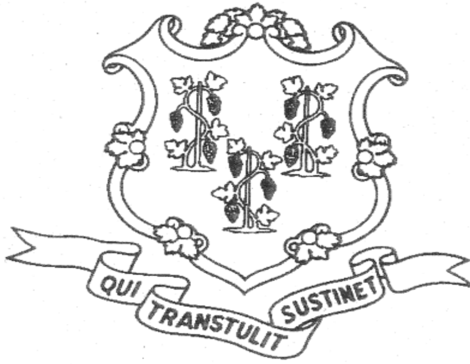
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed)	
The Holy Spirit Health Care Center	
Address (No. & Street, City, State, Zip Code)	
72 Church Street, Putnam, CT 06260	
Type of Facility	
☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☑ Residential Care Home	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH	RHNS	Residential Care Home	Medicare Provider
	2171C		1854-RH	07-5409

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	21717		42600

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)	License No.	Report for Year Ended	Page	of
The Holy Spirit Health Care Center	2171C	9/30/2015	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 The Holy Spirit Health Care Center [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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) A. Gary Spieker			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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility The Holy Spirit Health Care Center	Period Covered:		From 10/1/2014	To 9/30/2015
Address of Facility 72 Church Street, Putnam, CT 06260				
Report Prepared By O'Connor Davies, LLP	Phone Number 860-257-1870		Date 2/8/2015	

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.

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General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-928-0891	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
The Holy Spirit Health Care Center	72 Church Street, Putnam, CT 06260

License Numbers:	CCNH	RHNS	Residential Care Home	Medicare Provider No.
	2171C		1854-RH	07-5409

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.:
A. Gary Spieker	785

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

Name	License No.:
N/A	

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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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

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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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
Holy Spirit Health Care Center	72 Church Street, Putnam, CT 06260	Connecticut

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Gertrude Lanouette	31 Ravine St. Putnam CT	President	
Marian St Marie	31 Ravine St. Putnam CT	VP/Secretary	
Bonnie Morrow	72 Church Street, Putnam, CT 06260	Treasurer	
Jackie Robillard	65 Ballou St Putnam CT	Director	
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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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	%**				
Daughters of the Holy Spirit	72 Church Street, Putnam, CT 06260	○	⦿		Operating Subsidy & Contributions of Capit	pg 30 L IV8	417,000	417,000
Daughters of the Holy Spirit	72 Church Street, Putnam, CT 06260	○	⦿		Interest Expense	pg 26 12A	62,963	62,963
		○	⦿					
Daughters of the Holy Spirit	72 Church Street, Putnam, CT 06260	○	⦿		Loan ST Portion	pg 33 L A2	41,052	41,052
Daughters of the Holy Spirit	72 Church Street, Putnam, CT 06260	○	⦿		Loan LT Portion	pg 34 L B3	659,582	659,582
Daughters of the Holy Spirit	72 Church Street, Putnam, CT 06260	○	⦿		Payroll	32 D7	360	360
Daughters of the Holy Spirit	72 Church Street, Putnam, CT 06260	○	○		Sisters Salaries	See page 4a	20,592	20,592
		○	○					
		○	○					

* 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	License No.	Report for Year Ended	Page	of
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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 (*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.

Certain costs of the facility were directly allocated to the level of care.

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

All costs are allocated between SNF, the RCH and the DHS home based on floor space, usage, or poundage.

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
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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					
Wells Fargo	○	⊙	Copier	07/12/12	60 Month	1,992	1,992
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total * **	1,992

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

* 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
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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	O'Connor Davies LLC	100 Great Meadow Rd. Weathersfield CT
2		
3		
4		

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	Financial statements, cost report preparations	$ 12,900
2		$
3		$
4		$
	Charge for Services Provided	$ 12,900

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

(●) Yes ( ) No — Pg 15 Line 1D

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1		
2	Wiggin & Dana	203-498-4400
3		
4		
5		

Address (*No. & Street, City, State, Zip Code*)
1
2
3
4
5

Services Provided by This Firm (*describe fully*)

	Service	Amount
1		$
2	General Employment Information FMLA, Expept employees	$ 942
3		$
4		$
5		$
	Charge for Services Provided	$ 942

