Craig J. Lubitski Consulting LLC & CJLC LLC

CERTIFIED PUBLIC ACCOUNTANTS & ADVISORS

Mr. Chris LaVigne CON & Reimbursement Department of Social Services 55 Farmington Avenue Hartford, CT 06105

Mr. LaVigne:

This enclosed 2015 Medicaid Cost Report intentionally omits the following disallowances:

- a. Administrator and Related Party salaries
- b. Dues and Membership Fees to Professional Associations
- c. Physical or Speech Therapy salaries or fees
- d. Depreciation and/or interest expense related to capitalized items previously deemed unallowable by the Department

It is our understanding that the software utilized by the Department in the rate setting process computes the necessary disallowances for these areas and our intention is to eliminate the potential for a duplicate disallowance.

If you have any questions, please contact me at 860-610-9009.

Respectfully,

Craig J. Lubitski, CPA

Partner

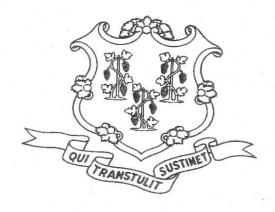


225 Pitkin Street East Hartford Connecticut 06108

860.610.9009 (t) 860.610.9030 (f)

cjlc.com

State of Connecticut



Annual Report of Long-Term Care FacilityCost Year 2015

Name of Facility (as I									
St. Lucian's Residenc									
Address (No. & Stree	et, City, State, Z	Zip Code)							
532 Burritt Street, Ne	ew Britain, CT	06053							
Type of Facility									
Chronic and C	Convalescent		Rest Home wit	h Nursing					
☐ Nursing Home	e only		Supervision on	ly	\checkmark	Residenti	al Ca	re Home	
(CCNH)			(RHNS)						
Report for Year Begi	nning		Report for Yea	r Ending					
10/1/2014			9/30/2015						
License Numbers: CCNH		CCNH	RHNS	HNS Residential Care Home Medical 1849-RCH		dicare Provider			
Medicaid Provider N	umbers:	CC	CNH	RI	INS		ICF-IID		
For Department Use	e Only								
Sequence Number	Signed and	Date	Sequence N	lumber	Cianad a	nd Motori	and.	Date Received	
Assigned	Notarized	Received	Assign	ed	Signed a	nd Notari	zea	Date Received	

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
St. Lucian's Residence, Inc.	1849-RCH	9/30/2015	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 St. Lucian's Residence, Inc. [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
Mather Mary Jenny	ir Carroll	2/15/16	Signed (Owner) Daughters of Mary Mather M. Janufer	2/15/16
Printed Name (Administrator)		1 '	Printed Name (Owner) (2010)	, ,
Mother Mary Jennifer Carroll			Daughters of Marcy Mother M. Jennifer Carvoll	2/15/16
Subscribed and Sworn	State of	Date	Signed (Notary Public)	Comm. Expires
to before me:	CT	2/15/16	Sophie Smitak	07131119
Address of Notary Public	f > 7			
63 CobuRN AVE.,	Newington	r, CT O	06/11	

(Notary Seal)

State of Connecticut **Department of Social Services**

25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjus	Page	of		
			1A	37
Name of Facility	Period Cov	ered:	From	То
St. Lucian's Residence, Inc.			10/1/2014	9/30/2015
Address of Facility 532 Burritt Street, New Britain, CT 06053				
Report Prepared By	Phone Nun	nber	Date	
Craig J. Lubitski Consulting LLC	860-610-90	009	2/12/2016	
Item	Total	CCNH	RHNS	Residentia 1 Care Home
1. Dietary wages paid	\$ 10001	001(11	1011	1101110
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 Report for Year Ended Page of 860-223-2123 9/30/2015 37 2 Name of Facility (as shown on license) Address (No. & Street, City, State, Zip) St. Lucian's Residence, Inc. 532 Burritt Street, New Britain, CT 06053 CCNH RHNS Residential Care Home Medicare Provider No. License Numbers: 1849-RCH Type of Facility (Check appropriate box(es)) Chronic and Convalescent Rest Home with Nursing ☑ Residential Care Home Nursing Home only (CCNH) Supervision only (RHNS) Type of Ownership (Check appropriate box) O Proprietorship O LLC O Partnership O Profit Corp. Non-Profit Corp. O Government O Trust Date Opened Date Closed If this facility opened or closed during report year provide: Has there been any change in ownership If "Yes," explain fully. or operation during this report year? O Yes O No Administrator Name of Administrator **Nursing Home** Mother Mary Jennifer Carroll Administrator's License No.: Other Operators/Owners who are assistant administrators (full or part time) of this facility. License No.: Name N/A

General Information and Questionnaire Partners/Members

Name of Facility St. Lucian's Residence, Inc.		License No. 1849-RCH	Report for Y 9/30/2015	ear Ended	Page 3	of 37
Legal Name of Parti	nership/LLC		Address	State(s) and Which F	or Town(Registered	s) in
Name of Partners/Members	Business Ac	ldress	,	Γitle	% Ow	vned
N/A						

CSP-3A Rev. 10/2005

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year E	naea	Page of
St. Lucian's Residence, Inc.	1849-RCH	9/30/2015		3A 37
If this facility is owned or operated as a cor	poration, provide the	ne following informa	ation:	
Legal Name of Corporation	Busine	ess Address	State(s) in Whi	ch Incorporated
St. Lucian's Residence, Inc.	532 Burritt Stree 06053	t, New Britain, CT	СТ	
Name of Directors, Officers	Busine	ess Address	Title	No. Shares Held by Each
Mother Mary Jennifer Carroll	314 Osgood Ave	e, New Britain, CT	President	N/A
Sister Mary Clare Milewski	532 Burritt Stree 06053	t, New Britain, CT	Secretary	N/A
Sister Mary Lucille Banach	799 Concord Av	e, Cambridge, MA	VP/Treasurer	N/A
Sister Mary Janice Zdunczyk	23 Orange Street	t, New Britain, CT	Director	N/A
Names of Stockholders Owning at Least 10% of Shares				
N/A				

CSP-3B Rev. 10/2005

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
St. Lucian's Residence, Inc.	1849-RCH	9/30/2015	3B	37
If this facility is owned or operated as an individua	l proprietorship, p	provide the following informat	ion:	
	ner(s) of Facility			
	•			
N/A				
2.4.2				

General Information and Questionnaire Related Parties*

Name of Facility		License	e No.		Report for Year Ended		Page	of
St. Lucian's Residence,	Inc.	1	849-RC	H	9/30/2015		4	37
Are any individuals rece	eiving compensation from the fa	acility re	elated th	rough		If "Yes," provide th	e Name/Ad	dress and
marriage, ability to cont	rol, ownership, family or busing	ess asso	ciation?	•	Yes O No	complete the inform	nation on Pa	age 11 of the report.
Are any individuals or c	companies which provide goods	or serv	ices,					
including the rental of p	property or the loaning of funds	to this f	acility,					
related through family a	ssociation, common ownership	, control	l, or bus	iness	• Yes • No			
association to any of the	e owners, operators, or officials	of this f	acility?			If "Yes," provide th	e following	information:
	-							
		Als	so Provi	des		Indicate Where		
		Good	ls/Servi	ces to		Costs are Included		
Name of Related	Business	Non-F	Related 1	Parties	Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	No	%**	Provided	Page # / Line #	Reported	Related Party
Daughters of Mary of the		0	•					
Immaculate Conception	314 Osgood Ave, New Britain, CT				Lendor of Funds	Page 26/Line12A1	90,656	90,656
Daughters of Mary of the Immaculate Conception	314 Osgood Ave, New Britain, CT	0	⊙		Provider of Land Lease	Page 22/Line 9	5,504	5,504
Daughters of Mary of the	311 Osgood 1110, 11011 Bittain, C1				1 Tovider of Land Lease	rage 22/Eme)	3,304	3,304
Immaculate Conception	314 Osgood Ave, New Britain, CT	0	•		Sisters volunteer services to the Residence	Page 10/Various lines	9,881	9,881
Daughters of Mary of the		0	•					
Immaculate Conception Daughters of Mary of the	314 Osgood Ave, New Britain, CT				Various Salaries - see page 11/12	Page 10/Various lines	110,268	110,268
Immaculate Conception	314 Osgood Ave, New Britain, CT	0	•		Religeous Services - Father Joseph	Page 20/Line 5j	26,918	26,918
*		0	•		· g	, and the same of		
		0	•					
		0	•					
		0	•					
		0	0					

^{*} Use additional sheets if necessary.

