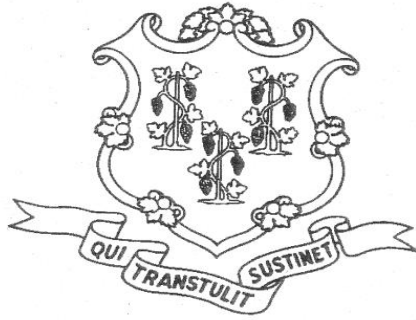


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2023

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 <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> Other <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 993-C	Other	(Specify)	Medicare Provider 07-5293
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Medicaid Provider Numbers:	CCNH / RHNS	Other	(Specify)
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General Information

Name of Facility (as licensed) Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2023	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Hartford Hospital d/b/a Jefferson House [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, 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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State of Connecticut
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 10/1/2022	To 9/30/2023
Address of Facility 1 John H. Stewart Drive, Newington, CT 06111				
Report Prepared By Dorothy Robinson		Phone Number 203-623-2930	Date	
Item	Total	CCNH / RHNS	Other	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-667- 4453		Report for Year Ended 9/30/2023	Page 2	of 37
Name of Facility (as shown on license) Hartford Hospital d/b/a Jefferson House		Address (No. & Street, City, State, Zip) 1 John H. Stewart Drive, Newington, CT 06111		
License Numbers:	CCNH / RHNS 993-C	Other	(Specify)	Medicare Provider No. 07-5293
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> Other <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box) <input type="checkbox"/> Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> Partnership <input type="checkbox"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="checkbox"/> Government <input type="checkbox"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Susan Vinal		Nursing Home Administrator's License No.:	001692	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

**General Information and Questionnaire
 Related Parties***

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2023	Page 4	of 37
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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.		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.
 ** Provide the percentage amount of revenue received from non-related parties.

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2023	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

General Information and Questionnaire
Other Lines of Business

Name of Facility Hartford Hospital d/b/a Jefferson Hou	License No. 993-C	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility.		75,869		
Outpatient Therapy				
Does the Facility provide outpatient therapy services?		Yes		
<i>If yes, please complete the following:</i>				
1,226		Square footage of therapy space.		
Meals on Wheels				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
		Square footage of kitchen		
		Number of meals served per week		
No		Are meals included in meals served on page 18 of the Annual Report?		
No		Are direct costs included in the Annual Report?		
<i>If yes, please state where costs are reported.</i>				
No		Are drivers for the program included in the facility's payroll?		
<i>If yes, please complete the following:</i>				
		Amount Reported		
		Annual Report page and line		
Please state the salary amounts of specific cooks and/or dietary aides				
Please state where the cooks and/or dietary aides are reported in the Annual Report				
Apartments, Independent Living, Assisted Living				
Does the facility have apartments, independent living, and/or assisted living?		No		
<i>If yes, please complete the following:</i>				
		Square footage of apartments		
		Square footage of independent living		
		Square footage of assisted living		
		Please identify the services provided:		

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility Hartford Hospital d/b/	License No. 993-C	Report for Year Ended 9/30/2023	Page 7	of 37
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Child Day Care

Does the Facility provide Child Day Care? No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care? No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

Schedule of Resident Statistics

Name of Facility Hartford Hospital d/b/a Jefferson House			License No. 993-C		Report for Year Ended 9/30/2023				Page 8	of 37			
	Total All Levels	Total CCNH / RHNS Level	Total	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH / RHNS	Other	(Specify)	Total	CCNH / RHNS	Other	(Specify)	
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	99	99			99	99							
B. As of midnight of THIS report period	97	97							97	97			
3. Total Number of Days Care Provided During Period													
A. Medicare	4,735	4,735			3,848	3,848			887	887			
B. Medicaid (Conn.)	19,767	19,767			14,682	14,682			5,085	5,085			
C. Medicaid (other states)													
D. Private Pay	8,005	8,005			5,715	5,715			2,290	2,290			
E. State SSI for RCH													
F. Other (Specify) Mgd Care, WC, Mgd Medicare	3,597	3,597			2,647	2,647			950	950			
G. Total Care Days During Period (3A thru F)	36,104	36,104			26,892	26,892			9,212	9,212			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	54	54			27	27			27	27			
B. Other Bed Reserve Days	184	184			154	154			30	30			
5. Total Resident Days (3G + 4A + 4B)	36,342	36,342			27,073	27,073			9,269	9,269			

Schedule of Resident Statistics (Cont'd)

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2023	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No
 If "YES", provide the following information:

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

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

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

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

Item	Medicare		Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS		CCNH / RHNS	Other	CCNH / RHNS	Other	(Specify)	R.C.H.	ICF-MR
No. of Residents	5	58	34						
Per Diem Rate									
a. One bed rm.	PDPM	320.00	565.00						
b. Two bed rms.			530.00						
c. Three or more bed rms.									

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	Other	Outpatient	(Specify)
A. Medicare - Part B	3,297	2,073		1,224	
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments	13	13			
C. Other	18,582	17,101		1,481	
D. Total Physical Therapy Treatments	21,892	19,187		2,705	
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	186	171		15	
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments	5	5			
C. Other	1,204	1,204			
D. Total Speech Therapy Treatments	1,395	1,380		15	
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	1,125	1,125			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments	27	27			
C. Other	17,079	17,079			
D. Total Occupational Therapy Treatments	18,231	18,231			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2023	Page 10	of 37
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Are time records maintained by all individuals receiving compensation? Yes No

