NOTE:
If amended pages are necessary, please submit the amended pages with changes highlighted in yellow, along with a signed and notarized Page 1. As a reminder, if any expense pages have changed, which result in a net increase or decrease to total expenses, please submit the necessary amended Pages 27, 35 and 36. If any depreciation and/or amortization expenses have changed, please submit the corresponding Page 23 or 24 along with the corresponding

General Information

Cover

Name of Facility	Address	Phone Number
Hartford Hospital d/b/a Jefferson House	1 John J. Stewart Drive, Newington, CT 06111	

Type of Facility and License Number(s)

☑ CCNH ☐ RHNS (Specify)

License Number	993-C		
Medicaid Provider Number			

Report for Year Beginning	Report for Year Ending
10/1/2016	9/30/2017

Page 1

Medicare Provider Number
07-5293

Printed Name (Administrator)	Printed Name (Owner)
Susan Vinal	

Page 1A

Report Prepared By	Phone Number	Date
Beth Ann Wetherell	860 696 6255	2/14/2018

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? If "Yes," explain fully.

○ Yes ◉ No

Page 2

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 #

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Page 3

Name of Partners/Members	Business Address	Title	% Owned

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

Page 3A

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

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

Page 3B

Owner(s) of Facility

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

Page 4

Hartford Healthcare Corp		○ Yes ○ No				
	Percentage Non-Related	0.00%				
		○ Yes ○ No				
	Percentage Non-Related	0.00%				
		○ Yes ○ No				
	Percentage Non-Related	0.00%				
		○ Yes ○ No				
	Percentage Non-Related	0.00%				
		○ Yes ○ No				
	Percentage Non-Related	0.00%				
		○ Yes ○ No				
	Percentage Non-Related	0.00%				
		○ Yes ○ No				
	Percentage Non-Related	0.00%				
		○ Yes ○ No				
	Percentage Non-Related	0.00%				
		○ Yes ○ No				
	Percentage Non-Related	0.00%				

Page 5

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

⊙ Yes ○ No

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

⊙ Yes ○ No

Page 6

A **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 and Address of Lessor	Description of Items Leased	Date of Lease	Term of Lease	Annual Amount of Lease	Amount Claimed	Related to Owners
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
					Total	0

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

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? If "No," explain.

⊙ Yes ○ No

	Name of Accounting Firm		Address of Accounting Firm
1	Ernst & Young	1	225 Asylum St., Hartford, CT
2	Hartford Hospital Accounting	2	Newington, CT 06111
3	NYASA	3	150 State St., Albany, NY 12207
4		4	

Page 7

	Services Provided by This Firm (describe fully)	Charge for Service Provided
1	200010-618020-Audit Fees	
2	207075-612010-HHC System Fees	15,548
3	207070-540010 Discounts	(631)
4	207070-612050-General Allocation	3,046

Are these charges reflected in the expenditure portion of this report? If Yes, specify expense classification and line number.

⊙ Yes ○ No

15.1.d

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

	Services Provided by This Firm	Charge for Service Provided
1		
2		
3		
4		
5		

Are these charges reflected in the expenditure portion of this report? If Yes, specify expense classification and line number.

⊙ Yes ○ No

Page 10

Are time records maintained by all individuals receiving compensation? ○ Yes ○ No

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

			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No

Page 14

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

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2H	**Is the cost of employee meals included in 2E?**	○ Yes	⊙ No		
2I	**Did you receive revenue from employees?**	⊙ Yes	○ No	**If yes, specify amt.**	
2J	**Where is the revenue received reported in the Cost Report?**			**(Page/Line Item)**	30IVI

Page 18

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

Page 19

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

	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.**

	Description	Total
11A1	**Date Land Purchased**	10/24/1978
11A2	**Date Structure Completed**	7/16/1980
11A3	**If NOT Original Owner, Date of Purchase**	N/A
11A4	**Date of Initial Licensure**	
11A5	**Total Licensed Bed Capacity**	104
11A6	**Square Footage**	75,868
11A7a	**Original Cost - Land**	262,539
11A7b	**Original Cost - Building**	2,038,052

