State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2020

Name of Facility (as licensed) Hartford Hospital d/b/a Jefferson House		
Address (No. & Street, City, State, Zip Code) 1 John H. Stewart Drive, Newington, CT 06111		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☑ Other
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Hartford Hospital d/b/a Jefferson House [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Hartford Hospital d/b/a Jefferson House	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 1 John H. Stewart Drive, Newington, CT 06111				
Report Prepared By Dorothy Robinson	Phone Number 203-623-2930/860-696-		Date	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-667- 4453	9/30/2020	2	37

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

License Numbers:	CCNH	RHNS	Other	Medicare Provider No.
	993-C			07-5293

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

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

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	3A	37

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

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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
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
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

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

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers: Yes	Related * to Owners, Operators, Officers: No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Wells Fargo Financial Leasing, Inc. 800 Walnut, 4th floor, Des Moines, Iowa 50309	○	⊙	Kyocera Taskalfa 5501I and Kyocera Taskalfa 356ci copier printers	07/05/16	60 months	9,540	
Wells Fargo Vendor Financial Services, LLC, PO Box 41564, Philadelphia, PA 19101-1564	○	⊙	9 Ricoh copier printers	11/20/17	60 months	2,195	
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	

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

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

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General Information and Questionnaire
Accounting Basis

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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

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

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

⊙ Yes ○ No page 15 1d

Legal Services Information

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

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

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

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

⊙ Yes ○ No

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Other	Total	CCNH	RHNS	Other
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	104	104			104	104						
B. On last day of THIS report period	104	104							104	104		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	104	104			104	104						
B. As of midnight of THIS report period	91	91							91	91		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,064	4,064			3,085	3,085			979	979		
B. Medicaid (Conn.)	20,500	20,500			15,184	15,184			5,316	5,316		
C. Medicaid (other states)												
D. Private Pay	5,924	5,924			4,701	4,701			1,223	1,223		
E. State SSI for RCH												
F. Other (Specify) Mgd Care, WC, Mgd Medicare	3,279	3,279			2,501	2,501			778	778		
G. Total Care Days During Period (3A thru F)	33,767	33,767			25,471	25,471			8,296	8,296		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	27	27			27	27						
B. Other Bed Reserve Days	172	172			138	138			34	34		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	33,966	33,966			25,636	25,636			8,330	8,330		

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Schedule of Resident Statistics (Cont'd)

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

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

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

Change in Resident Days	CCNH	RHNS	Other
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	Other	R.C.H.	ICF-MR
No. of Residents	8	61		22				
Per Diem Rate								
a. One bed rm.	PDPM	262.87		520.00				
b. Two bed rms.				490.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	Other
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,165	1,890		1,275
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	36	36		
C. Other	19,745	19,297		448
D. ***Total Physical Therapy Treatments***	22,946	21,223		1,723
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	182	179		3
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	22	22		
C. Other	808	808		
D. ***Total Speech Therapy Treatments***	1,012	1,009		3
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,753	1,514		239
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	37	37		
C. Other	17,231	17,222		9
D. ***Total Occupational Therapy Treatments***	19,021	18,773		248

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Report of Expenditures - Salaries & Wages

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	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)	144,845	2,091				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	399,455	15,374				
5. Dietary Service						
a. Head Dietitian	75,568	2,591				
b. Food Service Supervisor						
c. Dietary Workers	561,166	33,764				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	250,729	15,895			4,984	316
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	79,947	2,050			1,589	41
b. Other Maintenance Workers	85,129	5,106			1,692	101
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	223,865	3,962				
b. RN						
1. Direct Care	2,655,632	61,195				
2. Administrative**	383,551	8,065				
c. LPN						
1. Direct Care	299,954	8,530				
2. Administrative**						
d. Aides and Attendants	2,129,206	122,846				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	192,727	6,577				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists	138,447	2,113				
l. Podiatrists						
m. Social Workers/Case Management	288,022	7,201				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	407,893	10,161			2,115,236	59,883
A-13. Total Salary Expenditures	8,316,136	307,521			2,123,501	60,341

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
*** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		Other	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
SALARY AND WAGES EMERGENCY MANAGEMENT	$ 94,200	3,240				
SALARY AND WAGES COMMUNITY NETWORK ADMIN DISALLOWED					$ 130,713	1,048
SALARY AND WAGES CENTER FOR HEALTHY AGING DISALLOWED					$ 1,530,295	43,599
DISALLOWED					$ 304,382	12,628
SALARY RECLASS GOOD LIFE FITNESS DISALLOWED					$ (3,165)	(131)
PTO & HOLIDAY ACCRUAL - FRINGE BENEFITS DEPT - OUTPATIENT PORTION DISALLOWED	$ 73,276	2,594			$ 18,710	648
SALARY RECLASS GRANT ADMIN DISALLOWED					$ 134,301	2,091
SALARY AND WAGES HEALTH INFO MGMT	$ 45,546	1,561				
SALARY RECLASS EMPLOYEE HEALTH	$ 13,719	828				
SYSTEM FEE DIRECT PYRL SYS FEE GEN ALLOCATION	$ 181,152	1,938				
Total	$ 407,893	10,161	$ -	-	$ 2,115,236	59,883

Schedule of Other Fees (Page 13)

	CCNH		RHNS		Other	
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.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Other							
Section III - Administrators* **										
Susan Vinal	144,845			Non-discriminatory	Administrator - Management of Facility	2,091	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Other	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	9,416	40				
3. Pharmacist	12,149	190				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	478,849	9,012			39,553	744
b. Other						
6. Social Worker						
7. Recreation Worker	3,015	24				
8. Physicians						
a. Medical Director (entire facility)	48,600	520				
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	220,303	3,493			655	10
b. Other						
10. Occupational Therapist						
a. Resident Care	372,201	7,652			4,917	101
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides	116,213	4,925				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	1,260,746	25,856			45,125	855