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

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No	٠.	Report for Year Ended	Page	Of			
St. Lucian's Residence, Inc.	1849-RCH		9/30/2015	5	37			
If the facility is licensed as CDH and/or RCH or	r provides A	IDS or TB	I services with special Medicai	d rates,	costs			
must be allocated to CCNH and RHNS as follow	ws:		-					
Item			Method of Allocation					
Dietary		Number of	meals served to residents					
Laundry		Number of	pounds processed					
Housekeeping		Number of	square feet serviced					
		Number of	hours of routine care provided	by EAG	CH			
Nursing		employee c	classification, i.e., Director (or	Charge	Nurse),			
1.010.119		Registered	Nurses, Licensed Practical Nu	rses, Ai	des and			
		Attendants						
Direct Resident Care Consultants		Number of	hours of resident care provide	d by EA	CH			
		specialist ((See listing page 13)					
Maintenance and operation of plant		Square feet	i					
Property costs (depreciation)		Square feet	į.					
Employee health and welfare		Gross salar	ries					
Management services		Appropriate cost center involved						
All other General Administrative expenses		Total of Di	rect and Allocated Costs					
The preparer of this report must answer the foll-	owing quest	ions applications	able to the cost information pro	ovided.				
1. In the preparation of this Report, were all	O V	O N-	If "No," explain fully why suc	h alloca	tion was			
costs allocated as required?	• Yes	O No	not made.					
2. Explain the allocation of related company ex	penses and	attach copy	of appropriate supporting data	1.				
3. Did the Facility appropriately allocate and se	elf-disallow	direct and i	ndirect costs to non-nursing ho	me cost	t centers?			
(e.g., Assisted Living, Home Health, Outpati	ent Services	s, Adult Day	y Care Services, etc.)					
	O 1/	O N	If "No," explain fully why suc	h alloca	tion was			
	Yes	O 110	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 Y	ear Ended		Page	of
St. Lucian's Residence, Inc.			1849-RCH	9/30/2015	9/30/2015			
	Owi	ed * to ners,						
	Offi	ators,		Date of	Term of	Annual Amount	Amour	
Name and Address of Lessor	Yes	No •	Description of Items Leased	Lease**	Lease	of Lease	Claime	ed
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
Is a Mileage Log Book Maintained for A	ll Leased V	ehicles	o Ye	s O	No	Total ***		

Is a Mileage Log Book Maintained for All Leased Vehicles?

^{*} 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	License No.	Report for Year Ended		Page	of
St. Lucian's Residence, Inc.	1849-RCH	9/30/2015		7	37
The records of this facility for the p	eriod covered by this report	were maintained on the following basis:			
	Modified Cash				
Is the accounting basis for this	***	TC 113.7 . 11 . 1 . 1			
i i	Yes	If "No," explain.			
previous period?	No				
Independent Accounting Firm					
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code))		
1 Craig J. Lubitski Consulting Ll		225 Pitkin Street, East Hartford, CT 061	.08		
2 Brenner, McDonald & Tortolar	ni, Inc.	220 White Plains Road, Tarrytown, NY			
3 Patrick D. Gill, Consultant		17 Highfarm Road, East Granby, CT			
4 5					
Services Provided by This Firm (de	scribe fully)	1			
1 Year-end audit of Financial Statemer	nts		\$	9,075	
2 Bookkeeping and general ledger prep	paration		\$	23,100	
3 Year-end Medicaid cost report prepa	ration		\$	2,000	
4			\$		
5			\$		
			Charge fo	or Services P	rovided
			\$	34,175	
	diture Portion of This Report? If Pg 15/1d	Yes, Specify Expense Classification and Line No.			
Legal Services Information	15 13/14				
Name of Legal Firm or Independent	t Attorney		Telephon	e Number	
1 Cooney, Scully and Dowling	·		860-527-		
2					
3					
4					
5					
Address (No. & Street, City, State, 2	Zip Code)				
1 Columbus Ave, Hartford, CT					
2					
3					
5					
Services Provided by This Firm (de	scribe fully)				
1 Audit letter			\$	66	
2			\$		
3			\$		
4			\$		
5			\$		
-			1	or Services P	rovided
			\$	66	
Are These Charges Reflected in the Expen	•	Yes, Specify Expense Classification and Line No.			
⊙ Yes O No	Pg 15/1e				

Schedule of Resident Statistics

Name of Facility		License 1				Report for Year Ended				Page	of	
St. Lucian's Residence, Inc.			184	9-RCH			9/30/2015				8	37
						Period 10	10/1 Thru 6/30 Period 7/1			1 Thru 9/3	30	
		Total	Total	Total								
	Total All	CCNH	RHNS	Residential	T-4-1	COMI	DIING	Residential	T-4-1	COMI	DIING	Residential
	Levels	Level	Level	Care Home	Total	CCNH	RHNS	Care Home	Total	CCNH	RHNS	Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	42			42	42			42	42			42
B. On last day of THIS report period	42			42	42			42	42			42
2. Number of Residents												
A. As of midnight of PREVIOUS report period	42			42	42			42	42			42
B. As of midnight of THIS report period					42			42				
3. Total Number of Days Care Provided During Period												
A. Medicare												
B. Medicaid (Conn.)												
C. Medicaid (other states)												
D. Private Pay	3,422			3,422	2,546			2,546	876			876
E. State SSI for RCH	11,711			11,711	8,787			8,787	2,924			2,924
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	15,133			15,133	11,333			11,333	3,800			3,800
Total Number of Days Not Included in Figures in 3G												
4. 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)	15,133			15,133	11,333			11,333	3,800			3,800

CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Faci	•				ise No.				Repor	t for Year			Page	of	
St. Lucian's R	Residence	e, Inc.		1849-RCH 9/30/2015						9	37				
	-	-		he certified bed capacity during the report year? O Yes O Noving information:								No			
11 125	T -		Change		Cl	nange	in Bed	c		Cai	pacity Afte	er Change			
		1 lace of	Residential		CI	lange	III Deu	3		Caj	Jacity Aite	Change	ł		
Date of	CCNH	RHNS	Care Home		Lost	I	(Gaine	d			Residential			
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Care Home	Reason fo	or Change	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCIVII	KIIIVB	care frome	Reason is	or Change	
	•	_	in certified bed c 90 days followin	_		the re	eport y	ear (as	report	ed in item	4 above)	provide the nur	nber of		
			Change in Re	esider	nt Days					CC	NH	RHNS	Residential	Care Home	
1st chan															
2nd char															
3rd chan	_														
4th chan		1	1 D - (C (1	20 - f.C-	-4 37 -							<u></u>		
6. Number	of Resid	ients and	d Rates on Septe	mber			ar	I		C-	1f Dan		Other State Assiste		
		ŀ	Medicare		Medi	caid				Se	lf-Pay		Other Star	le Assisted	
	Item		CCNH	C	CNH	RI	HNS	CC	CNH	RH	INS	Residential Care Home	R.C.H.	ICF-IID	
No. of R		;										11	11		
Per Dien															
a. One b												110.00	105.00		
b. Two	bed rms.														
c. Three	or more	e											ļ		
bed r	ms.														
A.	Medica Medica	re - Part aid (Excl	usive of Part B)		3					TO	ΓAL	CCNH	RHNS	Residential Care Home	
			e Treatments												
		torative '	Treatments										ļ		
	Other	1	TI	4											
8. Total Nu	ımber of	Speech	Therapy Treatm Therapy Treatm												
		re - Part													
B.		,	usive of Part B)												
			e Treatments												
		torative '	Treatments												
	Other														
			herapy Treatme												
			tional Therapy	Гreatı	nents										
		re - Part													
В.		•	usive of Part B)												
			Treatments												
	2. Rest	wianve	Treatments							 			 		
)ccupati	onal Therapy T	roatn	ents										
υ.	1 oui C	ссирин	onai incrupy I	· cuiii	· · · · · · · · · · · · · · · · · · ·					ı			<u> </u>	J	

