

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as licensed) St Joseph's Residence	
Address (No. & Street, City, State, Zip Code) 1365 Enfield Street, Enfield CT 06082	
Type of Facility <input 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	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH 901-C	RHNS	Residential Care Home 1678-HA	Medicare Provider 075272
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Medicaid Provider Numbers:	CCNH 9019	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) St Joseph's Residence	License No. 901-C	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 St Joseph's Residence [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) Sister Genevieve Nugent			Printed Name (Owner) Little Sisters of the Poor		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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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 10/1/2017	To 9/30/2018
Address of Facility 1365 Enfield Street, Enfield CT 06082				
Report Prepared By Kevin P Kelleher CPA		Phone Number 860.677.8440	Date 1/26/2019	
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 860.741.0791		Report for Year Ended 9/30/2018	Page 2	of 37
Name of Facility (as shown on license) St Joseph's Residence		Address (No. & Street, City, State, Zip) 1365 Enfield Street, Enfield CT 06082		
License Numbers:	CCNH 901-C	RHNS	Residential Care Home 1678-HA	Medicare Provider No. 075272
Type of Facility (Check appropriate box(es))				
<input 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 Sister Genevieve Nugent		Nursing Home Administrator's License No.:	000695	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name none		License No.:		

General Information and Questionnaire
Individual Proprietorship

Name of Facility St Joseph's Residence	License No. 901-C	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

Basis for Allocation of Costs

Name of Facility St Joseph's Residence	License No. 901-C	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.

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	9/30/2018			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 Cable Communications, Manchester CT	<input type="radio"/>	<input checked="" type="radio"/>	Cable Televisioin outlets, Internet Access and Telephone Services	month to month	month to month	8,555	8,555
DeLage Laden Financial Services, Wayne PA	<input type="radio"/>	<input checked="" type="radio"/>	Ricoh Copier	04/04/13	60 months	1,051	1,051
	<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 checked="" type="radio"/> Yes	<input type="radio"/> No
Total ***							9,606

* 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 9/30/2018	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 Kelleher & Company 2 3 4	Address (No. & Street, City, State, Zip Code) 6 Forest Park Dr, Farmington CT 06032
--	--

Services Provided by This Firm (*describe fully*)

1 audited financial statements, cost report preparation, Form 990 preparation	\$ 45,440
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 45,440

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
 2 185 Asylum St, Hartford CT 06103
 3
 4
 5

Services Provided by This Firm (*describe fully*)

1 Nursing and related Medicare and Medicaid legal services	\$ 3,200
2 Estate and probate services and Corporation filing compliance services	\$ 101,311
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$ 104,511

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 9/30/2018				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	74	23		51	
B. As of midnight of THIS report period					74	23		51					
3. Total Number of Days Care Provided During Period													
A. Medicare	361	361			210	210			151	151			
B. Medicaid (Conn.)	8,265	8,265			6,207	6,207			2,058	2,058			
C. Medicaid (other states)													
D. Private Pay	2,696	396		2,300	2,113	365		1,748	583	31		552	
E. State SSI for RCH	17,773			17,773	13,404			13,404	4,369			4,369	
F. Other (Specify)													
G. Total Care Days During Period (3A thru F)	29,095	9,022		20,073	21,934	6,782		15,152	7,161	2,240		4,921	
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)	29,095	9,022		20,073	21,934	6,782		15,152	7,161	2,240		4,921	

Annual Report of Long-Term Care Facility

Schedule of Resident Statistics (Cont'd)