Page 25

	Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
11B1a	**Type of Financing (e.g., fixed, variable)**				
11B1b	**Date Mortgage Obtained**				
11B1c	**Interest Rate for the Cost Year**				
11B1d	**Term of Mortgage (number of years)**				
11B1e	**Amount of Principal Borrowed**				
11B1f	**Principal balance outstanding as of _____**				
	Complete if Mortgage was Refinanced During Current Cost Year				
11B1g	**Type of Financing (e.g., fixed, variable)**				
11B1h	**Date of Refinancing**				
11B1i	**New Interest Rate**				
11B1j	**Term of Mortgage (number of years)**				
11B1k	**Amount of Principal Borrowed**				
11B1l	**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
C	**Arms-length leases**					
	Arms-length leases					
	Arms-length leases					
	Arms-length leases					
	Arms-length leases					

Printed Name of Preparer
Beth Ann Wetherell

Page 37

Address of Preparer
Hartford Hospital

Phone Number of Preparer
860 696 6255

	A	B	C	D	E	F	G	H	I
355		27	Prescription Drugs	0					
356		28	Ambulance/Limousine	0					
357		29	X-rays, etc.	0					
358		30	Laboratory	0					
359		31	Medical Supplies	0					
360		32	Oxygen (not emergency)	0					
361		33	Occupational Therapy	0					
362		34	Other Ancillary Costs	0	-	-	-		
363			***Page 22 - Maintenance and Property***						
364		35	Excess Movable Equipment Depreciation	0	-	-	-		
365		36	Depreciation on Unallowable Motor Vehicles	0					
366		37	Unallowable Property and Real Estate Taxes	0					
367		38	Rental of Building Space or Rooms	0					
368	Page 29	39	Other Property Costs	0	-	-	-		
369			***Page 27 - Insurance***						
370		40	Mortgage Insurance	0					
371		41	Property Insurance	0					
372			***Other - Miscellaneous***						
373		42	Research or Experimental Activities	0					
374		43	Radio and Television Revenue	0					
375		44	Vending Machine Revenue	0					
376		45	Purchase Discounts and Allowances	0					
377		46	Duplication of functions or services	0					
378		47	Expenditures for protection, promotion of provider interest	0					
379		48	Interest Income on Account Rec.	0					
380		49	Other Adjustments to Expense	0	-	-	-		
381			***Not For Profit Providers Only***						
382		50	Building/Non Movable Eq. Depreciation Unallowable Build In	0	-	-	-		
383									
384		51	***Total Amount of Decrease***	0	0	0	0		
385									

		Line #	**Description**	**Total**	**CCNH**	**RHNS**	**(Specify)**
386							
387			*Resident Room, Board & Routine Care Revenue*				
388		I1a	Medicaid Residents (*CT Only*)	12,363,738	12,363,738		
389		I1b	Medicaid Room and Board Contractual Allowance	(5,436,081)	(5,436,081)		
390		I2a	Medicaid (*All Other States*)	0			
391		I2b	Other States Room and Board Contractual Allowance	0			
392		I3a	Medicare Residents *(all inclusive)*	3,088,195	3,088,195		
393		I3b	Medicare Room and Board Contractual Allowance	(1,346,520)	(1,346,520)		
394		I4a	Private-Pay Residents and Other	2,541,504	2,541,504		
395		I4b	Private-Pay Room and Board Contractual Allowance	0			
396			*Other Resident Revenue*				
397		II1a	Prescription Drugs - Medicare	236,381	236,381		
398		II1b	Prescription Drugs - Medicare Contractual Allowance	0			
399		II1c	Prescription Drugs - Non-Medicare	92,164	92,164		
400		II1d	Prescription Drugs - Non-Medicare Contractual Allowance	0			
401		II2a	Medical Supplies - Medicare	0			
402		II2b	Medical Supplies - Medicare Contractual Allowance	0			
403		II2c	Medical Supplies - Non-Medicare	0			
404		II2d	Medical Supplies - Non-Medicare Contractual Allowance	0			
405		II3a	Physical Therapy - Medicare	2,254,886	2,254,886		
406		II3b	Physical Therapy - Medicare Contractual Allowance	0			
407		II3c	Physical Therapy - Non-Medicare	0			
408	Page 30	II3d	Physical Therapy - Non-Medicare Contractual Allowance	0			
409		II4a	Speech Therapy - Medicare	0			
410		II4b	Speech Therapy - Medicare Contractual Allowance	0			
411		II4c	Speech Therapy - Non-Medicare	0			
412		II4d	Speech Therapy - Non-Medicare Contractual Allowance	0			
413		II5a	Occupational Therapy - Medicare	0			
414		II5b	Occupational Therapy - Medicare Contractual Allowance	0			
415		II5c	Occupational Therapy - Non-Medicare	0			
416		II5d	Occupational Therapy - Non-Medicare Contractual Allowance	0			
417		II6a	Other (Specify) - Medicare	0	-	-	-
418		II6b	Other (Specify) - Non-Medicare	0	-	-	-
419		III	***Total Resident Revenue***	13,794,267	13,794,267	0	0
420			*Other Revenue*				
421		IV1	Meals sold to guests, employees & others	8,214	8,214		
422		IV2	Rental of rooms to non-residents	0			
423		IV3	Telephone and Telegraph	0			
424		IV4	Rental of Televisions and Cable Services	0			
425		IV5	Interest Income (Specify)	0	-	-	-
426		IV6	Private Duty Nurses' Fees	0			
427		IV7	Barber, Coffee, Beauty & Gift shops	0			
428		IV8	Other (Specify)	48,768	48,768	-	-
429			**See Attached Schedule**				
430		V	***Total Other Revenue***	56,982	56,982	0	0
431	30	VI	***Total All Revenue***	13,851,249	13,851,249	0	0

