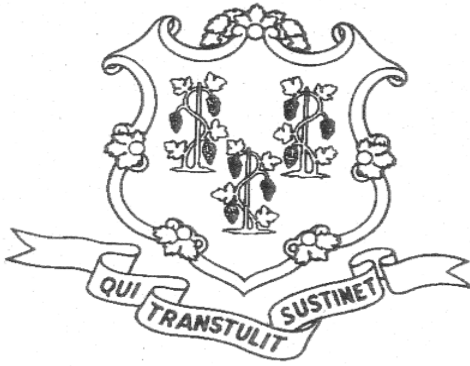


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015

Name of Facility (as licensed) Hebrew Home & Hospital	
Address (No. & Street, City, State, Zip Code) One Abrahms Boulevard, West Hartford, CT 06117	
Type of Facility <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) </div> <div style="width: 30%;"> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) </div> <div style="width: 30%;"> <input checked="" type="checkbox"/> Chronic Disease Hospital </div> </div>	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 2057C	RHNS	Chronic Disease Hospital 16CD	Medicare Provider 07-5109
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Medicaid Provider Numbers:	CCNH 927	RHNS	ICF-MR
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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) Hebrew Home & Hospital	License No. 2057C	Report for Year Ended 9/30/2015	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 Hebrew Home & Hospital [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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)			Printed Name (Owner)		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

State of Connecticut
Department of Social Services
 25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Hebrew Home & Hospital		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility One Abrahms Boulevard, West Hartford, CT 06117				
Report Prepared By Wonneberger & Morgan, LLC		Phone Number 8.6E+09	Date 2/1/2016	
Item	Total	CCNH	RHNS	Chronic Disease Hospital
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 860-523-3950		Report for Year Ended 9/30/2015		Page 2	of 37
Name of Facility (as shown on license) Hebrew Home & Hospital			Address (No. & Street, City, State, Zip) One Abrahms Boulevard, West Hartford, CT 06117		
License Numbers:		CCNH 2057C	RHNS	Chronic Disease Hospita 16CD	Medicare Provider No. 07-5109
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input checked="" type="checkbox"/> Chronic Disease Hospital	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:				Date Opened	Date Closed
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.					
Administrator					
Name of Administrator Lisa Holloway				Nursing Home Administrator's License No.:	1583
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name				License No.:	

**General Information and Questionnaire
 Corporate Owners**

Name of Facility Hebrew Home & Hospital	License No. 2057C	Report for Year Ended 9/30/2015	Page 3A	of 37
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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
Hebrew Home & Hospital, Inc	1 Abrahms Blvd., West Hartford	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
See Attached Listing			

Names of Stockholders Owning at Least 10% of Shares	Business Address	Title	No. Shares Held by Each



HEBREW HEALTH CARE
for health, for life



HEBREW HOME
& HOSPITAL
for health, for life

2015/2016 BOARD OF TRUSTEES

NAME	HOME ADDRESS	WORK ADDRESS
Bloom, Cheryl Auxiliary Co-Chair	17 Bay Hill Drive Bloomfield, CT 06002 860-205-1780 (cell) cbloom0203@yahoo.com	No Work Address
Cloud, Christopher	242 Talcott Notch Road Farmington, CT 06032 Cell: 860-371-5100 Cloud2464@gmail.com	Canilliere, Cloud & Kennedy 433 South Main Street Suite 328 West Hartford, CT 06110 860-561-5970 (office) 860-521-3981 (fax) chris@cckgov.com
Ebanks, Desmond	16 Heathcote Avon, CT 06001 Cell: 860-906-4609	Alternity Healthcare, LLC 639 Park Rd, 2 nd floor West Hartford, CT 06107 (p) 860.561.2294 (f) 860.561.2287 dr.ebanks@alternityhealthcare.com
Evans, Peter V.	44 High Ridge Road West Hartford, CT 06117 860-233-1920 (home) 860-836-1086 (cell)	Rogin, Nassau, LLC City Place 1, 22 nd Floor, 185 Asylum Street Hartford, CT 06103 860-256-6324 860-278-2179 (fax) pevans@roginlaw.com
Gauthier, Bonnie B. President and CEO	83R King Philip Drive West Hartford, CT 06117 860-521-0381(home) 860-573-4450 (cell)	One Abrahms Boulevard West Hartford, CT 06117 860-523-3892 860-523-3816 (fax) bgauthier@hebrewhealthcare.org
Greenberg, Gary S. Chair, HHC Foundation	6 High Ledge Road Bloomfield, CT 06002 860-242-4306 860-989-8906 (cell)	Birken Manufacturing Company 3 Old Windsor Road Bloomfield, CT 06002 860-242-2211 x319 860-242-2749 (fax) ggreenberg@birken.net
Hoffman, Jeffrey S.	149 Reverknolls Avon, CT 06001-2045 860-678-0674	Hoffman Auto Group 750 Connecticut Boulevard East Hartford, CT 06108 860-290-6140 860-290-6155 (fax) jsh1@hoffmanauto.com (use this one first) Jeffrey.hoffman@hoffmanauto.com Gladys.rivera@hoffmanauto.com (assistant)

**Note: bold typeface indicates preferred contact location information.*

If a board member has a business phone, reminders and cancellations should be made at business location.

**General Information and Questionnaire
Related Parties***

Name of Facility Hebrew Home & Hospital	License No. 2057C	Report for Year Ended 9/30/2015	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	%**				
Rogin, Nassau, Caplan	185 Asylum Street Hartford, CT	<input checked="" type="radio"/>	<input type="radio"/>		Legal	Pg 15 L 1.e	28,402	28,402
Hoffman Auto Group	600 Connecticut Blvd East Hartford, CT	<input checked="" type="radio"/>	<input type="radio"/>		Auto maintenance and repair	Pg 16 L 1.1.6	5,887	5,887
Pullman & Comley	90 State House Sq Hartford, CT	<input checked="" type="radio"/>	<input type="radio"/>		Legal	Pg 15 L 1.e	1,596	1,596
CGSG	1 Abrahms Blvd; West Hartford, CT 06117	<input checked="" type="radio"/>	<input type="radio"/>		Medical Director - SNF	Pg 13 L8a	50,000	50,000
CGSG	1 Abrahms Blvd; West Hartford, CT 06117	<input checked="" type="radio"/>	<input type="radio"/>		Staff Physicians	Pg 13 L8e	100,000	100,000
Blum Shapiro & Co PC	P.O. Box 150489 Hartford, CT 06115-0489	<input type="radio"/>	<input checked="" type="radio"/>		Consulting Services	Pg 16 L Cm.11	150,000	150,000
Hartford Healthcare	80 Seymour St Hartford, CT 06102	<input type="radio"/>	<input checked="" type="radio"/>		Lab Services	Pg 20 LC.5.h	6,955	6,955
Clinical Lab Partners	129 Patricia M. Genova Dr Newington, CT 06111	<input type="radio"/>	<input checked="" type="radio"/>		Lab Services	Pg 20 LC.5.h	94,107	94,107
Crown Supermarket	2471 Albany Ave West Hartford, CT 06117	<input type="radio"/>	<input type="radio"/>		Supermarket	Pg 16 L Cm.13	233	233

* Use additional sheets if necessary.

