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General Information

Name of Facility (as licensed) St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2017	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for St Joseph's Residence [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) 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)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility St Joseph's Residence	Period Covered:	From 10/1/2016	To 9/30/2017	
Address of Facility 1365 Enfield Street, Enfield CT 06082				
Report Prepared By Kevin P Kelleher CPA	Phone Number 860-677-8440	Date 2/12/2018		
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.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility		Report for Year Ended		Page	of
860-741-0791		9/30/2017		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		
License Numbers:	CCNH	RHNS	Residential Care Home	Medicare Provider No.	
901-C			1678-HA	075272	
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input checked="" type="checkbox"/> Residential Care Home	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?					
		<input type="radio"/> Yes		<input checked="" type="radio"/> No	
If "Yes," explain fully.					
Administrator					
Name of Administrator			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.:		
none					

General Information and Questionnaire Individual Proprietorship

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2017	Page 3B	of 37
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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

**General Information and Questionnaire
 Related Parties***

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2017	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Little Sisters of the Poor	1365 Enfield St, Enfield CT 06082	<input type="radio"/>	<input checked="" type="radio"/>		lendor of funds	pg 26 / ln 12A1		n/a Motherhouse of Orde
Little Sisters of the Poor	1365 Enfield St, Enfield CT 06082	<input type="radio"/>	<input checked="" type="radio"/>		10 Sisters employed by the facility	pg 10 / var lines	416,571	n/a Motherhouse of Orde
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					

* 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 St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2017	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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.

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
St Joseph's Residence			901-C	9/30/2017			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Cox Communications, Manchester CT	<input type="radio"/>	<input checked="" type="radio"/>	cable television outlets, internet access and telephone services	month to month	month to month	8,310	8,310	
DeLage Laden Financial Services, Wayne PA	<input type="radio"/>	<input checked="" type="radio"/>	Ricoh Copier	04/04/13	60 months	1,413	1,413	
DeLage Laden Financial Services, Wayne PA	<input type="radio"/>	<input checked="" type="radio"/>	Bix Hub Copier	12/15/11	lease ended May 5, 2017	640	640	
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input checked="" type="radio"/> Yes	<input type="radio"/> No
Total ***							10,363	

* 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 St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2017	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual Cash Modified Cash

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

Independent Accounting Firm

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

1 audited financial statements, cost report preparation, form 990 preparation, audit representation	\$ 39,912
2	\$
3	\$
4	\$
Charge for Services Provided	
\$ 39,912	

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

Legal Services Information

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

Address (No. & Street, City, State, Zip Code)	
1	Great Neck, NY 11201
2	Hartford, CT 06103
3	
4	
5	

Services Provided by This Firm (describe fully)

1 Nursing and related Medicare and Medicaid legal services	\$ 2,933
2 Estate and Probate services and Corporation filing compliance services	\$ 6,678
3	\$
4	\$
5	\$
Charge for Services Provided	
\$ 9,611	

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

Schedule of Resident Statistics

Name of Facility St Joseph's Residence		License No. 901-C			Report for Year Ended 9/30/2017				Page 8	of 37			
	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	77	25		52	77	25		52	77	25		52	
B. As of midnight of THIS report period	78	25		53	78	25		53	78	25		53	
3. Total Number of Days Care Provided During Period													
A. Medicare	188	188			149	149			39	39			
B. Medicaid (Conn.)	7,963	7,963			5,985	5,985			1,978	1,978			
C. Medicaid (other states)													
D. Private Pay	3,497	787		2,710	2,677	513		2,164	820	274		546	
E. State SSI for RCH	16,497			16,497	12,072			12,072	4,425			4,425	
F. Other (Specify)													
G. Total Care Days During Period (3A thru F)	28,145	8,938		19,207	20,883	6,647		14,236	7,262	2,291		4,971	
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)	28,145	8,938		19,207	20,883	6,647		14,236	7,262	2,291		4,971	

Schedule of Resident Statistics (Cont'd)

Name of Facility St Joseph's Residence			License No. 901-C			Report for Year Ended 9/30/2017			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	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	3	20		2			5		48				
Per Diem Rate													
a. One bed rm.	516.97	241.59		400.00		150.00	128.47						
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													