Name of Facility St Joseph's Residence			License No. 901-C			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	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				6	45					
Per Diem Rate													
a. One bed rm.	563.27		239.67		400.00		150.00	130.75					
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 St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2018	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	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)	23,342	645			51,934	1,435
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	122,977	6,135			273,611	13,648
5. Dietary Service						
a. Head Dietitian	19,720	675			42,939	1,501
b. Food Service Supervisor	12,904	645			28,096	1,435
c. Dietary Workers	146,281	10,665			322,822	23,320
6. Housekeeping Service						
a. Head Housekeeper	10,354	607			23,037	1,352
b. Other Housekeeping Workers	41,337	3,146			100,918	7,462
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	19,413	672			43,191	1,496
b. Other Maintenance Workers	16,312	792			36,292	1,761
8. Laundry Service						
a. Supervisor	7,960	476			17,709	1,060
b. Other Laundry Workers	24,018	1,956			53,437	4,352
9. Barber and Beautician Services						
10. Protective Services	18,444	1,220			41,037	2,713
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	96,936	2,120				
b. RN						
1. Direct Care	441,458	13,678				
2. Administrative**						
c. LPN						
1. Direct Care	124,486	4,211			143,290	5,220
2. Administrative**						
d. Aides and Attendants	627,382	36,311			409,965	26,743
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	70,501	4,223			74,703	3,608
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify) Medical Records	48,011	2,061				
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	15,921	605			35,422	1,347
n. Marketing						
o. Other (Specify) See Attached Schedule	25,393	1,400			56,499	3,115
<i>A-13. Total Salary Expenditures</i>	1,913,150	92,243			1,754,902	101,568

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

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

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

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

Name of Facility St Joseph's Residence				License No. 901-C	Report for Year Ended 9/30/2018			Page 11	of 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	145,759		202,741	Med Ins \$54,616	various	176,800		none		

* 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	9/30/2018				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	Residential Care Home							
Section III - Administrators***										
Sister Genevieve Nugent	23,342		51,934	Med Ins \$6,654	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	9/30/2018	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	1,308	43			2,847	94
2. Dentist	2,400	24			2,400	24
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	48,154					
b. Other						
6. Social Worker	600	25			600	25
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	27,584					
b. Other						
10. Occupational Therapist						
a. Resident Care	72,826					
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	12,000	1,144				
B-13 Total Fees Paid in Lieu of Salaries	182,872	1,328			5,847	143

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

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

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

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

Name of Facility St Joseph's Residence		License No. 901-C	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		
		<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"/>		
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		<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
St Joseph's Residence	901-C	9/30/2018	15	37
Item	Total	CCNH	RHNS	Residential Care Home
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 88,933	46,385		42,548
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 12,247	6,388		5,859
4. Social Security (F.I.C.A.)	\$ 240,158	125,259		114,899
5. Health Insurance	\$ 318,183	165,955		152,228
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 2,022	1,055		967
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 94,072	49,065		45,007
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 1,924	1,004		920
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 45,440	22,625		22,815
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 104,511	52,036		52,475
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 11,906	5,928		5,978
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 29,839	14,857		14,982
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	\$ 182,055	182,055		
Subtotal	\$ 1,131,290	672,612		458,678

* 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**

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
Staff Education	\$ 979		\$ 898
Staff Physicals	\$ 25		\$ 22
Total	\$ 1,004	\$ -	\$ 920

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	9/30/2018		16	37
Item	Total	CCNH	RHNS	Residential Care Home	
<i>Subtotals Brought Forward:</i>	1,131,290	672,612		458,678	
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 5,149	2,564		2,585	
5. Education Expenses Related to Seminars and Conventions	\$				
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 16,742	8,336		8,406	
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 1,611	802		809	
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 16,543	8,237		8,306	
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	\$ 9,062	4,512		4,550	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 9,826	4,892		4,934	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 626	312		314	
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>)	\$ 9,193	4,577		4,616	
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$ 208,859	103,990		104,869	
<i>C-14 Total Administrative & General Expenditures</i>	\$ 1,408,901	810,834		598,067	

* 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	\$ 8,237		\$ 8,306
Total Other Advertising	\$ 8,237	\$ -	\$ 8,306

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
Costco	\$ 90		\$ 90
CT Assn of Health Care Facilities	\$ 349		\$ 351
CT Community Non Profit Association	\$ 174		\$ 176
Foodshare	\$ 25		\$ 25
Leading Age	\$ 3,500		\$ 3,529
Visa	\$ 10		\$ 10
Amazon	\$ 105		\$ 105
Tech Soup	\$ 238		\$ 241
Academy of Nutrition and dietities	\$ 116		\$ 118
Chamber of Commerce	\$ 261		\$ 264
Staples	\$ 24		\$ 25
Total Dues	\$ 4,892	\$ -	\$ 4,934

