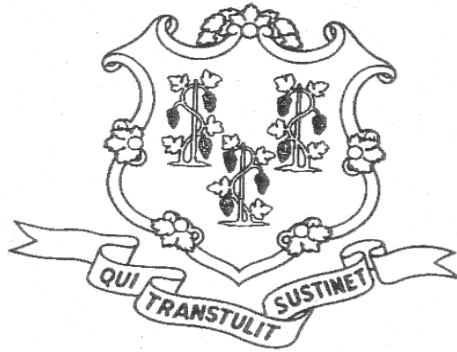


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as licensed) Saint Joseph Living Center LLC	
Address (No. & Street, City, State, Zip Code) 14 Club Rd. Windham, CT 06280	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH 20397	RHNS	(Specify)	Medicare Provider 07-5321
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2018	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 Saint Joseph Living Center LLC [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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) Ginny Person			Printed Name (Owner)		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Saint Joseph Living Center LLC	Period Covered:	From 10/1/2017	To 9/30/2018	
Address of Facility 14 Club Rd. Windham, CT 06280				
Report Prepared By CJLC LLC	Phone Number 860-610-9009	Date 2/15/2019		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid \$				
2. Laundry wages paid \$				
3. Housekeeping wages paid \$				
4. Nursing wages paid \$				
5. All other wages paid \$				
6. Total Wages Paid \$				
7. Total salaries paid \$				
8. Total Wages and Salaries Paid (As per page 10 of Report) \$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire

Type of Facility - Organization Structure

	Phone No. of Facility 806-456-1107	Report for Year Ended 9/30/2018	Page 2	of 37
Name of Facility (as shown on license) Saint Joseph Living Center LLC		Address (No. & Street, City, State, Zip) 14 Club Rd. Windham, CT 06280		
License Numbers:	CCNH 20397	RHNS	(Specify)	Medicare Provider No. 07-5321
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 type="checkbox"/> (Specify)				
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 Ginny Person		Nursing Home Administrator's License No.:	001882	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire Individual Proprietorship

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2018	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 Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2018	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	%**				
Diocese of Norwich		<input type="radio"/>	<input checked="" type="radio"/>		Heath Insurance	15/1a5	1,017,711	1,017,711
Diocese of Norwich		<input type="radio"/>	<input checked="" type="radio"/>		Auto Insurance	27/14b	4,867	4,867
Christian Brothers		<input type="radio"/>	<input checked="" type="radio"/>		Pension	15/1a7	148,652	148,652
See Attached List		<input type="radio"/>	<input checked="" type="radio"/>		Pastoral	12/B12	16,100	16,100
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" 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 Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2018	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.

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 Saint Joseph Living Center LLC			License No. 20397	Report for Year Ended 9/30/2018			Page 6	of 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							
Pitney Bowes. PO Box 371887, Pittsburg PA 15250-7887	<input type="radio"/>	<input checked="" type="radio"/>	Postage Machine	06/20/17	12 months	4,512	4,512		
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input checked="" type="radio"/> No	Total ***	4,512

* 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 Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2018	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 Blum, Shapiro & Co PC 2 CJLC LLC 3 4	Address (No. & Street, City, State, Zip Code) 29 South Main St West Hartford, Ct 06127-2000 225 Pitkin St Suite 200 East Hartford, Ct 06108
--	---

Services Provided by This Firm (*describe fully*)

1	Financial Consulting, Audited Financial Statements & Tax Form 990	\$	29,197
2	Medicaid Cost Report	\$	6,500
3		\$.
4		\$	
			Charge for Services Provided
			\$ 35,697

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

- Yes No 15/1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Gordon & Rees LLP 2 Mutha Cullina LLP 3 SB2 Inc 4 Wigginn & Dana 5	Telephone Number 860-278-7448 860-240-6000 717-585-7186 203-498-4400
--	--

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

- 1 95 Glastonbury Blvd Suite 206 Glastonbury Ct 06033
 2 City Place 1 Asylum Street Hartford, Ct 06103
 3 1426 N. 3rd Street Suite 200 Harrisburg, Pa 17102
 4 One Century Tower PO Box 1832 New Haven, Ct 06508
 5

Services Provided by This Firm (*describe fully*)

