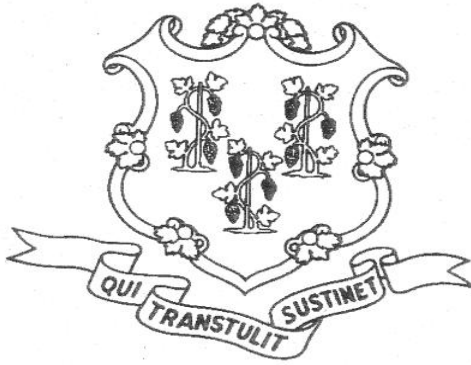


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Saint Joseph's Living Center Inc.	
Address (No. & Street, City, State, Zip Code) 14 Club Rd., Windham, CT 06280	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

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

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### General Information

Name of Facility (as licensed) Saint Joseph's Living Center Inc.	License No. 20397	Report for Year Ended 9/30/2017	Page 1	of 37
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#### Administrator's/Owner's Certification

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

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

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

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

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

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Saint Joseph's Living Center Inc.		Period Covered:	From 10/1/2016	To 9/30/2017
Address of Facility 14 Club Rd., Windham, CT 06280				
Report Prepared By CJLC LLC		Phone Number 860-610-9009	Date 2/14/2018	
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. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (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 860-456-1107	Report for Year Ended 9/30/2017	Page 2	of 37
Name of Facility (as shown on license) Saint Joseph's Living Center Inc.		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.				
<b>Administrator</b>				
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**  
**Related Parties\***

Name of Facility Saint Joseph's Living Center Inc.	License No. 20397	Report for Year Ended 9/30/2017	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?  Yes  No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Diocese of Norwich		<input type="radio"/>	<input checked="" type="radio"/>		Health Insurance	15/1a5	889,960	889,960
Diocese of Norwich		<input type="radio"/>	<input checked="" type="radio"/>		Auto Insurance	27/14b	4,189	4,189
Christian Brothers		<input type="radio"/>	<input checked="" type="radio"/>		Pension	15/1a7	145,584	145,584
See Attached List		<input type="radio"/>	<input checked="" type="radio"/>		Pastoral	13/B12	17,350	17,350
		<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 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's Living Center Inc.	License No. 20397	Report for Year Ended 9/30/2017	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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	
Saint Joseph's Living Center Inc.			20397	9/30/2017			6	37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease		Amount Claimed	
	Yes	No							
Pitney Bowes, PO Box 371887, Pittsburgh, PA 15250-7887	<input type="radio"/>	<input checked="" type="radio"/>	Postage Machine - 1000 Series	06/20/17	12 months	4,512		4,512	
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
<b>Is a Mileage Log Book Maintained for All Leased Vehicles ?</b>							<input type="radio"/> Yes <input type="radio"/> No	<b>Total ***</b>	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's Living Center Inc.	License No. 20397	Report for Year Ended 9/30/2017	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 CJLC	225 Pitkin St., East Hartford, CT 06108
2 Blum, Shapiro & Co. PC	29 South Main St., PO Box 272000, West Hartford, CT 06127-2000
3	
4	

Services Provided by This Firm (*describe fully*)

1 Cost Report Preparation & Accounting Assistance	\$ 6,500
2 Financial Consulting, Audited Financial Statements & Tax Form 990	\$ 29,885
3	\$
4	\$
	Charge for Services Provided
	\$ 36,385

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

- Yes     No    Pg 15/1d

**Legal Services Information**

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha, Cullina LLP	860-240-6000
2 Various	
3 Letizia, Ambrose & Falls	(203) 787-700
4 MCCarter & English	(973) 622-4444
5	

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

1 City Place 1, 185 Asylum Street Hartford, CT 06103-3469
2
3 667-669 State St, 2nd Fl., New Haven, CT 06511
4 4 Gateway Center, 100 Mulberry St., Newark, NJ 07102
5