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Licenses	\$ 1,507		\$ 1,520
Contracted Medicaid and Medicare Billing Services	\$ 45,032		\$ 45,412
Data Processing PR Fees	\$ 10,831		\$ 10,922
Data processing Supplies	\$ 10,577		\$ 10,667
Professional Background checks	\$ 3,543		\$ 3,573
Penalties	\$ 1		\$ 1
Development consultant	\$ 6,535		\$ 6,590
Development Mailing Service	\$ 5,439		\$ 5,485
Development expenses	\$ 436		\$ 440
Other Non Reimbursable	\$ 20,089		\$ 20,259
Total Other Administrative and General	\$ 103,990	\$ -	\$ 104,869

Schedule C-1 - Management Services*

Name of Facility St Joseph's Residence	License No. 901-C	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 #

*** 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
St Joseph's Residence		901-C	9/30/2018		18	37
Item		Total	CCNH	RHNS	Residential Care Home	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 296,497	93,315			203,182
2.	Non-Food Supplies	\$ 27,214	8,565			18,649
3.	Other (<i>Specify</i>) _____	\$				
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)		\$				
c. Other (<i>Specify</i>) _____ Equipment Repairs		\$ 4,230	1,331			2,899
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 327,941	103,211			224,730
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.

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	9/30/2018		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. \$	13,786	4,275			9,511
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. \$	1,305	405			900
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$					
c. Other (Specify) Equipment Repairs	\$	2,706	839			1,867
3D. Total Laundry Expenditures (3a + b + c)	\$	17,797	5,519			12,278
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	
St Joseph's Residence	901-C	9/30/2018	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. \$	26,866	8,331		18,535
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. \$	26,071	8,084		17,987
C. Other (<i>Specify</i>)		\$ 116	36		80
Equipment Repairs					
4D. Total Housekeeping Expenditures (4a + b + c)		\$ 53,053	16,451		36,602
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Omnicare Pharmacy	\$	35,000	35,000		
b. Medicine Cabinet Drugs	\$	16,832	15,543		1,289
c. Medical and Therapeutic Supplies	\$	50,667	50,126		541
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$				
f. X-rays and Related Radiological Procedures***	\$	2,326	2,326		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	1,717	1,717		
i. Recreation	\$	5,723	1,590		4,133
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$	20,096	13,930		6,166
5M. Total Resident Care Expenditures (5a - 5j)		\$ 132,361	120,232		12,129

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	Residential Care Home
Infectious waste	\$ 10,819		
Miscellaneous Medicare A	\$ (86)		
Other Resident Insurance	\$ 193		
Pharmacy fees			\$ (516)
Religious supplies	\$ 3,004		\$ 6,682
Total Other Resident Care	\$ 13,930	\$ -	\$ 6,166

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 9/30/2018	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	Residential Care Home	Pg	Line
NALCO		<input type="radio"/>	<input checked="" type="radio"/>		Water management	4,021		8,946	22	6f
BAY STATE ELEVATOR		<input type="radio"/>	<input checked="" type="radio"/>		Elevator maintenance	6,061		13,486	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"/>							
		<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"/>							

* 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	9/30/2018			22	37
Item	Total	CCNH	RHNS	Residential Care Home		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 180,200	55,878			124,322	
b. Heat	\$ 111,359	34,531			76,828	
c. Light & Power	\$ 146,349	45,381			100,968	
d. Water	\$ 119,085	36,927			82,158	
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 9,606	2,979			6,627	
f. Other (<i>itemize</i>)	\$ 59,105	18,328			40,777	
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 625,704	194,024			431,680	
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 6,547	2,030			4,517	
b. Building & Building Improvements	\$ 104,797	32,496			72,301	
c. Non-Movable Equipment	\$ 77,061	23,896			53,165	
d. Movable Equipment	\$ 67,897	21,054			46,843	
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 256,302	79,476			176,826	
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	\$					
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 256,302	79,476			176,826	

