property Questionnaire						
Part A						
Is the property either owned by the	ne Facility) Yes	0	No	If "Yes," complet	te Part B.
or leased from a Related Party?*) Yes	U	NO	If "No," complete	e Part C.
*If any owner or operator of this fac	cility is related by family,	marriage, ownership, abil	ity to control or			
business association to any person of	or organization from whom	n buildings are leased, the	n it is considered a			
related party transaction. Description		Total				
1. Date Land Purchased		1923	-			
2. Date Structure Completed		1923	-			
3. If NOT Original Owner, Date	e of Purchase	1725	-			
4. Date of Initial Licensure		Mid 1970's				
5. Total Licensed Bed Capacity		120	-			
6. Square Footage		72,812				
7. Acquisition Cost						
a. Land						
b. Building						
Part B - Owner and Related Pa	rties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortga	age
1. Financing						
a. Type of Financing (e.g., f	ixed, variable)	CHEFA variable				
b. Date Mortgage Obtained						
c. Interest Rate for the Cost		varies				
d. Term of Mortgage (numb		30				
e. Amount of Principal Borr		11,895,000				
f. Principal balance outstand		8,820,000				_
Complete if Mortgage was l						
During Current Cost Ye						
g. Type of Financing (e.g., f h. Date of Refinancing	ixed, variable)					
i. New Interest Rate						
j. Term of Mortgage (numb	er of years)					
k. Amount of Principal Borr						
1. Principal Outstanding on						
Part C - Arms-Length Leas		Improvements Only	v	1	1	
Name and Address of Lesso		operty Leased		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 Yea	ar Ended		Page of
Jerome Home	2065C		9/30/2019			26 37
						Residential Care
Item			Total	CCNH	RHNS	Home
12. Interest A. Building, Land Improvem	ent & Non-Movabl	e				
Equipment						
1. First Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage		\$				
Name of Lender		Rate				
Address of Lender		I				
3. Third Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information	l		-			
1. Original Loan Amount		\$	11,895,000			
2. Loan Origination Date			03/29/07			
3. Interest Rate %			varies			
4. Term			30 years			
5. CHEFA Interest Exper	ise		135,398	91,003		44,395
12 B7. Total Building Interest Expen	ese (A1 - A4 + B5)	\$	135,398	91,003		44,395

(Carry Subtotals forward to next page)

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

Name of Facility	License No.		Report for Ye	ear Ended		Page of
Jerome Home	2065C		9/30/2019			27 37
						Residential Care
Ite	m		Total	CCNH	RHNS	Home
		ught Forward:		91,003	Idii (b	44,395
12. C. Movable Equipment		ugiit i oi wara.	155,576	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		11,555
1. Automotive Equipment	nt	\$				
A. Item	Rate	Amount				
	Tute	1 millio unit				
Lender						
Address of Lender						
2. Other (<i>Specify</i>)		\$				
A. Item	Rate	Amount				
		1 1110 1110				
Lender	Į					
Address of Lender						
B. Item	Rate	Amount				
2.1.1.1		1 1110 1110				
Lender						
Address of Lender						
12. C. 3. Total Movable Equip	nent Interest					
Expense $(C1 + 2)$		\$				
12. D. Other Interest Expense (S	pecify)	\$				
	r55)	+				
13. Total All Interest Expense (1	2B7 + 12C3 + 12D)	\$	135,398	91,003		44,395
14. Insurance		*				,
a. Insurance on Property (b)	uildings only)	\$	33,712	20,628		13,084
b. Insurance on Automobile		\$	4,602	3,582		1,020
c. Insurance other than Prop			.,			-,
1. Umbrella (Blanket Co	• • •	\$	63,649	49,541		14,108
2. Fire and Extended Co		\$,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			,
3. Other (<i>Specify</i>)	0	\$				
(-r 5))		4				
14d. Total Insurance Expenditure	2s (14a + b + c)	\$	101,963	73,751		28,212
15. Total All Expenditures (A-13		\$	15,639,553	12,362,614		3,276,939