Services Provided by This Firm (*describe fully*)

1 Various Matters	\$ 36,360
2 AR Collection (Disallowed Pg 28/10)	\$ 8,444
3 Various Matters	\$ 593
4 Various Matters	\$ 4,892
5	\$
	Charge for Services Provided
	\$ 50,290

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

- Yes     No    Pg 15/1e

**Schedule of Resident Statistics**

Name of Facility Saint Joseph's Living Center Inc.			License No. 20397			Report for Year Ended 9/30/2017				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	108	108			108	108			114	114		
B. As of midnight of THIS report period	109	109			114	114			109	109		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,100	4,100			3,029	3,029			1,071	1,071		
B. Medicaid (Conn.)	29,255	29,255			21,820	21,820			7,435	7,435		
C. Medicaid (other states)												
D. Private Pay	5,787	5,787			4,703	4,703			1,084	1,084		
E. State SSI for RCH												
F. Other (Specify) MA Plans & Contracts	2,259	2,259			1,505	1,505			754	754		
G. Total Care Days During Period (3A thru F)	41,401	41,401			31,057	31,057			10,344	10,344		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	85	85			70	70			15	15		
B. Other Bed Reserve Days	76	76			44	44			32	32		
5. <b>Total Resident Days (3G + 4A + 4B)</b>	41,562	41,562			31,171	31,171			10,391	10,391		

### Schedule of Resident Statistics (Cont'd)

Name of Facility Saint Joseph's Living Center Inc.			License No. 20397			Report for Year Ended 9/30/2017			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <span style="float: right;"><input type="radio"/> Yes <input checked="" type="radio"/> No</span>													
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)				
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-IID				
No. of Residents	11		79		19								
Per Diem Rate													
a. One bed rm.			217.96		445.00								
b. Two bed rms.					415.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									3,532	3,532			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									160	160			
2. Restorative Treatments													
C. Other									14,101	14,101			
D. <b>Total Physical Therapy Treatments</b>									17,793	17,793			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									280	280			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									835	835			
D. <b>Total Speech Therapy Treatments</b>									1,115	1,115			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									3,402	3,402			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									81	81			
2. Restorative Treatments													
C. Other									13,917	13,917			
D. <b>Total Occupational Therapy Treatments</b>									17,400	17,400			

### Report of Expenditures - Salaries & Wages

Name of Facility Saint Joseph's Living Center Inc.	License No. 20397	Report for Year Ended 9/30/2017	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	(Specify)	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	148,861	2,228				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	399,727	14,544				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	50,751	1,725				
c. Dietary Workers	357,269	26,288				
6. Housekeeping Service						
a. Head Housekeeper	19,006	1,090				
b. Other Housekeeping Workers	168,212	13,683				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	91,290	4,619				
8. Laundry Service						
a. Supervisor	18,997	1,090				
b. Other Laundry Workers	140,604	9,485				
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	215,567	4,190				
b. RN						
1. Direct Care	1,213,292	37,988				
2. Administrative**	430,725	16,246				
c. LPN						
1. Direct Care	661,854	24,678				
2. Administrative**						
d. Aides and Attendants	1,861,154	121,304				
e. Physical Therapists	356,218	8,761				
f. Speech Therapists	36,207	751				
g. Occupational Therapists	232,867	7,589				
h. Recreation Workers	147,945	8,541				
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	93,117	3,490				
n. Marketing						
o. Other (Specify) See Attached Schedule	18,447	1,127				
<i>A-13. Total Salary Expenditures</i>	6,662,110	309,417				

\* 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
Wages - Pastoral Salaries	\$ 18,447	1,127				
<b>Total</b>	\$ 18,447	1,127	\$ -	-	\$ -	-

**Schedule of Other Fees (Page 13)**

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Purchased Services Chapel	\$ 19,150	378				
<b>Total</b>	\$ 19,150	378	\$ -	-	\$ -	-



**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's Living Center Inc.				20397	9/30/2017			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