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.		Report for Yea		Page	of
St. Lucian's Residence, Inc.	1849-RCH		9/30/2015		10	37
		0	Yes		No	
Are time records maintained by all individuals receiving co	ompensation?	•			NO	
			Total Cost a	and Hours	1	
T .	COM	**	DIDIG	***	Residential	**
Item A. Salaries and Wages*	CCNH	Hours	RHNS	Hours	Care Home	Hours
Operators/Owners (Complete also Sec. I						
of Schedule A1)						
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)					52,573	2,232
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)					26,162	2,423
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor					202.046	1 < 201
c. Dietary Workers 6. Housekeeping Service					203,846	16,281
a. Head Housekeeper						
b. Other Housekeeping Workers					140,003	11,152
7. Repairs & Maintenance Services					110,000	11,101
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers					57,223	2,232
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers					19,369	2,973
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						
b. RN						
1. Direct Care						
2. Administrative**						
c. LPN						
1. Direct Care						
2. Administrative**					50.270	6.02
d. Aides and Attendants e. Physical Therapists					58,378	6,030
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers					41,483	2,58
i. Physicians						
Medical Director						
2. Utilization Review					1	
3. Resident Care***						
4. Other (Specify)						
j. Dentists	+	+		+	+	
k. Pharmacists				+		
1. Podiatrists				†		
m. Social Workers/Case Management						
n. Marketing						
o. Other (Specify)						
See Attached Schedule						
A-13. Total Salary Expenditures				1	599,037	45,910

^{*} 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			INS			
Position	\$	Hours	\$	Hours	\$	Hours	
Total	¢		¢		¢		
Total	\$ -	-	\$ -	-	\$ -	-	

Schedule of Other Fees (Page 13)

	CCNH		RH	INS	Residential Care Home		
Service	\$	Hours	\$	Hours	\$	Hours	
Total	\$ -	-	\$ -	-	\$ -	-	

CSP-11 Rev. 10/2005

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
St. Lucian's Residence, Inc.				1849-RCH		9/30/2015			11	37
		Salary Pai	d							
Name	CCNH	RHNS	Residential Care Home	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
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).										
Sister Mary Ernestine			1,218	None	Other administrative work	111	A4	N/A		
Sister Mary John			3,718	None	Recreation work	338	A12h	N/A		
Sister Mary Gloriosa			4,945	None	Recreation work	450	A12h	N/A		
See Attached										

^{*} 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.

St. Lucians Residence 9/30/2015 Related Party Salaries

Name	Salary	Hours Worked	Line Number	Description of Dutes
Sister Mary Lisette	\$ 3,378	308	12h	Recreation
	\$ 11,382	961	6b	Housekeeping
	\$ 2,058	172	8b	Laundry
Sister Mary Joseph	\$ 33,955	2,108	5c	Dietary
Sister Mary Ernestine	\$ 5,809	557	12h	Recreation
	\$ 176	16	6b	Housekeeping
Mother Mary Jennifer	\$ 80	8	7b	Maintenance
	\$ 855	79	12d	Aides & Attendants

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Y	ear Ended		Page	of
St. Lucian's Residence, Inc.				1849-RCH		9/30/2015			12	37
		Salary Pai	Residential	Fringe Benefits and/or Other Payments	Full Description of	Total Hours		Name and Address of All	Total Hours	Compensation
Name	CCNH	RHNS	Care Home	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section III - Administrators***										
Mother Mary Jennifer Carroll			52,573	None	Administor	2,232	A2	N/A		
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.

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

•	License No.		Report for Y	ear Ended	Page	of
t. Lucian's Residence, Inc.	1849-	RCH	9/30/2015		13	37
		1	Total Cost	and Hours	1 1	
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	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						
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)						
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)						
 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						
Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule						

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

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

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

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

Name of Facility St. Lucian's Residence, Inc.	License No. 1849-RCH		Report for `9/30/2015	Year Ended	Page 14	of 37	
Name & Address of Individual	Full Explanation of Service	Operato	* to Owners, rs, Officers	Explanation of Relationship			
Reverend Joseph Tran	Religious services	Yes	No •	None			
		0	0				
		0	0				
		0	0				
		0	0				
		0	0				
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		0	0				
		0	0				

^{*} Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

3	License No.	Report for Y	ear Ended	Page	of
St. Lucian's Residence, Inc.	1849-RCH	9/30/2015		15	37
Item		Total	CCNH	RHNS	Residential Care Home
Administrative and General		1 3 00.1	001,12		
a. Employee Health & Welfare Benefits					
Workmen's Compensation	9	29,632			29,632
2. Disability Insurance		\$			_,,,,,
3. Unemployment Insurance		5			
4. Social Security (F.I.C.A.)		31,014			31,014
5. Health Insurance		119,135			119,135
6. Life Insurance (employees only)		,			
(not-owners and not-operators)		\$			
7. Pensions (Non-Discriminatory)		\$			
(not-owners and not-operators)					
8. Uniform Allowance		\$			
9. Other (<i>Specify</i>)		\$			
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and		\$			
Profit Sharing Plans for Owners and					
Operators (Discriminatory)*					
c. Bad Debts*		\$			
d. Accounting and Auditing	9	34,175			34,175
e. Legal (Services should be fully described	on Page 7)	\$ 66			66
f. Insurance on Lives of Owners and		\$			
Operators (Specify)*					
g. Office Supplies	(10,930			10,930
h. Telephone and Cellular Phones					
1. Telephone & Pagers	9	10,842			10,842
2. Cellular Phones		\$			
i. Appraisal (Specify purpose and		\$			
attach copy)*					
j. Corporation Business Taxes (franchise ta.	(x)	\$			
k. Other Taxes (Not related to property - Sec	e Page 22)				
1. Income*		3,650			3,650
2. Other (Specify)		\$			
See Attached Schedule					
Resident Day User Fee		\$			
Subtotal		\$ 239,443			239,443

 $^{^{\}ast}~$ Facility should self-disallow the expense on Page 28 of the Cost Report.

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

St. Lucian's Residence, Inc. 9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Y	Year Ended	Page	of
St. Lucian's Residence, Inc.	1849-RCH	9/30/2015		16	37
	•				
					Residential
Item		Total	CCNH	RHNS	Care Home
	s Brought Forward:	239,443			239,443
Travel and Entertainment	<u> </u>				
Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$	4,062			4,062
4. Employee Travel	\$				
5. Education Expenses Related to Seminars an	d Conventions \$				
6. Automobile Expense (not purchase or depre	eciation) \$	3,371			3,371
7. Other (<i>Specify</i>)	\$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (all such expense)	s) \$				
2. Advertising Telephone Directory (all such e	expenses)*** \$				
3. Advertising Other (Specify)***	\$	6,394			6,394
See Attached Schedule					
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service)	is supplied \$				
directly and not by contract or fee for service	e)***				
7. Postage	\$	746			746
* 8. Dues and Membership Fees to Professional	\$	618			618
Associations (Specify)					
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-A	llowable 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 indi	ividual)				
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>)	\$	15,023			15,023
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$	269,658			269,658

^{*} 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

			Residential
Description	CCNH	RHNS	Care Home
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

			Residential
Description	CCNH	RHNS	Care Home
Advertising			\$ 6,394
Total Other Advertising	\$ -	\$ -	\$ 6,394

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
Sams Club			\$ 45
AAA			\$ 151
Foodshare			\$ 20
NAEIR			\$ 59
Costco			\$ 110
Catholic Health Association			\$ 233
Total Dues	\$ -	\$ -	\$ 618

Schedule of Contributions

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

Schedule of Other Administrative and General

				lential
Description	CCNH	RHNS	Care	Home
Licenses			\$	250
Bank Fees			\$	235
Payroll Service			\$	4,333
Pension Admin Fees			\$	2,100
Fundraising Expense (disallowed)			\$	8,105
Total Other Administrative and General	\$ -	\$ -	\$	15,023

Schedule C-1 - Management Services*

Name of Facility St. Lucian's Residence, Inc.	License No. 1849-RCH	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 #
N/A			T

^{*} 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)