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	Residential Care Home
Contracted maintenance services	\$ 18,328		\$ 40,777
Total Other Repairs and Maintenance	\$ 18,328	\$ -	\$ 40,777

Depreciation Schedule

Name of Facility St Joseph's Residence		License No. 901-C			Report for Year Ended 9/30/2018			Page 23	of 37				
Property Item		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals				
A. Land Improvements													
1. Acquired prior to this report period		382,713		382,713	325,503	sl	var	6,547					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal									6,547				
B. Building and Building Improvements													
1. Acquired prior to this report period		7,779,225		7,779,225	7,033,618	sl	var	88,064					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)		828,324		828,324		sl	var	16,733					
B-4. Subtotal									104,797				
C. Non-Movable Equipment													
1. Acquired prior to this report period		2,763,456		2,763,456	1,963,936	sl	var	75,813					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)		23,555		23,555		sl	var	1,248					
C-4. Subtotal									77,061				
		Is a mileage logbook maintained?		Date of Acquisition									
		Yes	No	Month	Year	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a. 2003 Turtle Top, 2011 Honda Odyssey		x		6	2011	70,878		70,878	59,519	sl	10	3,029	
b. 2015 Dodge Ram, 2007 toyota Handi		x		1	2015	48,149		48,149	27,599	sl	4	12,038	
c. 2015 Alliance Chevy Handicapped B		x		1	2015	93,412		93,412	48,812	sl	4	23,353	
d. 2018 KIA, 2018 Ford Transi		x		8	2018	52,072		52,072		sl	4	4,327	
2. Movable Equipment													
a. Acquired prior to this report period						1,553,493		1,553,493	1,471,920	sl	var	18,714	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						225,505		225,505		sl	var	6,436	
D-3. Subtotal													67,897
E. Total Depreciation													256,302

Schedule of Land Improvements Acquired during this report period

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

*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:				
2/20/2018	Window and Door replacement	\$ 476,660	20	\$ 13,903
10/31/2017	Water meter upgrade	\$ 15,720	20	\$ 721
6/18/2018	Shower renovations	\$ 10,648	20	\$ 133
8/31/2018	Chapel renovations	\$ 295,787	20	\$ 1,232
2/28/2018	TYCO call bells	\$ 3,639	5	\$ 425
9/17/2018	S&R Engineers Main Switchboard	\$ 6,720	5	\$ -
9/11/2018	Adajian Engineering Hot Water Project	\$ 19,150	5	\$ 319
Total additions for Building Improvement		\$ 828,324		\$ 16,733 *
Deletions:				
Total deletions for Building Improvement		\$ -		\$ - **

*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:				
11/20/2017	Blake Motor and Pump	\$ 3,269	5	\$ 545
11/29/2017	K&M 6 Sprinkler Heads	\$ 2,995	10	\$ 250
4/20/2018	Bay State Elevator Power Unit	\$ 14,880	15	413
6/8/2018	TORRCO Moen Lavatory	\$ 2,411	20	40
Total additions for Non-Movable Equipment		\$ 23,555		\$ 1,248 *
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 peric

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
7/3/2018	IPAD computers for nursing	\$ 8,524	3	\$ 710
8/13/2018	IPAD computers for nursing	\$ 2,616	3	\$ 145
8/16/2018	Tryteen 4 computer carts	\$ 3,335	5	\$ 56
7/13/2018	Chapel Dresser	\$ 1,980	15	\$ 22
10/4/2017	Dietary Grease Trap	\$ 3,295	10	\$ 330
12/7/2017	Dietary Heated Carts	\$ 5,016	10	\$ 418
5/24/2018	Housekeeping Burnisher	\$ 1,850	15	\$ 41
7/16/2018	Nursing Wheelchair Scale	\$ 1,844	10	\$ 31
4/10/2018	Geratric Bladder Scanner	\$ 15,011	7	\$ 1,072
7/12/2018	3 Washing Machines	\$ 40,005	15	\$ 667
9/13/2018	Chapel Organ	\$ 29,780	20	\$ 124
7/12/2018	Nursing Med Cart	\$ 1,659	10	\$ 41
8/8/2018	Chapel Sound System	\$ 41,981	5	\$ 1,399
7/26/2018	Chapel Pews and Chairs	\$ 51,455	15	\$ 572
5/18/2018	NE Carpet, 1st Floor Cove Basee	\$ 2,764	5	\$ 184
9/24/2018	NE Door Front Door renovations	\$ 8,112	10	\$ -
11/19/2017	Brand Door Renovations	\$ 4,250	10	\$ 354
1/28/2018	Activity Board	\$ 2,028	5	\$ 270
Total additions for Movable Equipmen		\$ 225,505		\$ 6,436 *
Deletions:				
Total deletions for Movable Equipmen		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report peric