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Healthdrive Dental	Dental Services	○	⊙	
Hartford HealthCare Rehab Network	Therapy	⊙	○	
Jerome Home	Therapy, CNAs	⊙	○	
Hartford HealthCare Medical Group	Medical Director	⊙	○	
Hartford HealthCare Independence at Home	CNAs	⊙	○	
Beverly M Flaherty	Recreation Program	○	⊙	
Country Quilt Llama Farm LLC	Recreation Program	○	⊙	
CT Bristol Old Time Fiddlers Club	Recreation Program	○	⊙	
Jeanette Wheeler	Recreation Program	○	⊙	
John Paolillo	Recreation Program	○	⊙	
John W Banker	Recreation Program	○	⊙	
Jose Paulo Dos Santos	Recreation Program	○	⊙	
Joseph Giangrasso	Recreation Program	○	⊙	
Kaitlyn Raitz	Recreation Program	○	⊙	
Mark A Lanzieri	Recreation Program	○	⊙	
Mary Morse	Recreation Program	○	⊙	
Matthew Pidi	Recreation Program	○	⊙	
Paul Shlien	Recreation Program	○	⊙	
Peter Lehndroff	Recreation Program	○	⊙	
Rebecca Swett	Recreation Program	○	⊙	
Robert Nelson	Recreation Program	○	⊙	
Tom Alvord	Recreation Program	○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	15	37

Item		Total	CCNH	RHNS	Other
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$				
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	737,514	587,498		150,016
5. Health Insurance	$	1,521,459	1,211,983		309,476
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	720,578	574,007		146,571
(not-owners and not-operators)					
8. Uniform Allowance	$	2,995	2,386		609
9. Other (*Specify*)	$	48,276	8,452		39,824
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	61,995	61,995		
d. Accounting and Auditing	$				
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	64,470	30,469		34,001
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$				
2. Cellular Phones	$	14,510	5,433		9,077
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	562,494	562,494		
Subtotal	$	3,734,291	3,044,717		689,574

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Other
BACKGROUND VERIFICATIONS ADMIN & GENERAL	$ 8,452		$ 2,158
HSA ER CONTRIBUTION			$ 37,666
Total	$ 8,452	$ -	$ 39,824

Schedule of Other Taxes

Description	CCNH	RHNS	Other
Total	$ -	$ -	$ -

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	16	37

Item		Total	CCNH	RHNS	Other
Subtotals Brought Forward:		3,734,291	3,044,717		689,574
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	760	760		
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	7,621	7,621		
4. Employee Travel	$	43,081	8,462		34,619
5. Education Expenses Related to Seminars and Conventions	$	12,384	6,100		6,284
6. Automobile Expense (*not purchase or depreciation*)	$	2,381	2,381		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	15,087			15,087
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)***	$				
7. Postage	$	5,472	5,395		77
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	16,860	16,860		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions***	$	15,198			15,198
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	65,722	63,387		2,335
12. Administrative Management Services**	$	1,593,966	1,443,371		150,595
13. Other (*Specify*)	$	817,854	19,450		798,404
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	6,330,677	4,618,504		1,712,173

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	Other
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Other
ADVERTISING - ADMIN & GENERAL - DISALLOWED			$ 13,255
PROMOTIONAL EVENTS ADMIN & GENERAL - DISALLOWED			$ 430
SIGNS CENTER FOR HEALTHY AGING - DISALLOWED			$ 111
PACKAGING HEALTH INFO MANAGEMENT - DISALLOWED			$ 238
PACKAGING CENTER FOR HEALTHY AGING - DISALLOWED			$ 1,053
Total Other Advertising	$ -	$ -	$ 15,087

Schedule of Dues

Description	CCNH	RHNS	Other
MOTION PICTURE LICENSING CORP	$ 383		
CALTC	$ 350		
CDP RENEWAL CENTER FOR HEALTHY AGING	$ 135		
DEA LICENSE	$ 731		
STATE OF CT ELEVATOR CERT	$ 240		
CENTRAL CT HEALTH DISTRICT FOOD SERVICE LICENSE	$ 212		
IC EDUCATION DUES	$ 30		
AMDA 2020 MEMBERSHIP	$ 395		
LEADING AGE CT DUES	$ 10,449		
DMV	$ 20		
ALTCFM MEMBERSHIPS	$ 255		
STATE OF CT LICENSE	$ 960		
ASCP	$ 125		
MONARCH ENVIRONMENTAL GPLPE AIR PERMIT, TIER II CHEM INV REPORT AND NEWINGTON HAZARD MATERIAL REPORT	$ 2,575		
Total Dues	$ 16,860	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	Other
TOWN OF NEWINGTON DEPT OF HUMAN SERVICES DISALLOWED			$ 15,000
FOOD DRIVE DONATION DISALLOWED			$ 250
LEADING AGE - AGEISM 5K DONATION DISALLOWED			$ 29
LESS VALUE PPE DONATED TO JEFFERSON HOUSE DISALLOWED			$ (81)
Total Contributions	$ -	$ -	$ 15,198