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
St Joseph's Residence	901-C	9/30/2017	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	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)	23,483	661			50,462	1,419
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	122,234	6,245			262,668	13,420
5. Dietary Service						
a. Head Dietitian	18,960	686			40,807	1,474
b. Food Service Supervisor	12,788	661			27,521	1,419
c. Dietary Workers	142,534	10,617			317,672	23,239
6. Housekeeping Service						
a. Head Housekeeper	10,975	666			23,585	1,432
b. Other Housekeeping Workers	52,309	3,908			95,865	7,151
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	20,724	742			44,535	1,594
b. Other Maintenance Workers	23,192	1,177			49,838	2,529
8. Laundry Service						
a. Supervisor	8,950	540			19,234	1,159
b. Other Laundry Workers	22,262	1,834			47,839	3,940
9. Barber and Beautician Services						
10. Protective Services	19,363	1,319			41,608	2,833
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	97,818	2,168				
b. RN						
1. Direct Care	402,028	13,052				
2. Administrative**						
c. LPN						
1. Direct Care	142,278	5,304			156,324	5,949
2. Administrative**						
d. Aides and Attendants	623,865	36,589			395,712	26,276
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	46,504	2,127			108,737	6,400
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify) Medical Records	46,379	2,049				
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	16,443	645			35,335	1,387
n. Marketing						
o. Other (Specify) See Attached Schedule	25,283	1,429			54,329	3,069
<i>A-13. Total Salary Expenditures</i>	1,878,372	92,419			1,772,071	104,690

* 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)

Position	CCNH		RHNS		Residential Care Home	
	\$	Hours	\$	Hours	\$	Hours
Pastoral Care Salaries	\$ 25,283	1,429			\$ 54,329	3,069
Total	\$ 25,283	1,429	\$ -	-	\$ 54,329	3,069

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		Residential Care Home	
	\$	Hours	\$	Hours	\$	Hours
Chaplain Services	\$ 12,490	959			\$ 1,050	81
Total	\$ 12,490	959	\$ -	-	\$ 1,050	81

**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 Joseph's Residence				901-C	9/30/2017				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	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.

**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
St Joseph's Residence				901-C	9/30/2017				12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
Section III - Administrators***										
Sister Genevieve Nugent	23,483		50,462	Med Ins \$6,536	all in charge duties	2,080	2	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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
St Joseph's Residence	901-C	9/30/2017	13	37		
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	1,518	51			3,267	109
2. Dentist	2,200	24			2,200	24
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	84,202					
b. Other						
6. Social Worker	560	28			560	28
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	18,000	92				
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	25,145					
b. Other						
10. Occupational Therapist						
a. Resident Care	77,036					
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	12,490	959			1,050	81
B-13 Total Fees Paid in Lieu of Salaries	221,151	1,154			7,077	242

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

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

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
St Joseph's Residence	901-C	9/30/2017		15	37
Item	Total	CCNH	RHNS	Residential Care Home	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 90,394	46,513			43,881
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 12,225	6,291			5,934
4. Social Security (F.I.C.A.)	\$ 240,993	124,005			116,988
5. Health Insurance	\$ 270,849	139,368			131,481
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 2,486	1,279			1,207
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 104,582	53,814			50,768
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 3,376	1,737			1,639
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$				
d. Accounting and Auditing	\$ 39,912	19,828			20,084
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 9,611	4,775			4,836
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 8,676	4,310			4,366
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 28,485	14,151			14,334
2. Cellular Phones	\$				
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 184,031	184,031			
Subtotal	\$ 995,620	600,102			395,518

* 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
9/30/2017

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
Staff Education	\$ 1,678		\$ 1,583
Staff Physicals	\$ 59		\$ 56
Total	\$ 1,737	\$ -	\$ 1,639

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 Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2017	16	37
Item	Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:	995,620	600,102		395,518
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$			
3. Gifts to Staff and Residents	\$			
4. Employee Travel	\$ 1,487	739		748
5. Education Expenses Related to Seminars and Conventions	\$			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 14,185	7,047		7,138
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 404	201		203
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 7,333	3,643		3,690
4. Fund-Raising***	\$			
5. Medical Records	\$			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 5,000	2,484		2,516
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 8,072	4,010		4,062
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$ 121	60		61
10. Contributions*** See Attached Schedule	\$			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$			
12. Administrative Management Services**	\$ 8,535	4,240		4,295
13. Other (<i>Specify</i>) See Attached Schedule	\$ 179,473	89,163		90,310
C-14 Total Administrative & General Expenditures	\$ 1,220,230	711,689		508,541