1	Various See Attached	\$	(5,000)
2	Various See Attached	\$	11,668
3	Various See Attached	\$	144
4	Various See Attached	\$	3,014
5		\$	
			Charge for Services Provided
			\$ 9,826

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

- Yes No 15/1e

Schedule of Resident Statistics

Name of Facility Saint Joseph Living Center LLC		License No. 20397			Report for Year Ended 9/30/2018				Page 8	of 37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	120	120			120	120			120	120			
B. On last day of THIS report period	120	120			120	120			120	120			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	109	109			109	109			98	98			
B. As of midnight of THIS report period	103	103			98	98			103	103			
3. Total Number of Days Care Provided During Period													
A. Medicare	3,505	3,505			2,724	2,724			781	781			
B. Medicaid (Conn.)	27,196	27,196			20,486	20,486			6,710	6,710			
C. Medicaid (other states)													
D. Private Pay	6,100	6,100			4,520	4,520			1,580	1,580			
E. State SSI for RCH													
F. Other (Specify) MA Plans & Contracts	3,058	3,058			2,389	2,389			669	669			
G. Total Care Days During Period (3A thru F)	39,859	39,859			30,119	30,119			9,740	9,740			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	7	7			7	7							
B. Other Bed Reserve Days	80	80			54	54			26	26			
5. Total Resident Days (3G + 4A + 4B)	39,946	39,946			30,180	30,180			9,766	9,766			

Schedule of Resident Statistics (Cont'd)

Name of Facility Saint Joseph Living Center LLC			License No. 20397			Report for Year Ended 9/30/2018			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	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	6		73		24								
Per Diem Rate													
a. One bed rm.			218.06		445.00								
b. Two bed rms.			218.46		415.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									2,756	2,756			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									16,700	16,700			
D. Total Physical Therapy Treatments									19,456	19,456			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									193	193			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									1,175	1,175			
D. Total Speech Therapy Treatments									1,368	1,368			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									3,402	3,402			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									17,076	17,076			
D. Total Occupational Therapy Treatments									20,478	20,478			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Saint Joseph Living Center LLC	20397	9/30/2018	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	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	135,645	2,238				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	417,683	15,514				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	73,813	2,669				
c. Dietary Workers	329,486	25,629				
6. Housekeeping Service						
a. Head Housekeeper	22,293	1,133				
b. Other Housekeeping Workers	171,291	14,893				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	99,562	5,271				
8. Laundry Service						
a. Supervisor	22,293	1,133				
b. Other Laundry Workers	139,404	8,631				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	222,384	4,457				
b. RN						
1. Direct Care	1,168,393	37,337				
2. Administrative**	430,954	16,378				
c. LPN						
1. Direct Care	668,496	25,180				
2. Administrative**						
d. Aides and Attendants	1,853,097	121,281				
e. Physical Therapists	351,511	8,570				
f. Speech Therapists	44,613	886				
g. Occupational Therapists	228,958	7,439				
h. Recreation Workers	139,511	7,606				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	107,676	3,959				
n. Marketing						
o. Other (Specify) See Attached Schedule	30,116	1,842				
<i>A-13. Total Salary Expenditures</i>	6,657,181	312,046				

* 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		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Pastorial Wages	\$ 30,116	1,842				
Total	\$ 30,116	1,842	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
New Emergency Preparedness Plan & Legionella Risk Assessment	\$ 6,050					
Pastoral Service	\$ 17,825	343				
Total	\$ 23,875	343	\$ -	-	\$ -	-

**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	
Saint Joseph Living Center LLC				20397	9/30/2018			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

**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	
Saint Joseph Living Center LLC				20397	9/30/2018			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Ginny Person	135,645			Standard	Responsible for daily operations of the facility	2,238	A2			
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		
Saint Joseph Living Center LLC	20397	9/30/2018	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian	21,667	733				
2. Dentist	13,032	110				
3. Pharmacist	11,106	159				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	64,700	556				
b. Utilization Review (Title 18 and 19 only) monthly meeting	400	6				
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	23,875	343				
B-13 Total Fees Paid in Lieu of Salaries	134,780	1,907				

* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.
 ** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.
 *** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