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
MERCHANT FEES DISALLOWED			$ 3,507
CASH DISCOUNTS ACCOUNTING GENERAL	$ (983)		
TRANSLATOR SERVICES CENTER FOR HEALTHY AGING DISALLOWED			$ 245
BILLING SERVICES CENTER FOR HEALTHY AGING DISALLOWED			$ 1,144
PURCHASED SERVICES - AFFILIATE GRANT ADMINISTRATION DISALLOWED			$ 522
PURCHASED SERVICES - OTHER GRANT ADMIN DISALLOWED			$ (522)
STORAGE RENT/LEASE HEALTH INFO MGMT	$ 7,599		
CABLE TV/INTERNET	$ 13,315		
RECLASS CREDIT FROM LEGAL	$ (481)		
NON-OPERATING BANK FEES FUND DEPT DISALLOWED			$ 149,866
SPONSORSHIPS FUND DEPARTMENT DISALLOWED			$ 404,333
INTERNAL SPONSOR EXP AFFILIATE FUND DEPT DISALLOWED			$ 239,289
LATE FEES ADMIN & GENERAL DISALLOWED			$ 20
Total Other Administrative and General	$ 19,450	$ -	$ 798,404

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Schedule C-1 - Management Services*

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2020	Page 17 | of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Hartford HealthCare & Hartford HealthCare Senior Services	1,593,966	Contracting and Management	p 16 1m12
Morrison Community Living	661,551	Dietary Staff Management, Support, Food Purchase, Quantity Discount	p 18 2a1,2a2, 2a3,& 2b
Crothall Healthcare	110,596	Environmental Services Staff Management, Support, Supplies Purchase, Quantity Discount	p 20 4a1 & 4b
Hartford Hospital	49,737	Laundry Services (partial year)	p 19 3b

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	18 | 37

Item		Total	CCNH	RHNS	Other
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	340,287	340,287		
2. Non-Food Supplies	$	93,163	80,598		12,565
3. Other (*Specify*)_____	$	31,764	44,614		(12,850)
In House food for depts and non-residents - disallowed					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	183,867	183,867		
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	649,081	649,366		(285)

2E. Dietary Questionnaire		Total	CCNH	RHNS	Other
F. Resident Meals:	Total no. of meals served per day:*	277	277		

G.	Is cost of employee meals included in 2D?	◉ Yes	○ No		
H.	Did you receive revenue from employees?	◉ Yes	○ No	If yes, specify amt.	included below
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				30 IV1
J.	Is cost of meals provided to persons other 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.	$9,985
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				30 IV1
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.	
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	19 | 37

Item		Total	CCNH	RHNS	Other
3. Laundry					
a. In-House Processing*					
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	144,767	144,767		
c. Other (*Specify*)	$				
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	144,767	144,767		

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	20	37

Item			Total	CCNH	RHNS	Other
4. Housekeeping	Sq. Ft. Serviced by Personnel		62,900	61,674		1,226
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	89,817	88,066		1,751
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel		62,900	61,674		1,226
(Complete Schedule C-2 att. Page 21)	Amt.	$	44,181	43,320		861
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	133,998	131,386		2,612
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Neighborcare Pharmacy Services Inc.		$	230,584	230,584		
b. Medicine Cabinet Drugs		$	573	573		
c. Medical and Therapeutic Supplies		$	487,190	484,122		3,068
d. Ambulance/Limousine***		$	6,404	6,404		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	39,894	39,894		
f. X-rays and Related Radiological Procedures***		$	21,352	21,352		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	72,745	72,745		
i. Recreation		$	638	638		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	24,611	1,812		22,799
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	883,991	858,124		25,867

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	Other
PATIENT/RESIDENT RELATIONS FUND DEPT DISALLOWED			$ 296
PATIENT/RESIDENT RELATIONS NURSING DIRECT MANAGEMENT DISALLOWED			$ 2,177
PATIENT/RESIDENT RELATIONS NURSING RN ADMIN DISALLOWED			$ 53
PATIENT/RESIDENT RELATIONS RECREATIONAL THERAPY	$ 1,812		
HHCRN PT MANAGEMENT FEES DISALLOWED			$ 20,273
Total Other Resident Care	$ 1,812	$ -	$ 22,799

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CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	Other	Pg	Line
See attached list		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
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		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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

Name of Facility	License No.	Report for Year Ended			Page of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020			22 | 37

Item		Total	CCNH	RHNS	Other
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	277,055	271,335		5,720
b. Heat	$	54,574	53,510		1,064
c. Light & Power	$	123,473	121,066		2,407
d. Water	$	107,347	105,255		2,092
e. Equipment Lease (*Provide detail on page 6*)	$	26,871	25,343		1,528
f. Other (*itemize*)	$	136,991	134,321		2,670
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	726,311	710,830		15,481
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	8,297	8,135		162
b. Building & Building Improvements	$	316,045	309,885		6,160
c. Non-Movable Equipment	$	6,782	6,650		132
d. Movable Equipment	$	139,337	133,054		6,283
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	470,461	457,724		12,737
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	1,516			1,516
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	471,977	457,724		14,253

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	Other
MAINTENANCE - GROUNDS/LANDSCAPING OPERATION OF PLANT -OUTPATIENT PORTION DISALLOWED	$ 41,143		$ 818
WASTE REMOVAL OPERATION OF PLANT - OUTPATIENT PORTION DISALLOWED	$ 68,445		$ 1,361
STORAGE RENT/LEASE OPERATION OF PLANT - OUTPATIENT PORTION DISALLOWED	$ 8,674		$ 172
PURCHASED SERVICES - AFFILIATE OPERATION OF PLANT - OUTPATIENT PORTION DISALLOWED	$ 3,541		$ 70
OTHER NON-BILLABLE MED/SURG OPERATION OF PLANT - OUTPATIENT PORTION DISALLOWED	$ 12,518		$ 249
Total Other Repairs and Maintenance	$ 134,321	$ -	$ 2,670

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	98,834		98,834	8,409			8,297	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								8,297
B. **Building and Building Improvements**								
1. Acquired prior to this report period	8,073,852		8,073,852	6,157,514		various	310,666	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	119,656		119,656				5,379	
B-4. Subtotal								316,045
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	1,460,649		1,460,649	1,425,922		various	6,782	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								6,782