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

**General Information and Questionnaire
Related Parties***

Name of Facility Hebrew Home & Hospital	License No. 2057C	Report for Year Ended 9/30/2015	Page 4A	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	%**				
Hartford HealthCare	80 Seymour St Hartford, CT 06102	<input checked="" type="radio"/>	<input type="radio"/>		Lab Services	Pg 20 LC.5.h	645	645
Hebrew Home & Hospital Auxillary	1 Abrahms Blvd West Hartford, CT 06117	<input checked="" type="radio"/>	<input type="radio"/>		Café Lunches for Meetings	Pg 13 L B.8.e	131	131
St. Francis Hospital	114 Woodland St Hartford, CT 06105	<input type="radio"/>	<input checked="" type="radio"/>		Lab Services	Pg 20 LC.5.h	947	947
St. Francis Medical Group	114 Woodland St Hartford, CT 06105	<input checked="" type="radio"/>	<input type="radio"/>		Physician Services	Pg 13 L B.8.e	7,292	7,292
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input 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 Hebrew Home & Hospital	License No. 2057C	Report for Year Ended 9/30/2015	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.

Employee Benefits other than FICA are allocated based on total Payroll Hours by level of care. It is the position of the facility that the high salaries of the physicians over allocated expenses that are not salary based.

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

Expenses allocated from the parent company HHC have been recorded on the appropriate lines throughout the cost report.

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

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

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility			License No.	Report for Year Ended			Page	of
Hebrew Home & Hospital			2057C	9/30/2015			6	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						
Neopost Leasing	<input type="radio"/>	<input checked="" type="radio"/>	Postage Meter	10/01/14	12 Months			3,011
DocuSource	<input type="radio"/>	<input checked="" type="radio"/>	Copier, Printers	10/01/14	12 Months			37,364
Accelerated Care Plus	<input type="radio"/>	<input checked="" type="radio"/>	PT Rehab Equipment	10/01/13	12 Months			13,800
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
							Total ***	54,175

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.

General Information and Questionnaire

Accounting Basis

Name of Facility Hebrew Home & Hospital	License No. 2057C	Report for Year Ended 9/30/2015	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Crowe Horwath, LLP	175 Powder Forest Dr, Simsbury, CT 06089
2 Wonneberger & Morgan, LLC	1781 Highland Ave; Suite 207; Cheshire, CT 06410
3 Hooker & Holcombe	65 LaSalle Road; West Hartford, CT 06107
4	

Services Provided by This Firm (*describe fully*)

1 Financial Audit & Medicare Cost Report	\$ 112,564
2 Medicaid Cost Report	\$ 5,583
3 Pension (DBP) Actuarial Services	\$ 23,531
4	\$
Charge for Services Provided	
\$ 141,678	

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Page 15 - Line 1.d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 See Page 7A	
2	
3	
4	
5	

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

1

2

3

4

5

Services Provided by This Firm (*describe fully*)

1	\$ 211,009
2	\$
3	\$
4	\$
5	\$
Charge for Services Provided	
\$ 211,009	

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Page 15 - Line 1.e

General Information and Questionnaire
Legal Services Information

Name of Facility Hebrew Home & Hospital	License No. 2057C	Report for Year Ended 9/30/2015	Page 7A	of 37
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Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Michael J Croll, Esq	860-798-1748
2 Linda I. Feldman	860-232-2575
3 Murtha Cullina LLP	860-240-6090
4 Pullman & Comely	203-330-2000
5 Rogin Nassau	860-278-7480
6 Siegel,O,Connor,O'Donnell & Beck, PC	860-727-8900
7 Wiggins & Dana, LLP	203-498-4400
8 Kroll, O'Connor, O'Donnell & Beck, PC	860-561-7070
9 Bodner Shapiro Law Group, LLC	860-216-3796
10 Vlock & Associates, P.C.	212-557-0020
11 Boulanger, Richard	508-839-3750

Address (No. & Street, City, State, Zip Code)	
1 1028 Boulevard #188	West Hartford, CT 06109
2 30 Concord St	West Hartford, CT 06119
3 City Place 1 185 Asylum Street	Hartford, CT 06103-3469
4 850 Main Street, PO Box 7006	Bridgeport, CT 06601
5 City Place 1 22nd Floor 185 Asylum St	Hartford, CT 06103
6 150 Trumbull Street	Hartford, CT 06103
7 1 Century Tower, PO Box 1832	New Haven, CT 06508
8 65 Memorial Rd. Suite 300	West Hartford, CT 06107
9 650 Farmington Ave	Hartford, CT 06105
10 630 Third Ave 18th Floor	New York, NY 10017
11 P.O. Box 358	Grafton, MA 01519-0358

Services Provided by This Firm (*describe fully*)

1 BHU Probate Hearing		\$ 48,130
2 BHU Probate Hearing		\$ 365
3 Collections Matters A/R	Disallowed	\$ (2,340)
4 General Matters	Disallowed	\$ 1,596
5 General Business Advice and Resident Issues		\$ 28,402
6 Employment and Labor		\$ 36,851
7 General Matters		\$ 4,016
8 Collections Matters A/R	Disallowed	\$ 80,148
9 BHU Probate Hearing		\$ 4,590
10 General Matters		\$ 10,050
11 General Matters		\$ (800)

	Charge for Services Provided
	\$ 211,009

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

Schedule of Resident Statistics

Name of Facility Hebrew Home & Hospital			License No. 2057C		Report for Year Ended 9/30/2015				Page 8		of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Chronic Disease Hospital	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Chronic Disease Hospital	Total	CCNH	RHNS	Chronic Disease Hospital
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	322	277		45	322	277		45				
B. On last day of THIS report period	302	257		45					302	257		45
2. Number of Residents												
A. As of midnight of PREVIOUS report period	280	256		24	280	256		24				
B. As of midnight of THIS report period	263	245		18					263	245		18
3. Total Number of Days Care Provided During Period												
A. Medicare	16,392	9,066		7,326	12,547	6,933		5,614	3,845	2,133		1,712
B. Medicaid (Conn.)	64,276	63,835		441	48,766	48,501		265	15,510	15,334		176
C. Medicaid (other states)												
D. Private Pay	12,845	12,347		498	9,516	9,122		394	3,329	3,225		104
E. State SSI for RCH												
F. Other (Specify)	5,395	4,909		486	3,890	3,523		367	1,505	1,386		119
G. Total Care Days During Period (3A thru F)	98,908	90,157		8,751	74,719	68,079		6,640	24,189	22,078		2,111
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	379	379			318	318			61	61		
5. Total Resident Days (3G + 4A + 4B)	99,287	90,536		8,751	75,037	68,397		6,640	24,250	22,139		2,111

Schedule of Resident Statistics (Cont'd)

Name of Facility Hebrew Home & Hospital			License No. 2057C			Report for Year Ended 9/30/2015			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input checked="" type="radio"/> Yes <input type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH (1)	RHNS (2)	Chronic Disease Hospital (3)	Lost			Gained			CCNH	RHNS	Chronic Disease Hospital	
				(1)	(2)	(3)	(1)	(2)	(3)				
8/11/2015	X			20						257		45	Beds Taken Out of Service
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	Chronic Disease Hospital					
1st change						22,073		2,030					
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	Chronic Disease Hospital	R.C.H.	ICF-MR					
No. of Residents	25 CCH / 11 CDH	171 CCH / 4 CDH		49		3							
Per Diem Rate													
a. One bed rm.	Per RUG / Per DRG	264.65 / 573.83		440.00		1,100.00							
b. Two bed rms.	Per RUG / Per DRG	264.65 / 573.83		420.00		1,100.00							
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments						TOTAL	CCNH	RHNS	Chronic Disease Hospital				
A. Medicare - Part B						5,896	3,461		2,435				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments						286	284		2				
C. Other						18,602	18,544		58				
D. Total Physical Therapy Treatments						24,784	22,289		2,495				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B						2,417	2,072		345				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments						44	44						
C. Other						17,749	17,747		2				
D. Total Speech Therapy Treatments						20,210	19,863		347				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B						838	789		49				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments						27	23		4				
C. Other						1,285	1,193		92				
D. Total Occupational Therapy Treatments						2,150	2,005		145				

