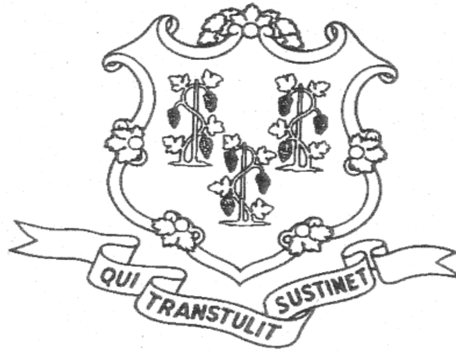
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2019

Name of Facility (as licensed)		
ST JOSEPH'S RESIDENCE		
Address (No. & Street, City, State, Zip Code)		
1365 ENFIELD ST, ENFIELD CT 06082		
Type of Facility		
☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	9019		

For Department Use Only

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

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CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for ST JOSEPH'S RESIDENCE [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) SISTER GENEVIEVE NUGENT			Printed Name (Owner) LITTLE SISTERS OF THE POOR	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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Department of Social Services

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility ST JOSEPH'S RESIDENCE		Period Covered:	From 10/1/2018	To 9/30/2019
Address of Facility 1365 ENFIELD ST, ENFIELD CT 06082				
Report Prepared By KEVIN P KELLEHER CPA		Phone Number 860.677.8440	Date 2/5/2020	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860.741.0791	9/30/2019	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
ST JOSEPH'S RESIDENCE	1365 ENFIELD ST, ENFIELD CT 06082

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

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
SISTER GENEVIEVE NUGENT	000695

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

Name	License No.:
NONE	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
N/A		

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
ST. JOSEPH'S RESIDENCE	1365 ENFIELD ST, ENFIELD CT 06082	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
SISTER GENEVIEVE NUGENT	1365 ENFIELD ST, ENFIELD CT 06082	PRESIDENT	N/A
SISTER REGINA TAMAYO	1365 ENFIELD ST, ENFIELD CT 06082	ICE PRESIDEN	N/A
SISTER JOANNA FRANCIS KUEEBOY YC	1365 ENFIELD ST, ENFIELD CT 06082	ETARY/TRUAS	N/A
Names of Stockholders Owning at Least 10% of Shares			
NONE			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ⦿ Yes ○ No

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
LITTLE SISTERS OF THE POOR	1365 ENFIELD ST, ENFIELD CT 06082	○	⦿		LENDOR OF FUNDS	PG 26 / LN 12A1		N/A MOTHERHOUSE
LITTLE SISTERS OF THE POOR	1365 ENFIELD ST, ENFIELD CT 06082	○	⦿		10 SISTERS EMPLOYED BY FACILITY	PG 10 / VAR LINES	411,971	N/A MOTHERHOUSE
		○	⦿					
		○	⦿					
		○	⦿					
		○	⦿					
		○	⦿					
		○	⦿					
		○	⦿					

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

RELATED PARTY EXPENSES WERE ALLOCATED USING THE STANDARD DEPARTMENTAL ALLOCATIONS. NO CHANGES FROM PRIOR COST REPORTING PERIODS. RELATED PARTY IS THE MOTHERHOUSE OF THE ORDER OF ROMAN CATHOLIC NUNS.

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers: Yes	No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
COX CABLE COMMUNICATIONS, MANCHESTER CT	○	⊙	CABLE TELEVISION OUTLETS, INTERNET ACCESS, TELEPHONE	MONTH TO MONTH	MONTH TO MONTH	9,398	9,398
DE LAGE LANDEN FINANCIAL SERVICES, WAYNE PA	○	⊙	RICOH COPIER	04/04/13	60 MONTHS	490	490
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ⊙ Yes ○ No

Total *** 9,888

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	7	37

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

⦿ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 KELLEHER & COMPANY	6 FOREST PARK DR, FARMINGTON CT 06032
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	AUDITED FINANCIAL STATEMENTS, COST REPORT AND FORM 990 PREPARATION	$ 49,862
2		$
3		$
4		$
	Charge for Services Provided	$ 49,862

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

⦿ Yes ○ No PAGE 15 LINE 1D

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 GARFUNKEL WILD PC	516.393.2200
2 MURTHA CULLINA LLP	860.240.6000
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1
2
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	$ 7,811
3		$
4		$
5		$
	Charge for Services Provided	$ 11,011