Name of Facility Saint Joseph Living Center LLC		License No. 20397	Report for Year Ended 9/30/2018	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Margaret B. Higgins, 635 RT 197, Woodstock, CT 06281	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
HeathDrive Dental Group, 1 Prestidge Drive, Meriden, CT 06450	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
Omnicare Pharmacy Services, PO Box 715268, Columbus, OJ 53271-5268	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>		
Charles Shooks, 237 Walnut St., Willimantic, CT 06226	Medical Staff/Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Michael Kilgannon, MD, 60 Fieldstone Dr., Storrs, CT 06268	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Steven Leach MD, 135 Elizabeth Street, Hartford, CT 06105	Medical Staff/Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Elizabeth Visone, APRN, 1 Enders Rd., Windsor, CT 06095	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
See List Attached to Page 4	Pastoral Care	<input checked="" type="radio"/>	<input type="radio"/>	Affiliate Organization	
Facility Compliance Services, 221 West Main Street, Plantsville, CT 06479	Emergency Preparedness & Risk Assessment	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Saint Joseph Living Center LLC	20397	9/30/2018		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 225,612	225,612			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 12,115	12,115			
4. Social Security (F.I.C.A.)	\$ 487,426	487,426			
5. Health Insurance	\$ 1,020,711	1,020,711			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 148,652	148,652			
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 7,096	7,096			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 136,635	136,635			
d. Accounting and Auditing	\$ 35,697	35,697			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 9,826	9,826			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 37,043	37,043			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 9,697	9,697			
2. Cellular Phones	\$ 286	286			
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	\$ 718,759	718,759			
Subtotal	\$ 2,849,555	2,849,555			

* 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**

Saint Joseph Living Center LLC
9/30/2018

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Employee Physicals	\$ 7,096		
Total	\$ 7,096	\$ -	\$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Saint Joseph Living Center LLC	20397	9/30/2018		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	2,849,555	2,849,555			
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	4,457	4,457		
5. Education Expenses Related to Seminars and Conventions	\$	8,908	8,908		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	1,503	1,503		
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	9,645	9,645		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	16,859	16,859		
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	\$	6,202	6,202		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	15,421	15,421		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	500	500		
9. Subscriptions	\$				
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>)	\$	48,163	48,163		
12. Administrative Management Services**	\$	89,220	89,220		
13. Other (<i>Specify</i>) See Attached Schedule	\$	53,988	53,988		
C-14 Total Administrative & General Expenditures	\$	3,104,421	3,104,421		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Business Promotion	\$ 7,643		
Advertising	\$ 9,217		
Total Other Advertising	\$ 16,859	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM	\$ 255		
Bank of America	\$ 205		
CAHCF	\$ 700		
CHA	\$ 1,853		
Leading Age	\$ 12,253		
Soroptimists	\$ 155		
Total Dues	\$ 15,421	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
New Hire Expenses	\$ 6,629		
Employee Relations	\$ 16,414		
Breakroom Expense	\$ 3,624		
Licenses	\$ 4,108		
Service Charges - Bank	\$ 4,609		
Citations/Fines	\$ 15,375		
Loss on Disposal of Asset	\$ 261		
Chapel Supplies	\$ 2,586		
Restricted Chapel	\$ 384		
Total Other Administrative and General	\$ 53,988	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2018	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Heathpro Management Services, 536 Old Howell Road, Greenville, SC 29615	89,220	Rehab Department Software and Consulting	16/m12

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Saint Joseph Living Center LLC		20397	9/30/2018		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1. Raw Food	\$	348,307	348,307			
2. Non-Food Supplies	\$	47,580	47,580			
3. Other (Specify) _____	\$					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)						
c. Other (Specify) _____						
2D. Total Dietary Expenditures (2a + b + c + d)		\$	395,888	395,888		
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)	
G. Resident Meals:	Total no. of meals served per day:*	3	3			
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.						
L. Is any revenue collected from these people? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify amt. \$1,907						
M. Where is the revenue received reported in the Cost Report? (Page/Line Item) 30/IV1						
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.

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

Name of Facility Saint Joseph Living Center LLC		License No. 20397	Report for Year Ended 9/30/2018	Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$			
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.			
		Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.			
		Amt. \$			
4. Repair and/or purchase of linens.***		Lbs.			
		Amt. \$	13,088	13,088	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Other (Specify)		\$	19,737	19,737	
3D. Total Laundry Expenditures (3a + b + c)		\$	32,825	32,825	
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.