	B	C	D	E	F	G
46	7A	**Physical Therapy - Medicare Part B**	**22,265**	22,265		
47	7B1	**Maintenance Treatments**	**0**			
48	7B2	**Restorative Treatments**	**0**			
49	7C	**Physical Therapy - Other**	**0**			
50	7D	***Total Physical Therapy Treatments***	**22,265**	**22,265**	**0**	**0**
51	8A	**Speech Therapy - Medicare Part B**	**639**	639		
52	8B1	**Maintenance Treatments**	**0**			
53	8B2	**Restorative Treatments**	**0**			
54	8C	**Speech Therapy - Other**	**0**			
55	8D	***Total Speech Therapy Treatments***	**639**	**639**	**0**	**0**
56	9A	**Occupational Therapy - Medicare Part B**	**18,018**	18,018		
57	9B1	**Maintenance Treatments**	**0**			
58	9B2	**Restorative Treatments**	**0**			
59	9C	**Occupational Therapy - Other**	**0**			
60	9D	***Total Occupational Therapy Treatments***	**18,018**	**18,018**	**0**	**0**
61						

Line #

Please fill out the following information for all Operators/Owners, Administrators, Assistant Administrators and other relatives of Owners employed in and paid by facility.

Page 11 & 12

	Name	CCNH	RHNS	(Specify)	Total Hours Worked	Line Where Claimed on Page 10	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Section I-Operators/Owners											
Section II-Other Related Parties											
Section III-Administrators	Susan Vinal	236,427			2,080	A.2	Same as any other hartford hospital				
Section IV-Assistant Administrators											

List all contracted services - not just those you consider pertain to resident care.

Page 21

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

Line #

Please fill in the Depreciation Schedule as follows:

Asset Addition Schedule

Page 23

Line #		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
A1	**Land Improvements - Acquired prior to report period**							
A2	**Land Improvements - Disposals**	-						-
A3	**Land Improvements - Acquired during this report period (attach schedule)**							-
B1	**Building Improvements - Acquired prior to this report period**	8,461,888			4,790,261			1,137,288
B2	**Building Improvements - Disposals**	-						-
B3	**Building Improvements - Acquired during this report period (attach schedule)**							-
C1	**Non-Movable Equipment - Acquired prior to this report period**	2,021,655			1,938,412			
C2	**Non-Movable Equipment -Disposals**	-						-
C3	**Non-Movable Equipment - Acquired during this report period (attach schedule)**							-