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. Ram Quad Cab 2500 Turck 4x4	x		9	2004	34,166		34,166	34,166		4 years		
b. 2017 Ford E-350 Cutaway	x		1	2017	49,988		49,988	31,243		4 years	12,497	
c. 2019 E350 Van	x		2	2020	61,533		61,533			4 years	7,692	
d.												
2. Movable Equipment												
a. Acquired prior to this report period					2,317,097		2,317,097	1,834,035		various	105,945	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					139,764		139,764				13,203	
D-3. Subtotal												139,337
E. ***Total Depreciation***												470,461

Schedule of Land Improvements Acquired during this report period

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

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

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

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
12/31/2019	Security System	$ 76,091	10	$ 3,804	
2/29/2020	Conference Room Air Conditioning	$ 7,354	10	$ 368	
2/29/2020	2.5 ton RTU HVAC	$ 11,251	15	$ 375	
2/29/2020	Laurel Room 5 ton HVAC	$ 13,000	15	$ 433	
8/31/2020	Boiler Room Sump Pump	$ 11,960	15	$ 399	
Total additions for Building Improvement		$ 119,656		$ 5,379	*
Deletions:					
		$ -			
Total deletions for Building Improvement		$ -		$ -	**

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

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

Schedule of Non-Movable Equipment Acquired during this report peri

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

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

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/30/2019	Joerns Ultracare Beds	$ 536		$ -	
11/30/2019	36" square tables	$ 1,476	15	$ 49	
2/29/2020	Cent for Aging F2 Desk	$ 3,545	10	$ 89	
2/29/2020	Office 2 Table 36x60	$ 936	15	$ 31	
2/29/2020	Office 3 42" round table	$ 531	15	$ 18	
2/29/2020	462 Queen St 1st floor VacuPro	$ 12,000	3	$ 2,000	
2/29/2020	Responder 5000 Nurse Call	$ 76,470	5	$ 7,647	
2/29/2020	Bladders Scan Ultrasound	$ 11,550	5	$ 1,155	
2/29/2020	CARESCAPE V100 vital signs	3710	7	265	
2/29/2020	Performa Lift Assist	3219	10	161	
2/29/2020	Space Edge Dining Tables	5092	15	170	
2/29/2020	Sara Flex Scale	4416	10	221	
2/29/2020	Scale, Wheelchair Fold Up	4598	10	229	
7/31/2020	Stratus 9.1 Pulsating Mattress	11685	5	1168	
	Note: Van acquired is shown in motor vehicle section page 23				
Total additions for Movable Equipmen		$ 139,764		$ 13,203	*
Deletions:					
		$ -			
Total deletions for Movable Equipmen		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report peri

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	24	37

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

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson Hous	993-C	9/30/2020	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	10/24/78
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	N/A
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	104
6. Square Footage	75,000
7. Acquisition Cost	
a. Land	262,539
b. Building	2,038,052

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

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
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Item	Total	CCNH	RHNS	Other
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage $				
Name of Lender / Rate				
Address of Lender				
2. Second Mortgage $				
Name of Lender / Rate				
Address of Lender				
3. Third Mortgage $				
Name of Lender / Rate				
Address of Lender				
4. Fourth Mortgage $				
Name of Lender / Rate				
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount $				
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $				

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson H	993-C	9/30/2020	27 | 37

Item	Total	CCNH	RHNS	Other
Subtotals Brought Forward:				
12. C. Movable Equipment 1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $				
14. Insurance				
a. Insurance on Property (buildings only) $	8,414	8,250		164
b. Insurance on Automobiles $	5,999	5,999		
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	42,512	42,512		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	56,925	56,761		164
15. ***Total All Expenditures (A-13 thru C-14)*** $	21,143,235	17,204,344		3,938,891

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Other
Page 10 - Salaries and Wages							
1.	10	A12e	Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.	10	A12g	Occupational Therapy $				
4.			Other - See attached Schedule $	2,123,501			2,123,501
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	B10a	Occupational Therapy $	377,118	372,201		4,917
7.			Other - See attached Schedule $	748,776	708,568		40,208
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	61,995	61,995		
10.			Accounting $				
10a.			Legal $				
11.	15	1h1	Telephone $				
12.	15	1h2	Cellular Telephone $	10,164	1,087		9,077
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.	16	1L5	Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	1m3	Unallowable Advertising * $	15,087			15,087
19.			Income Tax / Corporate Business Tax $				
20.	16	1m10	Fund Raising / Contributions $	15,198			15,198
21.	16	1m12	Unallowable Management Fees $	1,593,966	1,443,371		150,595
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	1,601,937	67,156		1,534,781
Page 18 - Dietary Expenditures							
24.	18	2a3	Meals to employees, guests and others who are not residents $	31,764	44,614		(12,850)
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	6,579,506	2,698,992		3,880,514

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	Other
10	A6b	Outpatient portion Housekeeper Wages			$ 4,984
10	A7a	Outpatient portion Chief of Maintenance Wages			$ 1,589
10	A7b	Outpatient portion Maintenance Wages			$ 1,692
10	A12o	SALARY AND WAGES COMMUNITY NETWORK ADMIN			$ 130,713
10	A12o	SALARY AND WAGES CENTER FOR HEALTHY AGING			$ 1,530,295
10	A12o	SALARY AND WAGES GOOD LIFE FITNESS			$ 304,382
10	A12o	SALARY AND WAGES RECLASS GOOD LIFE FITNESS			$ (3,165)
10	A12o	PTO ACCRUAL - FRINGE BENEFITS DEPT			$ 18,610
10	A12o	HOLIDAY ACCRUAL - FRINGE BENEFITS DEPT			$ 100
10	A12o	SALARY RECLASS GRANT ADMIN			$ 134,301
Total Other Salaries Adjustment			$ -	$ -	$ 2,123,501

