State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

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 10/1/2015	Report for Year Ending 9/30/2016	

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

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Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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, 2015 and ending September 30, 2016, 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)

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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 The Holy Spirit Health Care Center	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 72 Church Street, Putnam, CT 06260				
Report Prepared By PKF O'Connor Davies, LLP	Phone Number 860-257-1870		Date 2/8/2017	

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	9/30/2016	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	

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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

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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	470,000	470,000
Daughters of the Holy Spirit	72 Church Street, Putnam, CT 06260	○	◉		Interest Expense	pg 26 12A	65,126	65,126
Daughters of the Holy Spirit	72 Church Street, Putnam, CT 06260	○	◉		Loan	pg 34 L B3	659,582	659,582
		○	◉					
Daughters of the Holy Spirit	72 Church Street, Putnam, CT 06260	○	◉		Payroll	32 D7	28,801	28,801
Daughters of the Holy Spirit	72 Church Street, Putnam, CT 06260	○	◉		Sisters Salaries	See page 4a	22,256	22,256
		○	○					
		○	○					
		○	○					

* 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
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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.

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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Wells Fargo	O	⊙	Copier	07/12/12	60 Month	1,923	1,923
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
						Total ***	1,923

Is a Mileage Log Book Maintained for All Leased Vehicles ? O Yes O 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 PKF O'Connor Davies, LLP	100 Great Meadow Rd. Weathersfield CT
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Financial statements, cost report preparations	$ 13,202
2		$
3		$
4		$
		Charge for Services Provided $ 13,202

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 Wiggen and Dana	
2	
3	
4	
5	

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

Services Provided by This Firm (*describe fully*)

1	Closure of Facility	$ 1,156
2	Unemployment Comp	$ 385
3	General Labor	$ 606
4		$
5		$
		Charge for Services Provided $ 2,147

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

○ Yes ○ No

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Schedule of Resident Statistics

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					Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	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	26	10		16
B. As of midnight of THIS report period	17	0		17	26	10		16	17	0		17
3. Total Number of Days Care Provided During Period												
A. Medicare	17	17			17	17						
B. Medicaid (Conn.)	5,990	5,990			5,942	5,942			48	48		
C. Medicaid (other states)												
D. Private Pay												
E. State SSI for RCH	6,497			6,497	5,011			5,011	1,486			1,486
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	12,504	6,007		6,497	10,970	5,959		5,011	1,534	48		1,486
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	35	14		21	35	14		21				
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	12,539	6,021		6,518	11,005	5,973		5,032	1,534	48		1,486

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Schedule of Resident Statistics (Cont'd)

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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 (1)	RHNS (2)	Residential Care Home (3)	Lost (1)	Lost (2)	Lost (3)	Gained (1)	Gained (2)	Gained (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							17	
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	399	399		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	354	354		
D. ***Total Physical Therapy Treatments***	753	753		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	21	21		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	7	7		
D. ***Total Speech Therapy Treatments***	28	28		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	204	204		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	126	126		
D. ***Total Occupational Therapy Treatments***	330	330		

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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)	46,055	1,135			43,172	905
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	40,925	3,029			32,201	2,079
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	94,059	8,597			127,032	8,597
6. Housekeeping Service						
a. Head Housekeeper	18,622	1,277			13,111	426
b. Other Housekeeping Workers	53,037	5,573			20,183	1,564
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	37,805	2,738			56,411	2,738
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	45,069	4,369			5,830	517
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	72,647	1,975				
b. RN						
1. Direct Care	295,517	8,840			45,073	1,207
2. Administrative**	79,075	2,201				
c. LPN						
1. Direct Care	1,412	56			126,988	4,011
2. Administrative**						
d. Aides and Attendants	302,276	19,195			64,470	3,996
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	28,094	1,553			10,969	678
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	7,559	382				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	10,338	456				
A-13. Total Salary Expenditures	1,132,490	61,376			545,440	26,718

* 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**
Medical Records	$ 908	40				
Central Supply	$ 9,430	416				
Total	$ 10,338	456	$ -	-	$ -	-

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*

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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*

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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* **										
Section IV - Assistant Administrators										
A. Gary Spieker	46,055		43,172		Administrator	2,040	A2			

*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
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	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	6,727	189				
2. Dentist						
3. Pharmacist	1,089	24				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	8,572	94				
b. Other	6,522	84				
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	9,250	31				
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	1,360	12				
b. Other	559	5				
10. Occupational Therapist						
a. Resident Care	4,953	50				
b. Other	2,647	30				
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	41,679	519				

* 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
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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	○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
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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

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Item		Total	CCNH	RHNS	Residential Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	57,808	43,997		13,811
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	134,588	94,563		40,025
5. Health Insurance	$	168,473	109,964		58,509
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	$	18,018	13,142		4,876
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	13,202	7,491		5,711
e. Legal (*Services should be fully described on Page 7)*	$	2,147	2,147		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	13,139	10,203		2,936
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	3,654	1,709		1,945
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	$	126,315	126,315		
Subtotal	$	537,344	409,531		127,813