St. Lucian's Residence, Inc. 1849-RCH 9/30/2015 18 37	Nan	ne of Facility License No. Report for Year Ended			Page of			
Item	St. L	ucian's Residence, Inc.		18	849-RCH	9/30/201:	5	
2. Dietary a. In-House Preparation & Service 1. Raw Food S 54,471 54,471 2. Non-Food Supplies S 12,378 12,378 3. Other (Specify) S 12,378 b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services* d. Other (Specify) S 5 d. Other (Specify) S 66,849 2E. Total Dietary Expenditures (2a + b + c + d) S 66,849 2F. Dietary Questionnaire Total CCNH RHNS Residential Care Home G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other K. than employees or residents (i.e., Board Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify cost. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. If yes, specify cost. O Yes O No If yes, specify cost. If yes, specify cost. If yes, specify cost.		Itam			Total	CCNH	PHNS	
a. In-House Preparation & Service 1. Raw Food 2. Non-Food Supplies 3. Other (Specify) 5. Diter (Specify) 5. Diter (Specify) 6. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) 7. Management Services* 8. Diter (Specify) 8. Diter (Specify)	2.				Total	CCIVII	KIIIVS	Tionic
1. Raw Food \$ \$ 54,471								
2. Non-Food Supplies \$ 12,378 12,378 12,378 b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services** \$ d. Other (Specify) \$ 2E. Total Dietary Expenditures (2a + b + c + d) \$ 5 66,849 66,849 2F. Dietary Questionnaire Total CCNH RHNS Residential Care Home G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No If yes, specify amt. I. Did you receive revenue from employees? O Yes O No If yes, specify cost. Is cost of meals provided to persons other than employees or residents (i.e., Board O Yes O No If yes, specify amt. Is cost of foed (other than meals, e.g., snacks at monthly staff meetings) board meetings) provided to employees included in 2E? O Yes O No If yes, specify cost. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O Yes O No If yes, specify cost.				\$	54,471			54,471
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services** d. Other (Specify) 2E. Total Dietary Expenditures (2a + b + c + d) 3 66.849 2E. Total Dietary Expenditures (2a + b + c + d) 3 66.849 2E. Total Dietary Expenditures (2a + b + c + d) 4 66.849 2F. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No If yes, specify cost. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., N. snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. If yes, specify cost.		2. Non-Food Supplies						·
than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services** d. Other (Specify) 2E. Total Dietary Expenditures (2a + b + c + d) \$ 66,849 \$ 66,849 2F. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes O No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board O Yes O No If yes, specify Cost. L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees? O Yes O No If yes, specify cost. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. O Yes O No If yes, specify amt.		3. Other (<i>Specify</i>)		_ \$				
than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services** d. Other (Specify) 2E. Total Dietary Expenditures (2a + b + c + d) \$ 66,849 \$ 66,849 2F. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes O No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board O Yes O No If yes, specify Cost. L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees? O Yes O No If yes, specify cost. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. O Yes O No If yes, specify amt.								
Complete Schedule C-2 att. Page 21) c. Management Services** d. Other (Specify) S d. Other (Specify) S d. Other (Specify) S GE. Total Dietary Expenditures (2a + b + c + d) S GE. Total Dietary Expenditures (2a + b + c + d) S GE. Total Dietary Expenditures (2a + b + c + d) S GE. Total Dietary Questionnaire Total CCNH RHNS Residential Care Home GE. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? OF Yes NO If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other K. than employees or residents (i.e., Board Members, Guests) included in 2E? D. Is any revenue collected from these people? OF Yes NO If yes, specify cost. If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., Snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? OF Yes NO If yes, specify cost. If yes, specify cost. If yes, specify cost. If yes, specify cost.		· •		\$				
c. Management Services** d. Other (Specify) S 66,849 EE. Total Dietary Expenditures (2a + b + c + d) S 66,849 CCNH RHNS Residential Care RHNS Home RESIDENT ACTOR TOTAL CCNH RHNS RESIDENT ACTOR TOTAL CCNH RHNS RESIDENT ACTOR TOTAL RESIDENT ACTOR								
d. Other (Specify) \$ 66,849 66,849 66,849 2E. Total Dietary Expenditures (2a + b + c + d) \$ 66,849 Residential Care G. Resident Meals; Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes O No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No If yes, specify cost. L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost.				Φ.				
2E. Total Dietary Expenditures (2a + b + c + d) \$ 66,849		-						
2F. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E?		d. Other (Specify)		_ ֆ				
2F. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E?								
2F. Dietary Questionnaire G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. If yes, specify cost. If yes, specify cost.	2E.	Total Dietary Expenditures $(2a + b + c + d)$		\$	66,849			66,849
G. Resident Meals: Total no. of meals served per day:* H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes O No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board O Yes O No If yes, specify cost. L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. If yes, specify cost.								Residential Care
H. Is cost of employee meals included in 2E? O Yes O No I. Did you receive revenue from employees? O Yes No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify amt.	2F.	Dietary Questionnaire			Total	CCNH	RHNS	Home
I. Did you receive revenue from employees? O Yes O No If yes, specify amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify amt.	G.	Resident Meals: Total no. of meals served per	day	y:*				
I. Did you receive revenue from employees? O Yes amt. J. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify amt.	H.	Is cost of employee meals included in 2E?	0	Yes	•	No		
Is cost of meals provided to persons other K. than employees or residents (i.e., Board O Yes O No Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. If yes, specify cost.	I.	Did you receive revenue from employees?	0	Yes	•	No		
 K. than employees or residents (i.e., Board Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes No If yes, specify cost. O Yes No If yes, specify amt. 	J.	Where is the revenue received reported in the	Cos	st Repor	t? (Page/Line	Item)		
Members, Guests) included in 2E? L. Is any revenue collected from these people? O Yes O No If yes, specify amt. M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify amt.	K.		0	Yes	•	No		
M. Where is the revenue received reported in the Cost Report? (Page/Line Item) Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes No No If yes, specify cost. If yes, specify amt.							cost.	
Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes O No If yes, specify cost. If yes, specify amt.	L.	Is any revenue collected from these people?	0	Yes	•	No		
 N. snacks at monthly staff meetings, board meetings) provided to employees included in 2E? O. Is any revenue collected from employees? O Yes No If yes, specify cost. If yes, specify amt. 	M.	Where is the revenue received reported in the	Cos	st Repor	t? (Page/Line	Item)		
O. Is any revenue collected from employees? O Yes O No If yes, specify amt.	N.	snacks at monthly staff meetings, board	0	Yes	•	No		
O. Is any revenue conected from employees? Offes amt.		in 2E?						
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)	O.	Is any revenue collected from employees?	0	Yes	•	No		
	P.	Where is the revenue received reported in the	Cos	st Repor	t? (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		License			Year Ended	Page	of
St. L	ucian's Residence, Inc.	184	49-RCH	9/30/2015	5	19	37
	Item		Total	CCNH	RHNS		ential Care Home
	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies,	Lbs.	1 505				1.505
	gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	1,505				1,505
	2. Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.					
	processed.***	Amt. \$					
	3. Personal clothing of residents	Lbs.					
	washed, ironed, and/or processed.***	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)	\$					
	c. Management Services**	\$					
	d. Other (Specify)	\$					
3E.	Total Laundry Expenditures $(3a + b + c + d)$	\$	1,505				1,505
3F.	Laundry Questionnaire						
G.	Is cost of employee laundry included in 3E? O	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	e Item)		
	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? O	Yes	•	No	If yes, specify amt.		
L.	Where is the revenue received reported in the Cost	Report?		(Page/Line	e 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)