Report of Expenditures - Salaries & Wages

Name of Facility Hebrew Home & Hospital	License No. 2057C	Report for Year Ended 9/30/2015	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Chronic Disease Hospital	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)	\$ 112,173	2,080			\$ 162,297	2,080
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	\$ 1,755,420	79,279			\$ 413,392	18,671
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	\$ 963,358	59,049			\$ 93,507	5,732
6. Housekeeping Service						
a. Head Housekeeper	\$ 72,142	3,792			\$ 7,002	368
b. Other Housekeeping Workers	\$ 793,453	48,039			\$ 77,016	4,663
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	\$ 79,189	2,904			\$ 12,865	472
b. Other Maintenance Workers	\$ 239,094	13,414			\$ 38,842	2,179
8. Laundry Service						
a. Supervisor	\$ 36,952	1,896			\$ 3,587	184
b. Other Laundry Workers	\$ 296,330	18,210			\$ 28,763	1,767
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant	\$ 53,673	1,278			\$ 12,640	301
b. Other Accountants	\$ 155,321	5,834			\$ 36,577	1,374
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	\$ 248,034	4,107			\$ 123,921	2,080
b. RN						
1. Direct Care	\$ 4,429,901	133,286			\$ 1,613,496	26,976
2. Administrative**	\$ 536,528	11,835			\$ 374,043	11,400
c. LPN						
1. Direct Care	\$ 1,470,856	44,166			\$ 81,803	1,932
2. Administrative**						
d. Aides and Attendants	\$ 4,622,670	262,739			\$ 1,373,708	76,047
e. Physical Therapists	\$ 446,032	14,694			\$ 49,928	1,644
f. Speech Therapists	\$ 83,665	2,344			\$ 1,462	41
g. Occupational Therapists	\$ 322,298	10,003			\$ 23,309	723
h. Recreation Workers	\$ 284,751	15,728			\$ 27,638	1,527
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***					\$ 26,191	(171)
4. Other (Specify) HHH NURSING SERV 4N PER DIEM RNS	\$ 35,080	2,155			\$ 182,434	7,701
j. Dentists						
k. Pharmacists	\$ 455,462	16,441			\$ 44,209	1,596
l. Podiatrists						
m. Social Workers/Case Management	\$ 451,778	18,448			\$ 43,851	1,791
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	\$ 17,944,160	771,721			\$ 4,852,481	171,078

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Hebrew Home & Hospital				2057C	9/30/2015			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	Chronic Disease Hospital							
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	
Hebrew Home & Hospital				2057C	9/30/2015			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	Chronic Disease Hospital							
Section III - Administrators***										
Lisa Holloway (CCH)	112,173			Standard Employee Benefits	SNF Facility Administration	2,080	A.2			
Marcia Hickey (CDH)			162,297	Standard Employee Benefits	CDH Facility Administration	2,080	A.2			
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		
Hebrew Home & Hospital	2057C	9/30/2015	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	Chronic Disease Hospital	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	\$ 5,013	81			\$ 487	8
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	\$ 50,000	428			\$ 104,758	1,040
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) Physicians - Resident Care	\$ 31,213	170			\$ 161,150	2,275
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						
B-13 Total Fees Paid in Lieu of Salaries	\$ 86,226	679			\$ 266,395	3,323

* 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.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Hebrew Home & Hospital	2057C	9/30/2015		15	37
Item	Total	CCNH	RHNS	Chronic Disease Hospital	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 514,362	421,027			93,335
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 117,519	96,194			21,325
4. Social Security (F.I.C.A.)	\$ 1,689,587	1,329,942			359,645
5. Health Insurance	\$ 3,584,544	2,934,101			650,443
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 3,666	3,001			665
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 374,145	306,254			67,891
8. Uniform Allowance	\$ 2,042	1,671			371
9. Other (<i>Specify</i>) See Attached Schedule	\$ 250,958	205,419			45,539
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 346,829	280,721			66,108
d. Accounting and Auditing	\$ 145,595	117,844			27,751
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 211,009	170,789			40,220
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 75,295	60,943			14,352
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 87,571	70,879			16,692
2. Cellular Phones	\$ 11,363	9,197			2,166
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	\$ 1,319,498	1,319,498			
Subtotal	\$ 8,733,983	7,327,480			1,406,503

* 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**

Hebrew Home & Hospital
9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Chronic Disease Hospital
HHH HOSP-BHHU UNION LEGAL FUND ALLOC	5,530		1,226
HHH HOSP-CMU UNION LEGAL FUND ALLOC	2,162		479
HHH NUTRITIONAL UNION LEGAL FUND ALLOC	6,465		1,433
HHH EVS SERVICES UNION LEGAL FUND ALLOC	7,629		1,691
HHH NURSING ADMIN UNION LEGAL FUND ALLOC	29,118		6,455
HHH HHH ADMIN EMPLOYEE BENEFITS	74		17
	-	-	-
Disallowed Expenses - Discriminatory Benefits	-	-	-
HHC HHC ADMIN GROUP LIFE INSUR	4,478		993
HHH HHH ADMIN KEY PERSON PENSION	22,462		4,980
HHH HOSP-BHHU KEY PERSON PENSION	6,553		1,453
HHC HHC ADMIN KEY PERSON PENSION	120,948		26,812
	-	-	-
	-	-	-
Total	\$ 205,419	\$ -	\$ 45,539

Schedule of Other Taxes

Description	CCNH	RHNS	Chronic Disease Hospital
Total	\$ -	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended		Page	of
Hebrew Home & Hospital	2057C	9/30/2015		16	37
Item	Total	CCNH	RHNS	Chronic Disease Hospital	
Subtotals Brought Forward:	8,733,983	7,327,480		1,406,503	
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$	12,482	10,103	2,379	
4. Employee Travel	\$	12,167	9,848	2,319	
5. Education Expenses Related to Seminars and Conventions	\$	30,776	24,910	5,866	
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	7,314	5,920	1,394	
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	13,275	10,745	2,530	
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	2,619	2,119	500	
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	\$	34,323	27,781	6,542	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	64,571	52,263	12,308	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	275	223	52	
9. Subscriptions	\$	8,615	6,973	1,642	
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	311,362	252,015	59,347	
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$	285,109	230,763	54,346	
C-14 Total Administrative & General Expenditures	\$	9,516,871	7,961,143	1,555,728	

* 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	Chronic Disease Hospital
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Chronic Disease Hospital
HHH HHH ADMIN PUBLIC RELATIONS	1,917		452
HHH COGNITIVE PROG BROCHURES	202		48
-	-		-
-	-		-
-	-		-
-	-		-
Total Other Advertising	\$ 2,119	\$ -	\$ 500

Schedule of Dues

Description	CCNH	RHNS	Chronic Disease Hospital
ALTCFM	147		35
CHA	20,792		4,896
LeadingAge	30,515		7,186
CALTC	809		191
-	-		-
-	-		-
-	-		-
Total Dues	\$ 52,263	\$ -	\$ 12,308