* 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
Other Advertising	\$ 3,643		\$ 3,690
Total Other Advertising	\$ 3,643	\$ -	\$ 3,690

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
Leading Age	\$ 3,492		\$ 3,537
Foodshare	\$ 25		\$ 25
Amazon Prime	\$ 71		\$ 72
CT Assoc Health Care Facilities	\$ 174		\$ 176
CT Chamber of Commerce	\$ 248		\$ 252
Total Dues	\$ 4,010	\$ -	\$ 4,062

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Licenses	\$ 271		\$ 274
Billing Services	\$ 18,969		\$ 19,213
Data Processing Fees	\$ 5,676		\$ 5,750
Data Processing Supplies	\$ 8,869		\$ 8,983
Professional Background checks	\$ 3,423		\$ 3,467
Penalties	\$ 43		\$ 43
Development Consultant	\$ 6,737		\$ 6,823
Development mailing service	\$ 4,818		\$ 4,880
Development expensees	\$ 11,047		\$ 11,189
Miscellaneous	\$ 2,539		\$ 2,572
Other Non Reimbursable	\$ 26,771		\$ 27,116
Total Other Administrative and General	\$ 89,163	\$ -	\$ 90,310

Schedule C-1 - Management Services*

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2017	Page 17	of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #	

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

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

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2017	Page 18	of 37
Item	Total	CCNH	RHNS	Residential Care Home
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 287,837	91,313		196,524
2. Non-Food Supplies	\$ 19,438	6,167		13,271
3. Other (<i>Specify</i>) _____	\$			
b. Purchased Services (<i>by contract other than through Management Services (Complete Schedule C-2 att. Page 21)</i>)	\$			
c. Management Services**	\$			
d. Other (<i>Specify</i>) _____ Equipment repairs	\$ 7,033	2,231		4,802
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 314,308	99,711		214,597
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? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify cost. deminimus				
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2017	19	37
Item	Total	CCNH	RHNS	Residential Care Home
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	13,256	4,210	9,046
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. \$	9,388	2,981	6,407
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	\$	2,477	786	1,691
3E. Total Laundry Expenditures (3a + b + c + d)	\$	25,121	7,977	17,144
3F. Laundry Questionnaire				
G. Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3E.

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
St Joseph's Residence		901-C	9/30/2017		20	37
Item			Total	CCNH	RHNS	Residential Care Home
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	26,515	8,420		18,095
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$	23,126	7,344		15,782
c.	Management Services*	\$				
d.	Other (<i>Specify</i>) Housekeeping equipment repairs	\$	52	17		35
4E.	Total Housekeeping Expenditures (4a + b + c + d)	\$	49,693	15,781		33,912
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from Omnicare of CT	\$	16,913	16,913		
b.	Medicine Cabinet Drugs	\$	8,820	8,820		
c.	Medical and Therapeutic Supplies	\$	50,121	50,056		65
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$				
f.	X-rays and Related Radiological Procedures***	\$	936	936		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	836	836		
i.	Recreation	\$	6,268	3,510		2,758
j.	Other (<i>Specify</i>)**** See Attached Schedule	\$	25,135	15,957		9,178
5K.	Total Resident Care Expenditures (5a - 5j)	\$	109,029	97,028		12,001

* 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
Miscellaneous Medicare supplies	\$ 332		\$ 305
Infectious waste	\$ 11,496		
Religious Supplies	\$ 4,129		\$ 8,873
Total Other Resident Care	\$ 15,957	\$ -	\$ 9,178