Name	e of Fa ne Hor			Lic	cense No. 2065C	Report for Yea 9/30/2019	r Ended	Page of 28 37
Jeron		ne			Total	9/30/2019		28 37
Item	Page	Line			Amount of			Residential Care
	No.		Item Description		Decrease	CCNH	RHNS	Home
Page	10 - S	alari	es and Wages					
1.	10		Outpatient Service Costs	\$				
2.	10		Salaries not related to Resident Care	\$				
3.	10	A12g	Occupational Therapy	\$	291,789	286,803		4,986
4.		0	Other - See attached Schedule	\$	157,242	,		157,242
Page	13 - I	Profes	sional Fees		,			,
5.	_		Resident Care Physicians **	\$				
6.	13	B10a	Occupational Therapy	\$	4,914	4,830		84
7.			Other - See attached Schedule	\$	124,296	104,542		19,754
-	s 15 &	: 16 -	Administrative and General	+				
8.			Discriminatory Benefits	\$				
9.	15	1c	Bad Debts	\$	120,000	120,000		
10.			Accounting	\$,			
10a.			Legal	\$	22,577	17,360		5,217
11.			Telephone	\$;;;;	- , ,		-,,
12.			Cellular Telephone	\$				
13.			Life insurance premiums on the life	Ψ				
101			of Owners, Partners, Operators	\$				
14.			Gifts, flowers and coffee shops	\$				
15.	16	1m13	Education expenditures to colleges or	Ψ				
10.	10	11110	universities for tuition and related costs					
			for owners and employees	\$	4,100	3,191		909
16.	16	1L4	Travel for purposes of attending	Ψ	1,100	5,171		,0,
10.	10	121	conferences or seminars outside the					
			continental U.S. Other out-of-state					
			travel in excess of one representative	\$	399	311		88
17.			Automobile Expense (e.g. personal use)	\$	577	511		00
18.	16	1m3	Unallowable Advertising *	\$	12,168	9,471		2,697
19.	10	m	Income Tax / Corporate Business Tax	\$	12,100	,,,,,,		2,007
20.			Fund Raising / Contributions	\$				
20.	16	1m12	Unallowable Management Fees	\$	340,316			340,316
21.	10	111112	Barber and Beauty	\$	540,510			540,510
23.			Other - See attached Schedule	\$	1,030,692	147,138		883,555
	18 - T)i <i>otar</i>	y Expenditures	Ψ	1,050,092	147,150		005,555
24.			Meals to employees, guests and others					
Δ .	10	243	who are not residents	\$	15,842	12,331		3,511
Ρησο	19_1	aund	ry Expenditures	Ψ	13,042	12,551		5,511
25.	17 - L		Laundry services to employees, guests					
25.			and others who are not residents	\$				
Page	20 - 1	Touse	keeping Expenditures	Ψ				
26.	20-1	Louse	Housekeeping services to employees, guests					
20.			and others who are not residents	\$				
			Subtotal (Items 1 - 26)		2,124,336	705,976		1,418,359
L			Wanted".	ψ		arry Subtotal fo	1.	

D. Adjustments to Statement of Expenditures

* All except "Help Wanted".

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

⁽Carry Subtotal forward to next page)

Attachment Page 28

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	 sidential re Home
10	A6a	Outpatient portion Head Housekeeper Wages			\$ 130
10	A6b	Outpatient portion Housekeeper Wages			\$ 3,326
10	A7a	Outpatient portion Chief of Maintenance Wages			\$ 1,401
10	A7b	Outpatient portion Maintenance Wages			\$ 2,354
10	A12b1	To adjust wages - APRN wages in excess of Aides			\$ 2,200
10	A12b1	To adjust wages - RN Supervisors RCH wages in excess of Aides			\$ 44,449
10	A120	Good Life Fitness Wages			\$ 48,339
10	A12e	Outpatient - Physical Therapy Wages			\$ 54,713
10	A12f	Outpatient - Speech Therapy Wages			\$ 330
Total Othe	r Salaries A	ıdjustment	\$ -	\$ -	\$ 157,242

Schedule of Fees Adjustments

						sidential
Page Ref	Line Ref	Description	CCNH	RHNS	Ca	re Home
13	B2	Dental Purchased Services	\$ 8,190		\$	2,332
13	B5	Purchased Services - Physical Therapist	\$ 61,464		\$	10,964
13	B9	Purchased Services - Speech Therapist	\$ 34,888		\$	6,458
Total Othe	r Fees Adju	istments	\$ 104,542	\$ -	\$	19,754

Schedule of Other A&G Adjustments

ge Ref	Line Ref	Description	(CCNH	RHNS		esidential are Home
15	1a	Employee Benefits related to APRN RCH wages				\$	541
15	1a	Employee Benefits related to RN Supervisor RCH wages				\$	10,934
		Employee Benefits related to Occupational Therapists SNF portion (the					
15	1a	outpatient portion is included below)	\$	71,701			
15	1a1	Benefits related to Outpatient Therapy - Workers Comp				\$	1,764
15	1a2	Benefits related to Outpatient Therapy - Disability				\$	701
15	1a3	Benefits related to Outpatient Therapy - Unemployment				\$	460
15	1a4	Benefits related to Outpatient Therapy - FICA				\$	8,548
15	1a5	Benefits related to Outpatient Therapy - Health Insurance				\$	14,56
15	1a7	Benefits related to Outpatient Therapy - Pension				\$	2,16
15	1a8	Benefits related to Outpatient Therapy - Uniform Allowance				\$	
15	1a9	Benefits related to Outpatient Therapy - Other Benefits				\$	27
		Employee Benefits Preplacement Physicals for SNF & RCH. Note that					
		outpatient portions of physicals is inckluded in the \$170 on the line above in					
15		Outpatient Therapy Other Benefits above)	\$	10,896		\$	1,27
15	1g	Rehab Office Supplies - Outpatient				\$	19
16	1L3	Disallow gifts to employees that are discriminatory or in excess of \$25 each	\$	5,013		\$	1,42
16	1L4	Mileage reimbursement for Good Life Fitness Staff				\$	96
16	1m8a	Dues - New Britain Chamber of Commerce	\$	292		\$	8
16	1m8a	Dues - Lions Club	\$	260		\$	74
16	1m11	A&G Purchased Service - Allscripts	\$	620		\$	17
16	1m11	A&G Purchased Service - HHC/SCC Custormer Experience Survey	\$	1,554		\$	44
16	1m11	A&G Maintenance Agreements - Allscripts	\$	2,052		\$	584
16	1m11	A&G Consulting Fees Celtic Consulting	\$	14,354		\$	4,08
16	1m11	A&G Consulting Fees - Grant Writing Plus	\$	1,322		\$	2,67
16	1m13a	A&G Bank Charges	\$	8,346		\$	2,37
16	1m13a	A&G Penalties	\$	602		\$	17
16	1m13a	Non-Operating BHC Bank Fees				\$	70,512
16	1m13a	Non-Operating Other Expense				\$	749,95
16	1m13a	Recreation - Volunteer Relations	s	660		s	18
	1m13a	A&G Resident Relations - replacement of resident belongings	S	2.518		S	71
16	1m13a	A&G Resident Relations - refund resident bills	s	2,628		S	74
-	1m13a	Planetree	ŝ	4,266		ŝ	1.21
	1m13a	Cable TV Expense net of \$3,600 allowance	s	13,401		ŝ	3.81
	1m13a	A&G Management Fees - Trustee Fees	s	6,653		ŝ	1,89
10	mitsa	Acco Management Pees - Prasee Pees	\$	0,055		9	1,07
						1	
tal Other	· A&G Ad	iustments	s	147,138	s -	s	883,55