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
13	B2	CONTRACT LABOR-CLINICAL - ADMIN AND GENERAL - DENTAL	$ 9,416		
13	B5A	PURCHASED SERVICES AFFILIATE - PHYSICAL THERAPIST	$ 478,849		$ 39,553
13	b9	PURCHASED SERVICES AFFILIATE - SPEECH THERAPIST	$ 220,303		$ 655
Total Other Fees Adjustments			$ 708,568	$ -	$ 40,208

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
15	1A4	BENEFITS RELATED TO OUTPATIENT THERAPY, CHA, GRANT ADMIN - FICA			$ 150,016
15	1A5	BENEFITS RELATED TO OUTPATIENT THERAPY, CHA, GRANT ADMIN			$ 309,476
15	1A7	BENEFITS RELATED TO OUTPATIENT - PENSION			$ 146,571
15	1A8	BENEFITS RELATED TO OUTPATIENT - UNIFORMS			$ 609
15	1A9	OTHER EMPLOYEE BENEFITS RELATED TO OUTPATIENT INCLUDING PRE-EMPLOYMENT PHYSICALS OUTPATIENT PORTION			$ 39,824
15	1A9	PRE-EMPLOYMENT PHYSICALS	$ 5,449		
15	1G	OFFICE SUPPLIES, PRINTING, MINOR EQUIPMENT RELATED TO OUTPATIENT			$ 34,001
16	1L3	GIFTS IN EXCESS OF $25 OR DISCRIMINATORY IN NATURE	$ 4,006		
16	1L4	PARKING - CENTER FOR HEALTHY AGING			$ 180
16	1L4	TRAVEL - GOOD LIFE FITNESS, CENTER FOR HEALTHY AGING			$ 34,439
16	1L5	STAFF DEVELOPMENT AND TRAINING MATERIALS CENTER FOR HEALTHY AGING			$ 6,284
16	1M7	POSTAGE - GOOD IFE FITNESS			$ 77
16	1M111	MAINT & REPAIR - IT EQUIP/SOFT CENTER FOR HEALTHY AGING			$ 2,335
16	1M111	MAINT & REPAIR - IT EQUIP/SOFT ADMIN AND GENERAL - SALINA	$ 3,078		
16	1M111	CONSULTING ADMIN AND GENERAL - HARMONY HEALTHCARE	$ 44,908		
16	1M13	MERCHANT FEES			$ 3,507
16	1M13	TRANSLATOR SERVICES CENTER FOR HEALTHY AGING			$ 245
16	1M13	BILLNG SERVICES CENTER FOR HEALTHY AGING			$ 1,144
16	1M13	NON-OPERATING BANK FEES FUND DEPT			$ 149,866
16	1M13	SPONSORSHIPS FUND DEPARTMENT			$ 404,333
16	1M13	INTERNAL SPONSOR EXP AFFILIATE FUND DEPT			$ 239,289
16	1M13	CABLE TV NET OF $3,600 ALLOWANCE	$ 9,715		
16	1M13	LATE FEES ADMIN & GENERAL			$ 20
18	2A2	DIETARY SUPPLIES FOR NON-RESIDENTS			$ 12,565
Total Other A&G Adjustments			$ 67,156	$ -	$ 1,534,781

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

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	Other
			Subtotals Brought Forward	$	6,579,506	2,698,992		3,880,514
Page 20 - Resident Care Supplies***								
27.	20	5a2	Prescription Drugs	$	230,584	230,584		
28.	20	5d	Ambulance/Limousine	$	6,404	6,404		
29.	20	5f	X-rays, etc	$	21,352	21,352		
30.	20	5h	Laboratory	$	72,745	72,745		
31.	20	5c	Medical Supplies	$	27,775	24,707		3,068
32.	20	5e2	Oxygen (non emergency)	$	39,894	39,894		
33.	20	5L	Occupational Therapy	$				
34.			Other - See Attached Schedule	$	25,411			25,411
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$	6,677	394		6,283
36.			Depreciation on Unallowable Motor Vehicles	$				
37.	22	10c	Unallowable Property and Real Estate Taxes	$	1,516			1,516
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$	22,746	7,103		15,643
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.	27	14a	Property Insurance	$	164			164
Other - Miscellaneous								
42.			Other - Indirect	$				
43.			Interest Income on Account Rec.	$				
44.			Other - Miscellaneous Administrative	$	2,571,229	9,358,246		(6,787,017)
45.			Management Fees Direct	$				
46.			Management Fees Indirect	$				
47.			Other - Direct	$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$	6,292			6,292
49.	***Total Amount of Decrease (Items 1 - 48)***			$	9,612,295	12,460,421		(2,848,126)

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

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Other
20	4A	HOUSEKEEPING SUPPLIES OUTPATIENT			$ 1,751
20	4B	HOUSEKEEPING PURCHASED SERVICES OUTPATENT			$ 861
20	5L	HHC REHAB NETWORK MANAGEMENT FEES AND OPTIMA FEES - DISALLOWED			$ 20,273
20	5L	PATIENT/RESIDENT RELATIONS FUND DEPT			$ 296
20	5L	PATIENT/RESIDENT RELATIONS NURSING DIRECT MANAGEMENT			$ 2,177
20	5L	PATIENT/RESIDENT RELATIONS NURSING RN ADMIN			$ 53
Total Other Ancillary Costs			$ -	$ -	$ 25,411