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

( ) Yes (●) No — pg 15 Line 1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	46	22		24	46	22		24	46	22		24
B. On last day of THIS report period	46	22		24	46	22		24	46	22		24
2. Number of Residents												
A. As of midnight of PREVIOUS report period	43	22		21	43	22		21	43	22		21
B. As of midnight of THIS report period	43	22		21	43	22		21	43	22		21
3. Total Number of Days Care Provided During Period												
A. Medicare	100	100			100	100						
B. Medicaid (Conn.)	7,902	7,902			5,890	5,890			2,012	2,012		
C. Medicaid (other states)												
D. Private Pay												
E. State SSI for RCH	7,720			7,720	5,788			5,788	1,932			1,932
F. Other (Specify)	25			25	25			25				
G. Total Care Days During Period (3A thru F)	15,747	8,002		7,745	11,803	5,990		5,813	3,944	2,012		1,932
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	45	28		17	33	16		17	12	12		
B. Other Bed Reserve Days												
5. ***Total Resident Days* (3G + 4A + 4B)**	15,792	8,030		7,762	11,836	6,006		5,830	3,956	2,024		1,932

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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
	CCNH	RHNS	Residential Care Home	Lost			Gained			CCNH	RHNS	Residential Care Home	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

Change in Resident Days	CCNH	RHNS	Residential Care Home
1st change			
2nd change			
3rd change			
4th change			

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-MR
No. of Residents		22				21		
Per Diem Rate								
a. One bed rm.		238.13				98.32		
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	599	599		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	850	850		
D. ***Total Physical Therapy Treatments***	1,449	1,449		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	32	32		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. ***Total Speech Therapy Treatments***	32	32		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	188	188		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	411	411		
D. ***Total Occupational Therapy Treatments***	599	599		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⦿ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	58,764	1,256			39,176	837
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	57,237	3,092			27,539	1,992
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	118,767	9,265			118,122	9,265
6. Housekeeping Service						
a. Head Housekeeper	25,428	1,305			8,476	435
b. Other Housekeeping Workers	60,955	5,627			19,948	1,874
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	56,095	2,945			56,096	2,945
8. Laundry Service						
a. Supervisor	47,775	4,357			5,664	516
b. Other Laundry Workers						
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	96,430	2,111				
b. RN						
1. Direct Care	366,536	10,653			49,409	1,173
2. Administrative**	95,374	2,320				
c. LPN						
1. Direct Care	878	36			129,573	4,204
2. Administrative**						
d. Aides and Attendants	373,406	22,530			61,587	3,906
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	31,956	1,402			13,608	329
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	11,006	488				
n. Marketing						
o. Other (Specify) See Attached Schedule	10,153	456				
A-13. Total Salary Expenditures	1,410,760	67,843			529,198	27,476

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
*** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		Residential Care Home	
	$	Hours	$	Hours	$	Hours
Medical Records	$ 891	40				
Central Supply	$ 9,262	416				
Total	$ 10,153	456	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		Residential Care Home	
	$	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
The Holy Spirit Health Care Center	2171C	9/30/2015	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).										

* 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
The Holy Spirit Health Care Center	2171C	9/30/2015	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
Section III - Administrators* **										
A. Gary Spieker	58,764		39,176		Administrator	2,093	A2			
Section IV - Assistant Administrators										

*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
** Include **all** other employment worked during the cost year.
*** If more than one Administrator is reported, include dates of employment for each.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
The Holy Spirit Health Care Center	2171C	9/30/2015	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	12,110	310				
2. Dentist						
3. Pharmacist	1,468	36				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	11,377	136				
b. Other	18,132	212				
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	12,000	39				
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	1,451	16				
b. Other						
10. Occupational Therapist						
a. Resident Care	4,707	61				
b. Other	9,149	98				
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	70,394	908				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Susan Kancelor	Dietitian	○	⦿	
Bonneville Pharmacy	Pharmacist	○	⦿	
Medical Pharmacy	Pharmacy	○	⦿	
Dr. William Johnson	Medical Director	○	⦿	
		○	⦿	
Prefered Therapy Solutions	Physical/Speech/Occupational Therapy	○	⦿	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

* 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
The Holy Spirit Health Care Center	2171C	9/30/2015	15	37

Item		Total	CCNH	RHNS	Residential Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	58,969	43,496		15,473
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	145,180	106,444		38,736
5. Health Insurance	$	165,839	124,431		41,408
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$				
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$	22,102	17,699		4,403
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	12,900	6,450		6,450
e. Legal (*Services should be fully described on Page 7)*	$	942	942		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	16,165	11,818		4,347
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	4,002	2,470		1,532
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	$	164,271	164,271		
Subtotal	$	590,370	478,021		112,349