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

⦿ Yes ○ No PAGE 15 LINE 1E

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	8	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	74	23		51	74	23		51	82	25		57
B. As of midnight of THIS report period	82	25		57	82	25		57	82	25		57
3. Total Number of Days Care Provided During Period												
A. Medicare	377	377			313	313			64	64		
B. Medicaid (Conn.)	8,708	8,708			6,480	6,480			2,228	2,228		
C. Medicaid (other states)	3,756			3,756	2,823			2,823	933			933
D. Private Pay	16,445			16,445	12,162			12,162	4,283			4,283
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	29,286	9,085		20,201	21,778	6,793		14,985	7,508	2,292		5,216
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)**	29,286	9,085		20,201	21,778	6,793		14,985	7,508	2,292		5,216

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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		25				57		
Per Diem Rate								
a. One bed rm.		251.36		400.00		130.81		
b. Two bed rms.								
c. Three or more bed rms.								

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

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
	Total Cost and 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)	23,927	645			53,204	1,435
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	122,789	6,030			273,027	13,404
5. Dietary Service						
a. Head Dietitian	19,606	658			43,334	1,462
b. Food Service Supervisor	12,772	645			28,228	1,435
c. Dietary Workers	148,130	10,511			320,782	22,557
6. Housekeeping Service						
a. Head Housekeeper	10,383	597			23,087	1,327
b. Other Housekeeping Workers	45,327	3,462			84,113	5,930
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	19,516	658			43,395	1,462
b. Other Maintenance Workers	22,156	1,052			49,265	2,340
8. Laundry Service						
a. Supervisor	8,852	507			19,682	1,128
b. Other Laundry Workers	22,851	1,814			50,811	4,034
9. Barber and Beautician Services						
10. Protective Services	19,658	1,267			43,712	2,818
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	99,649	2,112				
b. RN						
1. Direct Care	382,980	11,346				
2. Administrative**	39,773	1,062				
c. LPN						
1. Direct Care	153,070	5,343			82,420	2,986
2. Administrative**						
d. Aides and Attendants	612,606	34,209			404,222	25,586
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	16,750	619			92,505	4,583
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify) MEDICAL RECORDS	75,259	3,125				
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	11,699	452			26,013	1,004
n. Marketing						
o. Other (Specify) See Attached Schedule	24,029	1,290			53,429	2,870
A-13. Total Salary Expenditures	1,891,782	87,404			1,691,229	96,361

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		Residential Care Home	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
PASTORAL CARE SALARIES	$ 24,029	1,290			$ 53,429	2,870
Total	$ 24,029	1,290	$ -	-	$ 53,429	2,870

Schedule of Other Fees (Page 13)

	CCNH		RHNS		Residential Care Home	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
SEE ATTAHCED SCHEDULE PAGE 11a										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	12	37

Name	Salary Paid: CCNH	Salary Paid: RHNS	Salary Paid: Residential Care Home	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
Section III - Administrators* **										
SISTER GENEVIEVE NUGENT	23,927		53,204	MED INS $1,112	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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	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	1,304	43			2,881	96
2. Dentist	2,100	30			2,462	35
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	67,390					
b. Other						
6. Social Worker	600	24			600	24
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	18,000	98				
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	18,081					
b. Other						
10. Occupational Therapist						
a. Resident Care	76,071					
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						
B-13 Total Fees Paid in Lieu of Salaries	183,546	195			5,943	155

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	15	37

Item		Total	CCNH	RHNS	Residential Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	92,231	48,697		43,534
2. Disability Insurance	$				
3. Unemployment Insurance	$	8,605	4,543		4,062
4. Social Security (F.I.C.A.)	$	232,045	122,517		109,528
5. Health Insurance	$	275,825	145,632		130,193
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	92,423	48,798		43,625
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$	5,972	3,153		2,819
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	49,862	24,871		24,991
e. Legal (*Services should be fully described on Page 7)*	$	11,011	5,492		5,519
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	14,330	7,148		7,182
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	48,082	23,983		24,099
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	183,042	183,042		
Subtotal	$	1,013,428	617,876		395,552