*** 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
Saint Joseph Living Center LLC		20397	9/30/2018		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	34,475	34,475		
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$				
C.	Other (<i>Specify</i>)	\$				
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	34,475	34,475		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from	\$	243,719	243,719		
b.	Medicine Cabinet Drugs	\$	32,221	32,221		
c.	Medical and Therapeutic Supplies	\$	203,962	203,962		
d.	Ambulance/Limousine***	\$	841	841		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	42,385	42,385		
f.	X-rays and Related Radiological Procedures***	\$	12,722	12,722		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	26,511	26,511		
i.	Recreation	\$	17,856	17,856		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	48,271	48,271		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	628,487	628,487		

* 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.

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

Name of Facility Saint Joseph Living Center LLC			License No. 20397	Report for Year Ended 9/30/2018	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	(Specify)	Pg	Line
ADP	PO Box 842875, Boston, MA 02284	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	45,393			16	11
CONN COMPUTER SERVICE INC	Box 35, Plantsville, CT 06479	<input type="radio"/>	<input checked="" type="radio"/>		Service Contracts	61,867			15\22	1g\6a
East Coast Insulation	12 Innes Avenue, Thomaston, CT 06787	<input type="radio"/>	<input checked="" type="radio"/>		Improvements, Repairs, Grounds Maintenance	33,706			var	var
Ellington Energy	PO Box 376, Ellington, CT 06029	<input type="radio"/>	<input checked="" type="radio"/>		Building Improvements	17,660			22	6f
Hawthorne, Ryan	Mansfield Center, CT 06250	<input type="radio"/>	<input checked="" type="radio"/>		Grounds Maintenance	34,360			22	6f
MDI Acheieve/Matrixcare	PO Box 86, Minneapolis, MN 55486	<input type="radio"/>	<input checked="" type="radio"/>		Office Supplies, Nursing Supplies	15,384			var	var
Ryan Business Systems Inc.	South Windsor, CT 06074	<input type="radio"/>	<input checked="" type="radio"/>		Supplies, Moveable Equipment, Prepaid	22,455			var	var
Seventy Two Degrees	PO Box 692, Baltic, CT 06330	<input type="radio"/>	<input checked="" type="radio"/>		Repairs and Maintenance	10,649			22	6f
Willimantic Waste Paper	PO Box 239, Willimantic, CT 06226	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal	26,143			22	6f
Yankee Equipment System Inc.	Po Box 630, Barrington, NH 03825	<input type="radio"/>	<input checked="" type="radio"/>		Moveable Equipment, Repairs and Maintenance	13,654			22	6f
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" 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
Saint Joseph Living Center LLC	20397	9/30/2018			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 85,299	85,299				
b. Heat	\$ 52,093	52,093				
c. Light & Power	\$ 97,773	97,773				
d. Water	\$ 25,891	25,891				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 4,512	4,512				
f. Other (<i>itemize</i>)	\$ 145,669	145,669				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 411,238	411,238				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 6,338	6,338				
b. Building & Building Improvements	\$ 427,105	427,105				
c. Non-Movable Equipment	\$ 34,791	34,791				
d. Movable Equipment	\$ 76,561	76,561				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 544,795	544,795				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$ 11,434	11,434				
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 11,434	11,434				
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	\$ 783	783				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 557,012	557,012				