* 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
9/30/2016

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
Longevity Bonus	$ 13,050		$ 4,876
Vaccines/physicals employee	$ 92		
	$ -		
	\		
Total	$ 13,142	$ -	$ 4,876

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	9/30/2016	16	37

Item		Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:		537,344	409,531		127,813
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	1,630	830		800
3. Gifts to Staff and Residents	$				
4. Employee Travel	$				
5. Education Expenses Related to Seminars and Conventions	$	40	40		
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*)	$	442	390		52
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	$	521	278		243
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	4,169	2,122		2,047
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	$	9,436	9,326		110
C-14 Total Administrative & General Expenditures	$	553,582	422,517		131,065

* 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 webinar	$ 75		$ -
Leading age	$ 2,047		$ 2,047
Total Dues	$ 2,122	$ -	$ 2,047

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	$ 7,721		
Banking Fees	$ 144		$ 3
Background Checks	$ 261		$ 25
Licenses	$ 800		
Other (See pg 28)	$ 400		$ 82
Total Other Administrative and General	$ 9,326	$ -	$ 110

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Schedule C-1 - Management Services*

Name of Facility The Holy Spirit Health Care Center	License No. 2171C	Report for Year Ended 9/30/2016	Page 17 of 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.**

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CSP-18 Rev. 9/2002

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	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	Residential Care Home
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	64,259	24,738		39,521
2. Non-Food Supplies	$	8,820	3,904		4,916
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)	$	73,079	28,642		44,437

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

H.	Is cost of employee meals included in 2E?	◉ Yes	○ No	
I.	Did you receive revenue from employees?	◉ Yes	○ No	If yes, specify amt. $1,332
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.

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CSP-19 Rev. 9/2002

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

Name of Facility The Holy Spirit Health Care Center	License No. 2171C	Report for Year Ended 9/30/2016	Page of 19 | 37

Item		Total	CCNH	RHNS	Residential Care Home
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
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	$	4,479	4,103		376
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	4,479	4,103		376

3F.	Laundry Questionnaire			
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.

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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
The Holy Spirit Health Care Center	2171C	9/30/2016	20	37

Item			Total	CCNH	RHNS	Residential Care Home
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	12,885	8,252		4,633
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)		$	12,885	8,252		4,633
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	3,678	3,678		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	17,565	17,565		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$	5,104	5,104		
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$				
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$				
i. Recreation		$	5,057	2,973		2,084
j. Other (Specify)**** See Attached Schedule		$	3,677	3,136		541
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	35,081	32,456		2,625

* 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	$ 1,007		$ 541
PPS Expense Med A	$ 769		
Rehab Supplies Med A	$ 1,360		
Total Other Resident Care	$ 3,136	$ -	$ 541

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CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Holy Spirit Health Care Center	2171C	9/30/2016	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
		O	O							
		O	O							
		O	O							
		O	O							
		O	O							
		O	O							
		O	O							
		O	O							
		O	O							
		O	O							
		O	O							
		O	O							
		O	O							
		O	O							

* 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 9/30/2016			Page 22 of 37
Item		Total	CCNH	RHNS	Residential Care Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	26,265	14,244		12,021
b. Heat	$	38,400	18,843		19,557
c. Light & Power	$	36,261	15,853		20,408
d. Water	$	13,104	5,726		7,378
e. Equipment Lease (*Provide detail on page 6*)	$	1,923	886		1,037
f. Other (*itemize*) See Attached Schedule	$	36,838	20,852		15,986
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	152,791	76,404		76,387
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	9,389	5,678		3,711
d. Movable Equipment	$	1,226	783		443
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	10,615	6,461		4,154
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	26,098	22,984		3,114
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	26,098	22,984		3,114
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)	$	36,713	29,445		7,268

* 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
Grease Trap	$ 80		$ 84
Trash Contract	$ 2,988		$ 3,674
Med Waste	$ 5,030		$ 599
Pest Control	$ 228		$ 256
Sprinklers	$ 1,008		$ 1,388
Elevator	$ 2,161		$ 2,161
Lifts	$ 2,353		
Generator	$ 765		$ 765
Fire Alarm	$ 1,230		$ 1,230
Kitchen Hood	$ 201		$ 211
Fire Extinguisher	$ 43		$ 43
HVAC	$ 2,281		$ 3,006
Kithchen Vents	$ 221		$ 396
Copier Maintenance	$ 872		$ 668
Computer contract	$ 1,391		$ 1,505
Total Other Repairs and Maintenance	$ 20,852	$ -	$ 15,986