Line #	**Movable Equipment - Motor vehicles (specify name, model and year of each vehicle)**	**Is a mileage logbook maintained?** Yes	No	**Date of Acquisition** Month	Year	**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**
D1a	2003 Ford E350 Supr	x										
D1b	2004 Dodge Ram	x										
D1c												
D1d												
D2a	**Movable Equipment - Acquired prior to this report period**					2,946,858			2,312,353			122,677
D2b	**Disposals**					-						-
D2c	**Movable Equipment - Acquired during this report period (attach schedule)**					-						-

Please fill in the Amortization Schedule as follows:

Page 24

Line #	**Organization Expense**	**Date of Acquisition** Month	Year	**Length of Amortization**	**Cost to be Amortized**	**Accumulated Amortization to Beginning of Year's Operations**	**Basis for Computing Amortization**	**Rate %**	**Amortization for This Year**
A1									
A2									
A3									
	Mortgage Expense								
B1									
B2									
B3									
C1	**Leasehold Improvements and Other - Acquired prior to this report period**								
C2	**Leasehold Improvements and Other - Disposals**				-				-
C3	**Leasehold Improvements and Other - Acquired during this report period (attach schedule)**								-

	A	B	C	D	E
1		**Line #**	**Description**	**Subtotal**	**Total**
2			*Current Assets*		
3		A1	Cash (*on hand and in banks*)		**7,106,898**
4		A2	Resident Accounts Receivable		
5		A3	Other Accounts Receivable		**698,668**
6		A4	Inventories		
7		A5	Prepaid Expenses (*itemize*)		**74,826**
8		a	**loan receivable from HH**	**74,826**	
9		b			
10		c			
11		d			
12		A6	Interest Receivable		
13		A7	Medicare Final Settlement Receivable		
14		A8	Other Current Assets (*itemize*)		**(1,598,757)**
15			**due to-from affiliates**	**(1,598,757)**	
16					
17					
18					
19		A9	***Total Current Assets*** (Lines A1 thru 8)		**6,281,635**
20					
21			*Fixed Assets*		
22		B1	Land		**262,536**
23	**Page 31**	B2	Land Improvements		**0**
24			Historical Cost		
25			Accumulated Depreciation		
26		B3	Buildings		**2,534,339**
27			Historical Cost	**8,461,888**	
28			Accumulated Depreciation	**5,927,549**	
29		B4	Leasehold Improvements		**0**
30			Historical Cost		
31			Accumulated Depreciation		
32		B5	Non-Movable Equipment		**83,243**
33			Historical Cost	**2,021,655**	
34			Accumulated Depreciation	**1,938,412**	
35		B6	Movable Equipment		**511,828**
36			Historical Cost	**2,946,858**	
37			Accumulated Depreciation	**2,435,030**	
38		B7	Motor Vehicles		**0**
39			Historical Cost		
40			Accumulated Depreciation		
41		B8	Minor Equipment-Not Depreciable		
42		B9	Other Fixed Assets (*itemize*)		**0**
43					
44					
45		B10	***Total Fixed Assets*** (Lines B1 thru 9)		**3,391,946**
46				**Total Brought Forward**	**9,673,581**
47			*Leasehold or like property recorded for Equity Purposes*		
48		C1	Land		
49		C2	Land Improvements		**0**
50			Historical Cost		
51			Accumulated Depreciation		
52		C3	Buildings		**0**
53			Historical Cost		
54			Accumulated Depreciation		
55		C4	Non-Movable Equipment		**0**
56			Historical Cost		
57			Accumulated Depreciation		
58		C5	Movable Equipment		**0**
59			Historical Cost		
60			Accumulated Depreciation		
61		C6	Motor Vehicles		**0**
62			Historical Cost		
63			Accumulated Depreciation		
64		C7	Minor Equipment -Not Depreciable		
65		C8	***Total Leasehold or Like Properties*** (C1 thru 7)		**0**
66	**Page 32**				
67			*Investment and Other Assets*		
68		D1	Deferred Deposits		
69		D2	Escrow Deposits		
70		D3	Organization Expense		**0**