\* 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's Living Center Inc.				20397	9/30/2017			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Geralyn Hines - Iverson (10/1/16 to 12/1/16)	18,219			Standard	Responsible for daily operations of facility	282	A2			
Laura Nelson (11/21/16 to 6/23/17)	91,460			Standard	Responsible for daily operations of facility	1,312	A2			
Ginny Person (6/23/17 to 9/30/17)	39,183			Standard	Responsible for daily operations of facility	634	A2			
<b>Section IV - Assistant Administrators</b>										

\*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's Living Center Inc.	20397	9/30/2017	13	37		
<b>Total Cost and Hours</b>						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian	22,451	764				
2. Dentist	13,032	186				
3. Pharmacist	11,095	177				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	62,000	634				
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) Medical Staff	600	9				
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	19,150	378				
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>128,327</b>	<b>2,148</b>				

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

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

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



**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended		Page	of
Saint Joseph's Living Center Inc.	20397	9/30/2017		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 181,052	181,052			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 19,235	19,235			
4. Social Security (F.I.C.A.)	\$ 484,044	484,044			
5. Health Insurance	\$ 892,960	892,960			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 145,584	145,584			
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 1,964	1,964			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 144,738	144,738			
d. Accounting and Auditing	\$ 36,385	36,385			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 50,290	50,290			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 37,073	37,073			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 9,559	9,559			
2. Cellular Phones	\$ 1,645	1,645			
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	\$ 756,259	756,259			
<b>Subtotal</b>	\$ 2,760,787	2,760,787			

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

(Carry Subtotals forward to next page)



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

Name of Facility	License No.	Report for Year Ended		Page	of
Saint Joseph's Living Center Inc.	20397	9/30/2017		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b><i>Subtotals Brought Forward:</i></b>	2,760,787	2,760,787			
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 928	928			
5. Education Expenses Related to Seminars and Conventions	\$ 12,287	12,287			
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$ 1,165	1,165			
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 11,770	11,770			
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 31,406	31,406			
4. Fund-Raising***	\$ 3,850	3,850			
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 6,720	6,720			
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 14,788	14,788			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 360	360			
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$ 500	500			
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$ 49,195	49,195			
12. Administrative Management Services**	\$ 63,614	63,614			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 148,433	148,433			
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$ 3,105,803	3,105,803			

\* 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)
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Business Promotion	\$ 20,969		
Advertising	\$ 10,437		
<b>Total Other Advertising</b>	\$ 31,406	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
ALTCFM	\$ 170		
APIC	\$ 195		
CAHCF	\$ 350		
CHA	\$ 1,821		
Leading Age	\$ 12,252		
<b>Total Dues</b>	\$ 14,788	\$ -	\$ -

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
Restricted Donation	\$ 500		
<b>Total Contributions</b>	\$ 500	\$ -	\$ -

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
New Hire Expenses	\$ 8,616		
Employee Relations	\$ 18,973		
Breakroom Expense	\$ 6,147		
Licenses	\$ 2,759		
Service Charges - Bank	\$ 3,529		
Loss on Disposal of Asset	\$ 1,018		
Chapel Supplies	\$ 3,062		
Restricted Chapel	\$ 86		
Loss on Property Deposit	\$ 104,243		
<b>Total Other Administrative and General</b>	\$ 148,433	\$ -	\$ -