Schedule of Contributions

Description	CCNH	RHNS	Chronic Disease Hospital
Total Contributions	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	Chronic Disease Hospital
HHC HHC ADMIN BANK/VENDOR SERV FEES	301		71
HHC HHC ADMIN GENERAL EXPENSE	3,395		799
HHH HOSP-BHHU LICENSE EXPENSE	356		84
HHH HHH ADMIN EE BACKGROUND CHECKS	14,864		3,500
HHH HHH ADMIN BANK/VENDOR SERV FEES	20,349		4,792
HHH HHH ADMIN LICENSE EXPENSE	2,645		623
HHH HHH ADMIN VOLUNTEER EXPENSE	1,516		357
HHH HHH ADMIN ADMIN FEES	335		79
HHH HHH ADMIN COMPANION RADIO EXPENSE	2,962		698
HHH BLDG OPS UNIFORMS & LAB COATS	614		144
OTHER DUES - NON INDUSTRY ASSOCIATIONS	7,075		1,666
-	-		-
EMPLOYEE INSERVICE	-		-
HHH HOSP-BHHU ALLOCATED TRAINING	3,233		761
HHH HOSP-CMU ALLOCATED TRAINING	1,583		373
HHH HHH ADMIN ALLOCATED TRAINING	1,148		270
HHH MEDICAL SERV ALLOCATED TRAINING	198		47
HHH HIMS ALLOCATED TRAINING	198		47
HHH NURSING ADMIN ALLOCATED TRAINING	16,363		3,853
HHH SOCIAL SERVICES ALLOCATED TRAINING	594		140
HHH LIFE ENRICHMENT ALLOCATED TRAINING	528		124
HHH REHAB SERVICES ALLOCATED TRAINING	726		171
HHH PHARMACY SERV ALLOCATED TRAINING	594		140
HHH NUTRITIONAL ALLOCATED TRAINING	2,771		653
HHH EVS SERVICES ALLOCATED TRAINING	2,573		606
HHH BLDG OPS ALLOCATED TRAINING	726		171
-	-		-
DISALLOWED EXPENSES	-		-
VENDOR FEES / PENALTIES	41,757		9,834
DEVELOPMENT - ASSOC DUES	642		151
HHH HOSP-BHHU MISCELLANEOUS EXP	197		46
HHH HHH ADMIN GENERAL EXPENSE	2,067		487
HHH MEDICAL SERV GENERAL EXPENSE	155		37
HHH NURSING ADMIN GENERAL EXPENSE	550		130
HHC HHC ADMIN PROFESSIONAL FEES	96,306		22,679
-	-		-
HHH HHH ADMIN PTO BENEFIT ADJ	2,873		677
HHH HIMS PTO BENEFIT ADJ	571		134
-	-		-
ADMIN ALLOCATIONS HHH & HHC	-		-
HHH HHH ADMIN ALLOCATED COST	172		41
HHH HHH ADMIN COST ALLOCATED TO HHH	1,762,270		415,003
HHC HHC ADMIN ALLOCATED COST	(1,757,607)		(413,904)
HHH HHH ADMIN COSTS ALLOCATED TO HMC	(4,198)		(988)
HHC HHC ADMIN COST ALLOCATED TO HHC	(639)		(150)
Total Other Administrative and General	\$ 230,763	\$ -	\$ 54,346

Schedule of Bank Fees

Description	CCNH	RHNS	Chronic Disease Hospital
BANK FEES			
October	1,819		428
November	1,577		371
December	1,679		395
January	1,623		382
February	1,705		402
March	1,638		386
April	1,934		455
May	1,596		376
June	1,613		380
July	1,883		444
August	1,576		371
September	1,706		402
Total Bank Fees	\$ 20,349	\$ -	\$ 4,792

Schedule C-1 - Management Services*

Name of Facility Hebrew Home & Hospital	License No. 2057C	Report for Year Ended 9/30/2015	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

*** 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
Hebrew Home & Hospital	2057C	9/30/2015		18	37
Item	Total	CCNH	RHNS	Chronic Disease Hospital	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$				
2. Non-Food Supplies	\$ 438	399			39
3. Other (<i>Specify</i>) _____	\$				
b. Purchased Services (<i>by contract other than through Management Services (Complete Schedule C-2 att. Page 21)</i>)	\$ 1,841,813	1,678,856			162,957
c. Management Services**	\$				
d. Other (<i>Specify</i>) _____	\$				
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 1,842,251	1,679,255			162,996
2F. Dietary Questionnaire	Total	CCNH	RHNS	Chronic Disease Hospital	
G. Resident Meals: Total no. of meals served per day:*	816	744			72
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No					
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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.

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

Name of Facility Hebrew Home & Hospital		License No. 2057C	Report for Year Ended 9/30/2015		Page 19	of 37
Item		Total	CCNH	RHNS	Chronic Disease Hospital	
3. Laundry						
a. In-House Processing*		Lbs.	1,051,518	910,429		141,089
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	61,060	52,867		8,193
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. \$	32,506	28,144		4,362
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Management Services**		\$				
d. Other (Specify) HHH EVS SERVICES DISPOSABLE SUPPLIES		\$	147,008	127,283		19,725
3E. Total Laundry Expenditures (3a + b + c + d)		\$	240,574	208,294		32,280
3F. Laundry Questionnaire						
G.	Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

**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	
Hebrew Home & Hospital	2057C	9/30/2015	20	37	
				Chronic Disease Hospital	
Item		Total	CCNH	RHNS	
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	87,857	80,084		7,773
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				
	Amt. \$				
c. Management Services*	\$				
d. Other (<i>Specify</i>)	\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)	\$	87,857	80,084		7,773
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$	1,283,401	1,169,851		113,550
2. Purchased from	\$				
b. Medicine Cabinet Drugs	\$	29,670	27,045		2,625
c. Medical and Therapeutic Supplies	\$	301,075	233,332		67,743
d. Ambulance/Limousine***	\$	16,931	8,107		8,824
e. Oxygen					
1. For Emergency Use	\$				
2. Other****	\$	73,174	66,700		6,474
f. X-rays and Related Radiological Procedures***	\$				
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory****	\$	140,357	127,939		12,418
i. Recreation	\$	44,743	40,784		3,959
j. Other (Specify)***** See Attached Schedule	\$	45,705	41,660		4,045
5K. Total Resident Care Expenditures (5a - 5j)	\$	1,935,056	1,715,418		219,638

* 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.

