State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed) St Joseph's Residence		
Address (No. & Street, City, State, Zip Code) 1365 Enfield Street, Enfield CT 06082		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☑ Residential Care Home		
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015	

License Numbers:	CCNH	RHNS	Residential Care Home	Medicare Provider
	901-C		1678-HA	075272

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	9019		

For Department Use Only

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

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General Information

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Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 Joseph's Residence [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Sister Genevieve Nugent			Printed Name (Owner) Little Sisters of the Poor	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility St Joseph's Residence	Period Covered:		From 10/1/2014	To 9/30/2015
Address of Facility 1365 Enfield Street, Enfield CT 06082				
Report Prepared By Kevin P Kelleher CPA	Phone Number 860-677-8440		Date 1/30/2016	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-741-0791	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
St Joseph's Residence	1365 Enfield Street, Enfield CT 06082

	CCNH	RHNS	Residential Care Home	Medicare Provider No.
License Numbers:	901-C		1678-HA	075272

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Sister Genevieve Nugent		000695

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
St Joseph's Residence	1365 Enfield Street, Enfield CT 06082	Connecticut

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Sister Genevieve Nugent	1365 Enfield Street, Enfield CT 06082	President	n/a
Sister Partice Ormerod	1365 Enfield Street, Enfield CT 06082	Vice President	n/a
Sister Mary Christine Moore	1365 Enfield Street, Enfield CT 06082	Secretary	n/a
Names of Stockholders Owning at Least 10% of Shares			
none			

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility
n/a

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Little Sisters of the Poor	1365 Enfield Street, Enfield CT 06082	○	⊙		lendor of funds	pg26 / ln 12A1		n/a Motherhouse of Ord
Little Sisters of the Poor	1365 Enfield Street, Enfield CT 06082	○	⊙		10 Sisters employed by the facility	pg 10 / various lines		n/a Motherhouse of Ord
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

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

Related party expenses were allocated using the standard departmental allocations. No changes from prior cost reporting periods. Related party is the Motherhouse of the Order of Roman Catholic Nuns.

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Cox communications, Manchester CT	○	⊙	cable television outlets	month to month	month to month	7,981	7,981
DeLage Laden Financial Services, Wayne PA	○	⊙	copy machine	12/15/11	61 months	1,130	1,040
DeLage Laden Financial Services, Wayne PA	○	⊙	copy machine	04/04/13	60 months	1,401	1,167
Mail Finance, Chicago IL	○	⊙	Mailing Equipment	year to year	year to year	866	866
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No **Total ***** 11,054

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

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Kelleher & Company	6 Forest Park Drive, Farmington CT 06032
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	audited financial statements, cost report preparation, form 990 preparation, audit representation	$ 37,404
2		$
3		$
4		$
	Charge for Services Provided	$ 37,404

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes ○ No pg 15 / line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Garfunkel Wild Travis LLP	516-393-2200
2 Murtha Cullina LLP	860-240-6000
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 Great Neck, NY 11021
2 Hartford, CT 06103
3
4
5

Services Provided by This Firm (*describe fully*)

1	Nursing and related Medicare and Medicaid legal services	$ 3,200
2	Estate and Probate services and Corporation filing compliance services	$ 2,000
3		$
4		$
5		$
	Charge for Services Provided	$ 5,200

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes ○ No page 15 / line 1e

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	83	25		58	83	25		58	83	25		58
B. On last day of THIS report period	83	25		58	83	25		58	83	25		58
2. Number of Residents												
A. As of midnight of PREVIOUS report period	79	25		54	79	25		54	80	25		55
B. As of midnight of THIS report period					80	25		55				
3. Total Number of Days Care Provided During Period												
A. Medicare	61	61			61	61						
B. Medicaid (Conn.)	8,534	8,534			6,369	6,369			2,165	2,165		
C. Medicaid (other states)												
D. Private Pay	4,302	413		3,889	3,289	290		2,999	1,013	123		890
E. State SSI for RCH	15,883			15,883	11,878			11,878	4,005			4,005
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	28,780	9,008		19,772	21,597	6,720		14,877	7,183	2,288		4,895
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	28,780	9,008		19,772	21,597	6,720		14,877	7,183	2,288		4,895