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility St Joseph's Residence			License No. 901-C		Report for Year Ended 9/30/2018			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 9/30/2018	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
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property 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	9/30/2018			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		9/30/2018			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	7,900		17,576	
b. Insurance on Automobiles				\$ 8,750	2,713		6,037	
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)				\$				
2. Fire and Extended Coverage				\$ 13,277	4,117		9,160	
3. Other (Specify) Surety bond				\$ 700	217		483	
14d. Total Insurance Expenditures (14a + b + c)				\$ 48,203	14,947		33,256	
15. Total All Expenditures (A-13 thru C-14)				\$ 6,727,033	3,440,716		3,286,317	

D. Adjustments to Statement of Expenditures

Name of Facility St Joseph's Residence				License No. 901-C	Report for Year Ended 9/30/2018	Page 28	of 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	\$ 74,764	23,184		51,580
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	10a	Occupational Therapy	\$ 72,826	72,826		
7.			Other - See attached Schedule	\$ 75,738	75,738		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.			Accounting	\$			
10a.			Legal	\$ 97,671	48,630		49,041
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.	16	l6	Automobile Expense (e.g. personal use)	\$ 12,370	6,159		6,211
18.	16	m3	Unallowable Advertising *	\$ 16,543	8,237		8,306
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 65,275	32,500		32,775
Page 18 - Dietary Expenditures							
24.	18	2a1,2	Meals to employees, guests and others who are not residents	\$ 42,436	13,356		29,080
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)				\$ 457,623	280,630		176,993

* 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	\$ 48,154		
13	9a	Speech Therapy	\$ 27,584		
Total Other Fees Adjustments			\$ 75,738	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	m13	Penalties	\$ 1		\$ 1
16	m13	Development consultant	\$ 6,535		\$ 6,590
16	m13	Development mailing service	\$ 5,439		\$ 5,485
16	m13	Development expenses	\$ 436		\$ 440
16	m13	Other Non Reimbursable	\$ 20,089		\$ 20,259
Total Other A&G Adjustments			\$ 32,500	\$ -	\$ 32,775

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	9/30/2018	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward				\$ 457,623	280,630		176,993
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 9,599	9,599		
28.			Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 2,326	2,326		
30.	20	5h	Laboratory	\$ 1,717	1,717		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ (86)	(86)		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.	22	7d	Depreciation on Unallowable Motor Vehicles	\$ 19,394	6,014		13,380
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 33,916	10,517		23,399
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)				\$ 524,489	310,717		213,772

*** 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.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
20	51	Other Medicare A expense	\$ (86)		
Total Other Ancillary Costs			\$ (86)	\$ -	\$ -

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)	\$ 6,946		\$ 15,454
22	6c	Light and Power (non-facility utilization)	\$ 1,174		\$ 2,613
22	6d	Water and Sewer (non-facility utilization)	\$ 882		\$ 1,961
22	6f	Elevator maintenance contract (non-facility utilization)	\$ 1,515		\$ 3,371
Total Other Property Adjustments			\$ 10,517	\$ -	\$ 23,399