71			Historical Cost		
72			Accumulated Depreciation		
73		D4	Goodwill		
74		D5	Investments Related to Resident Care		**0**
75					
76					
77		D6	Loans to Owners or Related Parties		**0**
78			Name and Address		
79			Amount		
80			Loan Date		
81					
82		D7	Other Assets		**147,324,286**
83			Board Designated	**104,558,609**	
84			Investments for restricted purposes	**7,136,318**	
85			funds held in trust by others	**35,629,359**	
86		D8	***Total Investments and Other Assets*** (Lines D1 thru 7)		**147,324,286**
87		D9	***Total All Assets*** (Lines A9 + B10 + C8 + D8)		**156,997,867**
88					
89		*Current Liabilities*			
90		A1	Trade Accounts Payable		**168,554**
91		A2	Notes Payable (itemize)		**0**
92					
93					
94					
95					
96		A3	Loans Payable for Equipment		**0**
97			Name of Lender		
98			Purpose		
99			Amount		
100			Date Due		
101					
102			Name of Lender		
103			Purpose		
104			Amount		
105			Date Due		
106	**Page 33**				
107		A4	Accrued Payroll (*Exclusive of Owners & Stockholders*)		**573,934**
108		A5	Accrued Payroll (*Owners & Stockholders only*)		
109		A6	Accrued Payroll Taxes Payable		
110		A7	Medicare Final Settlement Payable		
111		A8	Medicare Current Financing Payable		
112		A9	Mortgage Payable		
113		A10	Interest Payable		**976,646**
114		A11	Accrued Income Taxes		
115		A12	Other Current Liabilities (itemize)		**-**
116					
117					
118					
119					
120					
121					
122					
123					
124		A13	***Total Current Liabilities*** Lines A1 thru 12)		**1,719,134**
125				**Total Brought Forward**	**1,719,134**
126		*Long-Term Liabilities*			
127		B1	Loans Payable-Equipment		
128			Name of Lender		
129			Purpose		
130			Amount		
131			Date Due		
132					
133			Name of Lender		
134			Purpose		
135			Amount		
136			Date Due		
137					
138		B2	Mortgages Payable		
139		B3	Loans from Owners or Related Parties		**0**
140	**ge 34**		Name and Address of Lender		

	A	B	C	D	E
141	Pa		Amount		
142			Loan Date		
143					
144			Name and Address of Lender		
145			Amount		
146			Loan Date		
147					
148		B4	Other Long-Term Liabilities (itemize)		**5,623**
149			long term debt and cap leases	**5,623**	
150					
151					
152					
153		B5	***Total Long-Term Liabilities*** (Lines B1 thru 4)		**5,623**
154		C	***Total All Liabilities*** (Lines A13 + B5)		**1,724,757**
155					
156		*Reserves*			
157		A1	Reserve for value of leased land		
158		A2	Reserve for depreciation value of leased buildings and appurtenances to be amortized		
159		A3	Reserve for depreciation value of leased personal property (Equity)		
160		A4	Reserve for leasehold real properties on which fair rental value is based		
161		A5	Reserve for funds set aside as donor restricted		
162	**Page 35**	A6	***Total Reserves***		**0**
163		*Net Worth*			
164		B1	Owner's Capital		**112,294,987**
165		B2	Capital Stock		
166		B3	Paid-in Surplus		**4,810,043**
167		B4	Treasury Stock		**38,168,080**
168		B5	Cumulated Earnings		
169		B6	Gain or Loss for Period 10/1/2016 thru 09/30/2017		
170		B7	***Total Net Worth***		**155,273,110**
171		C	***Total Reserves and Net Worth***		**155,273,110**
172		D	***Total Liabilities, Reserves, and Net Worth***		**156,997,867**
173					
174		A	Balance at End of Prior Period		
175		B	Total Revenue		
176		C	Total Expenditures		
177		D	Net Income or Deficit		
178		E	Balance		
179		F1	Additional Capital Contributed (itemize)		
180					
181					
182					
183					
184		F2	Other (itemize)		
185					
186					
187					
188					
189	**Page 36**	F3	***Total Additions***		**0**
190		G1	Drawings of Owners/Operators/Partners		
191			Name and Address		
192			Title		
193			Amount		
194					
195			Name and Address		
196			Title		
197			Amount		
198		G2	Other Withdrawings		
199			Purpose		
200			Amount		
201					
202			Purpose		
203			Amount		
204		G3	Total Deductions		
205		H	***Balance at End of Period***		**0**