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Schedule of Resident Statistics (Cont'd)

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

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

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

Change in Resident Days	CCNH	RHNS	Residential Care Home
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-MR
No. of Residents		24		1		13	42	
Per Diem Rate								
a. One bed rm.	395.21	238.47		300.00		140.00	128.00	
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	Residential Care Home
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Physical Therapy Treatments***				
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Speech Therapy Treatments***				
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Occupational Therapy Treatments***				

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Report of Expenditures - Salaries & Wages

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

Item	Total Cost and Hours					
	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	20,172	651			44,276	1,429
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	114,348	6,211			250,987	13,633
5. Dietary Service						
a. Head Dietitian	18,333	757			40,241	1,660
b. Food Service Supervisor	5,104	274			11,204	600
c. Dietary Workers	129,558	10,763			293,126	24,235
6. Housekeeping Service						
a. Head Housekeeper	7,631	469			16,749	1,031
b. Other Housekeeping Workers	55,124	4,909			122,038	9,813
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	18,666	751			40,971	1,649
b. Other Maintenance Workers	23,028	1,323			50,545	2,903
8. Laundry Service						
a. Supervisor	7,826	489			17,178	1,074
b. Other Laundry Workers	22,431	2,116			49,236	4,646
9. Barber and Beautician Services						
10. Protective Services	17,978	1,302			39,460	2,857
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	96,171	2,200				
b. RN						
1. Direct Care	348,759	12,331				
2. Administrative**						
c. LPN						
1. Direct Care	353,379	14,595				
2. Administrative**	4,592	133				
d. Aides and Attendants	594,775	37,385			418,613	31,319
e. Physical Therapists	5,846	123				
f. Speech Therapists						
g. Occupational Therapists	1,253	32				
h. Recreation Workers	46,717	2,398			139,055	8,608
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
Medical Records	42,149	2,176				
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	16,170	671			35,491	1,473
n. Marketing						
o. Other (Specify)						
See Attached Schedule	31,439	1,830			69,005	4,017
A-13. Total Salary Expenditures	1,981,449	103,889			1,638,175	110,947

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		Residential Care Home	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Pastoral Care Salaries	$ 31,439	1,830			$ 69,005	4,017
Total	$ 31,439	1,830	$ -	-	$ 69,005	4,017

Schedule of Other Fees (Page 13)

	CCNH		RHNS		Residential Care Home	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Chaplain Services	$ 2,418	pd by masses			$ 5,307	pd by masses
Total	$ 2,418	-	$ -	-	$ 5,307	-

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
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).										
See Schedule Attached page 11a										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
Section III - Administrators* **										
Sister Genevieve Nugent	20,172		44,276	Medical Insurance $5,650	all incharge duties	2,080		none		
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total Cost and Hours					
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	1,521	51			3,339	111
2. Dentist	2,800	24			2,800	24
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker	520	26			520	26
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	18,035	116				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	2,560	64				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	2,418				5,307	
B-13 Total Fees Paid in Lieu of Salaries	27,854	281			11,966	161

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
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		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
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Item		Total	CCNH	RHNS	Residential Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	81,352	44,532		36,820
2. Disability Insurance	$				
3. Unemployment Insurance	$	10,068	5,511		4,557
4. Social Security (F.I.C.A.)	$	247,476	135,468		112,008
5. Health Insurance	$	399,813	218,858		180,955
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	2,694	1,475		1,219
7. Pensions (Non-Discriminatory)	$	92,143	50,439		41,704
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	2,104	1,151		953
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	37,404	20,475		16,929
e. Legal (*Services should be fully described on Page 7)*	$	5,200	2,846		2,354
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	5,547	3,036		2,511
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	21,581	11,813		9,768
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	192,141	192,141		
Subtotal	$	1,097,523	687,745		409,778