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			D. Adjustments to Statement	nt	of Expend				
Name	e of Fa	acility		Lic	cense No.	Report for Y	ear Ended	Page	of
Jeron	ne Hoi	me			2065C	9/30/2019		29	37
					Total				
Item	Page	Line			Amount of			Reside	ntial Care
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	Н	lome
			Subtotals Brought Forward	\$	2,124,336	705,976			1,418,359
Page	20 - K	Reside	nt Care Supplies***						
27.	20	5a2	Prescription Drugs	\$	213,627	213,627			
28.	20	5d	Ambulance/Limousine	\$	6,841	6,841			
29.	20	5f	X-rays, etc	\$	33,133	33,133			
30.	20	5h	Laboratory	\$	19,804	19,804			
31.			Medical Supplies	\$					
32.	20	5e2	Oxygen (non emergency)	\$	34,823	34,823			
33.	20	5L	Occupational Therapy	\$	1,032	1,014			18
34.			Other - See Attached Schedule	\$	34,012	17,508			16,504
Page	22 - N	Iainte	enance and Property						
35.			Excess Movable Equipment Depreciation						
			See Attached Schedule	\$	2,694				2,694
36.			Depreciation on Unallowable						
			Motor Vehicles	\$					
37.	22	10c	Unallowable Property and Real						
			Estate Taxes	\$	43,198				43,198
38.			Rental of Building Space or Rooms	\$					
39.			Other - See Attached Schedule	\$	27,365				27,365
Page	27 - I	nsura	nce						
40.			Mortgage Insurance	\$					
41.	27	14a	Property Insurance	\$	3,503				3,503
Other	r - Mis	scella	neous						
42.			Other - Indirect	\$					
43.			Interest Income on Account Rec.	\$					
44.			Other - Miscellaneous Administrative	\$					
45.			Management Fees Direct	\$					
46.			Management Fees Indirect	\$					
47.			Other - Direct	\$	304,182	81,857			222,325
Not F	For Pr	ofit P	roviders Only						
48.			Building/Non Movable Eq. Depreciation						
			Unallowable Building Interest -						
			See Attached Schedule	\$	32,208				32,208
49.	Total	Amo	unt of Decrease (Items 1 - 48)	\$	2,880,758	1,114,583			1,766,174

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

*** 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

						Res	sidential
Page Ref	Line Ref	Description	(CCNH	RHNS	Cai	re Home
20	5L	NURSING - EQUIPMENT RENTAL	\$	9,234			
20	5L	PT - SUPPLIES	\$	2,270		\$	405
20	5L	ANCILLARY - OTHER MEDICARE ANCILLARY (MEDICARE A)	\$	6,004		\$	1,710
20	5L	GOOD LIFE FIT - SENIOR FIT - SUPPLIES				\$	409
20	5L	PT OPTIMA SOFTWARE FEES				\$	4,199
20	5L	HHC REHAB NETWORK MANAGEMENT FEES				\$	9,000
20	4A1	HOUSEKEEPING SUPPLIES OUTPATIENT PORTION				\$	781
Total Othe	r Ancillary	Costs	\$	17,508	\$ -	\$	16,504

Schedule of Excess Movable Equipment Depreciation

					Resi	idential
Page Ref	Line Ref	Description	CCNH	RHNS	Car	e Home
22	7D	DEPRECIATION - COMPUTERS RELATED TO OUTPATIENT			\$	613
22	7D	DEPRECIATION - FURNITURE/EQUIPMENT RELATED TO OUTPATIENT	Γ		\$	2,015
22	7D	DEPRECIATION - AUTO RELATED TO OUTPATIENT			\$	66
Total Exce	ss Movable	Equipment Depreciation	\$ -	\$ -	\$	2,694
I						