* 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	$ 2,795		$ 2,499
STAFF PHYSICALS	$ 358		$ 320
Total	$ 3,153	$ -	$ 2,819

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	16	37

Item		Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:		1,013,428	617,876		395,552
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	7,123	3,553		3,570
5. Education Expenses Related to Seminars and Conventions	$				
6. Automobile Expense (*not purchase or depreciation*)	$	12,462	6,216		6,246
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	1,596	796		800
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	27,111	13,523		13,588
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	6,303	3,144		3,159
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	8,454	4,217		4,237
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	114	57		57
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	9,575	4,776		4,799
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	261,970	130,672		131,298
C-14 Total Administrative & General Expenditures	$	1,348,136	784,830		563,306

* 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	$ 13,523		$ 13,588
Total Other Advertising	$ 13,523	$ -	$ 13,588

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
LEADING AGE	$ 3,370		$ 3,386
CT ASSN HEALTH CARE FACILITIES	$ 175		$ 175
CT COMM NON PROFIT ASSOCIATION	$ 50		$ 50
CTATRD	$ 20		$ 20
VISA CREDIT CARDS	$ 43		$ 44
AMAZON PRIME	$ 156		$ 157
ACADEMY OF NUTRITION & DIETITICS	$ 117		$ 117
CHAMBER OF COMMERCE	$ 262		$ 263
STAPLES	$ 24		$ 25
Total Dues	$ 4,217	$ -	$ 4,237

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
LICENSES	$ 734		$ 737
CONSULTING SERVICES, BILLING SERVICES	$ 63,736		$ 64,043
DATA PROCESSING PAYROLL FEES	$ 8,422		$ 8,462
DATA PROCESSING SUPPLIES	$ 8,345		$ 8,385
PROFESSIONAL BACKGROUND CHECKS	$ 3,252		$ 3,268
BAD DEBTS - PENALTIES	$ 3,025		$ 3,040
DEVELOPMENT CONSULTANT	$ 8,457		$ 8,497
MISCELLANEOUS	$ 526		$ 529
DEVELOPMENT MAILING SERVICE	$ 5,987		$ 6,015
DEVELOPMENT EXPENSES	$ 589		$ 592
OTHER NON REIMBURSEABLE	$ 27,599		$ 27,730
Total Other Administrative and General	$ 130,672	$ -	$ 131,298

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	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	9/30/2019	18 | 37

Item		Total	CCNH	RHNS	Residential Care Home
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	259,616	80,870		178,746
2. Non-Food Supplies	$	17,015	5,300		11,715
3. Other (*Specify*)____________________	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)________________________ EQUIPMENT REPAIRS	$	7,775	2,422		5,353
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	284,406	88,592		195,814

2E. Dietary Questionnaire	Total	CCNH	RHNS	Residential Care Home
F. Resident Meals: Total no. of meals served per day:*				

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

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

Name of Facility	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	19 | 37

Item		Total	CCNH	RHNS	Residential Care Home
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $	23,554	7,307		16,247
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. $	3,801	1,179		2,622
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) EQUIPMENT REPAIRS	$	1,265	392		873
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	28,620	8,878		19,742

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	20	37

Item			Total	CCNH	RHNS	Residential Care Home
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	25,637	7,953		17,684
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	22,507	6,982		15,525
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	48,144	14,935		33,209
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from OMNICARE OF CONNECTICUT		$	26,463	26,463		
b. Medicine Cabinet Drugs		$	10,281	9,516		765
c. Medical and Therapeutic Supplies		$	51,109	48,875		2,234
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$	404	404		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	1,897	1,897		
i. Recreation		$	6,388	2,962		3,426
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	34,518	20,590		13,928
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	131,060	110,707		20,353

* 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
OTHER MEDICARE A EXPENSE	$ 562		
INFECTOUS WASTE	$ 13,763		
RELIGIOUS SUPPLIES	$ 2,542		$ 5,651
PASTORAL CARE FELICIAN SISTERS	$ 3,723		$ 8,277
Total Other Resident Care	$ 20,590	$ -	$ 13,928

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

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	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		○	⊙		WATER MANAGEMENT	543		1,207	22	6f
BAY STATE ELEVATOR		○	⊙		ELEVATOR MAINTENANCE	6,263		13,925	22	6f
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	22 | 37