* 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**

The Holy Spirit Health Care Center
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Schedule of Other Employee Benefits

Description	**CCNH**	**RHNS**	**Residential Care Home**
Tax Shelter Annuity	$ 16,211		$ 4,403
Employee Vaccine/xray	$ 1,488		
Total	$ 17,699	$ -	$ 4,403

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
The Holy Spirit Health Care Center	2171C	9/30/2015	16	37

Item		Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:		590,370	478,021		112,349
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	1,570	785		785
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	200	200		
5. Education Expenses Related to Seminars and Conventions	$	1,069	970		99
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	252	225		27
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$				
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	$	878	483		395
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	4,495	2,346		2,149
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	7,362	7,119		243
C-14 Total Administrative & General Expenditures	$	606,196	490,149		116,047

* 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
Total Other Advertising	$ -	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
			$ -
Leading Age	$ 1,973		$ 1,974
ICNC	$ 38		
ALTCFM	$ 80		
NFPA Membership	$ 80		
MutualAid organization	$ 175		$ 175
	$ -		
Total Dues	$ 2,346	$ -	$ 2,149

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Payroll Fees	$ 6,613		
LogMeIn software fee	$ 79		
Background Checks	$ 335		$ 151
Licenses	$ 92		$ 92
Total Other Administrative and General	$ 7,119	$ -	$ 243

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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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
The Holy Spirit Health Care Center	2171C	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	Residential Care Home
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	75,790	33,624		42,166
2. Non-Food Supplies	$	14,605	7,482		7,123
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*)_________________________	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	90,395	41,106		49,289

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

	Question	Yes	No	If yes	Amount
H.	Is cost of employee meals included in 2E?	⦿ Yes	○ No		
I.	Did you receive revenue from employees?	⦿ Yes	○ No	If yes, specify amt.	$2,151
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?	○ Yes	⦿ No	If yes, specify cost.	
L.	Is any revenue collected from these people?	○ Yes	⦿ No	If yes, specify amt.	
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	○ No	If yes, specify cost.	
O.	Is any revenue collected from employees?	○ Yes	⦿ 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
The Holy Spirit Health Care Center	2171C	9/30/2015	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. $				
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. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*) Supplies	$	5,360	4,905		455
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	5,360	4,905		455

3F. Laundry Questionnaire

	Question	Yes	No	
G.	Is cost of employee laundry included in 3E?	○ Yes	⦿ No	If yes, specify cost.
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 laundry provided to persons other than employees or residents included in 3E?	○ Yes	⦿ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⦿ 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
The Holy Spirit Health Care Center	2171C	9/30/2015	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.	$	17,949	11,997		5,952
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	17,949	11,997		5,952
5. Resident Care (Supplies)** a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	6,163	6,163		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	32,836	32,836		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	6,659	6,659		
f. X-rays and Related Radiological Procedures***		$				
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$				
i. Recreation		$	6,901	4,488		2,413
j. Other (Specify)**** See Attached Schedule		$	6,702	6,224		478
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	59,261	56,370		2,891

* 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
Nursing Supplies	$ 1,827		
Rehab Supplies	$ 102		
Rehab Med A	$ 1,920		
OTC Supplies			$ 478
PPS Expense	$ 2,375		
Total Other Resident Care	$ 6,224	$ -	$ 478

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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
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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
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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 The Holy Spirit Health Care Center	License No. 2171C	Report for Year Ended 9/30/2015	Page of 22 | 37

Item		Total	CCNH	RHNS	Residential Care Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	24,034	12,601		11,433
b. Heat	$	68,498	34,248		34,250
c. Light & Power	$	49,824	24,912		24,912
d. Water	$	15,330	7,665		7,665
e. Equipment Lease (*Provide detail on page 6*)	$	1,992	996		996
f. Other (*itemize*)	$	34,506	20,447		14,059
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	194,184	100,869		93,315
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	9,993	5,992		4,001
d. Movable Equipment	$	5,686	5,175		511
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	15,679	11,167		4,512
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	26,099	22,984		3,115
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	26,099	22,984		3,115
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)	$	41,778	34,151		7,627

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

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Schedule of Other Repairs and Maintenance