Item	Residential Care Home
4. Housekeeping a. In-House Care 1. Supplies - Cleaning (Mops, pails, brooms, etc.) b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services* d. Other (Specify) 4E. Total Housekeeping Expenditures (4a + b + c + d) 5. Resident Care (Supplies)** a. Prescription Drugs*** 1. Own Pharmacy 2. Purchased from b. Medicine Cabinet Drugs c. Medical and Therapeutic Supplies d. Ambulance/Limousine***	
a. In-House Care 1. Supplies - Cleaning (Mops, pails, brooms, etc.) b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services* d. Other (Specify) 4E. Total Housekeeping Expenditures (4a + b + c + d) 5. Resident Care (Supplies)** a. Prescription Drugs*** 1. Own Pharmacy 2. Purchased from b. Medicine Cabinet Drugs c. Medical and Therapeutic Supplies d. Ambulance/Limousine***	
a. In-House Care 1. Supplies - Cleaning (Mops, pails, brooms, etc.) b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services* d. Other (Specify) 4E. Total Housekeeping Expenditures (4a + b + c + d) 5. Resident Care (Supplies)** a. Prescription Drugs*** 1. Own Pharmacy 2. Purchased from b. Medicine Cabinet Drugs c. Medical and Therapeutic Supplies d. Ambulance/Limousine***	
1. Supplies - Cleaning (Mops, pails, brooms, etc.) b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services* d. Other (Specify) 4E. Total Housekeeping Expenditures (4a + b + c + d) 5. Resident Care (Supplies)** a. Prescription Drugs*** 1. Own Pharmacy 2. Purchased from b. Medicine Cabinet Drugs c. Medical and Therapeutic Supplies d. Ambulance/Limousine***	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) c. Management Services* d. Other (Specify) 4E. Total Housekeeping Expenditures (4a + b + c + d) 5. Resident Care (Supplies)** a. Prescription Drugs*** 1. Own Pharmacy 2. Purchased from b. Medicine Cabinet Drugs b. Medicine Cabinet Drugs c. Medical and Therapeutic Supplies d. Ambulance/Limousine*** Sq. Ft. Serviced by Personnel Amt. \$ 1,774 1,774	1,774
(Complete Schedule C-2 att. Page 21) c. Management Services* d. Other (Specify) 4E. Total Housekeeping Expenditures (4a + b + c + d) \$ 1,774 5. Resident Care (Supplies)** a. Prescription Drugs*** 1. Own Pharmacy \$ 2. Purchased from b. Medicine Cabinet Drugs \$ 539 c. Medical and Therapeutic Supplies \$ d. Ambulance/Limousine***	
c. Management Services* d. Other (Specify) 4E. Total Housekeeping Expenditures (4a + b + c + d) \$ 1,774 5. Resident Care (Supplies)** a. Prescription Drugs*** 1. Own Pharmacy \$ 2. Purchased from \$ 539 b. Medicine Cabinet Drugs \$ 539 c. Medical and Therapeutic Supplies \$ 4. Ambulance/Limousine***	
d. Other (Specify) 4E. Total Housekeeping Expenditures (4a + b + c + d) \$ 1,774 5. Resident Care (Supplies)** a. Prescription Drugs*** 1. Own Pharmacy \$ 2. Purchased from \$ 539 b. Medicine Cabinet Drugs \$ 539 c. Medical and Therapeutic Supplies \$ 4. Ambulance/Limousine***	+
5. Resident Care (Supplies)** a. Prescription Drugs*** 1. Own Pharmacy 2. Purchased from b. Medicine Cabinet Drugs c. Medical and Therapeutic Supplies d. Ambulance/Limousine*** \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	
5. Resident Care (Supplies)** a. Prescription Drugs*** 1. Own Pharmacy 2. Purchased from b. Medicine Cabinet Drugs c. Medical and Therapeutic Supplies d. Ambulance/Limousine*** \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	1,774
a. Prescription Drugs*** 1. Own Pharmacy 2. Purchased from b. Medicine Cabinet Drugs c. Medical and Therapeutic Supplies d. Ambulance/Limousine*** \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	
2. Purchased from \$ b. Medicine Cabinet Drugs \$ 539 c. Medical and Therapeutic Supplies \$ d. Ambulance/Limousine*** \$	
b. Medicine Cabinet Drugs \$ 539 c. Medical and Therapeutic Supplies \$ d. Ambulance/Limousine*** \$	
c. Medical and Therapeutic Supplies \$ d. Ambulance/Limousine*** \$	
c. Medical and Therapeutic Supplies \$ d. Ambulance/Limousine*** \$	539
d. Ambulance/Limousine***	1
e Oxygen	1
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***	
i. Recreation \$ 5,643	5,643
j. Other (Specify)**** \$ 41,049	41,049
See Attached Schedule 5K. <i>Total Resident Care Expenditures</i> (5a - 5j) \$ 47,231	47,231

^{*} 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	idential e Home
Religious Services			\$ 39,838
Religious Supplies			\$ 1,211
			_
Total Other Resident Care	\$ -	\$ -	\$ 41,049

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

Name of Facility St. Lucian's Residence, Inc.				License No. 1849-RCH	Report for Year Ended 9/30/2015					of 37
		Related ** Operators				Total Cost/Pa			ef.***	
Name of Individual or Company	Address	Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	Residential Care Home	Pg	Line
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							

^{*} 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

Naı	ne of Facility L	icense No.	Report for Ye	ear Ended		Page of
St.	Lucian's Residence, Inc.	1849-RCH	9/30/2015			22 37
						Residential Care
	Item		Total	CCNH	RHNS	Home
6.	Maintenance & Operation of Plant					
	a. Repairs & Maintenance	\$	25,155			25,155
	b. Heat	\$	18,166			18,166
	c. Light & Power	\$	50,968			50,968
	d. Water	\$	15,605			15,605
	e. Equipment Lease (Provide detail on page	ge 6) \$				
	f. Other (itemize)	\$	31,276			31,276
	See Attached Schedule					
6g.	Total Maint. & Operating Expense (6a - 6	(sf) \$	141,171			141,171
7.	Depreciation (complete schedule page 23*))				
	a. Land Improvements	\$				
	b. Building & Building Improvements	\$	92,242			92,242
	c. Non-Movable Equipment	\$	14,621			14,621
	d. Movable Equipment	\$	10,190			10,190
*7e	e. Total Depreciation Costs $(7a + b + c + d)$	\$	117,054			117,054
8.	Amortization (Complete att. Schedule Page	24*)				
	a. Organization Expense	\$				
	b. Mortgage Expense	\$				
	c. Leasehold Improvements	\$				
	d. Other (Specify)	\$				
*8e	e. Total Amortization Costs $(8a + b + c + d)$	\$				
9.	Rental payments on leased real property les	S				
	real estate taxes included in item 10b	\$	5,504			5,504
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 $(7e + 8e + 9 + 10)$	9) \$	122,558			122,558

^{*} 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	idential e Home
Contracted Services			\$ 21,825
Grounds Maintenance			\$ 9,451
Total Other Repairs and Maintenance	\$ -	\$ -	\$ 31,276

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Depreciation Schedule

Name of Facility St. Lucian's Residence, Inc.					License No. 1849-1	RCH		Report for Year E 9/30/2015	Ended		Page 23	of 37
Property Item					Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. Land Improvements												
Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (atta	ch sch	edule)										
A-4. Subtotal												
B. Building and Building Improvements												
Acquired prior to this report period					3,299,537		3,299,537	1,345,839	SL	Various	87,675	
2. Disposals (attach schedule)												
Property Item 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 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 3-4. Subtotal C. Non-Movable Equipment 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) 3. Acquired during this report period (attach schedule) 4. Subtotal Is a mileage logbook maintained? Acquis Yes No Month D. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle) a. 1999 Chyster Van b. 1999 Chevy Pickup c. 2008 Turtle Top Handicap Van X 8 1 C. 2008 Turtle Top Handicap Van X 1 2				68,500						4,567		
Acquired prior to this report period Disposals (attach schedule) Acquired during this report period (attach schedule) Non-Movable Equipment Acquired prior to this report period Disposals (attach schedule) Acquired during this report period (attach schedule) C-4. Subtotal		-										92,242
C. Non-Movable Equipment												
Acquired prior to this report period	Property Item Land Improvements 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) Subtotal Building and Building Improvements 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) Subtotal Non-Movable Equipment 1. Acquired prior to this report period 2. Disposals (attach schedule) 3. Acquired during this report period 2. Disposals (attach schedule) 3. Acquired during this report period (attach schedule) Subtotal Is a mileage logbook maintained? Non-Movable Equipment			239,568		239,568	171,613	SL	Various	13,348		
Acquired prior to this report period Disposals (attach schedule) Acquired during this report period (attach schedule) C-4. Subtotal												
		12,727						1,273				
										14,621		
	logl maint	oook ained?	Acqu		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
D. Movable Equipment	108	110	William	1 cai	Land	value	Bepreciated	Tear's Operations	Depreciation	Life	Tor This Tear	Totals
Motor Vehicles (Specify name, model and year of each vehicle)				1000	17.205		17.205	15.205				
					17,205 22,826		17,205 22,826	17,205 22,826		5 yrs		
				2008	38,114		38,114	38,117		5 yrs 5 yrs		
				2008	19,302		19,302	19,302	SL	5 yrs		
	11			2007	17,302		17,302	17,302		J y13		
= =					370,824		370,824	314,522	SI	Various	10,190	
1 1 1					370,024		370,024	317,322	SL.	7 411045	10,170	
•												
D-3. Subtotal												10,190
												117,054
E. Total Depreciation												117,034

St. Lucian's Residence, Inc. 9/30/2015

Schedule of Land Improvements Acquired during this report period

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

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:	-				
7/23/2015	Roof Replacement	\$ 68,500	15	\$	4,567
Total additions for	Building Improvements	\$ 68,500		\$	4,567
Deletions:					
Total deletions for	Building Improvements	\$ -		\$	-