State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Hartford Hospital d/b/a Jefferson House		
Address (No. & Street, City, State, Zip Code) 1 John J. Stewart Drive, Newington, CT 06111		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	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, 2016 and ending September 30, 2017, 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 10/1/2016	To 9/30/2017
Address of Facility 1 John J. Stewart Drive, Newington, CT 06111				
Report Prepared By Beth Ann Wetherell	Phone Number 860 696 6255		Date 2/14/2018	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

	Phone No. of Facility	Report for Year Ended	Page	of
		9/30/2017	2	37

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

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

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

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

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	3	37

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	9/30/2017	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
Douglas Elliott	Hartford Hospital, 80 Seymour St., Hartford, CT 06102	Chair	
Alexia Cruz	Hartford Hospital, 80 Seymour St., Hartford, CT 06102		
David R. McHale	Hartford Hospital, 80 Seymour St., Hartford, CT 06102	Vice Chair	
Yvette Melendez	Hartford Hospital, 80 Seymour St., Hartford, CT 06102		
Jeffery Nestler, MD	Hartford Hospital, 80 Seymour St., Hartford, CT 06102		
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	4	37

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	%**				
Hartford Healthcare Corp		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* 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
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	5	37

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
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	6	37

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
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						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

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1	200010-618020-Audit Fees	$
2	207075-612010-HHC System Fees	$ 15,548
3	207070-540010 Discounts	$ (631)
4	207070-612050-General Allocation	$ 3,046

Charge for Services Provided: $ 17,963

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

⊙ Yes ○ No 15.1.d

Legal Services Information

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

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	$
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
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	104	104			104	104			104	104		
B. On last day of THIS report period	104	104			104	104			104	104		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	98	98			98	98			101	101		
B. As of midnight of THIS report period	103	103			101	101			103	103		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,525	5,525			4,001	4,001			1,524	1,524		
B. Medicaid (Conn.)	23,891	23,891			17,798	17,798			6,093	6,093		
C. Medicaid (other states)												
D. Private Pay	5,208	5,208			3,775	3,775			1,433	1,433		
E. State SSI for RCH												
F. Other (Specify)	2,137	2,137			1,817	1,817			320	320		
G. Total Care Days During Period (3A thru F)	36,761	36,761			27,391	27,391			9,370	9,370		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	36,761	36,761			27,391	27,391			9,370	9,370		

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Schedule of Resident Statistics (Cont'd)

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	14	65		20			4	
Per Diem Rate								
a. One bed rm.	469.00	469.00		469.00			469.00	
b. Two bed rms.	441.00	441.00		441.00			441.00	
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	22,265	22,265		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Physical Therapy Treatments***	22,265	22,265		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	639	639		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Speech Therapy Treatments***	639	639		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	18,018	18,018		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Occupational Therapy Treatments***	18,018	18,018		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	10	37

Are time records maintained by all individuals receiving compensation? ○ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	236,427	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	316,614	12,515				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	300	17				
c. Dietary Workers	545,953	33,408				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	223,135	16,856				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	169,614	7,696				
b. Other Maintenance Workers						
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	126,982	2,086				
b. RN						
1. Direct Care	2,793,613	67,327				
2. Administrative**						
c. LPN						
1. Direct Care	285,138	8,398				
2. Administrative**						
d. Aides and Attendants	1,865,780	110,174				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	196,776	7,165				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists	129,077	2,086				
l. Podiatrists						
m. Social Workers/Case Management	278,835	7,090				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	7,168,244	276,898				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Consulting Other	$ 58,938					
Contract labor other	$ 3,392					
Health Info Mgmt	$ 42,837	1,554				
Total	$ 105,167	1,554	$ -	-	$ -	-

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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
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	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	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Susan Vinal	236,427			Same as any other hartford hospital employee		2,080				
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	11,294	213				
3. Pharmacist	9,374	156				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	984,276	16,404				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)						
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	105,167	1,554				
B-13 Total Fees Paid in Lieu of Salaries	1,110,111	18,327				