**Schedule C-1 - Management Services\***

Name of Facility Saint Joseph's Living Center Inc.	License No. 20397	Report for Year Ended 9/30/2017	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 #
Healthpro Management Services, 536 Old Howell Rd., Greenville, SC 29615	63,614	Rehab Department Software & 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 Saint Joseph's Living Center Inc.		License No. 20397	Report for Year Ended 9/30/2017	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$	331,429	331,429		
2. Non-Food Supplies	\$	46,413	46,413		
3. Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)					
c. Management Services**					
d. Other (Specify) _____					
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>		\$	377,842	377,842	
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.                      \$976					
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.  
 \*\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility		License No.	Report for Year Ended	Page	of
Saint Joseph's Living Center Inc.		20397	9/30/2017	19	37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry		Lbs.			
a. In-House Processing*		Amt. \$			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***					
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***					
3. Personal clothing of residents washed, ironed, and/or processed.***					
4. Repair and/or purchase of linens.***					
		Amt. \$	11,812	11,812	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Management Services**		\$			
d. Other (Specify) Supplies		\$	16,253	16,253	
<b>3E. Total Laundry Expenditures (3a + b + c + d)</b>		\$	<b>28,065</b>	<b>28,065</b>	
<b>3F. Laundry Questionnaire</b>					
G.	Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

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

All allocations should add to total recorded in 3E.

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Saint Joseph's Living Center Inc.		20397	9/30/2017		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. \$	31,688	31,688		
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.	Management Services*	\$				
d.	Other ( <i>Specify</i> )	\$				
4E.	<b>Total Housekeeping Expenditures</b> (4a + b + c + d)	\$	31,688	31,688		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	231,658	231,658		
b.	Medicine Cabinet Drugs	\$	36,629	36,629		
c.	Medical and Therapeutic Supplies	\$	223,241	223,241		
d.	Ambulance/Limousine***	\$	3,253	3,253		
e.	Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	39,659	39,659		
f.	X-rays and Related Radiological Procedures***	\$	13,744	13,744		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h.	Laboratory***	\$	25,891	25,891		
i.	Recreation	\$	23,741	23,741		
j.	Other (Specify)**** See Attached Schedule	\$	43,577	43,577		
5K.	<b>Total Resident Care Expenditures</b> (5a - 5j)	\$	641,390	641,390		

\* 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**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
Supplies - Patient Personal	\$ 1,049		
Physician Services Medicare	\$ 2,444		
Other - Nursing Admin Exp	\$ 7,204		
Supplies - PT	\$ 20		
Supplies - OT	\$ 3,472		
Purchased Services - OT	\$ 325		
Purchased Services - ST	\$ 6,120		
DME Rental	\$ 13,719		
IV Therapy Consultant	\$ 1,639		
IV Therapy Supplies	\$ 678		
IV Therapy Supplies Insurance	\$ 731		
IV Therapy Supplies Medicare	\$ 6,176		
<b>Total Other Resident Care</b>	<b>\$ 43,577</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility Saint Joseph's Living Center Inc.			License No. 20397		Report for Year Ended 9/30/2017			Page of 21   37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADP	PO Box 842875 Boston, MA 02284-2875	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	41,736			16	m11
Conn Computer Service Inc.	101 East Summer Street, PO Box 35, Plantsville,	<input type="radio"/>	<input checked="" type="radio"/>		Service Contracts (50,653), Repairs & Maintenance	75,491			15/22	1g/6a
Expense Consulting	811 Blue Hills Avenue Bloomfield, CT 06002	<input type="radio"/>	<input checked="" type="radio"/>		Paid share of savings on nursing supplies (34,466),	81,071			Various	Various
Hawthorne Tree Care, LLC	51 Adelaide Street Danielson, CT 06239	<input type="radio"/>	<input checked="" type="radio"/>		Grounds Maintenance & Snow Removal	13,085			22	6f
MDI Achieve / Matrixcare	PO Box 86 Minneapolis MN 55486-	<input type="radio"/>	<input checked="" type="radio"/>		Monthly software maintenance	15,276			Various	Various
Seventy Two Degrees	PO Box 692 Baltic, CT 06330	<input type="radio"/>	<input checked="" type="radio"/>		Repairs and maintenance	16,754			22	6f
Willimantic Waste Paper	PO Box239 Willimantic, CT 06226	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish removal	26,304			22	6f
Hawthorne, Ryan	861 Warrenville Road Mansfield Center, CT	<input type="radio"/>	<input checked="" type="radio"/>		Grounds Maintenance & Snow Removal	14,705			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 type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Saint Joseph's Living Center Inc.	20397	9/30/2017			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 96,649	96,649				
b. Heat	\$ 47,875	47,875				
c. Light & Power	\$ 101,144	101,144				
d. Water	\$ 27,313	27,313				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 4,512	4,512				
f. Other ( <i>itemize</i> )	\$ 146,550	146,550				
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 424,043	424,043				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 4,053	4,053				
b. Building & Building Improvements	\$ 430,818	430,818				
c. Non-Movable Equipment	\$ 42,340	42,340				
d. Movable Equipment	\$ 81,122	81,122				
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 558,333	558,333				
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. <b>Total Amortization Costs</b> (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	\$ 957	957				
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 570,725	570,725				