Item	Total Cost and Hours								
	CCNH / RHNS	Adjustment	Hours	Other	Adjustment	Hours	(Specify)	Adjustment	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)	155,778		2,086						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	405,488		15,533						
5. Dietary Service									
a. Head Dietitian	93,787		2,655						
b. Food Service Supervisor									
c. Dietary Workers	602,375		31,469						
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers	283,096		15,526	4,650	(4,650)	255			
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	86,570		2,052	1,422	(1,422)	34			
b. Other Maintenance Workers	87,154		4,804	1,431	(1,431)	79			
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	235,922		4,171						
b. RN									
1. Direct Care	2,507,868		52,501						
2. Administrative**	528,558		11,246						
c. LPN									
1. Direct Care	578,066		14,942						
2. Administrative**	2,826		80						
d. Aides and Attendants	2,593,699		114,772						
e. Physical Therapists	11,492	(11,492)	183	1,620	(1,620)	26			
f. Speech Therapists									
g. Occupational Therapists									
h. Recreation Workers	179,639		5,850						
i. Physicians									
1. Medical Director									
2. Utilization Review									
3. Resident Care***									
4. Other (Specify)									
j. Dentists									
k. Pharmacists	133,301		1,856						
l. Podiatrists									
m. Social Workers/Case Management	281,727		5,912						
n. Marketing									
o. Other (Specify) See Attached Schedule	235,291		3,662	2,360,300	(2,360,300)	65,105			
A-13. Total Salary Expenditures	9,002,637	(11,492)	289,300	2,369,423	(2,369,423)	65,499			

* 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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH / RHNS			Other			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
SALARY AND WAGES COMMUNITY NETWORK ADMIN				\$ 126,176	\$ (126,176)	928			
SALARY AND WAGES CENTER FOR HEALTHY AGING				\$ 1,672,368	\$ (1,672,368)	46,478			
SALARY AND WAGES GOOD LIFE FITNESS				\$ 307,832	\$ (307,832)	12,048			
PTO ACCRUAL - FRINGE BENEFITS DEPT	\$ 39,883		125						
SALARY RECLASS GRANT ADMIN				\$ 253,924	\$ (253,924)	5,651			
SALARY AND WAGES HEALTH INFO MGMT	\$ 36,929		1,231						
SALARY RECLASS EMPLOYEE HEALTH	\$ 13,719		828						
SYSTEM FEE DIRECT PYRL SYS FEE GEN ALLOCATION	\$ 144,760		1,478						
Total	\$ 235,291	\$ -	3,662	\$ 2,360,300	\$ (2,360,300)	65,105	\$ -	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH / RHNS			Other			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
Total	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-

**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	
Hartford Hospital d/b/a Jefferson House				993-C	9/30/2023			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	Other	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Hartford Hospital d/b/a Jefferson House				993-C	9/30/2023			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	Other	(Specify)							
Section III - Administrators***										
Susan Vinal	155,778			Non-discriminatory except for bonus	Administrator - Management of Facility	2,086				
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.

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	9/30/2023						13	37
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	Other	Adjustment	Hours	(Specify)	Adjustment	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	10,354	(10,354)	49						
3. Pharmacist	19,913		472						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	436,403	(436,403)	8,442	61,525	(61,525)	1,190			
b. Other									
6. Social Worker									
7. Recreation Worker	4,060		23						
8. Physicians									
a. Medical Director (entire facility)	48,600		324						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**	21,496	(21,496)	144						
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	226,049	(226,049)	3,263	2,457	(2,457)	35			
b. Other									
10. Occupational Therapist									
a. Resident Care	434,478	(434,478)	7,994						
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	72,856		995						
2. Administrative***									
b. LPN									
1. Direct Care	170,799		3,150						
2. Administrative***									
c. Aides	730,697		10,273						
d. Other									
12. Other (Specify) See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	2,175,705	(1,128,780)	35,129	63,982	(63,982)	1,225			

* 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 in the Adjustment column.

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

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

Name of Facility Hartford Hospital d/b/a Jefferson House		License No. 993-C		Report for Year Ended 9/30/2023	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Healthdrive Dental	Dental Services	<input type="radio"/>	<input checked="" type="radio"/>			
HartfordHealthcare Rehab Network	Therapy - disallowed	<input checked="" type="radio"/>	<input type="radio"/>			
Square Liberty Comedy Corp	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
John W. Banker	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
Joh J Brighenti	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
People Plant Connection	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
Robert Dean Devitt	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
Mary Morse	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
Tom Stankus	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
Country Quilt Llama Farm LLC	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
Diana Sheard	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
John Paolillo	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
Star Hill Farm	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
Richard Rothstein	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
Ross Tucker	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
Thirzah Bendokas	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
Tom Alvord	Recreation	<input type="radio"/>	<input checked="" type="radio"/>			
HartfordHealthcare Medical Group	Medical Director	<input checked="" type="radio"/>	<input type="radio"/>			
Starling Physicians	Pulmonary Medicine - disallowed	<input type="radio"/>	<input checked="" type="radio"/>			
Origin Incorporated	Agency Labor - RNs and CNAs	<input type="radio"/>	<input checked="" type="radio"/>			
Nurse Network	LPNs	<input type="radio"/>	<input checked="" type="radio"/>			
Independence at Home Alaya Care	CNAs	<input checked="" type="radio"/>	<input type="radio"/>			