Description	**CCNH**	**RHNS**	**Residential Care Home**
Grease Trap	$ 82		$ 82
Trash Contract	$ 3,433		$ 3,443
Med Waste	$ 4,103		$ 171
Pest Control	$ 276		$ 276
Sprinklers	$ 1,130		$ 1,130
Elevator	$ 2,029		$ 2,029
CLIA	$ 150		
Lifts	$ 1,562		
Generator	$ 214		$ 214
Fire Alarm	$ 1,207		$ 1,207
Kitchen Hood	$ 60		$ 63
Fire Extinguisher	$ 217		$ 217
HVAC	$ 2,701		$ 2,701
Kithchen Vents	$ 351		$ 387
Copier Maintenance	$ 657		$ 657
Computer contract	$ 1,484		$ 1,482
Parker tub	$ 791		
Total Other Repairs and Maintenance	$ 20,447	$ -	$ 14,059

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	504,849		504,849	348,077				
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	211,429		211,429	146,495	S/L		9,993	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								9,993

	Is a mileage logbook maintained? Yes	No	Date of Acquisition Month	Year	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					197,533		197,533	178,438			5,686	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												5,686
E. ***Total Depreciation***												15,679

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Schedule of Land Improvements Acquired during this report period

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

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Building Improvements		$ -		$ -	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Non-Movable Equipment		$ -		$ -	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Movable Equipment		$ -		$ -	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report period

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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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			Various	1,024,102	447,813			26,099	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									26,099
D. ***Total Amortization***									26,099

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page | of
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?*   ⦿ Yes   ○ No   If "Yes," complete Part B. If "No," complete Part C.

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	02/01/96
5. Total Licensed Bed Capacity	46
6. Square Footage	19,370
7. Acquisition Cost	
a. Land	
b. Building	1,050,826

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	06/30/95			
c. Interest Rate for the Cost Year	950.00%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	1,050,826			
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
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Item		Total	CCNH	RHNS	Residential Care Home
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	62,963	62,963		
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)	$	62,963	62,963		

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
The Holy Spirit Health Care Center	2171C	9/30/2015	27 | 37

Item		Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:		62,963	62,963		
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)	$	62,963	62,963		
14. Insurance a. Insurance on Property (buildings only)	$	9,600	4,805		4,795
b. Insurance on Automobiles	$				
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*)	$	7,277	7,277		
2. Fire and Extended Coverage	$				
3. Other (*Specify*) Boiler Ins.	$	3,565	1,784		1,781
14d. ***Total Insurance Expenditures (14a + b + c)***	$	20,442	13,866		6,576
15. ***Total All Expenditures (A-13 thru C-14)***	$	3,108,880	2,297,530		811,350

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
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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.			Salaries not related to Resident Care	$				
3.			Occupational Therapy	$				
4.			Other - See attached Schedule	$	94,187			94,187
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.			Bad Debts	$				
10.			Accounting & Legal	$				
11.			Telephone	$				
12.			Cellular Telephone	$				
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.			Gifts, flowers and coffee shops	$				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	$				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	$				
17.			Automobile Expense (e.g. personal use)	$				
18.			Unallowable Advertising *	$				
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$				
21.			Unallowable Management Fees	$				
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$				
Page 18 - Dietary Expenditures								
24.			Meals to employees, guests and others who are not residents	$				
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)	$	94,187			94,187

* 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
		See pg 28B			$ 94,187
Total Other Salaries Adjustment			$ -	$ -	$ 94,187

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

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

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

Name of Facility	License No.	Report for Year Ended	Page of
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Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward	$	94,187			94,187
Page 20 - Resident Care Supplies*								
27.	20	5A2	Prescription Drugs	$	6,163	6,163		
28.			Ambulance/Limousine	$				
29.			X-rays, etc	$				
30.			Laboratory	$				
31.			Medical Supplies	$				
32.	20	5 e 2	Oxygen (non emergency)	$	6,659	6,659		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$				
Page 22 - Maintenance and Property								
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	$	559	280		279
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
Other - Miscellaneous								
42.			Research or Experimental Activities	$				
43.			Radio and Television Revenue	$				
44.			Vending Machine Revenue	$				
45.			Purchase Discounts and Allowances	$				
46.			Duplications of functions or services	$				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	$				
48.			Interest Income on Accounts Rec	$				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	$	10,924	8,471		2,453
Not For Profit Providers Only								
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
51.			***Total Amount of Decrease (Items 1 - 50)***	$	118,492	21,573		96,919