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

(Carry Subtotals forward to next page)

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

St Joseph's Residence
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Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
Staff Education	$ 1,067		$ 883
Physicals	$ 84		$ 70
Total	$ 1,151	$ -	$ 953

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2015	16	37

Item		Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:		1,097,523	687,745		409,778
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	1,775	972		803
5. Education Expenses Related to Seminars and Conventions	$				
6. Automobile Expense (*not purchase or depreciation*)	$	17,974	9,839		8,135
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	652	357		295
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	5,330	2,918		2,412
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	18,853	10,320		8,533
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	7,561	3,848		3,713
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	438	240		198
9. Subscriptions	$				
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	11,091	6,071		5,020
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	140,612	76,971		63,641
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,301,809	799,281		502,528

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	Residential Care Home
Promotional advertising	$ 2,918		$ 2,412
Total Other Advertising	$ 2,918	$ -	$ 2,412

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
LeadingAge	$ 3,543		$ 3,419
ALTCFM	$ 41		$ 39
Foodshare	$ 25		$ 25
Costco	$ 46		$ 43
RP Assoc	$ 178		$ 172
Linkedin	$ 15		$ 15
Total Dues	$ 3,848	$ -	$ 3,713

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Licenses	$ 274		$ 226
Billing Services	$ 32,448		$ 26,828
Data Processing PR Fees	$ 7,059		$ 5,837
Data Processing supplies	$ 6,519		$ 5,390
Professional Background Checks	$ 314		$ 259
Penalties	$ 361		$ 299
Development Consultant	$ 7,899		$ 6,531
Development Printing	$ 276		$ 229
Development Software	$ 1,266		$ 1,047
Other Non-Reimburseable	$ 20,555		$ 16,995
Total Other Administrative and General	$ 76,971	$ -	$ 63,641

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
St Joseph's Residence	901-C	9/30/2015	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

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

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

Name of Facility	License No.	Report for Year Ended	Page of
St Joseph's Residence	901-C	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	Residential Care Home
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	231,476	72,451		159,025
2. Non-Food Supplies	$	16,327	5,110		11,217
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____	$	8,159	2,554		5,605
Dietary equipment repairs					
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	255,962	80,115		175,847

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

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

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

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

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2015		Page of 19 | 37

Item		Total	CCNH	RHNS	Residential Care Home
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $	15,441	4,833		10,608
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	2,821	883		1,938
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*) Laundry equipment repairs	$	1,470	460		1,010
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	19,732	6,176		13,556

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

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2015	20	37

Item			Total	CCNH	RHNS	Residential Care Home
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	21,259	6,654		14,605
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	19,681	6,160		13,521
c. Management Services*		$				
d. Other (*Specify*)		$	1,014	317		697
Repairs housekeeping equipment						
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	41,954	13,131		28,823
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	15,725	15,725		
Omnicare of CT						
b. Medicine Cabinet Drugs		$	10,275	5,793		4,482
c. Medical and Therapeutic Supplies		$	50,168	50,085		83
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$				
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	153	153		
i. Recreation		$	3,918	2,485		1,433
j. Other (Specify)****		$	12,553	8,853		3,700
See Attached Schedule						
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	92,792	83,094		9,698

* 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	Residential Care Home
Infectious waste	$ 7,211		
Barber and beauty supplies			$ 95
Religious supplies	$ 1,642		$ 3,605
Total Other Resident Care	$ 8,853	$ -	$ 3,700

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

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2015	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	Residential Care Home	Pg	Line
Enviro Systems Corp		○	⊙		HVAC maintenance	1,662		3,648	22	6f
NE Energy Controls		○	⊙			590		1,294	22	6f
Tyco Simplex/Grinnell		○	⊙		Fire alarm maintenance	518		1,137	22	6f
Cascade Water Services		○	⊙		Water maintenance	1,315		2,885	22	6f
Red Hawk Fire and Security		○	⊙		fire inspection service	1,286		2,824	22	6f
Kinsley Power		○	⊙		Generator maintenance	454		996	22	6f
Baystate Elevator		○	⊙		Elevator maintenance	5,486		12,043	22	6f
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
St Joseph's Residence	901-C	9/30/2015	22 | 37