Resident Care - Medical & Therapeutic Supplies Chargeable

Description	CCNH	RHNS	Chronic Disease Hospital
HHH HOSP-BHHU MEDICAL SUPPLIES & EXP	-		23,315
HHH HOSP-CMU MEDICAL SUPPLIES & EXP	-		44,049
HHH MEDICAL SERV MEDICAL SUPPLIES & EXP	1,144		111
HHH NURSING SERV 1N MEDICAL SUPPLIES & EXP	47,076		-
HHH NURSING SERV 2N MEDICAL SUPPLIES & EXP	32,527		-
HHH NURSING SERV 2S MEDICAL SUPPLIES & EXP	30,445		-
HHH NURSING SERV 3N MEDICAL SUPPLIES & EXP	28,513		-
HHH NURSING SERV 3S MEDICAL SUPPLIES & EXP	37,760		-
HHH NURSING SERV 4N MEDICAL SUPPLIES & EXP	27,631		-
HHH NURSING SERV 4S MEDICAL SUPPLIES & EXP	25,467		-
HHH REHAB SERVICES MEDICAL SUPPLIES & EXP	2,766		268
HHH HHH ADMIN MEDICAL SUPPLIES & EXP	3		-
-	-		-
-	-		-
-	-		-
Total Other Resident Care	\$ 233,332	\$ -	\$ 67,743

Schedule of Other Resident Care

Description	CCNH	RHNS	Chronic Disease Hospital
HHH NURSING ADMIN MEDICAL SUPPLIES & EXP	30,987		3,008
HHH LIFE ENRICHMENT MEDICAL SUPPLIES & EXP	32		3
HHH NUTRITIONAL MEDICAL SUPPLIES & EXP	4,270		415
HHH EVS SERVICES MEDICAL SUPPLIES & EXP	2,417		235
HHH NURSING ADMIN PROFESSIONAL FEES	174		17
HHH NURSING ADMIN RESPIRATORY THERAPIST	3,780		367
-	-		-
-	-		-
-	-		-
-	-		-
-	-		-
-	-		-
-	-		-
-	-		-
-	-		-
-	-		-
-	-		-
-	-		-
Total Other Resident Care	\$ 41,660	\$ -	\$ 4,045

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

Name of Facility Hebrew Home & Hospital				License No. 2057C	Report for Year Ended 9/30/2015	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	Chronic Disease Hospital	Pg	Line
ALTMAN & COMPANY		<input type="radio"/>	<input checked="" type="radio"/>		Management Consultants	\$ 9,461		\$ 2,228	16	m.11
LTC CONSULTING		<input type="radio"/>	<input checked="" type="radio"/>		Billing Consultant	\$ 17,248		\$ 4,062	16	m.11
KRONOS		<input type="radio"/>	<input checked="" type="radio"/>		Time Card Software	\$ 10,970		\$ 2,583	16	m.11
MEDITECH		<input type="radio"/>	<input checked="" type="radio"/>		Computer Software Maint	\$ 27,317		\$ 6,433	16	m.11
SOFT CHOICE		<input type="radio"/>	<input checked="" type="radio"/>		Computer Software Maint	\$ 20,885		\$ 4,918	16	m.11
ABILITY NETWORK		<input type="radio"/>	<input checked="" type="radio"/>		Electronic Billing Software	\$ 10,074		\$ 2,372	16	m.11
DELL		<input type="radio"/>	<input checked="" type="radio"/>		Site Recovery Services	\$ 21,827		\$ 5,140	16	m.11
SYSTEM INTEGRATION		<input type="radio"/>	<input checked="" type="radio"/>		Server Maintenance	\$ 19,034		\$ 4,482	16	m.11
3M		<input type="radio"/>	<input checked="" type="radio"/>		Computer Software Maint	\$ 9,298		\$ 2,189	16	m.11
FIRST DATABANK		<input type="radio"/>	<input checked="" type="radio"/>		Computer Software Maint	\$ 15,794		\$ 3,719	16	m.11
		<input type="radio"/>	<input checked="" type="radio"/>							
MORRISON MANAGEMENT		<input type="radio"/>	<input checked="" type="radio"/>		Nutritional Services Management	\$ 1,678,856		\$ 162,957	18	2.b
		<input type="radio"/>	<input checked="" type="radio"/>							
IRON MOUNTAIN RECORDS STORAGE		<input type="radio"/>	<input checked="" type="radio"/>		Records Storage	\$ 37,572		\$ 6,104	22	6.f
SIMPLEX GRINNELL		<input type="radio"/>	<input checked="" type="radio"/>		Fire Alarm Maintenance	\$ 16,746		\$ 2,721	22	6.f
KONE ELEVATORS		<input type="radio"/>	<input checked="" type="radio"/>		Elevator Maintenance	\$ 10,714		\$ 1,740	22	6.f
AEGIS ENERGY SERVICES		<input type="radio"/>	<input checked="" type="radio"/>		Power & Heat Maintenance Contract	\$ 16,732		\$ 2,718	22	6.f
ERRICO BROTHERS LANDSCAPING		<input type="radio"/>	<input checked="" type="radio"/>		Landscaping & Snow Removal	\$ 98,619		\$ 16,021	22	6.f

* 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 Hebrew Home & Hospital	License No. 2057C	Report for Year Ended 9/30/2015			Page 22	of 37
Item		Total	CCNH	RHNS	Chronic Disease Hospital	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	253,939	218,451			35,488
b. Heat	\$	106,097	91,270			14,827
c. Light & Power	\$	184,797	158,971			25,826
d. Water	\$	129,324	111,251			18,073
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$	54,175	46,603			7,572
f. Other (<i>itemize</i>)	\$	264,651	227,663			36,988
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	992,983	854,209			138,774
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$	42,224	36,323			5,901
b. Building & Building Improvements	\$	304,690	262,109			42,581
c. Non-Movable Equipment	\$	44,990	38,703			6,287
d. Movable Equipment	\$	161,196	138,669			22,527
*7e. Total Depreciation Costs (7a + b + c + d)	\$	553,100	475,804			77,296
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$	14,386	13,113			1,273
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$	14,386	13,113			1,273
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$	1,402	1,206			196
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	568,888	490,123			78,765

* 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	Chronic Disease Hospital
HHH EVS SERVICES PEST CONTROL	4,208		684
HHH HHH ADMIN OFF SITE STORAGE	-		-
HHH BLDG OPS TELEVISION & RADIO	6,553		1,065
HHH BLDG OPS GROUNDS MAINTENANCE EXP	-		-
HHH EVS SERVICES CONTRACTED SERVICES	17,432		2,832
HHH BLDG OPS MAINTENANCE AGREEMENT	10,883		1,768
HHH BLDG OPS CABLE	15,444		2,509
HHH HOSP-CMU MAINTENANCE AGREEMENT	14,092		2,289
HHH HOSP-BHHU MAINTENANCE AGREEMENT	2,044		332
HHH NURSING SERV 2S MAINTENANCE AGREEMENT	681		111
HHH NURSING SERV 3N MAINTENANCE AGREEMENT	681		111
HHH NURSING SERV 3S MAINTENANCE AGREEMENT	681		111
HHH NURSING SERV 4N MAINTENANCE AGREEMENT	681		111
HHH NURSING SERV 4S MAINTENANCE AGREEMENT	681		111
HHH SOCIAL SERVICES MAINTENANCE AGREEMENT	681		111
HHH NURSING SERV 1N MAINTENANCE AGREEMENT	681		111
HHH NURSING SERV 2N MAINTENANCE AGREEMENT	681		111
HHH EVS SERVICES MAINTENANCE AGREEMENT	681		111
HHC HHC ADMIN MAINTENANCE AGREEMENT	2,704		439
HHH MEDICAL SERV MAINTENANCE AGREEMENT	440		71
HHH NURSING ADMIN MAINTENANCE AGREEMENT	1,320		214
HHH BLDG OPS ALLOCATED COST	(34,409)		(5,590)
HHH NUTRITIONAL MAINTENANCE AGREEMENT	440		72
PAGE 21 DETAIL	-		-
IRON MOUNTAIN RECORDS STORAGE	37,572		6,104
SIMPLEX GRINNELL	16,746		2,721
KONE ELEVATORS	10,714		1,740
AEGIS ENERGY SERVICES	16,732		2,718
ERRICO BROTHERS LANDSCAPING	98,619		16,021
Total Other Repairs and Maintenance	\$ 227,663	\$ -	\$ 36,988