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended					Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2023					15	37
Item	Total	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment	
I. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 262,735	262,735		69,150	(69,150)			
2. Disability Insurance	\$							
3. Unemployment Insurance	\$							
4. Social Security (F.I.C.A.)	\$ 645,138	645,138		169,795	(169,795)			
5. Health Insurance	\$ 1,251,112	1,251,112		394,034	(394,034)			
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 542,680	542,680		142,829	(142,829)			
8. Uniform Allowance	\$			400	(400)			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 11,393	28,548	(17,155)	111,775	(111,775)			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$							
c. Bad Debts*	\$	568,670	(568,670)					
d. Accounting and Auditing	\$							
e. Legal (<i>Services should be fully described on Page 15b</i>)	\$							
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$							
g. Office Supplies	\$ 19,292	19,292		7,710	(7,710)			
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$							
2. Cellular Phones	\$ 2,800	3,552	(752)	6,768	(6,768)			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$							
j. Corporation Business Taxes (<i>franchise tax</i>)	\$							
k. Other Taxes (<i>Not related to property - See Page 22</i>)								
1. Income*	\$							
2. Other (<i>Specify</i>) See Attached Schedule	\$							
3. Resident Day User Fee	\$ 591,799	591,799						
Subtotal	\$ 3,326,949	3,913,526	(586,577)	902,461	(902,461)			

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment
BACKGROUND VERIFICATIONS ADMIN & GENERAL	\$ 11,362		\$ 2,991	\$ (2,991)		
BACKGROUND VERIFICATIONS EMPLOYEE HEALTH			\$ 8,988	\$ (8,988)		
BACKGROUND VERIFICATIONS HR TALENT ACQUISITION			\$ 440	\$ (440)		
EMPLOYEE WELLNESS ADMIN AND GENERAL	\$ 31		\$ 8	\$ (8)		
HSA ER CONTRIBUTION			\$ 88,833	\$ (88,833)		
STUDENT DEBT CONTRIBUTION EXP FRINGE BENEFITS	\$ 4,502	\$ (4,502)	\$ 1,185	\$ (1,185)		
TUITION ASSISTANCE ADMIN AND GENERAL	\$ 2,681	\$ (2,681)	\$ 705	\$ (705)		
TUITION ASSISTANCE NURSING RN DIRECT CARE	\$ 4,714	\$ (4,714)	\$ 1,241	\$ (1,241)		
TUITION ASSISTANCE NURSING LPN ADMINISTRATIVE	\$ 5,258	\$ (5,258)	\$ 1,384	\$ (1,384)		
TUITION ASSISTANCE CENTER FOR HEALTHY AGING			\$ 6,000	\$ (6,000)		
Total	\$ 28,548	\$ (17,155)	\$ 111,775	\$ (111,775)	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

General Information and Questionnaire
Accounting Basis

Name of Facility Hartford Hospital d/b/a Jefferson H	License No. 993-C	Report for Year Ended 9/30/2023	Page 15b	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual Cash Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1 Audit Fees - part of Hartford Hospital's audit and paid 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

Legal Services Information

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

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1 Jefferson House's legal fees are included in Hartford HealthCare 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

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	9/30/2023					16	37
Item	Total	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment	
Subtotals Brought Forward:	3,326,949	3,913,526	(586,577)	902,461	(902,461)			
l. Travel and Entertainment								
1. Resident Travel and Entertainment	\$ 968	968						
2. Holiday Parties for Staff	\$ 3,126	3,126						
3. Gifts to Staff and Residents	\$ 6,719	8,467	(1,748)	643	(643)			
4. Employee Travel	\$ 6,408	6,408		38,364	(38,364)			
5. Education Expenses Related to Seminars and Conventions	\$ 3,299	3,299		2,933	(2,933)			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 10,327	10,327						
7. Other (<i>Specify</i>) See Attached Schedule	\$							
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (<i>all such expenses</i>)	\$							
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$							
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$			64,456	(64,456)			
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	\$ 5,809	5,809		1,121	(1,121)			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 18,898	18,898		3,485	(3,485)			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$							
9. Subscriptions	\$ 1,696	1,696						
10. Contributions*** See Attached Schedule	\$			28,000	(28,000)			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 15,248	38,708	(23,460)					
12. Administrative Management Services**	\$	1,435,523	(1,435,523)	80,059	(80,059)			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 5,879	5,963	(84)	508,833	(508,833)			
C-14 Total Administrative & General Expenditures	\$ 3,405,326	5,452,718	(2,047,392)	1,630,355	(1,630,355)			

* 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 in the Adjustment column.