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

Name of Facility St Joseph's Residence			License No. 901-C		Report for Year Ended 9/30/2017			Page of 21 37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	Residential Care Home	Pg	Line
Enviro Systems Corp		<input type="radio"/>	<input checked="" type="radio"/>		HVAC maintenance	1,434		3,080	22	6f
NE Energy Controls		<input type="radio"/>	<input checked="" type="radio"/>		HVAC maintenance	149		322	22	6f
Aegis Energy Services Inc		<input type="radio"/>	<input checked="" type="radio"/>		CoGen maintenance	8,228		17,680	22	6f
Tyco Simplex/Grinnell		<input type="radio"/>	<input checked="" type="radio"/>		Fire alarm maintenance	591		1,271	22	6f
Cascade Water		<input type="radio"/>	<input checked="" type="radio"/>		Water maintenance	1,334		2,866	22	6f
Red Hawk Fire and Security		<input type="radio"/>	<input checked="" type="radio"/>		Fire inspection	1,344		2,888	22	6f
Landry Communications		<input type="radio"/>	<input checked="" type="radio"/>		Telephone System maintenance	794		1,706	22	6f
Kinsley Power		<input type="radio"/>	<input checked="" type="radio"/>		Generator maintenance	446		958	22	6f
Red Hawk Fire and Security - monitoring fee		<input type="radio"/>	<input checked="" type="radio"/>		Fire monitoring fee	98		211	22	6f
Baystate Elevator		<input type="radio"/>	<input checked="" type="radio"/>		Elevator maintenance	7,488		16,901	22	6f
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

* List all contracted services over \$10,000. Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended			Page	of
St Joseph's Residence	901-C	9/30/2017			22	37
Item	Total	CCNH	RHNS	Residential Care Home		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 156,994	49,857			107,137	
b. Heat	\$ 117,867	37,431			80,436	
c. Light & Power	\$ 128,016	40,654			87,362	
d. Water	\$ 124,392	39,503			84,889	
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 11,128	3,534			7,594	
f. Other (<i>itemize</i>)	\$ 68,979	21,906			47,073	
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 607,376	192,885			414,491	
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 6,848	2,175			4,673	
b. Building & Building Improvements	\$ 91,466	29,047			62,419	
c. Non-Movable Equipment	\$ 69,372	22,030			47,342	
d. Movable Equipment	\$ 58,994	18,735			40,259	
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 226,680	71,987			154,693	
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 118	37			81	
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 226,798	72,024			154,774	

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

Annual Report of Long-Term Care Facility

Depreciation Schedule

Name of Facility		License No.			Report for Year Ended			Page	of				
St Joseph's Residence		901-C			9/30/2017			23	37				
Property Item		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals				
A. Land Improvements													
1. Acquired prior to this report period		382,713		382,713	318,655	sl	var	6,848					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal									6,848				
B. Building and Building Improvements													
1. Acquired prior to this report period		7,626,538		7,626,538	6,942,152	sl	var	88,895					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)		152,687		152,687				2,571					
B-4. Subtotal									91,466				
C. Non-Movable Equipment													
1. Acquired prior to this report period		2,536,817		2,536,817	1,894,564	sl	var	63,552					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)		226,639		226,639				5,820					
C-4. Subtotal									69,372				
		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 and 2011 Honda		x		6	2011	70,878		70,878	56,490	sl	10	3,029	
b. 2015 Dodge Ram Pro 250 and 2017		x		1	2015	48,149		48,149	15,562	sl	4	12,037	
c. 2015 Alliance Handicap Bus		x		1	2015	88,900		88,900	25,929	sl	4	22,225	
d. 2015 Alliance Handicap Bus Improv		x		2	2017	4,512		4,512		sl	4	658	
2. Movable Equipment													
a. Acquired prior to this report period						1,536,033		1,536,033	1,450,875	sl	var	19,786	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						17,460		17,460				1,259	
D-3. Subtotal												58,994	
E. Total Depreciation												226,680	

St Joseph's Residence
9/30/2017

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:				
5/19/2017	Asbestos Abatement Project	\$ 149,750	20	\$ 2,496
11/15/2016	Sprinkler Additions	\$ 1,937	25	\$ 71
8/31/2017	Water System Upgrade	\$ 1,000	20	\$ 4
Total additions for Building Improvements		\$ 152,687		\$ 2,571 *
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:				
4/11/2017	Kitchen Hood Replacement Project	\$ 208,093	20	\$ 5,202
6/8/2017	Kitteredge Kitchen Casters	\$ 18,546	10	\$ 618
Total additions for Non-Movable Equipment		\$ 226,639		\$ 5,820 *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/12/2016	Office furniture	\$ 1,525	15	\$ 102
10/26/2016	Lobby furniture	\$ 12,620	10	\$ 1,157
11/22/2016	Kitchen Blixer Machine	\$ 1,414	10	0
11/1/2016	9 Mattresses	\$ 1,901	5	0
Total additions for Movable Equipment		\$ 17,460		\$ 1,259 *
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

Amortization Schedule*

Name of Facility St Joseph's Residence			License No. 901-C		Report for Year Ended 9/30/2017			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2017	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased					
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					
d. Term of Mortgage (number of years)	5				
e. Amount of Principal Borrowed	1,919,109				
f. Principal balance outstanding as of _____	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.