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Non-Movable Equipment		\$ -		\$ -
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	Cost	Useful Life	Depreciation
Additions:				
10/23/2014	DELL COMPUTERS - 3	\$ 1,663	3	\$ 554
10/16/2014	CHAIRS - 3	\$ 2,387	10	\$ 239
10/1/2014	MOTOR FOR DRYER	\$ 579	10	\$ 58
11/13/2014	DELL COMPUTER	\$ 959	3	\$ 293
11/20/2014	MOTOROLA PORTABLE RADIOS - 8	\$ 4,590	5	\$ 842
11/25/2014	CLOTHING LABEL SOFTWARE	\$ 509	3	\$ 156
12/16/2014	PAYPHONE - BHU LOBBY	\$ 533	5	\$ 89
12/9/2014	MEDICAL CARTS - (2)	\$ 1,407	10	\$ 117
1/6/2015	CHAIRS	\$ 2,500	15	\$ 125
2/5/2015	REPAIRS CONDENSATE PUMP	\$ 2,495	10	\$ 166
2/10/2015	SERVER	\$ 109,847	5	\$ 14,646
2/26/2015	TELEVISION MULTI-PURPOSE ROOM	\$ 2,397	5	\$ 320
2/11/2015	SOFTWARE-CODETWO EXCHANGE	\$ 835	3	\$ 186
2/18/2015	WASHING MACHINE REPAIRS	\$ 1,213	15	\$ 54
2/1/2015	ICE MACHINE	\$ 7,250	10	\$ 483
2/13/2015	DRYER REPAIRS	\$ 2,682	10	\$ 179
2/1/2015	OFFICE CHAIRS	\$ 3,188	10	\$ 213
10/1/2014	DEFIBRILLATOR	\$ 11,390	5	\$ 1,627
2/9/2015	MEDICAL SCALE	\$ 2,829	10	\$ 189
3/26/2015	USERLOCK-SOFTWARE LICENSE	\$ 840	3	\$ 163
3/24/2015	REFRIGERATOR	\$ 477	10	\$ 28
3/1/2015	BLADDER SCAN	\$ 12,860	7	\$ 1,072
3/1/2015	VITAL SIGN MONITOR	\$ 2,113	6	\$ 206
3/1/2015	COMPRESSOR-COOLER	\$ 2,240	12	\$ 109
3/11/2015	CONDENSATE PUMP - FINAL INSTALLMENT	\$ 2,495	10	\$ 146
3/30/2015	DRYER REPAIR	\$ 1,840	10	\$ 107
3/31/2015	COOLANT RECOVERY ON EMERGENCY GENERATOR	\$ 660	12	\$ 32
4/10/2015	2 Spirometers	\$ 3,147	8	\$ 197
4/1/2015	INSTALLATION OF TV	\$ 1,375	5	\$ 138
5/19/2015	PUMP MOTOR FOR CHILLER TOWER	\$ 675	10	\$ 28
5/1/2015	35 MATRESSES	\$ 7,140	5	\$ 595
5/1/2015	SLING CLIPS	\$ 2,732	10	\$ 114
5/28/2015	OUTDOOR GRILL REPAIR	\$ 1,201	10	\$ 50
6/1/2015	HYDRAULIC STRETCHER	\$ 13,661	7	\$ 651
6/13/2015	PATIENT LIFT	\$ 1,399	10	\$ 47
7/1/2015	EMERGENCY CARTS - 2	\$ 2,250	10	\$ 56
7/8/2015	PATIENT LIFT	\$ 2,721	10	\$ 68
7/21/2015	PATIENT LIFT HANDLE	\$ 877	10	\$ 22
7/13/2015	CHAIR - SHOWER	\$ 922	10	\$ 23
7/8/2015	PATIENT LIFT SLINGS	\$ 642	10	\$ 16

7/1/2015	SAFETY RESTRAINT CHAIR	\$ 2,090	10	\$ 52
8/11/2015	DEFIBRILLATOR	\$ 5,125	5	\$ 171
9/18/2015	BACKPACK BLOWER	\$ 510	5	\$ 9
Total additions for Movable Equipment		\$ 229,245		\$ 24,636 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
Hebrew Home & Hospital			2057C		9/30/2015			24	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. Mortgage Acquisition	June	2009		390,428	64,854			12,000	
2. Mortgage Restructuring	Aug	2015		376,077				2,386	
3.									
B-4. Subtotal									14,386
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									14,386

* 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 Hebrew Home & Hospital	License No. 2057C	Report for Year Ended 9/30/2015	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> 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		01/01/85		
2. Date Structure Completed		01/01/89		
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		302		
6. Square Footage				
7. Acquisition Cost				
a. Land		1,256,000		
b. Building		19,998,052		
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)		Fixed		
b. Date Mortgage Obtained		06/11/09		
c. Interest Rate for the Cost Year		5.00%		
d. Term of Mortgage (number of years)		32 yrs 3 mths		
e. Amount of Principal Borrowed		20,242,000		
f. Principal balance outstanding as of _____		19,375,475		
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
Hebrew Home & Hospital		2057C	9/30/2015			26	37
Item		Total	CCNH	RHNS	Chronic Disease Hospital		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$ 809,999	696,800			113,199	
Name of Lender		Rate					
HUD							
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)		\$ 809,999	696,800			113,199	

(Carry Subtotals forward to next page)

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

Name of Facility Hebrew Home & Hospital		License No. 2057C		Report for Year Ended 9/30/2015		Page 27 37	
Item				Total	CCNH	RHNS	Disease Hospital
Subtotals Brought Forward:				809,999	696,800		113,199
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
00							
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)				\$	225,691	194,150	31,541
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	1,035,690	890,950	144,740
14. Insurance							
a. Insurance on Property (buildings only)				\$	68,718	59,115	9,603
b. Insurance on Automobiles				\$	4,622	3,976	646
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$	69,847	60,086	9,761
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$	214,050	184,136	29,914
See Attached Page 27A							
14d. Total Insurance Expenditures (14a + b + c)				\$	357,237	307,313	49,924
15. Total All Expenditures (A-13 thru C-14)				\$	39,726,669	32,217,175	7,509,494

Schedule of Other Insurance Expense

Description	CCNH	RHNS	Chronic Disease Hospital
Directors & Officers	9,073		1,474
Employment Policy	19,609		3,186
Crime Policy	6,598		1,072
GL Liability	129,884		21,100
Indemnity Bond	1,632		265
Commercial Lines	10,733		1,744
Physicians Liability	6,607		1,073
-	-		-
-	-		-
Total Other Repairs and Maintenance	\$ 184,136	\$ -	\$ 29,914

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Hebrew Home & Hospital				2057C	9/30/2015	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Chronic Disease Hospital
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	12.g	Occupational Therapy	\$ 345,607	254,852		90,755
4.			Other - See attached Schedule	\$ 243,705	35,080		208,625
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 192,363	31,213		161,150
Pages 15 & 16 - Administrative and General							
8.	15	1.a.9	Discriminatory Benefits	\$ 188,679	154,441		34,238
9.	15	1.c	Bad Debts	\$ 346,829	316,143		30,686
10.	15	1.e	Accounting & Legal	\$ 79,404	64,269		15,135
11.			Telephone	\$			
12.			Cellular Telephone	\$ 9,563	7,740		1,823
13.	15	1.a.6	Life insurance premiums on the life of Owners, Partners, Operators	\$ 188,679	152,715		35,964
14.			Gifts, flowers and coffee shops	\$			
15.	16	1.5	Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$ 15,191	12,295		2,896
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m.3	Unallowable Advertising *	\$ 2,619	2,119		500
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m.4	Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 179,293	145,118		34,175
Page 18 - Dietary Expenditures							
24.	18	2.b	Meals to employees, guests and others who are not residents	\$ 68,516	62,453		6,063
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)				\$ 1,860,448	1,238,438		622,010

* 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.