Item		Total	CCNH	RHNS	Residential Care Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	129,094	40,406		88,688
b. Heat	$	161,515	50,553		110,962
c. Light & Power	$	127,422	39,882		87,540
d. Water	$	69,415	21,727		47,688
e. Equipment Lease (*Provide detail on page 6*)	$	11,054	3,460		7,594
f. Other (*itemize*)	$	36,138	11,311		24,827
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	534,638	167,339		367,299
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	7,575	2,371		5,204
b. Building & Building Improvements	$	86,126	26,957		59,169
c. Non-Movable Equipment	$	62,753	19,641		43,112
d. Movable Equipment	$	38,047	11,909		26,138
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	194,501	60,878		133,623
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	230	72		158
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	194,731	60,950		133,781

* 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	Residential Care Home
Contracted Maintenance services	$ 11,311		$ 24,827
Total Other Repairs and Maintenance	$ 11,311	$ -	$ 24,827

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	382,713		382,713	303,631	sl	var	7,575	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								7,575
B. **Building and Building Improvements**								
1. Acquired prior to this report period	7,537,879		7,537,879	6,766,363	sl	var	84,531	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	59,327		59,327		sl	var	1,595	
B-4. Subtotal								86,126
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	2,528,812		2,528,812	1,768,257	sl	var	61,952	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	8,005		8,005		sl	var	801	
C-4. Subtotal								62,753

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. 2003 Turtle Top Van		x	10	2002	40,587		40,587	40,587				
b. 2011 Honda Odyssey Van	x		6	2011	30,291		30,291	9,845	sl	10	3,029	
c. 2015 Dodge Ram Rro 250		x	1	2015	36,149		36,149		sl	4	6,025	
d. 2015 Alliance Handicap Bus		x	7	2015	88,900		88,900		sl	4	3,704	
2. Movable Equipment												
a. Acquired prior to this report period					1,469,486		1,469,486	1,400,534	sl	var	24,608	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					13,388		13,388		sl	var	681	
D-3. Subtotal												38,047
E. ***Total Depreciation***												194,501

St Joseph's Residence
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Schedule of Land Improvements Acquired during this report period

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

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
6/25/2015	Roof	$ 54,875	10	$ 1,372	
7/2/2015	Wallpaper and Paint	$ 4,452	5	$ 223	
Total additions for Building Improvements		$ 59,327		$ 1,595	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
3/23/2015	Motion Detectors Monitoring System	$ 8,005	5	$ 801	
Total additions for Non-Movable Equipment		$ 8,005		$ 801	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/20/2014	Gas Range for Kitchen	$ 4,655	10	$ 388	
8/14/2015	Freezer Door	$ 3,725	15	$ 41	
3/24/2015	Freezer Compressor	$ 3,318	15	$ 111	
12/4/2014	Dishwasher Backsplash for Kitchen	$ 1,690	10	$ 141	
Total additions for Movable Equipment		$ 13,388		$ 681	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report period

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2015	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	83
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained	01/01/93			
c. Interest Rate for the Cost Year	10 percent			
d. Term of Mortgage (number of years)	5 years			
e. Amount of Principal Borrowed	1,919,109			
f. Principal balance outstanding as of __09.30.2015	161,918			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
St Joseph's Residence	901-C	9/30/2015	26 | 37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
St Joseph's Residence	901-C	9/30/2015	27 | 37