Item		Total	CCNH	RHNS	Residential Care Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	167,980	52,110		115,870
b. Heat	$	129,896	40,296		89,600
c. Light & Power	$	135,279	41,966		93,313
d. Water	$	142,891	44,327		98,564
e. Equipment Lease (*Provide detail on page 6*)	$	9,888	3,067		6,821
f. Other (*itemize*)	$	72,953	22,631		50,322
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	658,887	204,397		454,490
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	6,547	2,031		4,516
b. Building & Building Improvements	$	133,148	41,305		91,843
c. Non-Movable Equipment	$	79,446	24,645		54,801
d. Movable Equipment	$	85,954	26,664		59,290
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	305,095	94,645		210,450
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	305,095	94,645		210,450

* 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	$ 22,631		$ 50,322
Total Other Repairs and Maintenance	$ 22,631	$ -	$ 50,322

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	382,713		382,713	332,050	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	8,607,549		8,607,549	7,138,415	sl	var	132,251	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	15,162		15,162		sl	var	897	
B-4. Subtotal								133,148
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	2,787,011		2,787,011	2,040,997	sl	var	77,342	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	134,067		134,067		sl	var	2,104	
C-4. Subtotal								79,446

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. 2003 Turtle Top, 2011 Honda Odyss	x		6	2011	70,878		70,878	62,548	sl	10	3,029	
b. 2015 Dodge, 2007 Toyota, 2015 Che	x		6	2015	129,561		129,561	102,302	sl	4	25,661	
c. 2018 KIA, 2018 Ford Transi	x		8	2018	52,072		52,072	4,327	sl	4	4,327	
d.												
2. Movable Equipment												
a. Acquired prior to this report period					1,778,998		1,778,998	1,497,070	sl	var	50,111	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					74,491		31,935		sl	4	2,826	
D-3. Subtotal												85,954
E. ***Total Depreciation***												305,095

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:					
4/2/2019	DROP CEILING IN LAUNDRY	$ 10,412	8	$ 651	
5/10/2019	REBUILD CATCH BASIN	$ 2,500	5	$ 208	
8/16/2019	NEW DRAINS	$ 2,250	5	$ 38	
Total additions for Building Improvement		$ 15,162		$ 897	*
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 peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
8/29/2019	HOT WATER STUDY AND PROJECT	$ 47,067	5	$ 291	
4/30/2019	COOLING TOWER	$ 87,000	20	$ 1,813	
Total additions for Non-Movable Equipmen		$ 134,067		$ 2,104	*
Deletions:					
Total deletions for Non-Movable Equipmen		$ -		$ -	**

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
9/25/2019	HONDA PILOT	$ 31,935	4	$ -	
9/12/2019	DELL COMPUTERS	$ 1,836	5	$ 31	
10/8/2018	PORTABLE RADIOS	$ 1,835	5	$ 367	
3/6/2019	DRAPES	$ 27,949	10	$ 1,630	
11/16/2018	SHADES	$ 1,755	10	$ 146	
3/21/2019	COPIER	$ 4,910	5	$ 491	
4/22/2019	REFRIGERATOR	$ 3,027	10	$ 126	
4/22/2019	GLIDER / BENCH	$ 1,244	15	$ 35	
Total additions for Movable Equipmen		$ 74,491		$ 2,826	*
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 peri

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	24	37

Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. **Organization Expense**									
1.									
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	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	25 | 37

11. Property Questionnaire

Part A

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

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

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

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

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
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.

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

Name of Facility	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	26 | 37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility ST JOSEPH'S RESIDENCE	License No. 901-C	Report for Year Ended 9/30/2019	Page 27 of 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)			$	25,473	7,902		17,571
b. Insurance on Automobiles			$	12,001	3,723		8,278
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*)			$				
2. Fire and Extended Coverage			$	13,599	4,219		9,380
3. Other (*Specify*) SURETY BOND			$	700	217		483
14d. ***Total Insurance Expenditures (14a + b + c)***			$	51,773	16,061		35,712
15. ***Total All Expenditures (A-13 thru C-14)***			$	6,628,621	3,398,373		3,230,248