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

			Useful		
Acquisition Date	Description of Item	Cost	Life	Depreciatio	n
Additions:	_				
11/13/2014	Paint & Wallpaper	\$ 12,727	10	\$ 1,27	13
Total additions for	Non-Movable Equipment	\$ 12,727		\$ 1,27	73
Deletions:					
Total deletions for	 Non-Movable Equipment	\$ -		\$ -	

^{*}Ties to Page 23, Line C3

^{**}Ties to Page 23, Line A2

^{**}Ties to Page 23, Line B2

^{**}Ties to Page 23, Line C2

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
Total additions for Movable	Equipment	\$ -		\$ -
Deletions:				
Total deletions for Movable	Fauinment	\$ -		\$ -

^{*}Ties to Page 23, Line D2c

Schedule of Leasehold Improvements Acquired during this report period

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

^{*}Ties to Page 24, Line C3

^{**}Ties to Page 23, Line D2b

^{**}Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Nam	e of Facility			License No.		Report for Year Ended			Page	of
St. L	ucian's Residence, Inc.			1849-RCH		9/30/2015			24	37
			e of sition			Accumulated Amort. to Beginning of	Basis for			
	_			Length of	Cost to Be	Year's	Computing		Amortization	
	Item	Month	Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A.	Organization Expense									
	1.									
	2.									
	3.									
A-4.										
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.

- 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.

^{**} Specify which of the following bases were used:

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

	of Facility fan's Residence, Inc.	License No. 1849-RO	СН	Report for Year 9/30/2015	Page of 25 37			
		1		ı				
Is	the property either owned by th	ne Facility	•	Yes		0	No	If "Yes," complete Part B. If "No," complete Part C.
	·	cility is related by	family, m	arriage, ownership,	abili	ty to control or		, 1
		or organization fro	om whom	buildings are leased	, the	n it is considered		
				Total				
1					.50			
					_			
	•	e of Purchase		-	7			
4.	-			19	25			
5.	Total Licensed Bed Capacity				42			
6.	1 0			37,1	46			
7.	<u>-</u>							
				Leased	_			
	<u> </u>			Unknown	4			
		rties		1st Mortgage		2nd Mortgage	3rd Mortgage	4th Mortgage
1.								
		ixed, variable)				10/01/12		
	<u> </u>	3 7						
	•							
	•			701,00	,	1,100,003		
	-							
		rica, variable)						
	j. Term of Mortgage (number	er of years)						
	1. Principal Outstanding on	Note Paid-Off						
					nly			
	Name and Address of Lesso	r	Prop	perty Leased		Date of Lease	Term of Lease	Annual Amount of Lease
	Pro Pa Is or 1. 2. 3. 4. 5. 6. 7.	Property Questionnaire Part A Is the property either owned by the or leased from a Related Party?* *If any owner or operator of this far business association to any persons a related party transaction. Description Description Date Land Purchased Date Structure Completed If NOT Original Owner, Date Acquisition Cost a. Land Building Part B - Owner and Related Pa Financing Type of Financing (e.g., financing (e.g., financing) Amount of Principal Borr for Principal balance outstance Complete if Mortgage (number of Refinancing) New Interest Rate Part C - Arms-Length Leas	Property Questionnaire Part A Is the property either owned by the Facility or leased from a Related Party?* *If any owner or operator of this facility is related by business association to any person or organization from a related party transaction. Description 1. Date Land Purchased 2. Date Structure Completed 3. If NOT Original Owner, Date of Purchase 4. Date of Initial Licensure 5. Total Licensed Bed Capacity 6. Square Footage 7. Acquisition Cost a. Land b. Building Part B - Owner and Related Parties 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 1. Principal Outstanding on Note Paid-Off Part C - Arms-Length Leases for Real Pr	Property Questionnaire Part A Is the property either owned by the Facility or leased from a Related Party?* *If any owner or operator of this facility is related by family, musiness association to any person or organization from whom a related party transaction. Description 1. Date Land Purchased 2. Date Structure Completed 3. If NOT Original Owner, Date of Purchase 4. Date of Initial Licensure 5. Total Licensed Bed Capacity 6. Square Footage 7. Acquisition Cost a. Land b. Building Part B - Owner and Related Parties 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 I	Property Questionnaire Part A Is the property either owned by the Facility or leased from a Related Party?* *If any owner or operator of this facility is related by family, marriage, ownership, business association to any person or organization from whom buildings are leased a related party transaction. Description Description Total Date Land Purchased Date Structure Completed If NOT Original Owner, Date of Purchase Loate of Initial Licensure Total Licensed Bed Capacity Square Footage Acquisition Cost a. Land b. Building Part B - Owner and Related Parties Ist Mortgage 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	Property Questionnaire Part A Is the property either owned by the Facility or leased from a Related Party?* *If any owner or operator of this facility is related by family, marriage, ownership, abilibusiness association to any person or organization from whom buildings are leased, the a related party transaction. Description Total Date Land Purchased Date Structure Completed If NOT Original Owner, Date of Purchase 4. Date of Initial Licensure Joaquare Footage Total Licensed Bed Capacity Square Footage Acquisition Cost Land Date Building Unknown Part B - Owner and Related Parties Fixed 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 (number of years) k. Amount of Principal Borrowed I. New Interest Rate j. Term of Mortgage (number of years) k. Amount of Principal Borrowed I. Principal Outstanding on Note Paid-Off Part C - Arms-Length Leases for Real Property Improvements Only	Property Questionnaire Part A Is the property either owned by the Facility or leased from a Related Party?* *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 Description Total Date Land Purchased Date Structure Completed In Date Land Purchased Date of Initial Licensure Square Footage Acquisition Cost Land Building Part B - Owner and Related Parties Ist Mortgage Interest Rate for the Cost Year Amount of Principal Borrowed Interest Rate Term of Mortgage (number of years) Amount of Principal Borrowed Part C - Arms-Length Leases for Real Property Improvements Only	Property Questionnaire Part A Is the property either owned by the Facility or leased from a Related Party?* "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 Description Total Date Land Purchased Date Structure Completed Date of Initial Licensure Square Footage Acquisition Cost Acquisition Cost Acquisition Cost Acquisition Cost Building Part B - Owner and Related Parties Is thortgage Infinancing Type of Financing (e.g., fixed, variable) Date Mortgage (number of years) Amount of Principal balance outstanding as of principal balance outstanding as of principal balance outstanding New Interest Rate Type of Financing (e.g., fixed, variable) Part G - Ornglete if Mortgage was Refinanced During Current Cost Year Building Orngle (e.g., fixed, variable) Date of Refinancing New Interest Rate Type of Financing (e.g., fixed, variable) Date of Refinancing New Interest Rate Type of Financing (e.g., fixed, variable) Part C - Arms-Length Leases for Real Property Improvements Only

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 Lice		Report for Year Ended			Page of	
St. Lucian's Residence, Inc.	1849-RCH		9/30/2015			26 37
						Residential Care
Item			Total	CCNH	RHNS	Home
12. Interest						
A. Building, Land Improvement	& Non-Movable	•				
Equipment						
1. First Mortgage		\$	90,656			90,656
Name of Lender		Rate				
Daughters of Mary of the Immaculate Cor	ception	6.00%				
Address of Lender						
314 Osgood AvenueNew Britain, CT		Φ.				
2. Second Mortgage Name of Lender		\$ D 242				
Ivame of Lender		Rate				
Address of Lender						
ridaress of Bender						
3. Third Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
4. Found Monton		Φ.				
4. Fourth Mortgage Name of Lender		\$ Rate		_		
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)	\$	90,656			90,656

(Carry Subtotals forward to next page)