Item	Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:				
12. C. Movable Equipment 1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $	89	28		61
Credit card, vendor finance charges				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	89	28		61
14. Insurance				
a. Insurance on Property (buildings only) $	25,476	7,974		17,502
b. Insurance on Automobiles $	10,000	3,129		6,871
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $	13,245	4,146		9,099
3. Other (*Specify*) $	699	219		480
Surety Bond				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	49,420	15,468		33,952
15. ***Total All Expenditures (A-13 thru C-14)*** $	6,150,571	3,234,885		2,915,686

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
St Joseph's Residence	901-C	9/30/2015	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.	10	A4	Salaries not related to Resident Care $	38,828	12,153		26,675
3.			Occupational Therapy $				
4.			Other - See attached Schedule $	7,099	7,099		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $	2,560	2,560		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.	15	1e	Accounting & Legal $	4,950	2,519		2,431
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.	16	L6	Automobile Expense (e.g. personal use) $	11,344	5,773		5,571
18.	16	m3	Unallowable Advertising * $	5,330	2,918		2,412
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.	20	5j	Barber and Beauty $	95			95
23.			Other - See attached Schedule $	64,771	32,962		31,809
Page 18 - Dietary Expenditures							
24.	18	2a1,2	Meals to employees, guests and others who are not residents $	53,106	16,622		36,484
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	188,083	82,606		105,477

* 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
10	12e	Physical Therapist	$ 5,846		
10	12g	Occupational Therapist	$ 1,253		
Total Other Salaries Adjustment			$ 7,099	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
13	B9a	Speech Therapist	$ 2,560		
Total Other Fees Adjustments			$ 2,560	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	m13	Development Consultant	$ 7,343		$ 7,087
16	m13	Development Postage	$ 5,071		$ 4,893
16	m13	Development Printing	$ 257		$ 248
16	m13	Development Data Processing	$ 1,177		$ 1,136
16	m13	Other Non-Reimburseable expenses	$ 19,114		$ 18,445
Total Other A&G Adjustments			$ 32,962	$ -	$ 31,809

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

Name of Facility	License No.	Report for Year Ended	Page of
St Joseph's Residence	901-C	9/30/2015	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward	$	188,083	82,606		105,477
Page 20 - Resident Care Supplies***								
27.	20	5a2	Prescription Drugs	$	10,704	10,704		
28.			Ambulance/Limousine	$				
29.			X-rays, etc	$				
30.	20	5h	Laboratory	$	153	153		
31.			Medical Supplies	$				
32.			Oxygen (non emergency)	$				
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$				
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$				
36.			Depreciation on Unallowable Motor Vehicles	$				
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$	43,992	13,770		30,222
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
Other - Miscellaneous								
42.			Research or Experimental Activities	$				
43.			Radio and Television Revenue	$				
44.			Vending Machine Revenue	$				
45.			Purchase Discounts and Allowances	$				
46.			Duplications of functions or services	$				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	$				
48.			Interest Income on Accounts Rec	$				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	$	89	28		61
Not For Profit Providers Only								
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
51.	***Total Amount of Decrease (Items 1 - 50)***			$	243,021	107,261		135,760

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

Attachment Page 29

St Joseph's Residence
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Ancillary Costs			$ -	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
22	6b	Heat (non-facility utilization)	$ 10,138		$ 22,251
22	6c	Light & Power (non-facility utilization)	$ 1,535		$ 3,369
22	6d	Water (non-facility utilization)	$ 736		$ 1,614
22	6f	Elevator Maintenance (non-facility utilization)	$ 1,097		$ 2,409
22	6f	Fire Maintenance (non-facilty utilization)	$ 264		$ 579
Total Other Property Adjustments			$ 13,770	$ -	$ 30,222

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
27	12D	Interest (finance charges credit cards, vendors)	$ 28		$ 61
Total Other Adjustments			$ 28	$ -	$ 61

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
St Joseph's Residence	901-C	9/30/2015	30 | 37

Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	4,783,820	2,560,200		2,223,620
b. Medicaid Room and Board Contractual Allowance **	$	(851,898)	(624,157)		(227,741)
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	24,108	24,108		
b. Medicare Room and Board Contractual Allowance **	$				
4. a. Private-Pay Residents and Other	$	668,360	123,900		544,460
b. Private-Pay Room and Board Contractual Allowance **	$	(103,036)	(4,681)		(98,355)
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	6,121	5,671		450
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	2,683	2,683		
b. Physical Therapy - Medicare Contractual Allowance **	$	(593)	(593)		
c. Physical Therapy - Non-Medicare	$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	536	536		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	968	968		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	4,531,069	2,088,635		2,442,434
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	444	139		305
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	1,353	423		930
8. Other (*Specify*)	$	1,155,444	361,648		793,796
V. Total Other Revenue (1 thru 8)	$	1,157,241	362,210		795,031
VI. Total All Revenue (III +V)	$	5,688,310	2,450,845		3,237,465

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Resident Revenue		$ -	$ -	$ -

Interest Income

		Account			Residential
Page Ref	**Account**	**Balance**	**CCNH**	**RHNS**	**Care Home**
30	Bank interest		$ 139		$ 305
Total Interest Income			$ 139	$ -	$ 305

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
30	Unrestricted Contributions	$ 320,724		$ 703,968
30	Donated Foods	$ 19,600		$ 43,022
30	Festivals and Events, net of expenses	$ 20,058		$ 44,026
30	Sales of scrap, cans, fully depreciated autos and rent	$ 1,266		$ 2,780
Total Other Revenue		$ 361,648	$ -	$ 793,796

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2015	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 206,316
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 279,002
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 71,457
a. Prepaid Insurance		53,417		
b. Prepaid Maintenance Contracts		18,040		
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 556,775
B. Fixed Assets				
1. Land				$ 598,500
2. Land Improvements	*Historical Cost	382,713		$ 71,507
	Accum. Depreciation	311,206	Net	
3. Buildings	*Historical Cost	7,597,206		$ 744,717
	Accum. Depreciation	6,852,489	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	2,536,817		$ 705,807
	Accum. Depreciation	1,831,010	Net	
6. Movable Equipment	*Historical Cost	1,482,874		$ 57,051
	Accum. Depreciation	1,425,823	Net	
7. Motor Vehicles	*Historical Cost	195,927		$ 132,737
	Accum. Depreciation	63,190	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 2,310,319

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2015	32	37

Account				Amount
			Total Brought Forward:	$ 2,867,094
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 2,867,094

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2015	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 172,169
2. Notes Payable (*itemize*)	$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)	$ 34,571
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$
7. Medicare Final Settlement Payable	$
8. Medicare Current Financing Payable	$
9. Mortgage Payable (*Current Portion*)	$ 161,918
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)	$
11. Accrued Income Taxes*	$
12. Other Current Liabilities (*itemize*)	$ 710,000
Due to Little Sisters of the Poor Broc 710,000	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 1,078,658

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2015	34	37

Account	Amount
Total Brought Forward:	1,078,658
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 1,078,658

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

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2015	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$ 2,500,000
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (711,564)
	6. Gain or Loss for Period 10/1/2014 thru 9/30/2015	$
	7. Total Net Worth	$ 1,788,436
C.	***Total Reserves and Net Worth***	$ 1,788,436
D.	***Total Liabilities, Reserves, and Net Worth***	$ 2,867,094

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2015	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			$ 2,250,697
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 5,688,310
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ (6,150,571)
D.	Net Income or Deficit			$ (462,261)
E.	Balance			$ 1,788,436
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/15		$ 1,788,436

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	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

Printed Name of Preparer	
Kevin P Kelleher CPA	
Addres Address	Phone Number
6 Forest Park Drive, Farmington CT 06032	860-677-8440

Error Check

Level	Item	Reported as		
CCH	Please complete page 9 for PT Treatments	-	As PT Expense is reported as	5,846
CCH	Please complete page 9 for ST Treatments	-	As ST Expense is reported as	2,560
CCH	Please complete page 9 for OT Treatments	-	As OT Expense is reported as	1,253