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	9/30/2017	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)

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	9/30/2017	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) \$					
13. Total All Interest Expense (12B7 + 12C3 + 12D) \$					
14. Insurance					
a. Insurance on Property (buildings only) \$ 25,476 8,090 17,386					
b. Insurance on Automobiles \$ 8,750 2,779 5,971					
c. Insurance other than Property (as specified above)					
1. Umbrella (Blanket Coverage) \$					
2. Fire and Extended Coverage \$ 13,869 4,404 9,465					
3. Other (Specify) \$ 700 222 478					
Surety bond					
14d. Total Insurance Expenditures (14a + b + c) \$ 48,795 15,495 33,300					
15. Total All Expenditures (A-13 thru C-14) \$ 6,480,021 3,312,113 3,167,908					

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
St Joseph's Residence				901-C	9/30/2017	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	\$ 40,309	12,801		27,508
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	10a	Occupational Therapy	\$ 77,036	77,036		
7.			Other - See attached Schedule	\$ 109,347	109,347		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.	15	1e	Accounting & Legal	\$ 9,611	4,775		4,836
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	16	Automobile Expense (e.g. personal use)	\$ 9,232	4,586		4,646
18.	16	m3	Unallowable Advertising *	\$ 7,333	3,643		3,690
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 104,578	51,955		52,623
Page 18 - Dietary Expenditures							
24.	18	2a1,2	Meals to employees, guests and others who are not residents	\$ 40,231	12,763		27,468
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)				\$ 397,677	276,906		120,771

* 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
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
13	5a	Physical Therapy	\$ 84,202		
13	9a	Speech Therapist	\$ 25,145		
Total Other Fees Adjustments			\$ 109,347	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	m13	Penalties	\$ 43		\$ 43
16	m13	Development consultant	\$ 6,737		\$ 6,823
16	m13	Development mailing service	\$ 4,818		\$ 4,880
16	m13	Development expenses	\$ 11,047		\$ 11,189
16	m13	Miscellaneous	\$ 2,539		\$ 2,572
16	m13	Other Non Reimbursable	\$ 26,771		\$ 27,116
Total Other A&G Adjustments			\$ 51,955	\$ -	\$ 52,623

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	9/30/2017	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward				\$ 397,677	276,906		120,771
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 16,913	16,913		
28.			Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 936	936		
30.	20	5h	Laboratory	\$ 836	836		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 637	332		305
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.	22	7d	Depreciation on Unallowable Motor Vehicles	\$ 15,066	4,785		10,281
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 48,101	15,212		32,889
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 480,166	315,920		164,246

*** 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 Joseph's Residence
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
20	5j	Miscellaneous Medicare supplies	\$ 332		\$ 305
Total Other Ancillary Costs			\$ 332	\$ -	\$ 305

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)	\$ 7,593		\$ 16,316
22	6c	Light & Power (non-facility utilization)	\$ 1,219		\$ 2,619
22	6d	Water & Sewer (non-facility utilization)	\$ 695		\$ 1,492
22	6a	Maintenance (non-facility utilization)	\$ 3,833		\$ 8,237
22	6F	Elevator maintenance contract	\$ 1,872		\$ 4,225
Total Other Property Adjustments			\$ 15,212	\$ -	\$ 32,889