* 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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CSP-14 Rev. 6/95

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	9/30/2017	14	37

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

* 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	9/30/2017	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	80,299	80,299		
2. Disability Insurance	$	28,428	28,428		
3. Unemployment Insurance	$	12,595	12,595		
4. Social Security (F.I.C.A.)	$	676,158	676,158		
5. Health Insurance	$	881,267	881,267		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	9,397	9,397		
7. Pensions (Non-Discriminatory)	$	614,624	614,624		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	46,566	46,566		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	2,415	2,415		
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	8,128	8,128		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	20,177	20,177		
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	626,543	626,543		
Subtotal	$	3,006,597	3,006,597		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
dental	$ 44,722		
tuition	$ 1,844		
Total	$ 46,566	$ -	$ -

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,006,597	3,006,597		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	2,724	2,724		
5. Education Expenses Related to Seminars and Conventions	$				
6. Automobile Expense (*not purchase or depreciation*)	$	868	868		
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*)***	$	916	916		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	760	760		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	5,476	5,476		
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	521,076	521,076		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	1,484,902	1,484,902		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	5,023,319	5,023,319		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
advertising	$ 916		
Total Other Advertising	$ 916	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
dues and licenses	$ 21,076		
GR administration	$ 500,000		
Total Dues	$ 521,076	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
System fee/office supplies/rental charge/late fees/minor equip see TB Detail	$ 1,484,474		
training materials	$ 376		
Gen supplies	$ 52		
Total Other Administrative and General	$ 1,484,902	$ -	$ -

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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 9/30/2017	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 Hospital, Human Resources		Personnel Services	15.1.a.9
Hartford Hospital, Accounting Finance		Financial Services	15.1.d
Michalic Bouer Silvia & Ciccarillo		Legal Matters	15.1.e
E&Y Auditors		Audit Fees	15.1.d
Hartford Hospital		Corporate Fee	15.1.d

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	14,832	14,832		
2. Non-Food Supplies	$	1,805	1,805		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	589,180	589,180		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	605,817	605,817		

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

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

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

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CSP-19 Rev. 9/2002

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	9/30/2017	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
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)*	$	105,080	105,080		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	105,080	105,080		

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

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel		45,004	45,004		
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	12,783	12,783		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel		45,004	45,004		
(Complete Schedule C-2 att. Page 21)	Amt.	$	93,554	93,554		
c. Management Services*		$				
d. Other (*Specify*)		$	57,528	57,528		
Waste Services						
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	163,865	163,865		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$	273,663	273,663		
2. Purchased from		$				
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	358,951	358,951		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$				
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	4,347	4,347		
i. Recreation		$	46,670	46,670		
j. Other (Specify)****		$	1,021,305	1,021,305		
See Attached Schedule						
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,704,936	1,704,936		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
purchases per T/B report	$ 1,021,305		
Total Other Resident Care	$ 1,021,305	$ -	$ -

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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	9/30/2017	21	37

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

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

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

Name of Facility	License No.	Report for Year Ended			Page of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017			22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	333,804	333,804		
b. Heat	$	36,767	36,767		
c. Light & Power	$	152,689	152,689		
d. Water	$	48,060	48,060		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	37,258	37,258		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	608,578	608,578		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	1,137,288	1,137,288		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	122,677	122,677		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	1,259,965	1,259,965		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,259,965	1,259,965		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
IT Repair/Soft	$ 25,014		
uniforms/dues/storage	$ 12,244		
Total Other Repairs and Maintenance	$ 37,258	$ -	$ -

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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	9/30/2017	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	8,461,888			4,790,261			1,137,288	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								1,137,288
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	2,021,655			1,938,412				
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	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. 2003 Ford E350 Supr	x											
b. 2004 Dodge Ram	x											
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					2,946,858			2,312,353			122,677	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												122,677
E. ***Total Depreciation***												1,259,965

Hartford Hospital d/b/a Jefferson House
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Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Land 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:					
Total additions for Building Improvemen		$ -		$ -	*
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 perio

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

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	9/30/2017	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	9/30/2017	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	07/16/80
3. If **NOT** Original Owner, Date of Purchase	N/A
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	104
6. Square Footage	75,868
7. Acquisition Cost	
a. Land	262,539
b. Building	2,038,052