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Other
22	7D	DEP EXP - EQUIPMENT ADMIN & GENERAL			$ 110
22	7D	DEP EXP - EQUIPMENT HHC FOOD & NUTRITION			$ 230
22	7D	DEP EXP - EQUIPMENT SYSTEM FEE GEN ALLOCATION			$ 18
22	7D	DEP EXP - EQUIPMENT LAUNDRY			$ 3
22	7D	DEP EXP - EQUIPMENT FACILITIES DEV SAFETY			$ 10
22	7D	DEP EXP - EQUIPMENT NURSING SERVICE OFFICE			$ 39
22	7D	DEP EXP - EQUIPMENT NURSING RN ADMIN			$ 765
22	7D	DEP EXP - EQUIPMENT NURSING RN DIRECT CARE			$ 12
22	7D	DEP EXP - EQUIPMENT SOCIAL WORK			$ 2
22	7D	DEP EXP - EQUIPMENT RECREATIONAL THERAPY			$ 2
22	7D	DEP EXP - EQUIPMENT CENTER FOR HEALTHY AGING			$ 3,637
22	7D	DEP EXP - EQUIPMENT ENVIRONMENTAL SERVICES GENERAL			$ 28
22	7D	DEP EXP - EQUIPMENT OPERATION OF PLANT			$ 1,408
22	7D	DEP EXP - EQUIPMENT REHAB GENERAL	$ 394		$ 8
22	7D	DEP EXP - CAP LEASE EQUIP ENVIRONMENTAL SERVICES GEN			$ 11
Total Excess Movable Equipment Depreciation			$ 394	$ -	$ 6,283

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
22	6A	MAINT & REPAIR BUILDING OPERATION OF PLANT			$ 2,034
22	6A	CLEANING & MAINT SUPPLIES OPERATION OF PLANT			$ 430
22	6A	CONTRACT LABOR - NON CLINICAL CENTER FOR HEALTHY AGING			$ 180
22	6A	MAINT & REPAIR - EQUIPMENT OPERATION OF PLANT			$ 2,536
22	6A	MAINT & REPAIR - AUTO/LOGISTIC GOOD LIFE FITNESS			$ 25
22	6A	MAINT & REPAIR - EQUIPMENT CENTER FOR HEALTHY AGING			$ 128
22	6A	MINOR EQUIPMENT AND FURNISHING OPERATION OF PLANT			$ 387
22	6B	NATURAL GAS/PROPANE/THERMAL OPERATION OF PLANT			$ 1,064
22	6C	ELECTRIC OPERATION OF PLANT			$ 2,407
22	6D	WATER OPERATION OF PLANT			$ 2,092
22	6E	LEASED - CLINICAL EQUIPMENT REHAB	$ 7,103		$ 587
22	6E	LEASED - OFFICE EQUIPMENT CENTER FOR HEALTHY AGING			$ 941
22	6F	MAINTENANCE - GROUNDS/LANDSCAPING OPERATION OF PLANT			$ 818

22	6F	WASTE REMOVAL OPERATION OF PLANT			$ 1,361
22	6F	STORAGE RENT/LEASE OPERATION OF PLANT			$ 172
22	6F	PURCHASED SERVICES - AFFILIATE OPERATION OF PLANT			$ 70
22	6F	OTHER NON-BILLABLE MED/SURG OPERATION OF PLANT			$ 249
22	7A	DEP EXP - LAND IMPROVEMENTS OPERATION OF PLANT			$ 162
Total Other Property Adjustments			$ 7,103	$ -	$ 15,643

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
30	IV8	MISC OTHER OPERATING INCOME GRANT ADMIN			$ 169,219
30	IV8	MISC OTHER OPERATING INCOME ADMIN AND GENERAL			$ 1,555
30	IV8	MISC OTHER OPERATING INCOME FINANCE ADMIN	$ 6,959,694		
30	IV8	MISC OTHR OPERATING INCOME EMERGENCY MANAGEMENT	$ 702,534		
30	IV8	MISC OTHER OPERATING INCOME CENTER FOR HEALTHY AGING			$ 1,600
30	IV8	INCOME FROM RESTRICTED FUNDS FUND DEPT	$ 17,330		
30	IV8	INVESTMENT INC - FUNDS HELD IN TRUST FINANCE ACCRUALS	$ 1,663,601		
30	IV8	INVESTMENT INCOME FUND DEPT			$ (6,959,391)
30	IV8	DIVIDEND INCOME FINANCE CORP TREASURY	$ 12,671		
30	IV8	RESTRICTED FUNDS - SNF SELF PAY FUND DEPT	$ (93,688)		
30	IV8	FREE BED INCOME	$ 96,567		
30	IV8	EQUIPMENT RENTAL	$ (463)		
Total Other Adjustments			$ 9,358,246	$ -	$ (6,787,017)

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
Total Other Adjustments			$ -	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
22	7B	DEP EXP - BUILDING ADMIN & GENERAL			$ 5,645
22	7B	DEP EXP - BUILDING OPERATION OF PLANT			$ 515
22	7C	DEP EXP - NON MOVABLE EQUIPMENT			$ 132
Total Unallowable Building Interest			$ -	$ -	$ 6,292