\* 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	(Specify)
Trash Removal	\$ 28,908		
Service Contracts	\$ 87,919		
Grounds Maintenance	\$ 19,906		
Rent - Storage	\$ 9,817		
<b>Total Other Repairs and Maintenance</b>	\$ 146,550	\$ -	\$ -

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Saint Joseph's Living Center Inc.  
9/30/2017

**Schedule of Land Improvements Acquired during this report period**

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
9/30/2017	Sidewalks and Loading Dock Concrete	\$ 3,800	5	\$ 380
<b>Total additions for Land Improvements</b>		\$ 3,800		\$ 380 *
<b>Deletions:</b>				
<b>Total deletions for Land Improvements</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
9/30/2017	Flooring-vinyl	\$ 400	10	\$ 20
9/30/2017	Window sills	\$ 3,900	20	\$ 98
<b>Total additions for Building Improvements</b>		\$ 4,300		\$ 118 *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
1/31/2017	Door Alarm	\$ 1,687	10	\$ 84
4/31/17	Water heater 120 gal. storage tank	\$ 4,865	10	\$ 243
9/30/2017	Shades	\$ 5,070	5	\$ 507
<b>Total additions for Non-Movable Equipment</b>		\$ 11,622		\$ 835 *
<b>Deletions:</b>				

<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ -

\*\*

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

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Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
4/30/2017	Laptops	\$ 3,735	3	\$ 622
11/30/2016	Kiosk	\$ 1,015	5	\$ 102
12/31/2016	Snow blower	\$ 1,099	5	\$ 110
2/28/2017	Kiosk	\$ 3,041	5	\$ 304
6/30/2017	Printers	\$ 1,107	5	\$ 111
7/31/2017	Printer	\$ 1,599	5	\$ 160
8/31/2017	Printers	\$ 358	5	\$ 36
8/31/2017	Kiosk	\$ 1,014	5	\$ 101
2/28/2017	Dryer	\$ 4,300	10	\$ 215
3/31/2017	Scale	\$ 2,283	10	\$ 114
4/30/2017	Mirrors	\$ 4,300	10	\$ 215
9/30/2017	Paper Dispenser	\$ 304	10	\$ 15
<b>Total additions for Movable Equipment</b>		\$ 24,154		\$ 2,105
<b>Deletions:</b>				
		\$ (40,795)		
<b>Total deletions for Movable Equipment</b>		\$ (40,795)		\$ -

\*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
<b>Additions:</b>				
<b>Total additions for Leasehold Improvement</b>		\$ -		\$ -
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ -

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Annual Report of Long-Term Care Facility**

**Amortization Schedule\***

Name of Facility Saint Joseph's Living Center Inc.			License No. 20397		Report for Year Ended 9/30/2017			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1. Issuance Costs	6	2016	87 Months	82,897	2,858			11,434	
2.									
3.									
A-4. Subtotal									11,434
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									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's Living Center Inc.	License No. 20397	Report for Year Ended 9/30/2017	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
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	2/17/1994			
2. Date Structure Completed	9/1/1988			
3. If <b>NOT</b> Original Owner, Date of Purchase				
4. Date of Initial Licensure	10/12/1988			
5. Total Licensed Bed Capacity	120			
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building	6,458,157			
<b>Part B - Owner and Related Parties</b>	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 9/30/17	2,750,000			
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
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				
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
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's Living Center Inc.		20397	9/30/2017		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			(16,670)	(16,670)		
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)			\$ (16,670)	(16,670)		