Schedule of Other Property Adjustments

					Res	idential
Page Ref	Line Ref	Description	CCNH	RHNS	Car	e Home
22	6A	REPAIR & MAINTENANCE RELATED TO OUTPATIENT			\$	2,348
22	6A	NON-OPERATING RENTAL EXPENSES			\$	18,588
22	6B	HEAT RELATED TO OUTPATIENT			\$	1,574
22	6C	LIGHT & POWER RELATED TO OUTPATIENT			\$	1,871
22	6D	WATER & SEWER RELATED TO OUTPATIENT			\$	571
22	6F	MAINTENANCE EQUIPMENT RELATED TO OUTPATIENT			\$	31
22	6F	MAINTENANCE - GROUNDS CONTRACT SERVICES RELATED TO OUTPATIENT			\$	616
22		MAINTENANCE - RUBBISH REMOVAL RELATED TO OUTPATIENT			\$	435
22	6F	MAINTENANCE - SECURITY CONTRACT SERVICES RELATED TO OUTPATIENT			\$	9
22	6F	MAINTENANCE - BUILDING CONTRACT SERVICES RELATED TO OUTPATIENT			\$	941
22	6F	EAGLE LEASING STORAGE CONTAINER RELATED TO OUTPATIENT			\$	10
22	7A	DEPRECIATION - LAND IMPROVEMENTS RELATED TO OUTPATIENT			\$	271
22	8B	AMORTIZATION - BOND ISSUE COST RELATED TO OUTPATIENT			\$	54
22	8B	AMORTIZATION - LOC RENEWAL FEES 2012 RELATED TO OUTPATIENT			\$	46

Total Other Property Adjustments	\$ -	\$ -	\$ 27,365 9

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Othe	r Adjustme	nts	\$ -	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
					-
Total Othe	r Adjustme	nts	\$ -	\$ -	\$ -

	Description	С	CNH	RHNS	C	are Home
6B	APRN REVENUE NET OF CONTRA ALLOWANCE	\$	60,393			
V8	ALLOWANCE				\$	19,903
V8	TRANSPORTATION - VAN FEE INCOME	\$	11,107		\$	3,163
V8	MISCELLANEOUS INCOME - SEE MISC. INCOME SCHEDULE	\$	10,357		\$	2,949
V8	NON-OPERATING - RENTAL INCOME				\$	32,869
V8	UNREALIZED GAIN (LOSS)				\$	(1,136,602)
V8	GAIN ON SALE				\$	1,300,043
Adjustme	nts	\$	81,857	\$ -	\$	222,325
	8 8 8 8 8 8 8 8	8ALLOWANCE8TRANSPORTATION - VAN FEE INCOME8MISCELLANEOUS INCOME - SEE MISC. INCOME SCHEDULE8NON-OPERATING - RENTAL INCOME8UNREALIZED GAIN (LOSS)	8 ALLOWANCE 1 8 TRANSPORTATION - VAN FEE INCOME \$ 8 MISCELLANEOUS INCOME - SEE MISC. INCOME SCHEDULE \$ 8 NON-OPERATING - RENTAL INCOME \$ 8 UNREALIZED GAIN (LOSS) \$ 8 GAIN ON SALE \$ 1 1 \$	8 ALLOWANCE 11,107 8 TRANSPORTATION - VAN FEE INCOME \$ 11,107 8 MISCELLANEOUS INCOME - SEE MISC. INCOME SCHEDULE \$ 10,357 8 NON-OPERATING - RENTAL INCOME 10,357 8 UNREALIZED GAIN (LOSS) 10 8 GAIN ON SALE 10 10 10 1	8 ALLOWANCE 10,107 8 TRANSPORTATION - VAN FEE INCOME \$ 11,107 8 MISCELLANEOUS INCOME - SEE MISC. INCOME SCHEDULE \$ 10,357 8 NON-OPERATING - RENTAL INCOME 10,357 8 UNREALIZED GAIN (LOSS) 10 8 GAIN ON SALE 10 1 1 10 1 <td>8 ALLOWANCE \$ \$ 8 TRANSPORTATION - VAN FEE INCOME \$ \$ \$ 8 MISCELLANEOUS INCOME - SEE MISC. INCOME SCHEDULE \$ \$ \$ 8 MISCELLANEOUS INCOME - SEE MISC. INCOME SCHEDULE \$ \$ \$ 8 NON-OPERATING - RENTAL INCOME \$ \$ \$ 8 UNREALIZED GAIN (LOSS) \$ \$ \$ 8 GAIN ON SALE \$ \$ \$ 1 </td>	8 ALLOWANCE \$ \$ 8 TRANSPORTATION - VAN FEE INCOME \$ \$ \$ 8 MISCELLANEOUS INCOME - SEE MISC. INCOME SCHEDULE \$ \$ \$ 8 MISCELLANEOUS INCOME - SEE MISC. INCOME SCHEDULE \$ \$ \$ 8 NON-OPERATING - RENTAL INCOME \$ \$ \$ 8 UNREALIZED GAIN (LOSS) \$ \$ \$ 8 GAIN ON SALE \$ \$ \$ 1