*** 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

The Holy Spirit Health Care Center
#######

Schedule of Other Ancillary Costs

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

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
29c		Sprinkler Head Depeciation variance	$ 280		$ 279
Total Other Property Adjustments			$ 280	$ -	$ 279

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
29 B, 22	6b, 6c	Heat and Light & Power - Outpatient Therapy Allocation	$ 1,053		$ 1,053
29B 27	14a	Property Insurance - Outpatient Therapy Allocation	$ 86		$ 85
29B		Fair Rent - Outpatient Therapy Allocation	$ 2,694		
29B 22:26	7e 8e:12A	Interest and Depreciation - Outpatient Therapy Allocation	$ 1,729		$ 136
29B		Maintenance Outpatient Therapy Allocation	$ 606		$ 471
29B		Housekeeping Outpatient Therapy Allocation	$ 2,069		$ 708
30a		Medical Records Revenue	$ 234		
		Note: See attachment page 29B for above disallowance calculations			
Total Other Adjustments			$ 8,471	$ -	$ 2,453

Schedule of Unallowable Building Interest

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

The Holy Spirit Health Care Center, Incorporated

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Attachment page 29B

The facility has an outpatient therapy program to provide therapy services to the general public. The associated costs must be disallowed. The outpatient therapy treatments are

Total Square Footage of Facility	25,664
Square Footage of Therapy Space	753
Therapy Space as a % of Total Space	2.93%
Total Therapy Treatments	2,080
Outpatient Therapy Treatments	1,261
Outpatient Therapy Treatments as a % of Total Treatments	60.63%
Outpatient Allocation of Therapy Space	1.78%

Expense Item					CCH	RCH
A&G:	Heat				34,248	34,250
	Light & Power				24,912	24,912
	Total				59,160	59,162
	Outpatient Allocation				1.78%	1.78%
	Unallowable Allocation				1,053	1,053
Total Maintenance -Repairs and Maint. Lease, Maint. Other					34,044	26,488
	Outpatient Allocation				1.78%	1.78%
	Unallowable Allocation				606	471
Housekeeping Wages			CCH	RCH	86,383	28,424
Fringes	Total All wages		1,410,760	529,198		
	Total Fringes		292,070	100,020		
	Fringe %		20.70%	18.90%		
	Housekeeping Fringe				17,884	5,372
	Housekeeping Supplies				11,997	5,952
					116,264	39,748
	- Outpatient Allocation				1.78%	1.78%
	Unallowable Allocation				2,069	708
Capital:	Property Insurance				4,805	4,795
	Outpatient Allocation				1.78%	1.78%
	Unallowable Allocation				86	85
Fair Rent: Land and Building					151,330	
	Outpatient Allocation				1.78%	
	Unallowable Allocation				2,694	
Interest and Depreciation						
	Interest				62,963	-
	Depreciation				11,167	4,512
	Amortization				22,984	3,115
	Total				97,114	7,627
	Outpatient Allocation				1.78%	1.78%
	Unallowable Allocation				1,729	136
				Grand Total	8,237	2,453

The Holy Spirit Health Care Center, Incorporated

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Attachment page 28B

Reduction of RN and LPN Rates to CNA for RCH Attendants

Pg 10	Attendant Wages	61,587
Pg 10	Attendant Hours	3,906
	Wage per hour	$ 15.77
Pg 10	RN Hours	1,173
	Allowable Rate of Attendants	$ 15.77
	Allowable Salary	18,498
	Actual RN Salary pg 10	49,409
	Disallowed RN Wages	30,911
Pg 10	LPN Hours	4,204
	Allowable Rate of Attendants	$ 15.77
	Allowable Salary	66,297
	Actual LPN Salary pg 10	129,573
	Disallowed RN Wages	63,276
Total Wages Disallowed		$ 94,187

The Holy Spirit Health Care Center, Incorporated

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Attachment page 4A

HCC Sisters - Related Party Wages

Name	Position	Wages	Hours	PG Line #
Sr. Marion Pepin	Attendant	$ 20,592	1,560	Pg 10 Line A12d. - 100% RCH Level
Total		$ 20,592		

Holy Spirit Health Care Center
Sprinkler System Depreciation Adjustment
#######
Page 29 Attachment

Note: The State should allow these additions to be depreciated on an accelerated basis over 5 years. The variance for each year below will be reflected on page 29 as a positive or negative adjustment/disallowance.