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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	156,488			9,389	
2. Disposals (attach schedule)	(17,805)		(17,805)	(17,805)				
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								9,389

	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.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					197,533		197,533	184,124			4,518	
b. Disposals (attach schedule)					(59,663)		(59,663)	(53,253)			(3,292)	
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												1,226
E. ***Total Depreciation***												10,615

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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:					
	Parker Tub	$ (10,291)			
	Window Blinds	$ (1,846)			
	Tub	$ (5,065)			
	Bed Call System	$ (603)			

Total deletions for Non-Movable Equipment	$ (17,805)		$ -	**

Attachment Pages 23 24

***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:					
	Call Chair system	(1,289)			
	4 Beds	(2,374)			
	6 Alarm Beds	(1,596)			
	Electric Bed	(1,244)			
	Electric Bed	(1,437)			
	Matress & Bed Alarm	(642)			
	16 Electric Beds	(17,090)		(1,068)	
	16 Matresses	(4,974)		(311)	
	Refrigerator	(500)			
	Bed Alarms	(1,350)		(113)	
	Bed and Chair Alarms	(1,110)		(92)	
	11 Bed Chairs	(2,570)		-	
	Partial Weight bed	(4,033)		-	
	Roho Cushions	(1,542)		(129)	
	Lift	(7,579)		(758)	
	Lift	(4,662)		(466)	
	Ultrasound Machine	(2,017)		(288)	
	Bed Call Sensor	(638)		-	
	Commode Equipment	(718)		-	
	Lift Chairs	(945)		-	
	Computer equipment	(553)		-	
	Recliners	(800)		(67)	
Total deletions for Movable Equipment		$ (59,663)		$ (3,292)	**

***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: Month	Date of Acquisition: Year	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
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				1,024,102	473,912			26,098	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									26,098
D. ***Total Amortization***									26,098

* 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	

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	9.50%			
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	$	65,126	65,126		
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)	$	65,126	65,126		

(*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 Cente	2171C	9/30/2016	27 | 37

Item	Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:	65,126	65,126		
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) $	65,126	65,126		
14. Insurance				
a. Insurance on Property (buildings only) $	11,209	6,415		4,794
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $ General Liability	8,888	7,277		1,611
14d. ***Total Insurance Expenditures (14a + b + c)*** $	20,097	13,692		6,405
15. ***Total All Expenditures (A-13 thru C-14)*** $	2,673,442	1,854,806		818,636

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
The Holy Spirit Health Care Center	2171C	9/30/2016	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.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $	87,876			87,876
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 $	482	400		82
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) $	88,358	400		87,958

* 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			$ 87,876
Total Other Salaries Adjustment			$ -	$ -	$ 87,876

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
Pg 16a		Other A&G	$ 400		$ 82
Total Other A&G Adjustments			$ 400	$ -	$ 82

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Holy Spirit Health Care Center	2171C	9/30/2016	29	37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward	$	88,358	400		87,958
Page 20 - Resident Care Supplies***								
27.	20	5A2	Prescription Drugs	$	3,678	3,678		
28.			Ambulance/Limousine	$				
29.			X-rays, etc	$				
30.			Laboratory	$				
31.			Medical Supplies	$				
32.	20	5e2	Oxygen (non emergency)	$	5,104	5,104		
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	$	9,712	7,466		2,246
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)***			$	107,410	16,928		90,482

*** 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
9/30/2016

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 Depreciation 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	$ 618		$ 711
29B 27	14a	Property Insurance - Outpatient Therapy Allocation	$ 114		$ 85
29B		Fair Rent - Outpatient Therapy Allocation	$ 2,694		$ -
29B 22;26	7e,8e;12A	Interest and Depreciation - Outpatient Therapy Allocation	$ 1,683		$ 129
29B		Maintenance Outpatient Therapy Allocation	$ 640		$ 517
29B		Housekeeping Outpatient Therapy Allocation	$ 1,717		$ 802
		Note: See attachment page 29B for above disallowance calculations			
Total Other Adjustments			$ 7,466	$ -	$ 2,246

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

9/30/16
Attachment page 29B

the cost report. Although all direct therapy costs are disallowed, the associated overhead and fair rent must be as well. See calculation below.