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	30	37

Item		Total	CCNH	RHNS	Other
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	10,444,518	10,444,518		
b. Medicaid Room and Board Contractual Allowance **	$	(5,005,716)	(5,005,716)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,103,814	2,103,814		
b. Medicare Room and Board Contractual Allowance **	$	524,320	524,320		
4. a. Private-Pay Residents and Other	$	4,861,628	4,861,628		
b. Private-Pay Room and Board Contractual Allowance **	$	250,773	250,773		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	136,210	136,210		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(136,210)	(136,210)		
c. Prescription Drugs - Non-Medicare	$	134,170	134,170		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(134,170)	(134,170)		
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	$	481,080	436,985		44,095
b. Physical Therapy - Medicare Contractual Allowance **	$	(391,873)	(385,731)		(6,142)
c. Physical Therapy - Non-Medicare	$	399,684	380,293		19,391
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(291,050)	(289,199)		(1,851)
4. a. Speech Therapy - Medicare	$	45,287	45,031		256
b. Speech Therapy - Medicare Contractual Allowance **	$	(26,517)	(26,517)		
c. Speech Therapy - Non-Medicare	$	51,525	51,525		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(33,135)	(33,135)		
5. a. Occupational Therapy - Medicare	$	418,649	410,126		8,523
b. Occupational Therapy - Medicare Contractual Allowance **	$	(361,303)	(359,908)		(1,395)
c. Occupational Therapy - Non-Medicare	$	373,038	372,660		378
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(303,456)	(303,441)		(15)
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	285,802	848		284,954
III. *Total Resident Revenue* (Section I. thru Section II.)	$	13,827,068	13,478,874		348,194
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	9,985			9,985
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	7,482,107	7,482,107		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	2,571,229	9,358,246		(6,787,017)
V. Total Other Revenue (1 thru 8)	$	10,063,321	16,840,353		(6,777,032)
VI. Total All Revenue (III +V)	$	23,890,389	30,319,227		(6,428,838)

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	Other
30 II6a	IP LAB SERVICES MEDICARE ANCILLARY SRV	$ 35,484		
30 II6a	IP RADIOLOGY SERVICES MEDICARE ANCILLARY SRV	$ 7,733		
30 II6a	IP LAB SERVICES PROF CA MEDICARE ANCILLARY SRV	$ (35,484)		
30 II6a	IP RADIOLOGY SERV PROF CA MEDICARE ANCILLARY SRV	$ (7,733)		
30 II6a	IP OXYGEN PROF CA MEDICARE ANCILLARY SRV	$ (4,565)		
30 II6a	IP OTHER SERVICES MEDICARE ANCILLARY SRV	$ 4,565		
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Other
30 II 6b	IP LAB SERVICES MGD MEDICARE ANCILLARY SRV	$ 24,696		
30 II 6b	IP LAB SERVICES MEDICAID ANCILLARY SRV	$ 464		
30 II 6b	IP LAB SERVICES OTHER MANAGED CARE ANCILLARY SRV	$ 1,494		
30 II 6b	IP LAB SERVICES SELF PAY ANCILLARY SRV	$ 198		
30 II 6b	IP OTHER SERVICES MGD MEDICARE ANCILLARY SRV	$ 4,129		
30 II 6b	IP OTHER SERVICES MEDICAID ANCILLARY SRV	$ 6,867		
30 II 6b	IP OTHER SERVICES OTHER MANAGED CARE ANCILLARY SRV	$ 346		
30 II 6b	IP OTHER SERVICES SELF PAY ANCILLARY SRV	$ 149		
30 II 6b	IP RADIOLOGY SERVICES MANAGED MEDICARE ANCILLARY SRV	$ 3,835		
30 II 6b	IP RADIOLOGY SERVICES MEDICAID ANCILLARY SRV	$ 74		
30 II 6b	IP RADIOLOGY SERVICES OTHER MANAGED CARE	$ 150		
30 II 6b	OP OTHER SERVICES SELF PAY CENTER FOR HEALTHY AGING			$ 236,781
30 II 6b	OP OTHER SERVICES SELF PAY GOOD LIFE FITNESS			$ 48,173
30 II 6b	IP LAB SERVICES PROF CA MANAGED MEDICARE ANCILLARY SRV	$ (24,696)		
30 II 6b	IP LAB SERVICES PROF CA MEDICAID ANCILLARY SRV	$ (464)		
30 II 6b	IP LAB SERVICES PROF CA OTHER MANAGED CARE ANCILLARY SRV	$ (1,494)		
30 II 6b	IP RADIOLOGY SERV PROF CA MANAGED MEDICARE ANCILLARY SRV	$ (3,835)		
30 II 6b	IP RADIOLOGY SERV PROF CA MEDICAID ANCILLARY SRV	$ (74)		
30 II 6b	IP RADIOLOGY SERV PROF CA OTHER MANAGED CARE ANCILLARY SRV	$ (150)		
30 II 6b	IP OXYGEN PROF CA MANAGED MEDICARE ANCILLARY SRV	$ (4,129)		
30 II 6b	IP OXYGEN PROF CA MEDICAID B ANCILLARY SRV	$ (6,867)		
30 II 6b	IP OXYGEN PROF CA OTHER MANAGED CARE B ANCILLARY SRV	$ (39)		
30 II 6b	IP OXYGEN PROF CA SELF PAY ANCILLARY SRV	$ (31)		
30 II 6b	IP RADIOLOGY SERVICES OTHER MANAGED CARE	$ 225		
Total Other Resident Revenue		$ 848	$ -	$ 284,954

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	Other
30 IV5	INVESTMENT INC - ENDOWMENT LLC FUND DEPT		$ 7,482,107		
Total Interest Income			$ 7,482,107	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Other
30 IV8	MISC OTHER OPERATING INCOME ADMIN AND GENERAL			$ 1,555
30 IV8	MISC OTHER OPERATING INCOME GRANT ADMIN			$ 169,219
30 IV8	MISC OTHER OPERATING INCOME FINANCE ADMIN	$ 6,959,694		
30 IV8	MISC OTHER OPERATING INCOME EMERGENCY MANAGEMENT	$ 702,534		
30 IV8	MISC OTHER OPERATING INCOME CENTER FOR HEALTHY AGING			$ 1,600
30 IV8	INCOME FROM RESTRICTED FUNDS FUND DEPT	$ 17,330		
30 IV8	INVESTMENT INC - FUNDS HELD IN TRUST FINANCE ACCRUALS	$ 1,663,601		
30 IV8	INVESTMENT INCOME FUND DEPT			$ (6,959,391)
30 IV8	DIVIDEND INCOME FINANCE CORP TREASURY	$ 12,671		
30 IV8	RESTRICTED FUNDS - SNF SELF PAY FUND DEPT	$ (93,688)		
30 IV8	FREE BED INCOME	$ 96,567		
30 IV8	EQUIPMENT RENTAL	$ (463)		
Total Other Revenue		$ 9,358,246	$ -	$ (6,787,017)