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment
ADVERTISING- MARKETING & ADVERTISING			\$ 2,744	\$ (2,744)		
PROMOTIONAL EVENTS CENTER FOR HEALTHY AGING			\$ 30	\$ (30)		
ADVERTISING - CENTER FOR HEALTHY AGING			\$ 60,826	\$ (60,826)		
PRINTING/PRINT SHOP MARKETING & ADVERTISING			\$ 856	\$ (856)		
Total Other Advertising	\$ -	\$ -	\$ 64,456	\$ (64,456)	\$ -	\$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment
LEADING AGE DUES	\$ 17,000					
CAHCF	\$ 87					
HARTFORD HOSPITAL - DR. ROBBINS LICENSE RENEWAL	\$ 80					
CLIA	\$ 180					
CT DEA LICENSE	\$ 40					
DEA LICENSE	\$ 888					
FOOD SERVICE LICENSE	\$ 213					
IN SECOND WIND DREAMS - MEMBERSHIP VIRTUAL DEMENTIA TOUR FACILITATOR			\$ 400	\$ (400)		
LEADING AGE ACADEMY TUITION			\$ 3,000	\$ (3,000)		
QPR RECERTIFICATION - MICHELLE LAVOIE			\$ 85	\$ (85)		
LTC IP INITIAL CERT EXAM - KRISTEN PARENTEAU	\$ 410					
Total Dues	\$ 18,898	\$ -	\$ 3,485	\$ (3,485)	\$ -	\$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment
TOWN OF NEWINGTON			\$ 28,000	\$ (28,000)		
Total Contributions	\$ -	\$ -	\$ 28,000	\$ (28,000)	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment
MERCHANT FEES			\$ 10,425	\$ (10,425)		
CASH DISCOUNTS ACCOUNTING GENERAL	\$ (121)					
STORAGE RENT/LEASE HEALTH INFO MGMT	\$ 5,204					
STORAGE RENT/LEASE ADMIN & GENERAL	\$ 2,811					
RECORD STORAGE AND DESTRUCTION HEALTH INFO MGMT	\$ 243					
Reclass FY22 extra reversal of Nurse Network invoices never booked from pg13	\$ (2,258)					
NON-OPERATING BANK FEES FUND DEPT			\$ 79,826	\$ (79,826)		
SPONSORSHIPS FUND DEPARTMENT			\$ 368,902	\$ (368,902)		
INTERNAL SPONSOR EXP AFFILIATE FUND DEPT			\$ 49,500	\$ (49,500)		
INTERNAL SPONSOR EXP AFFILIATE GRANT ADMIN			\$ 20,759	\$ (20,759)		
SPONSORSHIPS GRANT ADMINISTRATION			\$ (20,759)	\$ 20,759		
OTHER NON-OPERATING EXPENSE FUND DEPT			\$ 38	\$ (38)		
OTHER FEES HR TALENT ACQUISITION			\$ 122	\$ (122)		
LATE FEES OPERATION OF PLANT			\$ 20	\$ (20)		
PATIENT/RESIDENT RELATIONS ADMIN & GENERAL	\$ 84	\$ (84)				
Total Other Administrative and General	\$ 5,963	\$ (84)	\$ 508,833	\$ (508,833)	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2023	17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Hartford HealthCare & Hartford HealthCare Senior Services	1,515,582	Contracting and Management	p 16 1m12
Morrison Community Living	751,408	Dietary Staff Management, Support, Food Purchase, Quantity Discount	p 18 2a1,2a2, 2a3,& 2b
Crothall Healthcare	109,533	Environmental Services Staff Management, Support, Supplies Purchase, Quantity Discount	p 20 4a1 & 4b

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
Hartford Hospital d/b/a Jefferson House		993-C	9/30/2023			18	37
Item	Total	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment
2. Dietary							
a. In-House Preparation & Service							
1. Raw Food	\$ 396,688	396,688					
2. Non-Food Supplies	\$ 113,071	113,071		11,003	(11,003)		
3. Other (Specify) _____	\$	1,058	(1,058)	22,221	(22,221)		
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)	\$ 202,033	202,033					
c. Other (Specify) _____	\$						
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 711,792	712,850	(1,058)	33,224	(33,224)		
2E. Dietary Questionnaire		Total	CCNH / RHNS		Other	(Specify)	
F. Resident Meals: Total no. of meals served per day:*	297	297					
G. Is cost of employee meals included in 2D?	<input checked="" type="radio"/> Yes	<input type="radio"/> No					
H. Did you receive revenue from employees?	<input checked="" type="radio"/> Yes	<input type="radio"/> No		If yes, specify amt.	included below		
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				30 IV 1			
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input checked="" type="radio"/> Yes	<input type="radio"/> No		If yes, specify cost.			
K. Is any revenue collected from these people?	<input checked="" type="radio"/> Yes	<input type="radio"/> No		If yes, specify amt.	8374		
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				30 IV 1			
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input checked="" type="radio"/> Yes	<input type="radio"/> No		If yes, specify cost.			
N. Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify amt.			
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)							

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

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

Name of Facility		License No.	Report for Year Ended				Page	of
Hartford Hospital d/b/a Jefferson House		993-C	9/30/2023				19	37
Item		Total	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment
3. Laundry								
a. In-House Processing*		Lbs.						
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$						
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.						
		Amt. \$						
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.						
		Amt. \$						
4. Repair and/or purchase of linens.***		Lbs.						
		Amt. \$						
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	246,466	246,466		54	(54)	
c. Other (Specify)		\$						
3D. Total Laundry Expenditures (3a + b + c)		\$	246,466	246,466		54	(54)	
3E. Laundry Questionnaire								
F. Is cost of employee laundry included in 3D?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		If yes, specify cost.		
G. Did you receive revenue from employees?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report? (Page/Line Item)								
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		If yes, specify cost.		
J. Did you receive revenue from these people?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		If yes, specify amt.		
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.

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	9/30/2023				20	37
Item		Total	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment
4.	Housekeeping		75,869	74,643		1,226		
a.	In-House Care	Sq. Ft. Serviced by Personnel						
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	48,815	48,815		802	(802)	
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel	75,869	74,643		1,226		
		Amt. \$	70,095	70,095		1,151	(1,151)	
	C. Other (<i>Specify</i>)	\$						
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	118,910	118,910		1,953	(1,953)	
5.	Resident Care (Supplies)**							
a.	Prescription Drugs***							
	1. Own Pharmacy	\$						
	2. Purchased from Omnicare of CT	\$		305,625	(305,625)			
b.	Medicine Cabinet Drugs	\$	40,244	40,244				
c.	Medical and Therapeutic Supplies	\$	471,884	513,161	(41,277)	2,840	(2,840)	
d.	Ambulance/Limousine***	\$		10,215	(10,215)			
e.	Oxygen							
	1. For Emergency Use	\$						
	2. Other***	\$		35,568	(35,568)			
f.	X-rays and Related Radiological Procedures***	\$		12,365	(12,365)			
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$						
h.	Laboratory***	\$		72,954	(72,954)			
i.	Recreation	\$	2,171	2,171				
j.	Direct Management Services*	\$						
k.	Indirect Management Services*	\$						
l.	Cable TV	\$	7,200	18,585	(11,385)			
m.	Other (Specify)**** See Attached Schedule	\$				20,054	(20,054)	
n.	Physical Therapy Expense	\$						
o.	Speech Therapy Expense	\$						
5P.	Total Resident Care Expenditures (5a - 5o)	\$	521,499	1,010,888	(489,389)	22,894	(22,894)	