	FS Life	CR Life	Date Acquired	Cost	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Sprinkler I SNF	25	5	3/30/2009	6985											
Sprinkler I RCH	25	5	3/30/2009	6985											
				13970											
Depreciation for CR					1397	2794	2794	2794	2794	1397					
Depreciation for FS					279	559	559	559	559	559	559	559	559	559	559
Variance for Page 29, line 39					(1,118)	(2,235)	(2,235)	(2,235)	(2,235)	(838)	559	559	559	559	559

	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033
Depreciation for CR											
Depreciation for FS	559	559	559	559	559	559	559	559	559	559	559
Variance for Page 29, line 39	559	559	559	559	559	559	559	559	559	559	559

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
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Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	2,651,359	1,888,371		762,988
b. Medicaid Room and Board Contractual Allowance **	$	25,198	25,198		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	53,280	53,280		
b. Medicare Room and Board Contractual Allowance **	$				
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	$	9,895	9,895		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	2,739,732	1,976,744		762,988
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)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	408,573	376,573		32,000
V. Total Other Revenue (1 thru 8)	$	408,573	376,573		32,000
VI. Total All Revenue (III +V)	$	3,148,305	2,353,317		794,988

* *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
	Other Ancillary	$ 9,895		
Total Other Resident Revenue		$ 9,895	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	Residential Care Home
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
	Operating Subsidy	$ 385,000		$ 32,000
	DSS Recoupment	$ (8,661)		
	Medical Records fee	$ 234		
Total Other Revenue		$ 376,573	$ -	$ 32,000

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page of
The Holy Spirit Health Care Center	2171C	9/30/2015	31 | 37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 109,309
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 251,899
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$
a.				
b.				
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 361,208
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	1,024,102		$ 550,190
	Accum. Depreciation	473,912	Net	
5. Non-Movable Equipment	*Historical Cost	211,429		$ 54,941
	Accum. Depreciation	156,488	Net	
6. Movable Equipment	*Historical Cost	197,533		$ 13,409
	Accum. Depreciation	184,124	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 618,540

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

(*Carry Total forward to next page*)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
The Holy Spirit Health Care Center	2171C	9/30/2015	32 | 37

Account				Amount
			Total Brought Forward:	$ 979,748
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*)				$ 360
Due From Payroll - Related Party		360		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 360
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 980,108

* 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
The Holy Spirit Health Care Center	2171C	9/30/2015	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 22,453
2. Notes Payable (*itemize*)					$ 41,052
Due to DHS - Related Party		41,052			
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 120,100
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 14,320
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*)					$ 55,439
Meals W/H	77	Accrued Acct Fees	10,500		
Pension Withhold	1,035	Accrued Provider Tax	42,544		
Medical Withhold	1,204				
Employee Disability Withhold	79				
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 253,364

* 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
The Holy Spirit Health Care Center	2171C	9/30/2015	34 | 37

Account				Amount
			Total Brought Forward:	253,364
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$ 659,582
Name and Address of Lender	Amount	Loan Date		
Daughters of the Holy Spirit	659,582			
4. Other Long-Term Liabilities (*itemize*)				$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 659,582
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 912,946

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

Name of Facility	License No.	Report for Year Ended	Page of
The Holy Spirit Health Care Center	2171C	9/30/2015	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				$ (548,550)
2. Capital Stock				$
3. Paid-in Surplus				$
4. Treasury Stock				$
5. Cumulated Earnings				$ 576,287
6. Gain or Loss for Period	10/1/2014	thru	9/30/2015	$ 39,425
7. Total Net Worth				$ 67,162
C. ***Total Reserves and Net Worth***				$ 67,162
D. ***Total Liabilities, Reserves, and Net Worth***				$ 980,108

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page of
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	Account			Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			$ 27,736
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 3,148,305
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 3,108,880
D.	Net Income or Deficit			$ 39,425
E.	Balance			$ 67,161
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Rounding		1	
	2. Other (*itemize*)			
F-3.	Total Additions			$ 1
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***	09/30/15		$ 67,162

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
The Holy Spirit Health Care Center	2171C	9/30/2015	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

O'Connor Davies, LLP

Addres Address	Phone Number
100 Great Meadow Rd. Wethersfield, CT	860-257-1870

Error Check

Level	Item	Reported as