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

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson Hou	993-C	9/30/2017	26 | 37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson H	993-C	9/30/2017	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $				
14. Insurance				
a. Insurance on Property (buildings only) $	8,509	8,509		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $	32,031	32,031		
pro liab/gen liab/audo/director insurance				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	40,540	40,540		
15. ***Total All Expenditures (A-13 thru C-14)*** $	17,790,455	17,790,455		

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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	9/30/2017	28 | 37

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

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	29 | 37

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

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

Attachment Page 29

Hartford Hospital d/b/a Jefferson House
9/30/2017

Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	12,363,738	12,363,738		
b. Medicaid Room and Board Contractual Allowance **	$	(5,436,081)	(5,436,081)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	3,088,195	3,088,195		
b. Medicare Room and Board Contractual Allowance **	$	(1,346,520)	(1,346,520)		
4. a. Private-Pay Residents and Other	$	2,541,504	2,541,504		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	236,381	236,381		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	92,164	92,164		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	2,254,886	2,254,886		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$				
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$				
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	13,794,267	13,794,267		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	8,214	8,214		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	48,768	48,768		
V. Total Other Revenue (1 thru 8)	$	56,982	56,982		
VI. Total All Revenue (III +V)	$	13,851,249	13,851,249		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	laboratory	$ 36,732		
	Radiology	$ 12,036		
Total Other Revenue		$ 48,768	$ -	$ -

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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	9/30/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 7,106,898
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 698,668
4 Inventories				$
5. Prepaid Expenses				$ 74,826
a. loan receivable from HH		74,826		
b.				
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (1,598,757)
due to-from affiliates		(1,598,757)		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 6,281,635
B. Fixed Assets				
1. Land				$ 262,536
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	8,461,888		$ 2,534,339
	Accum. Depreciation	5,927,549	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	2,021,655		$ 83,243
	Accum. Depreciation	1,938,412	Net	
6. Movable Equipment	*Historical Cost	2,946,858		$ 511,828
	Accum. Depreciation	2,435,030	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 3,391,946

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hartford Hospital d/b/a Jefferson House	993-C	9/30/2017	32	37

Account				Amount
			Total Brought Forward:	$ 9,673,581
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*)			$ 147,324,286
	Board Designated		104,558,609	
	Investments for restricted purposes		7,136,318	
	funds held in trust by others		35,629,359	
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)			$ 147,324,286
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ 156,997,867

* 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	9/30/2017	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 168,554
2. Notes Payable (*itemize*)					$
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*)					$ 573,934
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$ 976,646
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 1,719,134

* 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	9/30/2017	34	37

Account	Amount
Total Brought Forward:	1,719,134
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*)		$ 5,623
long term debt and cap leases	5,623	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 5,623
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 1,724,757

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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	9/30/2017	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	$ 112,294,987
	2. Capital Stock	$
	3. Paid-in Surplus	$ 4,810,043
	4. Treasury Stock	$ 38,168,080
	5. Cumulated Earnings	$
	6. Gain or Loss for Period 10/1/2016 thru 9/30/2017	$
	7. Total Net Worth	$ 155,273,110
C.	***Total Reserves and Net Worth***	$ 155,273,110
D.	***Total Liabilities, Reserves, and Net Worth***	$ 156,997,867

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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	9/30/2017	36	37

Account	Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2016	$
B. Total Revenue (*From Statement of Revenue Page 30*)	$
C. Total Expenditures (*From Statement of Expenditures Page 27*)	$
D. Net Income or Deficit	$
E. Balance	$
F. Additions	
1. Additional Capital Contributed (*itemize*)	
2. Other (*itemize*)	
F-3. Total Additions	$
G. Deductions	
1. Drawings of Owners/Operators/Partners (*Specify*)	$

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

2. Other Withdrawings *(Specify)*	$

Purpose	Amount

3. Total Deductions		$
H. ***Balance at End of Period***	09/30/17	$

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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	9/30/2017	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Beth Ann Wetherell

Address	Phone Number
Hartford Hospital	860 696 6255

Level	Item	Reported as