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Hebrew Home & Hospital			2057C	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Chronic Disease Hospital
Subtotals Brought Forward				\$ 1,860,448	1,238,438		622,010
Page 20 - Resident Care Supplies***							
27.	20	5.a.1	Prescription Drugs	\$ 1,283,401	1,169,851		113,550
28.	20	5.d	Ambulance/Limousine	\$ 16,931	15,244		1,687
29.			X-rays, etc	\$			
30.	20	5.h	Laboratory	\$ 140,357	127,940		12,417
31.			Medical Supplies	\$			
32.	20	5.e.2	Oxygen (non emergency)	\$ 73,174	66,700		6,474
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	\$ 25,487	21,926		3,561
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	\$ 9,444	8,124		1,320
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)			\$ 3,409,242	2,648,223		761,019

*** 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.

Hebrew Home & Hospital
9/30/2015

D.34 - Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Chronic Disease Hospital
20	5.c		-	-	-
20	5.c		-	-	-
20	5.c		-	-	-
20	5.c		-	-	-
20	5.c		-	-	-
20	5.c		-	-	-
20	5.c		-	-	-
20	5.c		-	-	-
20	5.c		-	-	-
20	5.c		-	-	-
20	5.c		-	-	-
20	5.c		-	-	-
20	5.c		-	-	-
20	5.c		-	-	-
20	5.c		-	-	-
20	5.c		-	-	-
Total Other Ancillary Costs			\$ -	\$ -	\$ -

D.35 - Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Chronic Disease Hospital
22	C.7.d		-	-	-
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

D.39 - Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Chronic Disease Hospital
22		Adult Day Center - Plant Operation Allocation	7,198		1,169
22		Meals On Wheels - Plant Operation Allocation	-		-
22		Outpatient Therapy - Plant Operation Allocation	685		111
22		CGSG - Plant Operation Allocation	14,043		2,281
Total Other Property Adjustments			\$ 21,926	\$ -	\$ 3,561

Page Ref	Line Ref	Description	CCNH	RHNS	Chronic Disease Hospital
22	6.a-f	Adult Day Center - Property Insurance Allocation	498		81
22	6.a-f	Meals On Wheels - Property Insurance Allocation	-		-
22	6.a-f	Outpatient Therapy - Property Insurance Allocation	47		8
22	6.a-f	CGSG - Property Insurance Allocation	972		158
		-	-		-
27	6.a-f	Physician Liability Insurance	6,607		1,073
		-	-		-
		-	-		-
		-	-		-
Total Other Adjustments			\$ 8,124	\$ -	\$ 1,320

D.50 - Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Chronic Disease Hospital
Total Unallowable Building Interest			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility Hebrew Home & Hospital	License No. 2057C	Report for Year Ended 9/30/2015			Page 30	of 37
Item	Total	CCNH	RHNS	Chronic Disease Hospital		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 27,366,116	26,771,675		594,441		
b. Medicaid Room and Board Contractual Allowance **	\$ (10,058,923)	(9,643,150)		(415,773)		
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 12,091,662	3,884,800		8,206,862		
b. Medicare Room and Board Contractual Allowance **	\$ (2,527,663)	(1,021,037)		(1,506,626)		
4. a. Private-Pay Residents and Other	\$ 8,698,516	8,146,268		552,248		
b. Private-Pay Room and Board Contractual Allowance **	\$ (1,403,199)	(1,118,167)		(285,032)		
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 479,657	437,218		42,439		
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 1,428,984	1,302,553		126,431		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$ (5)	(5)				
b. Medical Supplies - Medicare Contractual Allowance **	\$ 144			144		
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 696,009	625,942		70,067		
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 144,152	129,640		14,512		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 117,879	115,856		2,023		
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 25,065	24,635		430		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 621,554	579,636		41,918		
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 117,661	109,726		7,935		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$ 47,281	1,852		45,429		
b. Other (<i>Specify</i>) - Non-Medicare	\$ 91,081	74,800		16,281		
III. Total Resident Revenue (Section I. thru Section II.)	\$ 37,935,971	30,422,242		7,513,729		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$ 68,516	62,454		6,062		
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 237	216		21		
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ (593,288)	(540,795)		(52,493)		
V. Total Other Revenue (1 thru 8)	\$ (524,535)	(478,125)		(46,410)		
VI. Total All Revenue (III +V)	\$ 37,411,436	29,944,117		7,467,319		

* 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	Chronic Disease Hospital
20	HHH HOSP-CMU LAB MCRB	\$ -		\$ 90
20	HHH HOSP-BHHU PHYSICIANS MCRA	\$ -		\$ 1,506
20	HHH HOSP-BHHU PHYSICIANS MCRB	\$ -		\$ 15
20	HHH HOSP-CMU PHYSICIANS MCRA	\$ -		\$ 294
20	HHH HOSP-CMU PHYSICIANS MCRB	\$ -		\$ (596)
20	HHH SNF BLOOD ADMIN MCRA	\$ 1,852		\$ -
20	HHH HOSP-CMU BLOOD ADMIN MCRB	\$ -		\$ 41,390
20	HHH HOSP-BHHU BLOOD ADMIN MCRA	\$ -		\$ 265
20	HHH HOSP-BHHU ANCILLARY MCRB	\$ -		\$ 694
20	HHH HOSP-CMU BLOOD ADMIN MCRA	\$ -		\$ 1,771
	-	\$ -		\$ -
	-	\$ -		\$ -
Total Other Resident Revenue - Medicare		\$ 1,852	\$ -	\$ 45,429

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Chronic Disease Hospital
20	HHH SNF NURSING WOUND CARE REV	\$ 13,400		\$ -
20	HHH SNF PRIVATE PAY SP/INS	\$ 11,808		\$ -
20	HHH HOSP-BHHU PHYSICIANS MCD	\$ -		\$ (22)
20	HHH HOSP-BHHU PHYSICIANS SP/INS	\$ -		\$ 105
20	HHH HOSP-CMU PHYSICIANS SP/INS	\$ -		\$ 1,354
20	HHH HOSP-BHHU PHYSICIANS T19 PENDING	\$ -		\$ (42)
20	HHH SNF BLOOD ADMIN SP/INS	\$ 529		\$ -
20	HHH HOSP-CMU BLOOD ADMIN MCD	\$ -		\$ 707
20	HHH HOSP-CMU BLOOD ADMIN SP/INS	\$ -		\$ 9,413
20	HHH HOSP-CMU LAB SP/INS	\$ -		\$ 4
20	HHH COGNITIVE PROG DEMENTIA CONSULTATION	\$ 48,981		\$ 4,754
20	HHH COGNITIVE PROG DEMENTIA SP/INS	\$ 82		\$ 8
20	-	\$ -		\$ -
20	-	\$ -		\$ -
20	-	\$ -		\$ -
20	-	\$ -		\$ -
20	-	\$ -		\$ -
20	-	\$ -		\$ -
20	-	\$ -		\$ -
Total Other Resident Revenue		\$ 74,800	\$ -	\$ 16,281