* 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 in the Adjustment column.
 **** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment
PURCHASED SERVICE OUTSOURCE NURSING RN DIRECT CARE			\$ 4	\$ (4)		
PURCHASED SERVICE OUTSOURCE NURSING RN ADMINISTRATIVE			\$ 50	\$ (50)		
HHCRN PT Mgmt fees 690090-409050 and 611020-409510 from p 13 line B5			\$ 20,000	\$ (20,000)		
Total Other Resident Care	\$ -	\$ -	\$ 20,054	\$ (20,054)	\$ -	\$ -

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

Name of Facility Hartford Hospital d/b/a Jefferson House			License No. 993-C		Report for Year Ended 9/30/2023				Page of 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	(Specify)	Pg	Line
See attached.		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
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		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

* 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 Year Ended					Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2023					22	37
Item	Total	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment	
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$ 438,439	438,439		9,008	(9,008)			
b. Heat	\$ 46,254	46,254		760	(760)			
c. Light & Power	\$ 102,814	102,814		1,689	(1,689)			
d. Water	\$ 88,860	88,860		1,460	(1,460)			
e. Equipment Lease (<i>Provide detail on page 22b</i>)	\$ 10,016	17,536	(7,520)	3,097	(3,097)			
f. Other (<i>itemize</i>)	\$ 182,622	182,622		4,429	(4,429)			
See Attached Schedule								
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 869,005	876,525	(7,520)	20,443	(20,443)			
7. Depreciation (<i>complete schedule page 23*</i>)								
a. Land Improvements	\$ 8,163	8,163		134	(134)			
b. Building & Building Improvements	\$ 441,195	441,195		7,247	(7,247)			
c. Non-Movable Equipment	\$ 8,565	8,565		141	(141)			
d. Movable Equipment	\$ 115,920	115,920		5,931	(5,931)			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 573,843	573,843		13,453	(13,453)			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)								
a. Organization Expense	\$							
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$							
d. Other (<i>Specify</i>)	\$							
*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	\$			255	(255)			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 573,843	573,843		13,708	(13,708)			

* 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	Adjustment	Other	Adjustment	(Specify)	Adjustment
MAINTENANCE - GROUNDS/LANDSCAPING OPERATION OF PLANT	\$ 65,284		\$ 1,072	\$ (1,072)		
WASTE REMOVAL OPERATION OF PLANT	\$ 94,002		\$ 1,544	\$ (1,544)		
STORAGE RENT/LEASE OPERATION OF PLANT	\$ 18,533		\$ 304	\$ (304)		
PURCHASED SERVICES - AFFILIATE OPERATION OF PLANT (Biomed)	\$ 4,803		\$ 79	\$ (79)		
OVER ACCRUAL OF ACP LEASE - DISALLOWED			\$ 1,430	\$ (1,430)		
Total Other Repairs and Maintenance	\$ 182,622	\$ -	\$ 4,429	\$ (4,429)	\$ -	\$ -

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	
Hartford Hospital d/b/a Jefferson House		993-C	9/30/2023			22b	37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Wells Fargo Vendor Financial Services, LLC, PO Box 41564, Philadelphia, PA 19101-1564	<input type="radio"/>	<input checked="" type="radio"/>	Ricoh copier printer MP301SPF	1/1/18-1/1/23	60 months	370	370	
Wells Fargo Financial Services, PO Box 41564, Philadelphia, PA 19101-1564	<input type="radio"/>	<input checked="" type="radio"/>	Ricoh copier printers IM430F for Skytop (CHA disallowed)	12/1/19-11/30/24	60 months	411	411	
Wells Fargo Financial Services, PO Box 41564, Philadelphia, PA 19101-1564	<input type="radio"/>	<input checked="" type="radio"/>	Ricoh copier printers IM430F	12/10/19-12/9/24	60 months	432	432	
Wells Fargo Financial Services, PO Box 41564, Philadelphia, PA 19101-1564	<input type="radio"/>	<input checked="" type="radio"/>	Ricoh copier printers IM430F for Skytop (CHA disallowed)	3/9/20-3/8/25	60 months	411	411	
Accelerated Care Plus Leasing, Inc. 4999 Aircenter Circle Ste 103, Reno, NV 89502	<input type="radio"/>	<input checked="" type="radio"/>	Omni Versa Multi-Modality Therapy System, Transducer, Cart, Shortwave Diathermy	and 1/1/26-12/31/23	12 months	8,580	8,580	
Wells Fargo Financial Services, PO Box 41564, Philadelphia, PA 19101-1564	<input type="radio"/>	<input checked="" type="radio"/>	Ricoh Copier P501	7/1/23-8/1/28	60 months	123	20	
Wells Fargo Financial Services, PO Box 41564, Philadelphia, PA 19101-1564	<input type="radio"/>	<input checked="" type="radio"/>	Ricoh copier printers IM8000 (1), IMC4500 (2), MP4055 (1) & P8000 (4)	5/25/21-5/24/26	60 months	9,258	9,258	
Wells Fargo Financial Services, PO Box 41564, Philadelphia, PA 19101-1564	<input type="radio"/>	<input checked="" type="radio"/>	Printer for DR Computer	1/13/21-1/12/26	60 months	65	65	
Wells Fargo Financial Services, PO Box 41564, Philadelphia, PA 19101-1564	<input type="radio"/>	<input checked="" type="radio"/>	Ricoh copier printers IM550F	9/1/21-8/31/26	60 months	675	675	
Wells Fargo Financial Services, PO Box 41564, Philadelphia, PA 19101-1564	<input type="radio"/>	<input checked="" type="radio"/>	Ricoh copier printers IM430F B/W MFP CHA bridge (disallow)	8/28/20-8/27/25	60 months	411	411	
Is a Mileage Log Book Maintained for All Leased Vehicles ?						<input type="radio"/> Yes <input checked="" type="radio"/> No	Total ***	20,633

* 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.