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

Name of Facility		Report for Y	ear Ended		Page of	
St. Lucian's Residence, Inc.	1849-RCH		9/30/2015			27 37
						Residential
Ite			Total	CCNH	RHNS	Care Home
	Subtotals Bro	ught Forward:	90,656			90,656
12. C. Movable Equipment						
1. Automotive Equipme		\$				
A. Item	Rate	Amount				
Lender		<u> </u>				
Address of Lender						
2. Other (<i>Specify</i>)						
A. Item	Rate	\$ Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender		<u> </u>				
Address of Lender						
12 C 2 Total Mayable Equip	mant Intanast					
12. C. 3. Total Movable Equip: Expense (C1 + 2)	ment interest	\$				
12. D. Other Interest Expense (A	Specify)	\$ \$				
12. B. Other Interest Expense (i	оресду)	Ψ				
13. Total All Interest Expense (1	12B7 + 12C3 + 12D))	90,656			90,656
14. Insurance						
a. Insurance on Property (b		\$				40,176
b. Insurance on Automobile		\$	8,647			8,647
c. Insurance other than Pro						
1. Umbrella (Blanket Co	_	\$ \$				8,418
2. Fire and Extended Co	overage					
3. Other (<i>Specify</i>)		\$				
14d. Total Insurance Expenditure	es(14a+b+c)	\$	57,240			57,240
15. Total All Expenditures (A-1).					1,397,679	
Zout III Zaponania os (II II	21)	\$	2,021,012		1	2,007,010

D. Adjustments to Statement of Expenditures

	e of Fa			Lic	cense No.	Report for Ye	ar Ended	Page of
St. Lı	ucian's	Resid	lence, Inc.		1849-RCH	9/30/2015		28 37
					Total			
Item	Page	Line			Amount of			Residential Care
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	Home
Page	10 - S	alarie	es and Wages					
1.			Outpatient Service Costs	\$				
2.			Salaries not related to Resident Care	\$				
3.			Occupational Therapy	\$				
4.			Other - See attached Schedule	\$				
Page	13 - F	rofes	sional Fees					
5.			Resident Care Physicians **	\$				
6.			Occupational Therapy	\$				
7.			Other - See attached Schedule	\$				
Page	s 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	Ψ				
13.			of Owners, Partners, Operators	\$				
14.	16	13	Gifts, flowers and coffee shops	\$	3,056			3,056
15.	10	13	Education expenditures to colleges or	φ	3,030			3,030
15.			universities for tuition and related costs					
				ф				
1.6			for owners and employees	\$				
16.			Travel for purposes of attending					
			conferences or seminars outside the					
			continental U.S. Other out-of-state	Ф				
1.7			travel in excess of one representative	\$				
17.		_	Automobile Expense (e.g. personal use)	\$				
18.	16	m3	Unallowable Advertising *	\$	6,394			6,394
19.			Income Tax / Corporate Business Tax	\$				<u> </u>
20.			Fund Raising / Contributions	\$				
21.			Unallowable Management Fees	\$				
22.			Barber and Beauty	\$				
23.			Other - See attached Schedule	\$	8,105			8,105
	18 - L)ietar <u>;</u>	y Expenditures					
24.			Meals to employees, guests and others					
			who are not residents	\$				
_	19 - L	aund	ry Expenditures					
25.			Laundry services to employees, guests					
			and others who are not residents	\$				
		Iouse	keeping Expenditures					
26.			Housekeeping services to employees, guests					
			and others who are not residents	\$				
			Subtotal (Items 1 - 26)) \$	17,555			17,555

^{*} 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	Residential Care Home
		T. C.			
Total Othe	r Salaries A	Adjustment	\$ -	\$ -	\$ -

.....

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
I ugo Itor		2001.1940.1	0.01,12		
Total Othe	Total Other Fees Adjustments		\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

					Resid	ential
Page Ref	Line Ref	Description	CCNH	RHNS	Care	Home
16	m13	Fundraising Expenses			\$	8,105
Total Othe	otal Other A&G Adjustments		\$ -	\$ -	\$	8,105

......

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

			D. Adjustments to Statemen						
	e of Fa	-		Lic	ense No.	Report for Y	Page	of	
St. Lı	ucian's	Resid	dence, Inc.		1849-RCH	9/30/2015		29	37
					Total				
Item	Page	Line			Amount of			Reside	ential Care
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	F	Iome
			Subtotals Brought Forward	\$	17,555				17,555
Page	20 - K	Reside	nt 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 - N	<i>Iainte</i>	enance 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 - I	nsura	nce						
40.			Mortgage Insurance	\$					
41.			Property Insurance	\$					
Other	r - Mis	scella	neous						
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 I	or Pr	ofit P	roviders Only						
50.			Building/Non Movable Eq. Depreciation						
			Unallowable Building Interest -						
			See Attached Schedule	\$					
51.	Total	Amo	unt of Decrease (Items 1 - 50)	\$	17,555				17,555

^{***} 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.

St. Lucian's Residence, Inc. 9/30/2015

Schedule of Other Ancillary Costs

					Residential
Page Ref	Line Ref	Description	CCNH	RHNS	Care Home
Total Othe	er Ancillary	Costs	\$ -	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Exce	ss Movable	Equipment Depreciation	\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

					Residential
Page Ref	Line Ref	Description	CCNH	RHNS	Care Home
Total Othe	r Property	Adjustments	\$ -	\$ -	\$ -

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

Schedule of Unallowable Building Interest

					Residential
Page Ref	Line Ref	Description	CCNH	RHNS	Care Home
Total Unal	lowable Bu	ilding Interest	\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility	License No.	veni	Report for Ye	ar Ended		Page of
St. Lucian's Residence, Inc.	1849-RCH		9/30/2015	ai Ellucu		30 37
S. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routi	ne Care Revenue					
1. a. Medicaid Residents (CT of	only)	\$	905,489			905,489
b. Medicaid Room and Boar	d Contractual Allowance **	\$				
2. a. Medicaid (All other states		\$				
b. Other States Room and Bo	oard Contractual Allowance **	\$				
3. a. Medicare Residents (all in	aclusive)	\$				
b. Medicare Room and Boar	d Contractual Allowance **	\$				
4. a. Private-Pay Residents and	Other	\$	552,264			552,264
b. Private-Pay Room and Bo	ard Contractual Allowance **	\$				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medi	icare	\$				
b. Prescription Drugs - Medi	care Contractual Allowance **	\$				
c. Prescription Drugs - Non-	Medicare	\$				
d. Prescription Drugs - Non-	Medicare Contractual Allowance **	\$				
2. a. Medical Supplies - Medic	are	\$				
b. Medical Supplies - Medic	are Contractual Allowance **	\$				
c. Medical Supplies - Non-N	Medicare Tedicare	\$				
d. Medical Supplies - Non-N	Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medic	are	\$				
b. Physical Therapy - Medic	are Contractual Allowance **	\$				
c. Physical Therapy - Non-M	ledicare	\$				
d. Physical Therapy - Non-M	Iedicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medica	re	\$				
b. Speech Therapy - Medica	re Contractual Allowance **	\$				
c. Speech Therapy - Non-Mo	edicare	\$				
d. Speech Therapy - Non-Mo	edicare Contractual Allowance **	\$				
5. a. Occupational Therapy - N	Medicare	\$				
b. Occupational Therapy - N	Medicare Contractual Allowance **	\$				
c. Occupational Therapy - N	Non-Medicare	\$				
d. Occupational Therapy - N	Non-Medicare Contractual Allowance **	\$				
6. a. Other (Specify) - Medicar	e	\$				
b. Other (Specify) - Non-Me	edicare	\$				
III. Total Resident Revenue (Section	on I. thru Section II.)	\$	1,457,753			1,457,753
IV. Other Revenue*						
1. Meals sold to guests, employ	ees & others	\$				
2. Rental of rooms to non-resident		\$				
3. Telephone		\$				
4. Rental of Television and Cab	le Services	\$				
5. Interest Income (Specify)		\$	4,882			4,882
6. Private Duty Nurses' Fees		\$				
7. Barber, Coffee, Beauty and C	Gift shops	\$				
8. Other (<i>Specify</i>)		\$	108,308			108,308
V. Total Other Revenue (1 thru 8)		\$	113,190			113,190
VI. Total All Revenue (III+V)		\$	1,570,943			1,570,943

 $^{* \ \}textit{Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost \textit{Report}.}$

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
	•			
Total Othe	r Resident Revenue - Medicare	\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
Total Othe	r Resident Revenue	\$ -	\$ -	\$ -

Interest Income

Account

					Resid	dential
Page Ref	Account	Balance	CCNH	RHNS	Care	Home
31 A8	Investments				\$	4,882
Total Inte	rest Income		\$ -	\$ -	\$	4,882

Schedule of Other Revenue

				Resi	idential
Page Ref	Description	CCNH	RHNS	Care	e Home
	Unrestricted Donations			\$	25,615
	Fund Raising			\$	66,959
	Cell Tower Revenue			\$	24,427
	Unrealized Gains/(Losses) on Investments			\$	(18,574)
	Donated Services by Sisters			\$	9,881
Total Othe	er Revenue	\$ -	\$ -	\$	108,308