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	 sidential re Home
22	7B	DEPRECIATION - BUILDING RELATED TO OUTPATIENT			\$ 1,608
		DEPRECIATION - BUILDING IMPROVEMENTS RELATED TO			
22	7B	OUTPATIENT			\$ 5,731
22	7B	NON-OPERATING DEPRECIATION - RENTAL BUILDING			\$ 23,736
22	7C	DEPRECIATION - FIXED EQUIPMENT RELATED TO OUTPATIENT			\$ 1,133
Total Unal	lowable Bu	ilding Interest	\$ -	\$ -	\$ 32,208

State of Connecticut Annual Report of Long-Term Care Facility CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.		Report for Y	ear Ended		Page of
Jerome Home	2065C		9/30/2019			30 37
	Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board	& Routine Care Revenue					
1. a. Medicaid Residen	its (CT only)	\$	8,389,721	7,252,611		1,137,110
b. Medicaid Room a	and Board Contractual Allowance **	\$	(3,666,624)	(3,645,466)		(21,158)
2. a. Medicaid (All oth	er states)	\$				
b. Other States Roor	m and Board Contractual Allowance **	\$				
3. a. Medicare Residen	its (all inclusive)	\$	1,216,262	1,216,262		
b. Medicare Room a	and Board Contractual Allowance **	\$	110,871	110,871		
4. a. Private-Pay Resid	ents and Other	\$	8,172,104	8,007,264		164,840
b. Private-Pay Room	n and Board Contractual Allowance **	\$	86,595	86,595		
II. Other Resident Reven	ue					
1. a. Prescription Drug	js - Medicare	\$	87,762	87,762		
b. Prescription Drug	s - Medicare Contractual Allowance **	\$	(87,762)	(87,762)		
c. Prescription Drug	js - Non-Medicare	\$				
d. Prescription Drug	s - 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	\$	408,350	295,362		112,988
b. Physical Therapy	- Medicare Contractual Allowance **	\$	(269,621)	(261,523)		(8,098
c. Physical Therapy	- Non-Medicare	\$	(335)	(335)		
d. Physical Therapy	- Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy -	Medicare	\$	31,774	31,774		
b. Speech Therapy -	Medicare Contractual Allowance **	\$	(20,858)	(20,858)		
c. Speech Therapy -	Non-Medicare	\$	(931)	(931)		
d. Speech Therapy -	Non-Medicare Contractual Allowance **	\$				
5. a. Occupational The	erapy - Medicare	\$	278,530	278,530		
b. Occupational The	erapy - Medicare Contractual Allowance **	\$	(247,502)	(247,653)		151
c. Occupational The	erapy - Non-Medicare	\$	(1,312)	(665)		(647
d. Occupational The	erapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (Specify) -	Medicare	\$	(461)	(461)		
b. Other (Specify) -	Non-Medicare	\$	60,393	60,393		
III. Total Resident Revenu	<i>ue</i> (Section I. thru Section II.)	\$	14,546,956	13,161,770		1,385,186
IV. Other Revenue*						
1. Meals sold to guests,	employees & others	\$				
2. Rental of rooms to no		\$				
3. Telephone		\$				1
4. Rental of Television	and Cable Services	\$				1
5. Interest Income (Spec		\$	662,251	515,456		146,795
6. Private Duty Nurses'		\$,			ĺ ĺ
	ity and Gift shops	\$				1
7. Darber, Collee, Beau			201.1/2	(()))		
8. Other (<i>Specify</i>)		\$	301,463	66,354		235,109
	thru 8)	\$ \$	301,463 963,714	66,354 581,810		235,109 381,904

* 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

					Residential
Page Ref	Description	C	CNH	RHNS	Care Home
30 II 6A	MEDICARE A - X-RAY	\$	9,416		
30 II 6A	MEDICARE A - LAB	\$	8,903		
30 II 6A	LAB - MEDICARE B	\$	1,920		
30 II 6A	CONTR ALLOW - X RAY MED A	\$	(9,416)		
30 II 6A	CONTR ALLOW - LAB MED A	\$	(9,205)		
30 II 6A	MEDICARE B MPPR	\$	(2,079)		
Total Oth	er Resident Revenue - Medicare	\$	(461)	\$-	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

					Residential
Page Ref	Description	0	CNH	RHNS	Care Home
30 II 6B	APRN - DISALLOWED	\$	61,988		
30 II 6B	CONTR.ALLOW - OTHER ANCILLARY APRN - DISALLOWED	\$	(1,595)		
Total Oth	er Resident Revenue	\$	60,393	\$-	\$ -

Interest Income

Account

Page Ref Account	Balance	CCNH	RHNS		sidential re Home
30 IV 5 INTEREST INCOME		\$ 509,304		\$	145,043
30 IV 5 GALAXY FUND INT. INCOME		\$ 2,888		\$	822
30 IV 5 INTEREST INCOME - EARNINGS FUND		\$ 3,264		\$	930
Total Interest Income		\$ 515,456	\$	\$	146,795