*(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's Living Center Inc.		20397		9/30/2017		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				(16,670)	(16,670)		
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$	147	147	
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)				\$	147	147	
12. D. Other Interest Expense (Specify)				\$			
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)				\$	(16,522)	(16,522)	
14. Insurance							
a. Insurance on Property (buildings only)				\$	200,271	200,271	
b. Insurance on Automobiles				\$	4,189	4,189	
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. <b>Total Insurance Expenditures</b> (14a + b + c)				\$	204,461	204,461	
15. <b>Total All Expenditures</b> (A-13 thru C-14)				\$	12,157,931	12,157,931	



### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Saint Joseph's Living Center Inc.				20397	9/30/2017	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 232,867	232,867		
4.			Other - See attached Schedule	\$			
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 144,738	144,738		
10.	15	1e	Accounting & Legal	\$ 8,444	8,444		
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 205	205		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	30	IV7	Gifts, flowers and coffee shops	\$ 517	517		
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 *	\$ 31,406	31,406		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m4/m	Fund Raising / Contributions	\$ 4,350	4,350		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 110,885	110,885		
<b>Page 18 - Dietary Expenditures</b>							
24.	18	2a1	Meals to employees, guests and others who are not residents	\$ 1,594	1,594		
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
<b>Subtotal (Items 1 - 26)</b>				\$ 535,005	535,005		

\* 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)
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

**Schedule of Fees Adjustments**

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

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	8a	Chamber of Commerce Dues	\$ 360		
30	IV8	Restricted Revenue	\$ 1,100		
30	IV8	End Of Life Suite Restrict Rev	\$ 3,390		
30	IV8	Chaple-Restricted Revenue	\$ 280		
30	IV8	Rec-Restricted Revenue	\$ 628		
30	IV8	Eden-Restricted Revenue	\$ 884		
16	m13	Loss on Property Deposit	\$ 104,243		
<b>Total Other A&amp;G Adjustments</b>			\$ 110,885	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Saint Joseph's Living Center Inc.			20397	9/30/2017	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 535,005	535,005		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 231,658	231,658		
28.	20	5d	Ambulance/Limousine	\$ 3,253	3,253		
29.	20	5f	X-rays, etc	\$ 13,744	13,744		
30.	20	5h	Laboratory	\$ 25,891	25,891		
31.			Medical Supplies	\$			
32.	20	5e	Oxygen (non emergency)	\$ 39,659	39,659		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 28,859	28,859		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
<b>Not For Profit Providers Only</b>							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$ 1,298	1,298		
51.	<b>Total Amount of Decrease (Items 1 - 50)</b>			\$ 879,366	879,366		

\*\*\* 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.



Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

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	7c	Depreciation on Wire Runs To Basement/Chapel Camera 1/31/15	\$ 72		
<b>Total Unallowable Building Interest</b>			\$ 1,298	\$ -	\$ -

### F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Saint Joseph's Living Center Inc.	20397	9/30/2017			30	37
Item	Total	CCNH	RHNS	(Specify)		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 11,877,945	11,877,945				
b. Medicaid Room and Board Contractual Allowance **	\$ (10,115)	(10,115)				
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,718,000	1,718,000				
b. Medicare Room and Board Contractual Allowance **	\$ (682,864)	(682,864)				
4. a. Private-Pay Residents and Other	\$ 3,664,085	3,664,085				
b. Private-Pay Room and Board Contractual Allowance **	\$ (6,132,287)	(6,132,287)				
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 200,478	200,478				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 88,378	88,378				
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	\$ 546,859	546,859				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 188,061	188,061				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 83,341	83,341				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 33,711	33,711				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 528,064	528,064				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 225,402	225,402				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (72,396)	(72,396)				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (49,035)	(49,035)				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 12,207,627	12,207,627				
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others	\$ 976	976				
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income ( <i>Specify</i> )	\$ 2,868	2,868				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$ 517	517				
8. Other ( <i>Specify</i> )	\$ 66,162	66,162				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 70,523	70,523				
<b>VI. Total All Revenue</b> (III +V)	\$ 12,278,150	12,278,150				

\* 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.



### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Joseph's Living Center Inc.	20397	9/30/2017	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	2,279,093
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,015,062
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	67,091
5. Prepaid Expenses			\$	144,899
a. Prepaid - Expenses	49,012			
b. Prepaid - Insurance	95,887			
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	2,900
Refundable Deposits	2,900			
A-9. <b>Total Current Assets</b> (Lines A1 thru 8)			\$	3,509,046
B. Fixed Assets				
1. Land			\$	1,220,000
2. Land Improvements	*Historical Cost	133,218	\$	28,232
	Accum. Depreciation	104,986		Net
3. Buildings	*Historical Cost	7,949,070	\$	(2,581,790)
	Accum. Depreciation	10,530,860		Net
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation			Net
5. Non-Movable Equipment	*Historical Cost	678,444	\$	168,259
	Accum. Depreciation	510,185		Net
6. Movable Equipment	*Historical Cost	2,012,650	\$	1,034,663
	Accum. Depreciation	977,987		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> )			\$	3,344,419
Construction In Progress		80,000		
Cost vrs book		3,264,419		
B-10. <b>Total Fixed Assets</b> (Lines B1 thru 9)			\$	3,213,784

\* 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 Saint Joseph's Living Center Inc.	License No. 20397	Report for Year Ended 9/30/2017	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	6,722,829
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 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			*Historical Cost 82,897	
			Accum. Depreciation 14,292	Net
			\$	68,605
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> )			\$	
_____				
_____				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	68,605
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	6,791,434

\* 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 Saint Joseph's Living Center Inc.		License No. 20397	Report for Year Ended 9/30/2017	Page 33	of 37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	323,857
2. Notes Payable ( <i>itemize</i> )				\$	
_____					
_____					
_____					
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$	867,807
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	11,656
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> )				\$	7,613
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities ( <i>itemize</i> )				\$	393,920
Accrued Expense Other		108,452	Short-Term Bond	72,000	
Accrued Provider Tax		183,484			
Resident Refunds & Exchange		(60)			
Resident Trust		30,044			
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				<b>\$</b>	<b>1,604,854</b>

\* 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's Living Center Inc.		License No. 20397	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,604,854	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> )					
\$					
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$ 2,678,000	
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> )				\$ 54,999	
Interest Rate Swap Obligation		54,999			
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 2,732,999	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 4,337,853	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Joseph's Living Center Inc.	20397	9/30/2017	35	37
Account			Amount	
<b>A. Reserves</b>				
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>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	2,333,363
6. Gain or Loss for Period			\$	120,218
	10/1/2016	thru	9/30/2017	
7. Total Net Worth			\$	2,453,581
<b>C. Total Reserves and Net Worth</b>			\$	2,453,581
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	6,791,434

### H. Changes in Total Net Worth

Name of Facility Saint Joseph's Living Center Inc.	License No. 20397	Report for Year Ended 9/30/2017	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	2,333,363
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	12,278,150
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	12,157,931
D. Net Income or Deficit			\$	120,218
E. Balance			\$	2,453,581
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. <b>Balance at End of Period</b>			\$	2,453,581
				09/30/17

### I. Preparer's/Reviewer's Certification

Name of Facility Saint Joseph's Living Center Inc.	License No. 20397	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<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			Phone Number	
225 Pitkin Street, East Hartford, CT 06108			860-610-9009	