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

Saint Joseph Living Center LLC
9/30/2018

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
4/20/2018	Brick Sign	\$ 6,500	25	\$ 158
5/1/2018	Brick Sign	\$ 9,300	25	\$ 158
8/27/2018	Coutyard Pavers	\$ 4,031	20	\$ 107
8/27/2018	Coutyard Pavers-Statue Base	\$ 4,500	20	\$ 107
9/12/2018	Sealcoat Parking lot	\$ 5,500	2	\$ 1,375
Total additions for Land Improvements		\$ 29,831		\$ 1,905 *
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:				
12/9/2017	EAST COAST INSULATION	\$ 3,750	15	
1/9/2018	EAST COAST INSULATION	\$ 3,750	15	
3/7/2018	CT ROOFING	\$ 3,595	5	
3/29/2018	CONSTRUCTION SPECIALTIES	\$ 3,195	15	
4/11/2018	ELLINGTON ENERGY	\$ 17,660	20	
5/28/2018	EAST COAST INSULATION	\$ 950	15	
Total additions for Building Improvements		\$ 32,900		\$ 1,189 *
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:				
Total additions for Non-Movable Equipment		\$ -		\$ - *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/5/2017	hp laserjet	\$ 1,905	5	
10/5/2017	hp laserjet	\$ 165	5	
11/8/2017	washer	\$ 12,300	10	
2/7/2018	hp elitebook laptops	\$ 3,670	3	
2/15/2018	cannon coppier	\$ 7,295	5	
2/15/2018	cannon coppier	\$ 7,295	5	
2/27/2018	cannon ir install	\$ 248	5	
2/27/2018	cannon ir install	\$ 248	5	
7/17/2018	neurogym Equipment	\$ 11,400	10	
8/1/2018	hp printer	\$ 1,999	5	
8/20/2018	hp sff600 computer	\$ 2,350	5	
8/20/2018	hp sff600 computer licences	\$ 958	3	
9/1/2018	garbage disposal	\$ 3,488	5	
9/26/2018	hp sff600 computer install	\$ 1,114	5	
Total additions for Movable Equipment		\$ 54,433		\$ 4,566 *
Deletions:				
3/13/2014	food disposer	\$ (2,608)	5	
7/31/2013	cannon copier	\$ (5,090)	3	
5/31/2011	Computers SA & SP Nursing Units Touch Computer	\$ (2,880)	5	
3/30/2009	Washing Mach Upgrade Panel	\$ (1,250)	3	
4/30/2008	Washer repairs	\$ (682)	3	
12/31/2007	Washer control panel	\$ (709)	3	
6/30/2004	washers # 3	\$ (10,022)	10	
7/31/2002	5 n printer	\$ (8,739)	5	
Total deletions for Movable Equipment		\$ (31,981)		\$ - **

*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			License No.		Report for Year Ended			Page	of
Saint Joseph Living Center LLC			20397		9/30/2018			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1. Insurance Costs	6	2016	87 months	82,897	14,292	SL		11,434	
2.									
3.									
A-4. Subtotal									11,434
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									11,434

* 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 Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2018	Page 25	of 37
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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	02/17/94			
2. Date Structure Completed	09/01/88			
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure	10/12/88			
5. Total Licensed Bed Capacity	120			
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building	6,458,157			

Part B - Owner and Related Parties

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	09/20/13			
c. Interest Rate for the Cost Year	3.32%			
d. Term of Mortgage (number of years)	10			
e. Amount of Principal Borrowed	5,000,000			
f. Principal balance outstanding as of <u>9/30/18</u>	2,678,000			
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
Saint Joseph Living Center LLC		20397	9/30/2018			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$	5,000,000				
2. Loan Origination Date			09/20/13				
3. Interest Rate %			3.32%				
4. Term			10				
5. CHEFA Interest Expense			4,678	4,678			
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$	4,678	4,678			

(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
Saint Joseph Living Center LLC		20397		9/30/2018		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				4,678	4,678		
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)				\$	4,678	4,678	
14. Insurance							
a. Insurance on Property (buildings only)				\$	193,919	193,919	
b. Insurance on Automobiles				\$	4,867	4,867	
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$	198,786	198,786	
15. Total All Expenditures (A-13 thru C-14)				\$	12,159,769	12,159,769	

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC				20397	9/30/2018	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	a12g	Occupational Therapy	\$ 228,958	228,958		
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 136,635	136,635		
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$ 16,859	16,859		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 37,288	37,288		
Page 18 - Dietary Expenditures							
24.	30	iv8	Meals to employees, guests and others who are not residents	\$ 2,473	2,473		
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)				\$ 422,213	422,213		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	8a	Chamber of Commerce Dues	\$ 500		
16	m13	Loss on Property	\$ 261		
30	iv8	Restricted Revenue	\$ 4,600		
30	iv8	Chapel-Restricted Revenue	\$ 666		
30	iv8	Rec-Restricted Revenue	\$ 200		
30	iv8	Eden-Restricted Revenue	\$ 251		
16	m13	citations & Fines	15375		
30	iv8	Stericycle Settlement	15434.95		
Total Other A&G Adjustments			\$ 37,288	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC				20397	9/30/2018	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 422,213	422,213		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 243,719	243,719		
28.	20	d	Ambulance/Limousine	\$ 841	841		
29.	20	f	X-rays, etc	\$ 12,722	12,722		
30.	20	j	Laboratory	\$ 26,511	26,511		
31.			Medical Supplies	\$			
32.	20	5e	Oxygen (non emergency)	\$ 47,770	47,770		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 37,260	37,260		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 1,299	1,299		
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49.	Total Amount of Decrease (Items 1 - 48)			\$ 792,335	792,335		