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Adjustments			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
St Joseph's Residence	901-C	9/30/2017			30	37
Item	Total	CCNH	RHNS	Residential Care Home		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 5,377,550	2,903,000		2,474,550		
b. Medicaid Room and Board Contractual Allowance **	\$ (1,308,133)	(940,182)		(367,951)		
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 93,190	93,190				
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 710,600	304,100		406,500		
b. Private-Pay Room and Board Contractual Allowance **	\$ (44,504)	(12,029)		(32,475)		
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 9,025	9,025				
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	\$ 132,591	132,591				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (56,382)	(56,382)				
c. Physical Therapy - Non-Medicare	\$					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 31,890	31,890				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 126,493	126,493				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 5,072,320	2,591,696		2,480,624		
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 (<i>Specify</i>)	\$ 11,834	3,758		8,076		
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$ 4,331	1,375		2,956		
8. Other (<i>Specify</i>)	\$ 2,007,950	637,664		1,370,286		
V. Total Other Revenue (1 thru 8)	\$ 2,024,115	642,797		1,381,318		
VI. Total All Revenue (III +V)	\$ 7,096,435	3,234,493		3,861,942		

* 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			
Page Ref	Account	Balance	CCNH	RHNS	Residential Care Home
30	Bank account interest		\$ 3,758		\$ 8,076
Total Interest Income			\$ 3,758	\$ -	\$ 8,076

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
30	Unrestricted Contributions	\$ 598,638		\$ 1,286,421
30	Donated Foods	\$ 20,069		\$ 43,127
30	Festivals and Events, net of expenses	\$ 18,658		\$ 40,095
30	Miscellaneous	\$ 299		\$ 643
Total Other Revenue		\$ 637,664	\$ -	\$ 1,370,286

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	384,386
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	541,892
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	73,073
a. Prepaid Insurance	54,351			
b. Prepaid Maintenance Agreements	18,722			
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

A-9. Total Current Assets (Lines A1 thru 8)			\$	999,351
B. Fixed Assets				
1. Land			\$	598,500
2. Land Improvements	*Historical Cost	382,713	\$	57,210
	Accum. Depreciation	325,503		
	Net			
3. Buildings	*Historical Cost	7,779,225	\$	745,607
	Accum. Depreciation	7,033,618		
	Net			
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		
	Net			
5. Non-Movable Equipment	*Historical Cost	2,763,456	\$	799,520
	Accum. Depreciation	1,963,936		
	Net			
6. Movable Equipment	*Historical Cost	1,553,493	\$	81,573
	Accum. Depreciation	1,471,920		
	Net			
7. Motor Vehicles	*Historical Cost	212,439	\$	76,509
	Accum. Depreciation	135,930		
	Net			
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

B-10. Total Fixed Assets (Lines B1 thru 9)			\$	2,358,919

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2017	32	37
Account			Amount	
Total Brought Forward:			\$	3,358,270
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	373,976
Construction in progress		373,976		

D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	373,976
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	3,732,246

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

G. Balance Sheet (cont'd)

Name of Facility St Joseph's Residence		License No. 901-C	Report for Year Ended 9/30/2017	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	249,312
2. Notes Payable (<i>itemize</i>)				\$	

3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	63,825
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	161,918
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	710,000
Due to the Little Sisters of the Poor I		710,000			

A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,185,055

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2017	Page 34	of 37
Account			Amount	
Total Brought Forward:			1,185,055	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$
C. Total All Liabilities (Lines A-13 + B-5)				\$ 1,185,055

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	9/30/2017	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	2,500,000
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(569,223)
6. Gain or Loss for Period			\$	616,414
	10/1/2016	thru 9/30/2017		
7. Total Net Worth			\$	2,547,191
C. Total Reserves and Net Worth			\$	2,547,191
D. Total Liabilities, Reserves, and Net Worth			\$	3,732,246

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of	
St Joseph's Residence	901-C	9/30/2017	36	37	
Account			Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	1,930,777	
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	7,096,435	
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	(6,480,021)	
D. Net Income or Deficit			\$	616,414	
E. Balance			\$	2,547,191	
F. Additions					
1. Additional Capital Contributed (<i>itemize</i>)					
2. Other (<i>itemize</i>)					
F-3. Total Additions			\$		
G. Deductions					
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$		
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount		
2. Other Withdrawings (<i>Specify</i>)			\$		
Purpose		Amount			
3. Total Deductions			\$		
H. Balance at End of Period			\$	2,547,191	
				09/30/17	

I. Preparer's/Reviewer's Certification

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Residential Care Home		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
Kevin P Kelleher CPA				
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 84,202
CCH	Please complete page 9 for ST Treatments	-	As ST Expense is reported as 25,145
CCH	Please complete page 9 for OT Treatments	-	As OT Expense is reported as 77,036