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Pag	e of
St. Lucian's Residence, Inc.	1849-RCH	9/30/2015	31	37
	Account			Amount
Assets				
A. Current Assets				
1. Cash (on hand and in bank	(s)		\$	328,774
2. Resident Accounts Receiva		,	\$	102,489
Other Accounts Receivable	e (Excluding Owners or	r Related Parties)	\$	
4 Inventories			\$	
Prepaid Expenses			\$	45,614
a. Prepaid Interest		42,914		
b. Prepaid Accounting		2,700		
c				
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement	Receivable		\$	
8. Other Current Assets (<i>item</i>	ize)		\$	149,843
Investments		137,700		
Resident Funds		12,143	_	
-				
A-9. Total Current Assets (Lines A	.1 thru 8)		\$	626,720
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Depreciati	on Net		
3. Buildings	*Historical Cost	3,368,038	\$	1,929,957
_	Accum. Depreciati	on 1,438,081 Net		
4. Leasehold Improvements	*Historical Cost		\$	
_	Accum. Depreciati	on Net		
5. Non-Movable Equipment	*Historical Cost	252,295	\$	66,061
	Accum. Depreciati	on 186,234 Net		
6. Movable Equipment	*Historical Cost	370,824	\$	46,111
2 2	Accum. Depreciati	on 324,713 Net		
7. Motor Vehicles	*Historical Cost	97,450	\$	(0)
	Accum. Depreciati	on 97,450 Net		
8. Minor Equipment-Not Dep			\$	
9. Other Fixed Assets (<i>itemize</i>	2)		\$	(92,839)
Book Vs Cost Report		(92,839)		
B-10. Total Fixed Assets (Lines	B1 thru 9)		\$	1,949,290

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

G. Balance Sheet (cont'd)

Name	Name of Facility		License No.	Report for Year Ended		Page		of
St. L	ucian'	s Residence, Inc.	1849-RCH	9/30/2015		32		37
			Account			Amo	ount	
				Total Brought Forward:	\$		2,576,	,010
C.	Lease	ehold or like property record	ded for Equity Purpose	es.				
	1. L	and			\$			
	2. L	and Improvements	*Historical Cost					
			Accum. Depreciatio	n Net	\$			
	3. B	Buildings	*Historical Cost					
			Accum. Depreciatio	n Net	\$			
	4. N	Non-Movable Equipment	*Historical Cost					
			Accum. Depreciatio	n Net	\$			
	5. N	Movable Equipment	*Historical Cost					
			Accum. Depreciatio	n Net	\$			
	6. N	Notor Vehicles	*Historical Cost					
			Accum. Depreciatio	n Net	\$			
		Inor Equipment-Not Depre			\$			
C-8	Total	l Leasehold or Like Proper	ties (C1 thru 7)		\$			
D.	Inves	stment and Other Assets						
		Deferred Deposits			\$			
		Escrow Deposits			\$			
	3. C	Organization Expense	*Historical Cost					
			Accum. Depreciatio	n Net	\$			
		Goodwill (Purchased Only)			\$			
	5. In	nvestments Related to Resid	lent Care (itemize)		\$			
	6. L	oans to Owners or Related	Parties (itemize)		\$			
		Name and Address	Amount	Loan Date				
	- -							
	7. C	Other Assets (itemize)			\$			
D 0	<i>m</i>	17 / 101	, /T! P.1.1 =		Φ.			
		l Investments and Other As	,		\$		0.555	010
D-9.	1 Otal	l All Assets (Lines A9 + B1	U + C8 + D8)		\$		2,576,	010

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

G. Balance Sheet (cont'd)

Name of Fac	Name of Facility		License No. Report for Year Ended		Ended	Pag	je	of
St. Lucian's I	St. Lucian's Residence, Inc.		1849-RCH	9/30/2015		33		37
			Account				Amount	
Liabilities								
A.	Cu	rrent Liabilities						
	1.	Trade Accounts Payable				\$	11,5	
	2.	Notes Payable (itemize)				\$	30,5	547
		Current Portion of Long-To	erm Debt	30,547	'			
	3	Loans Payable for Equipm	ent (Current portion) (itemize)		\$		
	<u>J.</u>	Name of Lender	Purpose	Amount	Date Due	Ψ		
		Traine of Bender	1 urpose	Timount	Bute Bue			
					1 1			
					1 1			
					1 1			
					1 1			
					1 1			
					1 1			
					1 1			
	4.	Accrued Payroll (Exclusive	-	•		\$	28,2	224
	5.	Accrued Payroll (Owners of		only)		\$		
	6.	Accrued Payroll Taxes Pay				\$		
	7.	Medicare Final Settlement				\$		
	8.	Medicare Current Financin	<u> </u>			\$		
	9.	Mortgage Payable (Curren				\$		
		Interest Payable (Exclusive	of Owner and/or Re	lated Parties)		\$	20,0	000
		Accrued Income Taxes*				\$		
	12.	Other Current Liabilities (i	temize)			\$	394,7	776
		Lease Esclalation Liability	30,55					
		Resident Trust	6,39					
		Due to DSS	356,00					
	70	Accrued Income Taxes	1,82	24		ф	105 (00.4
A-13.	10	tal Current Liabilities (Line	es A1 thru 12)			\$	485,0	J94

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended		Page	of
St. Lucian's Residence, Inc.	1849-RCH	9/30/2015		34	37
A	Account			An	nount
		Total Broug	ht Forward:		485,094
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 (<i>itemize</i>)					1,837,179
Name and Address of Lender	Jame and Address of Lender Amount Loan Date		Date		
			_		
			_		
Daughters of Mary	1,837,179		_		
	, ,		_		
			_		
			_		
			_		
			_		
			_		
4 Other Long-Term Liabilitie	(itemize)	<u> </u>	\$		
4. Other Long-Term Liabilities (<i>itemize</i>)					
B-5. Total Long-Term Liabilities (I	\$		1,837,179		
C. Total All Liabilities (Lines A-			\$		2,322,274
S. = = = = = = = = = (2.110 111 1	,		Ψ		2,322,21T

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

	ne of Facility	License No.	Report for Y	ear Ended	Page	of
St. 1	Lucian's Residence, Inc.	1849-RCH	9/30/2015		35	37
	Account					Amount
A.	Reserves					
	Reserve for value of leased land				\$	
	2. Reserve for depreciation val	lue of leased building	ngs and appurte	nances		
	to be amortized				\$	
	3. Reserve for depreciation va	lue of leased person	al property (<i>Eq</i>	uity)	\$	
	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				\$	80,471
	6. Gain or Loss for Period	10/1/201	4 thru	9/30/2015	\$	173,264
	7. Total Net Worth				\$	253,735
C.	Total Reserves and Net Worth				\$	253,735
D.	Total Liabilities, Reserves, and	Net Worth			\$	2,576,009

H. Changes in Total Net Worth

Name	of Facility	License No.	Report for Year	Ended	Page	of	
St. Lu	cian's Residence, Inc.	1849-RCH	9/30/2015		36	37	
	Account				Amount		
A.]						116,945	
В. ′					\$	1,570,943	
	Total Expenditures (From Statemen	nt of Expenditures Pa	ige 27)		\$	1,397,679	
	Net Income or Deficit				\$	173,264	
	Balance				\$	290,209	
	Additions						
	1. Additional Capital Contributed	(itemize)					
2	2. Other (<i>itemize</i>)						
F-3.	Total Additions				\$		
G. 1							
	1. Drawings of Owners/Operators/Partners (Specify)						
	Name and Address (No., City,	State, Zip)	Title	Amount			
	2. Other Withdrawings (<i>Specify</i>)				\$		
Purpose Amount							
	7 Milouit			-			
	3. Total Deductions			-	\$		
	Balance at End of Period	09/30/15	<u> </u>		\$ \$	290,209	
п.	Dumice ai Bia oj 1 erioa	09/30/13)		Φ	290,209	

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of				
St. Lucian's Residence, Inc.	1849-RCH	9/30/2015	37	37				
Check appropriate category								
Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home						
Preparer/Reviewer Certification								
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.								
Signature of Preparer	Title	Date Signed						
CORT	Partner	2-12-16						
Printed Name of Preparer								
Craig J. Lubitski Consulting LLC								
Address		Phone Number	·					
225 Pitkin Street, East Hartford, CT 06108		860-610-9009	P					