Schedule of Other Revenue

						Residential
Page Ref	Description	(CCNH	RHNS	0	Care Home
30 IV8	GLF REVENUE - DISALLOWED	\$	-		\$	19,903
30 IV8	TRANSPORTATION - VAN FEE INCOME - DISALLOWED	\$	11,107		\$	3,163
30 IV8	UNRESTRICTED DONATIONS	\$	9,263		\$	2,638
30 IV8	MISCELLANEOUS INCOME - DISALLOWED	\$	10,357		\$	2,949
30 IV8	TEMP NET ASSET RELEASED FROM RESTR-OPERATIONS	\$	35,627		\$	10,146
30 IV8	NON OPERATING-RENTAL INCOME - DISALLOWED	\$	-		\$	32,869
30 IV8	UNREALIZED GAIN / (LOSS) - DISALLOWED	\$	-		\$	(1,136,602)
30 IV8	GAIN ON SALE - DISALLOWED	\$	-		\$	1,300,043
Total Oth	er Revenue	\$	66,354	\$-	\$	235,109

State of Connecticut Annual Report of Long-Term Care Facility CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	
Jerome Home	2065C	9/30/2019	31	37
	Account			Amount
Assets				
A. Current Assets				
1. Cash (on hand and	,		\$	3,152,094
	Receivable (Less Allowance		\$	945,771
3. Other Accounts Ree	ceivable (Excluding Owners	or Related Parties)	\$	
4 Inventories			\$	
5. Prepaid Expenses			\$	133,033
a				
b				
C				
d. See Schedule		133,033		
6. Interest Receivable			\$	13
7. Medicare Final Sett	lement Receivable		\$	
8. Other Current Asse	ts (itemize)		\$	237,005
			-	
See Schedule		237,005	-	
A-9. Total Current Assets (Lines A1 thru 8)		\$	4,467,916
B. Fixed Assets	· · · · · · · · · · · · · · · · · · ·			
1. Land			\$	719,914
2. Land Improvement	s *Historical Cost	498,087	\$	113,979
1	Accum. Deprecia			,
3. Buildings	*Historical Cost	12,699,224	\$	3,309,409
8-	Accum. Deprecia		+	-,,-,,
4. Leasehold Improve			\$	
	Accum. Deprecia	tion Net	÷	
5. Non-Movable Equi	*	1,754,090	\$	349,157
	Accum. Deprecia		Ψ	517,107
6. Movable Equipmen	*	4,075,742	\$	440,732
	Accum. Deprecia		Ψ	110,752
7. Motor Vehicles	*Historical Cost	91,110	\$	37,460
	Accum. Deprecia		Ψ	57,700
8. Minor Equipment-N	*		\$	
	*			0.100.000
9. Other Fixed Assets	(<i>itemize</i>)		\$	9,190,664
See Schedule		9,190,664		

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

(Carry Total forward to next page)

Attachment Page 31-34

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	PREPAID-OTHER - see additional schedule	\$ 117,701
31	A5	MISCELLANEOUS RECEIVABLE	\$ 14,932
31	A5	A/R - GOOD LIFE FITNESS	\$ 400
Total Prepa	id Expense	5	\$ 133,033

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

Page Ref Line Ref Description

31	A8	PATIENT REFUND ARBOR ROSE	\$	21,937
31	A8	A/R PRIVATE RENT Arbor Rose	\$	71,992
31	A8	A/R-PROVISION (RESERVE) FOR BAD DEBT	\$	(9,340)
31	A8	PREPAID-OTHER	\$	19,273
31	A8	DEBT SERVICE FUND 2007 - PRINCIPLE	\$	123,473
31	A8	DEBT SERVICE FUND 2007 - INTEREST	\$	9,670
Total Other	Total Other Current Assets (Itemize)			237,005

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

Page Ref Line Ref Description

'age Ref	Line Ref	Description	
31	B9	FIXED ASSET CLEARING ACCOUNT ARBOR ROSE	\$ 510,538
31	B9	FIXED ASSET-LAND IMPROVEMENTS ARBOR ROSE	\$ 96,279
31	B9	FIXED ASSET-BUILDING ARBOR ROSE	\$ 13,381,598
31	B9	FIXED ASSET-BUILDING IMPROVEMENTS ARBOR ROSE	\$ 684,071
31	B9	FIXED ASSET-FIXED EQUIPMENT ARBOR ROSE	\$ 307,354
31	B9	FIXED ASSET-FURNITURE & EQUIPMENT ARBOR ROSE	\$ 845,945
31	B9	FIXED ASSET - COMPUTERS (MOVEABLE) ARBOR ROSE	\$ 185,579
31	B9	FIXED ASSET-AUTO ARBOR ROSE	\$ 150,765
31	B9	ACCUM DPRN-ACCUM DEPRN - LAND IMPROVEMENT ARBOR ROSE	\$ (46,217
31	B9	ACCUM DPRN-ACCUM DEPRN - BUILDING ARBOR ROSE	\$ (5,460,065)
31	B9	ACCUM DPRN-ACCUM DEPRN - BUILDING IMPROVE ARBOR ROSE	\$ (286,732
31	B9	ACCUM DPRN-ACCUM DEPRN - FIXED EQUIPMENT ARBOR ROSE	\$ (195,317
31	B9	ACCUM DPRN-ACCUM DEPN - FURNITURE & EQUIPMENT ARBOR ROSE	\$ (670,082
31	B9	ACCUMULATED DEPRECIATION - COMPUTERS ARBOR ROSE	\$ (182,651
31	B9	ACCUM DPRN-ACCUM DEPRECIATION - AUTO ARBOR ROSE	\$ (130,401)
otal Other	Other Fixe	ed Assets (Itemize)	\$ 9,190,664

Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

rage Rei	Line Kei	Description			
32	D7	CASH- INVESTMENTS COMMONWEALTH FINANCIAL	\$	24,218	,607
32	D7	BOND ISSUANCE COST 2007	\$	419	,534
32	D7	CAPITALIZED INTEREST 2007	\$	234	,896
32	D7	DEFERRED FINANCE FEES	\$	113	,636
32	D7	BOND ISSUE COST 2007 - ACCUM AMORTIZATION	\$	(177	,841)
32	D7	CAPITALIZED INTEREST 2007 - ACCUM AMORTIZATION	\$	(90	,044)
32	D7	LOC RENEWAL FEES - AMORTIZATION	\$	(102	,037)
32	D7	PERMANENT RESTRICTED NET ASSET HELD IN TRUST	\$	328	,934
Total Other	Total Other Assets			24,945	,685

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref Line Ref Description

Total Notes	Total Notes Payable		\$ -

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

Page Ref	Line Ref	Description		
33	A12	SECURITY DEPOSITS PAYABLE ARBOR ROSE	\$	11,360
33	A12	SECURITY DEPOSIT-LAST MONTH ARBOR ROSE	\$	293,533
33	A12	DEFERRED REVENUE	\$	18,487
33	A12	DEFERRED REVENUE ARBOR ROSE	\$	6,658
33	A12	ACCRUED VAC/SICK/HOLIDAY	\$	263,169
33	A12	ACCRUED VAC/SICK/HOLIDAY ARBOR ROSE	\$	52,080
33	A12	ACCRUED EXPENSES - OTHER - see additional schedule	\$	224,913
33	A12	ACCRUED EXPENSES-OTHER ARBOR ROSE	\$	79,329
33	A12	DUE TO THIRD PARTIES	\$	22,828
33	A12	ACCRUED PENSION PAYABLE	\$	22,648
33	A12	ACCRUED PENSION PAYABLE ARBOR ROSE	\$	2,880
33	A12	ACCRUED WORKERS COMP ARBOR ROSE	\$	12,261
33	A12	DUE TO CT - PROVIDER TAX	\$	148,523
Fotal Other	Current L	iabilities (Itemize)	s	1,158,669

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

Page Ref	Line Ref	Description	
3.	4 B4	ACCRUED WORKERS COMPENSATION	\$ 298,428
3.	4 B4	OTHER LONG TERM LIABILITY - SWAP 2	\$ (2,633)
Total Other Current Liabilities (Itemize)			\$ 295,795

State of Connecticut Annual Report of Long-Term Care Facility CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility Jerome Home			License No.	Report for Year Ended	Page		of
Jeroi	me I	Iome	2065C	9/30/2019	32		37
			Account		Aı	mount	
				Total Brought Forward:	\$	18,62	9,231
C.		asehold or like property recor	ded for Equity Purpose	S.			
	1. Land 2. Land Improvements 3. Buildings				\$ 		
	2. Land Improvements		*Historical Cost				
			Accum. Depreciation	n Net	\$ 		
	3.	Buildings	*Historical Cost				
			Accum. Depreciation	n Net	\$		
	4.	Non-Movable Equipment	*Historical Cost				
			Accum. Depreciation	n Net	\$ 		
	5.	Movable Equipment	*Historical Cost				
			Accum. Depreciation	Net	\$ 		
	6.	Motor Vehicles	*Historical Cost				
			Accum. Depreciation	n Net	\$		
	7.	Minor Equipment-Not Depre	eciable		\$		
C-8		tal Leasehold or Like Proper	ties (C1 thru 7)		\$		
D.	Inv	vestment 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 Resid	dent Care (temize)		\$		
	6.	Loans to Owners or Related	Parties (itemize)		\$		
		Name and Address	Amount	Loan Date			
	7.	Other Assets (itemize)			\$	24,94	5,685
		See Schedule		24,945,685			
D-8.		tal Investments and Other As			\$ 	24,94	5,685
D-9.	То	tal All Assets (Lines A9 + B)	10 + C8 + D8)		\$ 	43,57	4,916

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year	Ended	Page	e	of	
Jerome Hom	ne		2065C	9/30/2019		33		37
			Account				Amount	
Liabilities								
А.	Cu	rrent Liabilities						
	1.	Trade Accounts Payable				\$	338	8,171
	2.	Notes Payable (itemize)				\$		
		See Schedule				•		
	3.	Loans Payable for Equipm				\$		
		Name of Lender	Purpose	Amount	Date Due			
	4.	Accrued Payroll(Exclusive	e of Owners and/or S	Stockholders only)		\$	53	6,998
	5.	Accrued Payroll (Owners a	ě.	. /		<u>+</u> \$		
	6.	Accrued Payroll Taxes Pay				\$		
	7.	Medicare Final Settlement				\$		
	8.	Medicare Current Financin				\$		
	9.	Mortgage Payable (Curren	<u> </u>			\$	36	5,000
	10	Interest Payable (Exclusive		elated Parties)		\$		5,909
		Accrued Income Taxes*	0	,		\$		5,900
	12	Other Current Liabilities (i	temize)			\$		8,669
				See Schedule	1,158,669			
A-13	. To	tal Current Liabilities (Lin	es A1 thru 12)			\$	2,420	0,647