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	28 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Page 10 - Salaries and Wages								
1.			Outpatient Service Costs	$				
2.	10	A4	Salaries not related to Resident Care	$	89,765	27,847		61,918
3.			Occupational Therapy	$				
4.			Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.	13	10a	Occupational Therapy	$	76,071	76,071		
7.			Other - See attached Schedule	$	85,471	85,471		
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.			Bad Debts	$				
10.			Accounting	$				
10a.			Legal	$	16,503	11,011		5,492
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	l 6	Automobile Expense (e.g. personal use)	$	12,723	6,346		6,377
18.	16	m3	Unallowable Advertising *	$	27,111	13,523		13,588
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$				
21.			Unallowable Management Fees	$				
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	92,586	46,183		46,403
Page 18 - Dietary Expenditures								
24.	18	2a1,2	Meals to employees, guests and others who are not residents	$	49,942	15,557		34,385
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)	$	450,172	282,009		168,163

* 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	B5a	PHYSICAL THERAPY	$ 67,390		
13	B9a	SPEECH THREAPY	$ 18,081		
Total Other Fees Adjustments			$ 85,471	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	m13	BAD DEBTS - PENALTIES	$ 3,025		$ 3,040
16	m13	DEVELOPMENT CONSULTANT	$ 8,457		$ 8,497
16	m13	MISCELLANEOUS	$ 526		$ 529
16	m13	DEVELOPMENT MAILING SERVICE	$ 5,987		$ 6,015
16	m13	DEVELOPMENT EXPENSES	$ 589		$ 592
16	m13	OTHER NON REIMBURSEABLE	$ 27,599		$ 27,730
Total Other A&G Adjustments			$ 46,183	$ -	$ 46,403

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

Name of Facility	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward	$	450,172	282,009		168,163
Page 20 - Resident Care Supplies*								
27.	20	5a2	Prescription Drugs	$	15,146	15,146		
28.			Ambulance/Limousine	$				
29.	20	5f	X-rays, etc	$	404	404		
30.	20	5h	Laboratory	$	1,897	1,897		
31.			Medical Supplies	$				
32.			Oxygen (non emergency)	$				
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	562	562		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$				
36.	22	7d	Depreciation on Unallowable Motor Vehicles	$	22,059	6,843		15,216
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$	41,295	12,810		28,485
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)***	$	531,535	319,671		211,864

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

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
20	5l	OTHER MEDICARE A EXPENSE	$ 562		
Total Other Ancillary Costs			$ 562	$ -	$ -

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)	$ 8,952		$ 19,906
22	6c	LIGHT AND POWER (NON FACILITY UTILIZATION)	$ 1,237		$ 2,751
22	6d	WATER AND SEWER (NON FACILITY UTILIZATION)	$ 1,055		$ 2,347
22	6f	ELEVATOR MAINTENANCE (NON FACILITY UTILIZATION)	$ 1,566		$ 3,481
Total Other Property Adjustments			$ 12,810	$ -	$ 28,485

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home

Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

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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	9/30/2019	30 | 37

Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	5,949,950	3,483,200		2,466,750
b. Medicaid Room and Board Contractual Allowance **	$	(1,590,222)	(1,346,504)		(243,718)
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,080,273	516,873		563,400
b. Medicare Room and Board Contractual Allowance **	$	(136,895)	(128,801)		(8,094)
4. a. Private-Pay Residents and Other	$				
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$				
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$				
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$				
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$				
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	5,303,106	2,524,768		2,778,338
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	32,634	10,123		22,511
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	5,509	1,709		3,800
8. Other (*Specify*)	$	2,076,192	644,068		1,432,124
V. Total Other Revenue (1 thru 8)	$	2,114,335	655,900		1,458,435
VI. Total All Revenue (III +V)	$	7,417,441	3,180,668		4,236,773

* *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

Page Ref	Account	Account Balance	CCNH	RHNS	Residential Care Home
30	BANK INTEREST		$ 10,123		$ 22,511
Total Interest Income			$ 10,123	$ -	$ 22,511

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
30	UNRESTRICTED CONTRIBUTIONS	$ 619,921		$ 1,378,432
30	DONATED FOODS	$ 16,230		$ 36,089
30	FESTIVALS AND EVENTS NET OF EXPENSES	$ 7,502		$ 16,680
30	MISCELLANEOUS, RECYCLING, EXHIBITIONS	$ 415		$ 923
Total Other Revenue		$ 644,068	$ -	$ 1,432,124