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	1,111
Outpatient Therapy Treatments	487
Outpatient Therapy Treatments as a % of Total Treatments	43.83%
Outpatient Allocation of Therapy Space	1.29%

Expense Item			CCH	RCH
A&G:	Heat		18,843	19,557
	Light & Power		15,853	20,408
		Total	34,696	39,965
		Outpatient Allocation	1.78%	1.78%
		Unallowable Allocation	618	711
Total Maintenance -Repairs and Maint, Lease, Maint. Other			35,982	29,044
		Outpatient Allocation	1.78%	1.78%
		Unallowable Allocation	640	517

			CCH	RCH		
Housekeeping Wages					71,659	33,294
	Fringes	Total All wages	1,132,490	545,440		
		Total Fringes	261,666	117,221		
		Fringe %	23.11%	21.49%		
	Housekeeping Fringe				16,557	7,155
	Housekeeping Supplies				8,252	4,633
					96,468	45,082
	-	Outpatient Allocation			1.78%	1.78%
		Unallowable Allocation			1,717	802

Capital:	Property Insurance	6,415	4,794
	Outpatient Allocation	1.78%	1.78%
	Unallowable Allocation	114	85
Fair Rent: Land and Building		151,330	
	Outpatient Allocation	1.78%	
	Unallowable Allocation	2,694	
Interest and Depreciation			
	Interest	65,126	-
	Depreciation	6,461	4,154
	Amortization	22,984	3,114
	Total	94,571	7,268
	Outpatient Allocation	1.78%	1.78%
	Unallowable Allocation	1,683	129
	Grand Total	**7,466**	**2,246**

The Holy Spirit Health Care Center, Incorporated

9/30/16
Attachment page 29B

Reduction of RN and LPN Rates to CNA for RCH Attendants

Pg 10	Attendant Wages	64,470
Pg 10	Attendant Hours	3,996
	Wage per hour	$ 16.13
Pg 10	RN Hours	1,207

	Allowable Rate of Attendants	$ 16.13
	Allowable Salary	19,473
	Actual RN Salary pg 10	45,073
	Disallowed RN Wages	25,600
Pg 10	LPN Hours	4,011
	Allowable Rate of Attendants	$ 16.13
	Allowable Salary	64,712
	Actual LPN Salary pg 10	126,988
	Disallowed RN Wages	62,276
Total Wages Disallowed		$ 87,876

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. Norma Bourdon	Receptionist	$ 1,664	160	Pg 10 Line A4. - 100% RCH Level
Sr. Marion Pepin	Attendant	$ 20,592	1,560	Pg 10 Line A12d. - 100% RCH Level
	Total	$ 22,256		

Holy Spirit Health Care Center
Sprinkler System Depreciation Adjustment
9/30/2016
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 F 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
The Holy Spirit Health Care Center	2171C	9/30/2016			30 | 37

Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	2,077,759	1,438,653		639,106
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	8,329	8,329		
b. Medicare Room and Board Contractual Allowance **	$	(5,906)	(5,906)		
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	$	34,158	34,158		
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	2,114,340	1,475,234		639,106
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*)	$	463,592	314,190		149,402
V. Total Other Revenue (1 thru 8)	$	463,592	314,190		149,402
VI. Total All Revenue (III +V)	$	2,577,932	1,789,424		788,508

* *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
	Ancillary Charges	$ 2,889		
	Medicare B	$ 31,269		
Total Other Resident Revenue - Medicare		$ 34,158	$ -	$ -

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
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
	Loss on Disposal of Assets	$ (5,810)		$ (598)
	Operating Subsity	$ 320,000		$ 150,000
Total Other Revenue		$ 314,190	$ -	$ 149,402

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
The Holy Spirit Health Care Center	2171C	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 68,356
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 40,954
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)				$ 109,310
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		$ 524,092
	Accum. Depreciation	500,010	Net	
5. Non-Movable Equipment	*Historical Cost	193,624		$ 45,552
	Accum. Depreciation	148,072	Net	
6. Movable Equipment	*Historical Cost	137,870		$ 5,773
	Accum. Depreciation	132,097	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (1)
Rounding		(1)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 575,416

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

(Carry Total forward to next page)

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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	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 684,726
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*)				$ 28,801
Due from Daughters of HS - Related Party	28,801			
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 28,801
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 713,527

* 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	9/30/2016	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 10,803
2. Notes Payable (*itemize*)				$
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*)				$ 42,568
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 14,214
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*)				$ 14,709
Employee Benefits WH	3,089			
Accrued Acct. Fees	10,500			
Accrued Provider Tax	1,120			
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 82,294

* Business Income Tax (not that withheld from employees). Attach copy of owner's Federal Income Tax Return.

(Carry Total forward to next page)

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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	9/30/2016	34	37

Account	Amount
Total Brought Forward:	82,294
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)	$ 741,876

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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	9/30/2016	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	$ (535,225)
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 602,386
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ (95,510)
	7. Total Net Worth	$ (28,349)
C.	***Total Reserves and Net Worth***	$ (28,349)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 713,527

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
The Holy Spirit Health Care Center	2171C	9/30/2016	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ 67,161
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 2,577,932
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 2,673,442
D.	Net Income or Deficit			$ (95,510)
E.	Balance			$ (28,349)
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***	09/30/16		$ (28,349)

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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	9/30/2016	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	
PKF O'Connor Davies, LLP	
Addres Address	Phone Number
100 Great Meadow Rd Wethersfield, CT	860-257-1870