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	Chronic Disease Hospital
31	HHH HHH ADMIN DIV/INTEREST INCOME		\$ 209		\$ 20
31	HHH DEBT SERVICE DIV/INTEREST INCOME		\$ 7		\$ 1

	-	\$ -		\$ -
Total Interest Income		\$ 216	\$ -	\$ 21

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Chronic Disease Hospital
20	HHH SNF FLU SHOT ADMINISTRATION	\$ 6,729		\$ 653
18	HHH HHH ADMIN CAFE	\$ 813		\$ 79
15	HHH HHH ADMIN TRANSCRIPTION SERVICES	\$ 4,072		\$ 395
20	HHH HHH ADMIN MATERIALS MGMT INCOME	\$ 9,079		\$ 881
22	HHH REHAB SERVICES MISCELLANEOUS INCOME	\$ 80		\$ 8
15	HHH HHH ADMIN MISCELLANEOUS INCOME	\$ 365		\$ 35
31	HHH HHH ADMIN GRANT FROM AFFILIATE	\$ 551,414		\$ 53,522
31	HHH HHH ADMIN UNREALIZED GAIN/(LOSS)	\$ (113)		\$ (11)
31	HHH HHH ADMIN GILMAN EDUC/RESEARCH	\$ 11		\$ 1
31	HHH HHH ADMIN SINKING FUND INCOME	\$ 137		\$ 13
31	HHH HHH ADMIN CHG IN PENSION FUND	\$ (1,118,851)		\$ (108,600)
31	HHH PHARMACY SERV UCONN/SFH TEACHING	\$ 5,469		\$ 531
34	-	\$ -		\$ -
13	-	\$ -		\$ -
10	-	\$ -		\$ -
13	-	\$ -		\$ -
15	-	\$ -		\$ -
Total Other Revenue		\$ (540,795)	\$ -	\$ (52,493)

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Hebrew Home & Hospital	2057C	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	183,137
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	3,587,354
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4 Inventories			\$	278,025
5. Prepaid Expenses			\$	161,197
a. HHH HHH BS/OH PREPAID EXP - GENERAL	93,189			
b. HHH HHH BS/OH PREPAID EXP. - INSURANCE	68,008			
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	231,948
HHH HHH BS/OH SINKING FUND	40,920			
HHH HHH BS/OH DEPOSITS	191,028			
A-9. Total Current Assets (Lines A1 thru 8)			\$	4,441,661
B. Fixed Assets				
1. Land			\$	1,256,001
2. Land Improvements	*Historical Cost	2,127,291	\$	110,944
	Accum. Depreciation	(2,016,347) Net		
3. Buildings	*Historical Cost	23,930,287	\$	1,483,410
	Accum. Depreciation	(22,446,877) Net		
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____ Net		
5. Non-Movable Equipment	*Historical Cost	744,791	\$	192,396
	Accum. Depreciation	(552,395) Net		
6. Movable Equipment	*Historical Cost	3,558,635	\$	576,241
	Accum. Depreciation	(2,982,394) Net		
7. Motor Vehicles	*Historical Cost	_____	\$	
	Accum. Depreciation	_____ Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	231,420
HHH HHH BS/OH RENOVATIONS IN PROGRESS	237,658			
COST REPORT vs FINANCIAL STATEMENTS	(6,238)			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	3,850,412

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hebrew Home & Hospital	2057C	9/30/2015	32	37
Account			Amount	
Total Brought Forward:			\$	8,292,073
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	766,505		
	Accum. Depreciation	(79,240)	Net	\$ 687,265
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>)			\$	711,361
See Attached Page 32A		711,361		
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	1,398,626
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	9,690,699

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

D.7 - Schedule of Other Assets

Description	Amount
HHH HHH BS/OH NEW FACILITY MAIN BOND	5,000
HHH HHH BS/OH REPLACEMENT RESV-WELLS	496,032
HHH HHH BS/OH MIP ESCROW-WELLS	55,232
HHH HHH BS/OH PROP INSUR ESCROW-WELLS	155,097
-	-
-	-
-	-
-	-
Total Other Assets	\$ 711,361

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hebrew Home & Hospital	2057C	9/30/2015	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	2,550,736
2. Notes Payable (<i>itemize</i>)			\$	25,548,570
HHH HHH BS/OH TD BANK LOC			3,499,999	
HHH HHH BS/OH MORTGAGE PAYABLE-WI			10,997,760	
HHH HHH BS/OH MORTGAGE PAYABLE-HU			11,050,811	
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>)			\$	1,307,719
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	45,653
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>)			\$	49,792
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities (<i>itemize</i>)			\$	916,816
See Attached Page 33A			916,816	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	30,419,286

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

(*Carry Total forward to next page*)

A.12 - Schedule of Other Current Liabilities

Description	Amount
HHH HHH BS/OH RESIDENT SAVINGS	158,484
HHH HHH BS/OH CAPITAL LEASE LIABILITY	62,071
HHH HHH BS/OH ACCRUED PENSION INSUR	31,821
HHH HHH BS/OH NURSING HOME USE TAX	628,992
HHH HHH BS/OH ACCR KEY PERSON PENSION	35,448
-	-
-	-
-	-
-	-
Total Other Assets	\$ 916,816

G. Balance Sheet (cont'd)

Name of Facility Hebrew Home & Hospital	License No. 2057C	Report for Year Ended 9/30/2015		Page 34	of 37
Account				Amount	
Total Brought Forward:				30,419,286	
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>)				\$ 4,244,641	
HHH HHH BS/OH TPA INSUR PAYABLE		332,233			
HHH HHH BS/OH DEFERRED REVENUE		144,598			
HHH HHH BS/OH L T ACC NON UNION PENS		3,767,810			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 4,244,641	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 34,663,927	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hebrew Home & Hospital	2057C	9/30/2015	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			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(22,657,995)
6. Gain or Loss for Period			\$	(2,315,233)
	10/1/2014	thru	9/30/2015	
7. Total Net Worth			\$	(24,973,228)
C. Total Reserves and Net Worth			\$	(24,973,228)
D. Total Liabilities, Reserves, and Net Worth			\$	9,690,699

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of	
Hebrew Home & Hospital	2057C	9/30/2015	36	37	
Account			Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	(24,435,010)	
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	37,411,436	
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	39,726,669	
D. Net Income or Deficit			\$	(2,315,233)	
E. Balance			\$	(26,750,243)	
F. Additions					
1. Additional Capital Contributed (<i>itemize</i>)					
1,777,015					
2. Other (<i>itemize</i>)					
Rounding					
F-3. Total Additions			\$	1,777,015	
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			\$	(24,973,228)	
09/30/15					

I. Preparer's/Reviewer's Certification

Name of Facility Hebrew Home & Hospital	License No. 2057C	Report for Year Ended 9/30/2015	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Chronic Disease Hospital		
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 <i>Wonneberger & Morgan, LLC</i>		Title Title		Date Signed 2/1/2016
Printed Name of Preparer Wonneberger & Morgan, LLC				
Address Address 1781 Highland Ave, Suite 207, Cheshire, CT 06410			Phone Number (860) 202-4980	

Error Check

Level	Item	Reported as	
	Page 24 - Accumulated Amort. of Org. Expense	(79,240) is inconsistent with Page 32	(79,240)
	Page 25 - Total Bed Capacity	302 is inconsistent with page 8	302