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 2,028,314
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 509,399
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 66,484
a. Prepaid Insurance and Maintenance		66,484		
b.				
c.				
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 9,306
Due from Motherhouse		6,550		
Exchange		2,756		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,613,503
B. Fixed Assets				
1. Land				$ 598,500
2. Land Improvements	*Historical Cost	382,713		$ 44,116
	Accum. Depreciation	338,597	Net	
3. Buildings	*Historical Cost	8,622,711		$ 1,351,148
	Accum. Depreciation	7,271,563	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	2,921,078		$ 800,635
	Accum. Depreciation	2,120,443	Net	
6. Movable Equipment	*Historical Cost	1,853,489		$ 303,482
	Accum. Depreciation	1,550,007	Net	
7. Motor Vehicles	*Historical Cost	252,511		$ 50,317
	Accum. Depreciation	202,194	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 71,392
CONSTRUCTION IN PROGRESS		71,392		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 3,219,590

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

(*Carry Total forward to next page*)

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)			$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	32 | 37

	Account				Amount
				Total Brought Forward:	$ 5,833,093
C.	Leasehold or like property recorded for Equity Purposes.				
	1. Land				$
	2. Land Improvements	*Historical Cost Accum. Depreciation		Net	$
	3. Buildings	*Historical Cost Accum. Depreciation		Net	$
	4. Non-Movable Equipment	*Historical Cost Accum. Depreciation		Net	$
	5. Movable Equipment	*Historical Cost Accum. Depreciation		Net	$
	6. Motor Vehicles	*Historical Cost Accum. Depreciation		Net	$
	7. Minor Equipment-Not Depreciable				$
C-8	***Total Leasehold or Like Properties*** (C1 thru 7)				$
D.	Investment and Other Assets				
	1. Deferred Deposits				$
	2. Escrow Deposits				$
	3. Organization Expense	*Historical Cost Accum. Depreciation		Net	$
	4. Goodwill (Purchased Only)				$
	5. Investments Related to Resident Care (*itemize*)				$
	6. Loans to Owners or Related Parties (*itemize*)				$
	Name and Address	Amount	Loan Date		
	7. Other Assets (*itemize*) See Schedule				$
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 5,833,093

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	33 | 37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 258,530
2. Notes Payable (*itemize*)	$
See Schedule	
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)	$ 78,995
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$
7. Medicare Final Settlement Payable	$
8. Medicare Current Financing Payable	$
9. Mortgage Payable (*Current Portion*)	$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)	$
11. Accrued Income Taxes*	$
12. Other Current Liabilities (*itemize*)	$ 618,813
ACCRUED EXPENSES 46,895	
DUE TO LITTLE SISERS OF THE 571,918	
See Schedule	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 956,338

* 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	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	34	37

Account	Amount
Total Brought Forward:	956,338
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

Account	Amount
4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 956,338

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	9/30/2019	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$ 2,500,000
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 2,376,755
	6. Gain or Loss for Period 10/1/2018 thru 9/30/2019	$
	7. Total Net Worth	$ 4,876,755
C.	***Total Reserves and Net Worth***	$ 4,876,755
D.	***Total Liabilities, Reserves, and Net Worth***	$ 5,833,093

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	36 | 37

Account			Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2018			$ 4,087,935
B. Total Revenue (*From Statement of Revenue Page 30*)			$ 7,417,441
C. Total Expenditures (*From Statement of Expenditures Page 27*)			$ (6,628,621)
D. Net Income or Deficit			$ 788,820
E. Balance			$ 4,876,755
F. Additions			
1. Additional Capital Contributed (*itemize*)			
2. Other (*itemize*)			
F-3. Total Additions			$
G. Deductions			
1. Drawings of Owners/Operators/Partners (*Specify*)			$
Name and Address (*No., City, State, Zip*)	Title	Amount	
2. Other Withdrawings (*Specify*)			$
Purpose	Amount		
3. Total Deductions			$
H. ***Balance at End of Period*** 09/30/19			$ 4,876,755

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2019	37	37

Check appropriate category

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

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
KEVIN P KELLEHER CPA

Addres Address	Phone Number
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