Depreciation Schedule

Name of Facility Hartford Hospital d/b/a Jefferson House			License No. 993-C			Report for Year Ended 9/30/2023			Page 23	of 37			
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
A. Land Improvements													
1. Acquired prior to this report period			98,834		98,834	33,300		various	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			10,577,453		10,577,453	6,839,225		various	445,974				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			37,025		37,025			15 years	2,468				
B-4. Subtotal										448,442			
C. Non-Movable Equipment													
1. Acquired prior to this report period			1,110,166		1,110,166	1,086,953		various	7,319				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			51,285		51,285			various	1,387				
C-4. Subtotal										8,706			
		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	49,988		4 years		
c. 2019 E350 Van			x		2	2020	61,533	61,533	38,458		4 years	15,383	
d.													
2. Movable Equipment													
a. Acquired prior to this report period							2,302,837	2,302,837	1,958,998		various	103,684	
b. Disposals (attach schedule)							(3,533)		(3,533)				
Acquired during this report period (attach schedule):													
c. Administrative							28,639	28,639			various	2,531	
d. Standard Resident							5,051	5,051			10 years	253	
e. Specialized Resident													
Total Acquired during this report period							33,690	33,690				2,784	
D-3. Subtotal													121,851
E. Total Depreciation													587,296

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
11/30/2022	Hitchcock Renovation Gen Construction - Adjustment to FY22 addition due to late invoices	\$ 37,025	15	\$ 2,468
Total additions for Building Improvements		\$ 37,025		\$ 2,468 *
Deletions:				
Total deletions for Building Improvements		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
11/30/2022	Backflow Preventer Project	\$ 38,700	20	\$ 968
2/28/2023	Counter, Hot Food Serving	\$ 12,585	15	\$ 419
Total additions for Non-Movable Equipment		\$ 51,285		\$ 1,387 *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
6/30/2023	Tennant M-T300 Autoscrubber	Administrative	\$ 5,684	5	\$ 568
7/31/2023	Video Recorder Lenel Network	Administrative	\$ 16,295	5	\$ 1,630
8/31/2023	Berkel Premium Food Slicer	Administrative	\$ 6,660	10	\$ 333
9/30/2023	Cart, Crash Emergency	Standard Resident	\$ 5,051	10	\$ 253
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipment			\$ 33,690		\$ 2,784 *
Deletions:					
11/30/2022	Handbike		\$ (514)		
11/30/2022	Emergency Cart		\$ (1,075)		
11/30/2022	Personal Alarm Devices		-1544		
11/30/2022	Thermometer		-400		
Total deletions for Movable Equipment			\$ (3,533)		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility Hartford Hospital d/b/a Jefferson House			License No. 993-C		Report for Year Ended 9/30/2023			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
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.

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

Name of Facility Hartford Hospital d/b/a Jefferson Hous	License No. 993-C	Report for Year Ended 9/30/2023	Page 25	of 37
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11. Property Questionnaire

Part A

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

Yes No

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

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

Description	Total
1. Date Land Purchased	10/24/78
2. Date Structure Completed	
3. If NOT Original Owner, Date of Purchase	N/A
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	104
6. Square Footage	75,869
7. Acquisition Cost	
a. Land	262,539
b. Building	2,028,052

Part B - Owner and Related Parties

1st Mortgage 2nd Mortgage 3rd Mortgage 4th Mortgage

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

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

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

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

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

Name of Facility		License No.	Report for Year Ended				Page	of
Hartford Hospital d/b/a Jefferson Hou		993-C	9/30/2023				26	37
Item		Total	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment
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)

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		9/30/2023				27	37	
Item				Total	CCNH / RHNS	Adjustment	Other	Adjustment	(Specify)	Adjustment
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)				\$ 9,959	9,959		164	(164)		
b. Insurance on Automobiles				\$ 8,587	8,587					
c. Insurance other than Property (as specified above)										
1. Umbrella (Blanket Coverage)				\$ 70,697	70,697					
2. Fire and Extended Coverage				\$						
3. Other (Specify)				\$ 17,678	17,678					
EPL Defense and EPL Indemnity										
14d. Total Insurance Expenditures (14a + b + c)				\$ 106,921	106,921		164	(164)		
15. Total All Expenditures (A-13 thru C-14)				\$ 16,591,832	20,277,463	(3,685,631)	4,156,200	(4,156,200)		