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

(Carry Total forward to next page)

State of Connecticut Annual Report of Long-Term Care Facility CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility Jerome Home			Ended	Page 34	of 37
	Account			Amo	1
	ht Forward:		2,420,647		
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment	(itemize)		\$		
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable		ł	\$		8,455,000
3. Loans from Owners or Rela	ted Parties (itemize)		\$		
Name and Address of Lender	Amount	Loan D			
4. Other Long-Term Liabilitie	s (itemize)		\$		295,795
See Schedule		295,795			
B-5. Total Long-Term Liabilities ()			\$		8,750,795
C. Total All Liabilities (Lines A-		11,171,442			

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

	ne of Facility	License No.	Report for Y	ear Ended	Page	of
Jero	ome Home	Account	9/30/2019		35	mount 37
A.	Reserves	Account				mount
	1. Reserve for value of leased	and			\$	
	2. Reserve for depreciation val to be amortized	ue of leased buildin	gs and appurten	ances	\$	
	3. Reserve for depreciation val	ue of leased person	al property (<i>Equ</i>	ity)	\$	
	4. Reserve for leasehold real pr	roperties on which f	fair rental value	is based	\$	
	5. Reserve for funds set aside a	as donor restricted			\$	
	6. Total Reserves				\$	
B.	Net Worth 1. Owner's Capital				\$	32,421,881
	2. Capital Stock				\$	
	3. Paid-in Surplus				\$	
	4. Treasury Stock				\$	
	5. Cumulated Earnings				\$	110,476
	6. Gain or Loss for Period	10/1/20	18 thru	9/30/2019	\$	(128,883)
	7. Total Net Worth				\$	32,403,474
C.	Total Reserves and Net Worth				\$	32,403,474
D.	Total Liabilities, Reserves, and	Net Worth			\$	43,574,916

H. Changes in Total Net Worth

Nam	ne of Facility	License No.	Report for Year	Ended	Page	of
Jero	me Home	2065C	9/30/2019		36	37
		Account			A	mount
A.	Balance at End of Prior Period as s	hown on Report of	f 09/30/2018	9	5	32,421,881
B.	Total Revenue (From Statement of	Revenue Page 30)		9	5	15,510,670
C.	Total Expenditures (From Statement	nt of Expenditures	Page 27)	9	5	15,639,553
D.	Net Income or Deficit			9		(128,883)
E.	Balance			9	5	32,292,998
F.	Additions 1. Additional Capital Contributed Temp Restricted	(įtemize)	(26,697)			
	2. Other (<i>itemize</i>) Arbor Rose Net Income Change in Perm Restricted Rounding	Net Assets	146,549 (9,378) 2			
F-3.	Total Additions			9	5	110,476
G.	Deductions				,	-)
	1. Drawings of Owners/Operators	Partners (Specify))	5	5	
	Name and Address (No., City,	State, Zip)	Title	Amount		
	2. Other Withdrawings(<i>Specify</i>)			9	5	
	Purpose		Amo	unt		
**	3. Total Deductions	0.0.17.5	(1.0	9		
H.	Balance at End of Period	09/30	/19	9	5	32,403,474

			· · · · · · · · · · · · · · · · · · ·							
Name of Facility	License No.	Report for Year Ended	Page of							
Jerome Home	2065C	9/30/2019	37 37							
Check appropriate category										
☑ Chronic and Convalescent Nursing Home only (CCNH)	☑ Residential Care Home									
	Preparer/Reviewer Certificat	tion								
have read the most recent Federal and personnel as to the possible inclusion regulations. All non-reimbursable ex removed in the State rate computation are properly reported as such in this r	report and am familiar with the applicab d State issued field audit reports for the F in this report of expenses which are not spenses of which I am aware (except tho n system) as a result of reading reports, in report on Pages 28 and 29 (adjustments to eement with the books and records, as pro-	Facility and have inquired of appr reimbursable under the applicabl se expenses known to be automa nquiry or other services performe to statement of expenditures). Fur	ropriate le tically ed by me							
Signature of Preparer	Title	Date Signed								
-g		2 2.g								
Printed Name of Preparer										
Dorothy Robinson										
Addres Address		Phone Number								
Hartford HealthCare Senior Services, Curtis I	Bldg., 181 Patricia M Genova Dr 5th Fl.,	Newing 860-696-6438								
Contacted Person Regarding Additional Info	rmation Needed Regarding This Report	Phone Number								
Dorothy Robinson	860-696-6438									
Contact Email Address										
Dorothy.Robinson@hhchealth.org										

I. Preparer's/Reviewer's Certification