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 1,017,940
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 889,831
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 79,947
a.				
b.				
c.				
d. See Schedule		79,947		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (2,226,568)
See Schedule		(2,226,568)		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ (238,850)
B. Fixed Assets				
1. Land				$ 262,536
2. Land Improvements	*Historical Cost	98,834		$ 82,128
	Accum. Depreciation	16,706	Net	
3. Buildings	*Historical Cost	8,193,508		$ 1,719,949
	Accum. Depreciation	6,473,559	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	1,460,649		$ 27,945
	Accum. Depreciation	1,432,704	Net	
6. Movable Equipment	*Historical Cost	2,456,861		$ 503,678
	Accum. Depreciation	1,953,183	Net	
7. Motor Vehicles	*Historical Cost	145,687		$ 60,089
	Accum. Depreciation	85,598	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 978,847
See Schedule		978,847		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 3,635,172

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	LEADING AGE CT	$ 2,640
31	A5	JOHNSON CONTROLS	$ 12,330
31	A5	OTIS ELEVATOR	$ 741
31	A5	PRIME SELF STORAGE	$ 6,216
31	A5	MORRISON MANAGEMENT	$ 41,010
31	A5	CROTHALL HEALTH CARE INC	$ 17,010
Total Prepaid Expenses			$ 79,947

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

Page Ref	Line Ref	Description	
31	A8	DUE AFFILIATE GENERAL CONTROL	$ 986,598
31	A8	DUE AFFILIATE ACCOUNTS PAYABLE CONTROL	$ (86,615)
31	A8	DUE AFFILIATE PAYROLL CONTROL	$ (3,738,163)
31	A8	DUE AFFILIATE SYSTEM ALLOCATION CONTROL	$ 647,904
31	A8	DUE AFFILIATE INVENTORY CONTROL	$ (36,292)
Total Other Current Assets (Itemize)			$ (2,226,568)

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

Page Ref	Line Ref	Description	
31	B9	CAPITAL IN PROCESS	$ 978,847
Total Other Other Fixed Assets (Itemize)			$ 978,847

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	INVESTMENT IN ENDOWMENT LLC	$ 116,362,687
32	D7	TEMPORARY RESTRICTED CASH	$ 216,095
32	D7	INVESTMENT IN ENDOWMENT LLC TEMP	$ 4,721,957
32	D7	INVESTMENT IN ENDOWMENT LLC PERM	$ 2,538,722
32	D7	ASSETS HELD IN TRUST B OTHERS	$ 36,519,144
Total Other Assets			$ 160,358,605

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description	
33	A12	DEFERRED REVENUES	$ 1,048,997
33	A12	DEFERRED MISC INCOME	$ 7,269
33	A12	ACCRUED STATE PROVIDER TAX	$ 139,299
33	A12	ER ACCRUAL PENSION TRANSITION	$ 50,867
33	A12	ER 401K CORE	$ 152,378
33	A12	ER 401K MATCH TRUE UP	$ 5,039
33	A12	ER 401K MATCH STATIC ACCRUAL	$ 23,171
33	A12	RETIREMENT FORFEITURES	$ (4,249)
33	A12	RESIDENT CASH LIABILITY	$ 21,247
33	A12	DEFER STATE TAX LIABILITY CURRENT	$ 334
33	A12	ACCRUED EXPENSES	$ 176
33	A12	EE WH FLEX SPENDING FSA	$ (3,531)
Total Other Current Liabilities (Itemize)			$ 1,440,997

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	32	37

Account				Amount
			Total Brought Forward:	$ 3,396,322
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 160,358,605
See Schedule		160,358,605		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 160,358,605
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 163,754,927

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 275,332
2. Notes Payable (*itemize*)	$
See Schedule	
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)	$ 862,623
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$
7. Medicare Final Settlement Payable	$ 745
8. Medicare Current Financing Payable	$
9. Mortgage Payable (*Current Portion*)	$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)	$
11. Accrued Income Taxes*	$ 122
12. Other Current Liabilities (*itemize*)	$ 1,440,997
See Schedule 1,440,997	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 2,579,819

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	34	37

Account	Amount
Total Brought Forward:	2,579,819
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$ 5,622
See Schedule 5,622	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 5,622
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 2,585,441

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson Hous	993-C	9/30/2020	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$ 158,422,332
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$
	6. Gain or Loss for Period 10/1/2019 thru 9/30/2020	$ 2,747,154
	7. Total Net Worth	$ 161,169,486
C.	***Total Reserves and Net Worth***	$ 161,169,486
D.	***Total Liabilities, Reserves, and Net Worth***	$ 163,754,927

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2019			$ 157,501,056
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 23,890,389
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 21,143,235
D.	Net Income or Deficit			$ 2,747,154
E.	Balance			$ 160,248,210
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
	TR Contributions & TR Investment Held by End		2,015,380	
	TR Investment Income		(1,793,862)	
	TR NA Released & TR Other		(24,210)	
	PR Unrealized Gain on Funds Held in Trust		723,968	
F-3.	Total Additions			$ 921,276
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/20		$ 161,169,486

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2020	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Dorothy Robinson

Addres Address	Phone Number
HHC Senior Services 80 Meriden Ave, Southington, CT 06489	203-623-2930

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Dorothy Robinson	203-623-2930

Contact Email Address
Dorothy.Robinson@hhchealth.org