F. Statement of Revenue

Name of Facility		License No.		Report for Year Ended		Page	of
Hartford Hospital d/b/a Jefferson House		993-C		9/30/2023		30	37
Item				Total	CCNH / RHNS	Other	(Specify)
I. Resident Room, Board & Routine Care Revenue							
1.	a.	Medicaid Residents (<i>CT only</i>)	\$	10,779,396	10,779,396		
	b.	Medicaid Room and Board Contractual Allowance **	\$	(4,947,722)	(4,947,722)		
2.	a.	Medicaid (<i>All other states</i>)	\$				
	b.	Other States Room and Board Contractual Allowance **	\$				
3.	a.	Medicare Residents (<i>all inclusive</i>)	\$	2,629,285	2,629,285		
	b.	Medicare Room and Board Contractual Allowance **	\$	427,048	427,048		
4.	a.	Private-Pay Residents and Other	\$	6,726,898	6,726,898		
	b.	Private-Pay Room and Board Contractual Allowance **	\$	241,079	241,079		
II. Other Resident Revenue							
1.	a.	Prescription Drugs - Medicare	\$	159,629	159,629		
	b.	Prescription Drugs - Medicare Contractual Allowance **	\$	(159,629)	(159,629)		
	c.	Prescription Drugs - Non-Medicare	\$	152,388	152,388		
	d.	Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(152,005)	(152,005)		
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	\$	415,389	374,743	40,646	
	b.	Physical Therapy - Medicare Contractual Allowance **	\$	(323,911)	(317,446)	(6,465)	
	c.	Physical Therapy - Non-Medicare	\$	350,816	307,457	43,359	
	d.	Physical Therapy - Non-Medicare Contractual Allowance **	\$	(254,564)	(262,829)	8,265	
4.	a.	Speech Therapy - Medicare	\$	61,419	60,420	999	
	b.	Speech Therapy - Medicare Contractual Allowance **	\$	(44,818)	(44,818)		
	c.	Speech Therapy - Non-Medicare	\$	62,926	62,926		
	d.	Speech Therapy - Non-Medicare Contractual Allowance **	\$	(38,570)	(38,570)		
5.	a.	Occupational Therapy - Medicare	\$	366,009	366,009		
	b.	Occupational Therapy - Medicare Contractual Allowance **	\$	(331,317)	(331,317)		
	c.	Occupational Therapy - Non-Medicare	\$	328,874	328,947	(73)	
	d.	Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(283,522)	(283,522)		
6.	a.	Other (<i>Specify</i>) - Medicare	\$				
	b.	Other (<i>Specify</i>) - Non-Medicare	\$	(513)	(52,980)	52,467	
III. Total Resident Revenue (Section I. thru Section II.)				\$	16,164,585	16,025,387	139,198
IV. Other Revenue*							
1.	Meals sold to guests, employees & others		\$	8,374		8,374	
2.	Rental of rooms to non-residents		\$				
3.	Telephone		\$				
4.	Rental of Television and Cable Services		\$				
5.	Interest Income (<i>Specify</i>)		\$	5,836,480	5,836,480		
6.	Private Duty Nurses' Fees		\$				
7.	Barber, Coffee, Beauty and Gift shops		\$				
8.	Other (<i>Specify</i>)		\$	1,991,552	3,848,727	(1,857,175)	
V. Total Other Revenue (1 thru 8)				\$	7,836,406	9,685,207	(1,848,801)
VI. Total All Revenue (III +V)				\$	24,000,991	25,710,594	(1,709,603)

* 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	(Specify)
30II6a	IP LAB SERVICES MEDICARE ANCILLARY SRV	\$ 26,289		
30II6a	IP RADIOLOGY SERVICES MEDICARE ANCILLARY SRV	\$ 7,154		
30II6a	IP LAB SERVICES PROF CA MEDICARE ANCILLARY SRV	\$ (26,289)		
30II6a	IP RADIOLOGY SERV PROF CA MEDICARE ANCILLARY SRV	\$ (7,154)		
30II6a	IP OTHER SERVICES MEDICARE ANCILLARY SRV	\$ 4,393		
30II6a	IP OTHER SERV PROF CA MEDICARE ANCILLARY SRV	\$ (4,393)		
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	Other	(Specify)
30II6b	IP LAB SERVICES MGD MEDICARE ANCILLARY SRV	\$ 19,481		
30II6b	IP LAB SERVICES ANTHEM ANCILLARY SRV	\$ 77		
30II6b	IP LAB SERVICES UNITED/OXFORD ANCILLARY SRV	\$ 18		
30II6b	IP OTHER SERVICES MGD MEDICARE ANCILLARY SRV	\$ 2,766		
30II6b	IP OTHER SERVICES MEDICAID ANCILLARY SRV	\$ 264		
30II6b	IP RADIOLOGY SERVICES MANAGED MEDICARE ANCILLARY SRV	\$ 4,914		
30II6b	OP OTHER SERVICES SELF PAY CENTER FOR HEALTHY AGING		\$ 7,988	
30II6b	OP OTHER SERVICES SELF PAY GOOD LIFE FITNESS		\$ 44,479	
30II6b	IP LAB SERVICES PROF CA MANAGED MEDICARE ANCILLARY SRV	\$ (19,481)		
30II6b	IP LAB SERVICES PROF CA ANTHEM ANCILLARY SRV	\$ (77)		
30II6b	IP LAB SERVICES PROF CA UNITED/OXFORD ANCILLARY SRV	\$ (18)		
30II6b	IP RADIOLOGY SERV PROF CA MANAGED MEDICARE ANCILLARY SRV	\$ (5,105)		
30II6b	RESTRICTED FUNDS - SNF SELF PAY SENIOR SERVICES REVENUE	\$ (52,830)		
30II6b	IP OTHER SERV PROF CA MANAGED MEDICARE ANCILLARY SRV	\$ (2,766)		
30II6b	IP OTHER SERV PROF CA MEDICAID ANCILLARY SRV	\$ (223)		
Total Other Resident Revenue		\$ (52,980)	\$ 52,467	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	Other	(Specify)
30IV5	INVESTMENT INC - ENDOWMENT LLC FUND DEPT		\$ 5,836,480		
Total Interest Income			\$ 5,836,480	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	Other	(Specify)
30IV8	MISC OTHER OPERATING INCOME GRANT ADMIN		\$ 318,674	
30IV8	MISC OTHER OPERATING INCOME ADMIN AND GENERAL		\$ 48,688	
30IV8	MISC OTHER OPERATING INCOME FINANCE ADMIN	\$ 8,672,801		
30IV8	MISC OTHER OPERATING INCOME CENTER FOR HEALTHY AGING		\$ 500	
30IV8	MISC OTHER OPERATING INCOME SENIOR SERVICES REVENUE	\$ 1,304		
30IV8	INCOME FROM RESTRICTED FUNDS FUND DEPT	\$ 28,374		
30IV8	INVESTMENT INC - FUNDS HELD IN TRUST FINANCE ACCRUALS	\$ 1,529,472		
30IV8	INVESTMENT INCOME FUND DEPT		\$ (2,226,537)	
30IV8	FREE BED INCOME	\$ (1,152)		
30IV8	FREE BED INCOME	\$ 53,982		
30IV8	UNRESTRICTED REVENUE RELEASED	\$ 38		
30IV8	INVESTMENT INCOME FINANCE ADMIN	\$ (8,662,351)		
30IV8	INVESTMENT INCOME FINANCE ACCRUALS	\$ 2,226,537		
30IV8	CONTRIBUTIONS OPERATIONAL ADMIN AND GENERAL		\$ 1,500	
30IV8	EQUIPMENT RENTAL	\$ (278)		
Total Other Revenue		\$ 3,848,727	\$ (1,857,175)	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2023	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,838,022
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	81,050
a. _____				
b. _____				
c. _____				
d. See Schedule		81,050		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(5,528,998)