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			\$ -	\$ -	\$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
St Joseph's Residence	901-C	9/30/2018			30	37
Item	Total	CCNH	RHNS	Residential Care Home		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 5,971,950	3,306,000		2,665,950		
b. Medicaid Room and Board Contractual Allowance **	\$ (1,915,510)	(1,432,252)		(483,258)		
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 272,994	272,994				
b. Medicare Room and Board Contractual Allowance **	\$ (74,094)	(74,094)				
4. a. Private-Pay Residents and Other	\$ 503,400	158,400		345,000		
b. Private-Pay Room and Board Contractual Allowance **	\$ (57,484)	(1,531)		(55,953)		
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 4,095	4,095				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$ 3,081	3,081				
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 70,789	70,789				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (42,780)	(42,780)				
c. Physical Therapy - Non-Medicare	\$					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 39,718	39,718				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 118,545	118,545				
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.)	\$ 4,894,704	2,422,965		2,471,739		
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>)	\$ 17,844	5,533		12,311		
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$ 294	91		203		
8. Other (<i>Specify</i>)	\$ 3,384,630	1,049,532		2,335,098		
V. Total Other Revenue (1 thru 8)	\$ 3,402,768	1,055,156		2,347,612		
VI. Total All Revenue (III +V)	\$ 8,297,472	3,478,121		4,819,351		

* 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 interest		\$ 5,533		\$ 12,311
Total Interest Income			\$ 5,533	\$ -	\$ 12,311

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
30	Unrestricted contributions	\$ 992,754		\$ 2,208,771
30	Donated Foods	\$ 18,156		\$ 40,396
30	Festivals and Events, net of expenses	\$ 38,487		\$ 85,631
30	Miscellaneous, Recycling income	\$ 135		\$ 300
Total Other Revenue		\$ 1,049,532	\$ -	\$ 2,335,098

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2018	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	1,304,472
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	404,336
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	66,224
a. Prepaid Insurance	54,464			
b. prepaid Maintenance Agreements	11,760			
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	7,670
Exchange	670			
Deposits	7,000			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,782,702
B. Fixed Assets				
1. Land			\$	598,500
2. Land Improvements	*Historical Cost	382,713	\$	50,663
	Accum. Depreciation	332,050		Net
3. Buildings	*Historical Cost	8,607,549	\$	1,469,134
	Accum. Depreciation	7,138,415		Net
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation			Net
5. Non-Movable Equipment	*Historical Cost	2,787,011	\$	746,014
	Accum. Depreciation	2,040,997		Net
6. Movable Equipment	*Historical Cost	1,778,998	\$	281,928
	Accum. Depreciation	1,497,070		Net
7. Motor Vehicles	*Historical Cost	264,511	\$	85,834
	Accum. Depreciation	178,677		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	3,232,073

* 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	9/30/2018	32	37
Account			Amount	
Total Brought Forward:			\$	5,014,775
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>)			\$	

See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	5,014,775

* 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	
Total Prepaid Expenses			\$ -

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

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			\$ -

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

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			\$ -

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	
Total Other Current Liabilities (Itemize)			\$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			\$ -

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G. Balance Sheet (cont'd)

Name of Facility St Joseph's Residence		License No. 901-C	Report for Year Ended 9/30/2018	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	120,679
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>)				\$	65,934
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>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	740,227
Accrued Expenses		68,309			
Due to Little Sisters of the Poor		671,918			

See Schedule					
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	926,840

* 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 9/30/2018	Page 34	of 37
Account				Amount
Total Brought Forward:				926,840
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>)				\$

See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$
C. Total All Liabilities (Lines A-13 + B-5)				\$ 926,840

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	9/30/2018	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			\$	2,500,000
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	17,496
6. Gain or Loss for Period			\$	1,570,439
	10/1/2017	thru 9/30/2018		
7. Total Net Worth			\$	4,087,935
C. Total Reserves and Net Worth			\$	4,087,935
D. Total Liabilities, Reserves, and Net Worth			\$	5,014,775

H. Changes in Total Net Worth

Name of Facility St Joseph's Residence	License No. 901-C	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			\$	2,517,496
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	8,297,472
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	(6,727,033)
D. Net Income or Deficit			\$	1,570,439
E. Balance			\$	4,087,935
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			\$	4,087,935

I. Preparer's/Reviewer's Certification

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2018	Page 37	of 37
<i>Check appropriate category</i>				
<input 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				
Address Address		Phone Number		
6 Forest Park Drive, Farmington CT 06032		860.677.8440		