*** 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.

Saint Joseph Living Center LLC
9/30/2018

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Supplies - OT	\$ 3,359		
20	5j	Physician Services Medicare	\$ 2,172		
20	5j	Other	\$ 7,325		
20	5j	DME Rental	\$ 15,502		
20	5j	IV Therapy Supplies	\$ 262		
20	5j	IV Therapy Supplies Insurance	\$ 2,994		
20	5j	IV Therapy Supplies Medicare	\$ 5,646		
Total Other Ancillary Costs			\$ 37,260	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7c	Depreciation of Chapel Video System 12/31/14	\$ 1,000		
22	7c	Depreciation of Install Box Camera/Tested Audio for PA Systems 1/31/15	\$ 227		
22	7b	Depreciation on Wire Runs To Basement/Chapel Camera 1/31/15	\$ 72		
Total Excess Movable Equipment Depreciation			\$ 1,299	\$ -	\$ -

Schedule of Other Property Adjustments

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

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Saint Joseph Living Center LLC	20397	9/30/2018			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 11,274,625	11,274,625				
b. Medicaid Room and Board Contractual Allowance **	\$ (5,383,066)	(5,383,066)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,473,745	1,473,745				
b. Medicare Room and Board Contractual Allowance **	\$ (568,965)	(568,965)				
4. a. Private-Pay Residents and Other	\$ 2,986,510	2,986,510				
b. Private-Pay Room and Board Contractual Allowance **	\$ 171,624	171,624				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 186,961	186,961				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 83,362	83,362				
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	\$ 379,861	379,861				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 323,821	323,821				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 196,189	196,189				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 68,751	68,751				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 465,323	465,323				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 389,979	389,979				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$ (168,195)	(168,195)				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 34,212	34,212				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 11,914,738	11,914,738				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$ 1,907	1,907				
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 5,545	5,545				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 161,697	161,697				
V. Total Other Revenue (1 thru 8)	\$ 169,149	169,149				
VI. Total All Revenue (III +V)	\$ 12,083,888	12,083,888				

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Medicare A - IV Therapy	\$ 6,721		
	Medicare A - X-Ray	\$ 10,075		
	Medicare A - Physician Care	\$ 219		
	Medicare A - Lab	\$ 15,589		
	Insurance - Contractual Adjustment	\$ (58,717)		
	Medicare B - Speech Therapy	\$ 16,196		
	Medicare B - Contractual Adjustment	\$ (80,988)		
	Managed Care B - Lab	\$ 13,277		
	Managed Care B - Contractual Adjustment	\$ (90,566)		
Total Other Resident Revenue - Medicare		\$ (168,195)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Managed Care - IV Therapy	\$ 4,004		
	Managed Care - X-Ray	\$ 5,692		
	Managed Care - Physician Care	\$ 45		
	Insurance - Occupational Therapy	\$ 18,035		
	Insurance - IV Therapy	\$ 675		
	Insurance - X-Ray	\$ 381		
	Insurance - Lab	\$ 778		
	Managed Care B - Vaccines	\$ 4,602		
Total Other Resident Revenue		\$ 34,212	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income		\$ 5,545		
Total Interest Income			\$ 5,545	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Charitable Donations	\$ 7,595		
	Misc. Income	\$ 16,812		
	Recovery Of Bad Debt	\$ 130,411		
	Restricted Revenue	\$ 4,600		
	Chapel Offering Box	\$ 1,163		
	Chapel-Restricted Revenue	\$ 666		
	Rec-Restricted Revenue	\$ 200		
	Eden-Restricted Revenue	\$ 251		
Total Other Revenue		\$ 161,697	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC	20397	9/30/2018	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	2,968,651
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	618,487
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	63,571
5. Prepaid Expenses			\$	109,556
a. _____				
b. _____				
c. _____				
d. See Schedule		109,556		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	2,660