See Schedule		(5,528,998)		
A-9. Total Current Assets (Lines A1 thru 8)			\$	(3,609,926)
B. Fixed Assets				
1. Land			\$	262,536
2. Land Improvements	*Historical Cost	98,834	\$	57,237
	Accum. Depreciation	41,597	Net	
3. Buildings	*Historical Cost	10,614,478	\$	3,326,811
	Accum. Depreciation	7,287,667	Net	
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
5. Non-Movable Equipment	*Historical Cost	1,161,451	\$	65,792
	Accum. Depreciation	1,095,659	Net	
6. Movable Equipment	*Historical Cost	2,332,994	\$	271,061
	Accum. Depreciation	2,061,933	Net	
7. Motor Vehicles	*Historical Cost	145,687	\$	7,692
	Accum. Depreciation	137,995	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	3,991,129

* 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	\$ 4,250
31	A5	CAHCF	\$ 263
31	A5	JOHNSON CONTROLS	\$ 16,399
31	A5	MORRISON MANAGEMENT	\$ 41,010
31	A5	CROTHALL HEALTH CARE INC.	\$ 17,010
31	A5	INSURANCE ANNUAL 3RD PARTY CRIME	\$ 2,118
Total Prepaid Expenses			\$ 81,050

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

Page Ref	Line Ref	Description	
31	A8	DUE AFFILIATE GENERAL CONTROL	\$ (5,413,283)
31	A8	DUE AFFILIATE INVENTORY CONTROL	\$ (115,715)
Total Other Current Assets (Itemize)			\$ (5,528,998)

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

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	INVESTMENT IN ENDOWMENT LLC	\$137,476,438
32	D7	INVESTMENT INCOME ENDOWMENT LLC TEMP	\$ 5,860,655
32	D7	INVESTMENT INCOME ENDOWMENT LLC PERM	\$ 2,538,722
32	D7	ASSETS HELD IN TRUST BY OTHERS	\$ 37,311,373
Total Other Assets			\$183,187,188

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	12	DEFERRED REVENUES	\$ 1,881,519
33	12	ACCRUED STATE PROVIDER TAX	\$ 157,377
33	12	ER 401K CORE	\$ 166,787
33	12	ER 401K MATCH TRUE UP	\$ 2,633
33	12	RETIREMENT FORFEITURES	\$ (10,331)
33	12	ACCRUED EXPENSES	\$ 200,346
33	12	GENERAL RESERVE	\$ 4,000
Total Other Current Liabilities (Itemize)			\$ 2,402,331

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			\$ -

G. Balance Sheet (cont'd)

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2023	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 381,203	
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 (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$ 183,187,188	

See Schedule			183,187,188	
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 183,187,188	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 183,568,391	

* 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 Hartford Hospital d/b/a Jefferson House		License No. 993-C	Report for Year Ended 9/30/2023	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	453,314
2. Notes Payable (<i>itemize</i>)				\$	

See Schedule					
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	454,404
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	2,402,331

See Schedule					2,402,331
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	3,310,049

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2023	Page 34	of 37
Account				Amount
Total Brought Forward:				3,310,049
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$

See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$
C. Total All Liabilities (Lines A-13 + B-5)				\$ 3,310,049

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 Hou	993-C	9/30/2023	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 (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	180,691,014
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	
6. Gain or Loss for Period			\$	(432,672)
	10/1/2022	thru	9/30/2023	
7. Total Net Worth			\$	180,258,342
C. Total Reserves and Net Worth			\$	180,258,342
D. Total Liabilities, Reserves, and Net Worth			\$	183,568,391

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	9/30/2023	36	37		
Account			Amount			
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	178,744,166		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	24,000,991		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	24,433,663		
D. Net Income or Deficit			\$	(432,672)		
E. Balance			\$	178,311,494		
F. Additions						
1. Additional Capital Contributed (<i>itemize</i>)						
Rounding					(1)	
2. Other (<i>itemize</i>)						
TR Contributions					274,280	
TR Investment Income					(176,341)	
TR NA Released & TR Other					(32,126)	
PR Unrealized Gain on Funds Held in Trust					1,881,036	
F-3. Total Additions					\$	1,946,848
G. Deductions						
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$			
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount			
2. Other Withdrawings (<i>Specify</i>)			\$			
Purpose		Amount				
3. Total Deductions			\$			
H. Balance at End of Period			\$	180,258,342		
				09/30/23		

I. Preparer's/Reviewer's Certification

Name of Facility Hartford Hospital d/b/a Jefferson House	License No. 993-C	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> Home (CCNH) & RHNS Combined	<input type="checkbox"/> Other	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Dorothy Robinson				
Address 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				