See Schedule		2,660		
A-9. Total Current Assets (Lines A1 thru 8)			\$	3,762,926
B. Fixed Assets				
1. Land			\$	1,220,000
2. Land Improvements	*Historical Cost	163,049	\$	51,725
	Accum. Depreciation	111,324		
		Net		
3. Buildings	*Historical Cost	7,981,970	\$	(2,975,995)
	Accum. Depreciation	10,957,965		
		Net		
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation			
		Net		
5. Non-Movable Equipment	*Historical Cost	678,444	\$	132,633
	Accum. Depreciation	545,811		
		Net		
6. Movable Equipment	*Historical Cost	2,035,102	\$	1,021,349
	Accum. Depreciation	1,013,753		
		Net		
7. Motor Vehicles	*Historical Cost	69,985	\$	
	Accum. Depreciation	69,985		
		Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	3,336,179

See Schedule		3,336,179		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	2,785,891

* 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	License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC	20397	9/30/2018	32	37
Account			Amount	
Total Brought Forward:			\$	6,548,817
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	82,897		
	Accum. Depreciation	25,727	Net	\$ 57,171
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>)			\$	
_____			\$	
See Schedule			\$	
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	57,171
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	6,605,988

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		Prepaid-Expenses	\$ 19,270
		Prepaid-Insurance	\$ 90,287
		Total Prepaid Expenses	\$ 109,556

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref	Line Ref	Description	
		Refundable Deposits	\$ 2,660
		Total Other Current Assets (Itemize)	\$ 2,660

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref	Line Ref	Description	
		Construction in Progress	\$ 80,000
		Book Vs Cost	\$ 3,256,179
		Total Other Fixed Assets (Itemize)	\$ 3,336,179

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Total Other Assets	\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
		Total Notes Payable	\$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref	Line Ref	Description	
		Accured Expense Other	\$ 106,546
		Bonds Payable Non Taxable-ST	\$ 81,000
		Accured Provider Tax	\$ 177,325
		Resident Refunds & Exchanges	\$ 9,913
		Resident Trust	\$ 28,039
		Total Other Current Liabilities (Itemize)	\$ 402,823

Schedule of Other Long-Term Liabilities (itemize) Page 34 Line B4

Page Ref	Line Ref	Description	
		Interest Rate Swap Obligation	\$ (34,050)
		Total Other Current Liabilities (Itemize)	\$ (34,050)

G. Balance Sheet (cont'd)

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2018	Page 33	of 37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	339,314
2. Notes Payable (<i>itemize</i>)			\$	

See Schedule				
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>)			\$	901,556
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	14,233
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable (<i>Current Portion</i>)			\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$	7,412
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities (<i>itemize</i>)			\$	402,823

See Schedule				402,823
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	1,665,339

* 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 Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2018	Page 34	of 37
Account				Amount
Total Brought Forward:				1,665,339
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$ 2,597,000
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>)				\$ (34,050)
See Schedule				(34,050)
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 2,562,950
C. Total All Liabilities (Lines A-13 + B-5)				\$ 4,228,289

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

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC	20397	9/30/2018	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	2,453,581
6. Gain or Loss for Period	10/1/2017	thru 9/30/2018	\$	(75,881)
7. Total Net Worth			\$	2,377,700
C. Total Reserves and Net Worth			\$	2,377,700
D. Total Liabilities, Reserves, and Net Worth			\$	6,605,988

H. Changes in Total Net Worth

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2018	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2017			\$	2,453,581
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	12,083,888
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	12,159,769
D. Net Income or Deficit			\$	(75,881)
E. Balance			\$	2,377,700
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			\$	2,377,700

I. Preparer's/Reviewer's Certification

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2018	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 type="checkbox"/> (Specify)		
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				
CJLC LLC				
Address Address		Phone Number		
225 Pitkin St., East Hartford, CT 06108		860-610-9009		
Annual Report Contact		Phone Number		
CJLC		860-610-9009		
Annual Report Contact Email Address				
annualreports@cjlc.com				