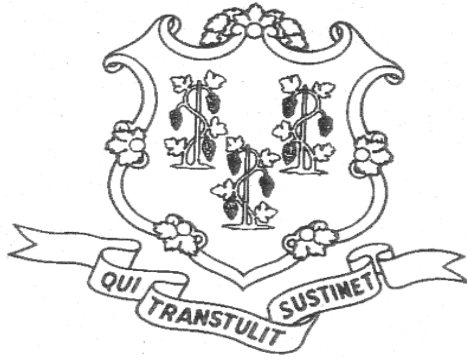


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as licensed) St. Joseph's Manor Care and Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 6448 Main Street, Trumbull, CT 06611	
Type of Facility Chronic and Convalescent                      Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH)                      (RHNS)	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH 2321-C	RHNS	(Specify)	Medicare Provider 07-5001
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Medicaid Provider Numbers:	CCNH 6841	RHNS	ICF-IID
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**For Department Use Only**

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

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**General Information**

Name of Facility (as licensed) St. Joseph's Manor Care and Rehabilitation Center	License No. 2321-C	Report for Year Ended 9/30/2018	Page 1	of 37
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**Administrator's/Owner's Certification**

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for St. Joseph's Manor Care and Rehabilitation Center [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Gaudioso, Marian			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare		
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**  
 25 Sigourney Street, Hartford, Connecticut 06106

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility St. Joseph's Manor Care and Rehabilitation Center		Period Covered:	From 10/1/2017	To 9/30/2018
Address of Facility 6448 Main Street, Trumbull, CT 06611				
Report Prepared By Thomas Farnan		Phone Number 978-247-5029	Date 12/21/2018	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$	9,175,827	9,168,049	7,778
5. All other wages paid	\$	1,627,133	1,545,776	81,357
6. <b>Total Wages Paid</b>	\$	10,802,960	10,713,826	89,135
7. Total salaries paid	\$	545,875	538,217	7,658
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$	11,348,835	11,252,043	96,793

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility 203-268-6204		Report for Year Ended 9/30/2018		Page 2	of 37
Name of Facility (as shown on license) St. Joseph's Manor Care and Rehabilitation Center			Address (No. & Street, City, State, Zip) 6448 Main Street, Trumbull, CT 06611		
License Numbers:	CCNH 2321-C	RHNS	(Specify)	Medicare Provider No. 07-5001	
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No      If "Yes," explain fully.					
<b>Administrator</b>					
Name of Administrator Gaudioso, Marian			Nursing Home Administrator's License No.:	1650	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		



## General Information and Questionnaire Corporate Owners

Name of Facility St. Joseph's Manor Care and Rehabilitation C	License No. 2321-C	Report for Year Ended 9/30/2018	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation St. Joseph's Manor Care and Rehabilitation Center	Business Address 101 East State Street, Kennett Square, PA 19348	State(s) in Which Incorporated PA		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
N/A				
Names of Stockholders Owning at Least 10% of Shares				
N/A				





**General Information and Questionnaire  
Related Parties\***

Name of Facility St. Joseph's Manor Care and Rehabilitation Center	License No. 2321-C	Report for Year Ended 9/30/2018	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?     Yes     No    If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Genesis Healthcare	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	1,044,307	1,044,307
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	63%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	870,339	870,339
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input type="radio"/>	<input checked="" type="radio"/>	50%	Staffing Pool	Pg 10/A12, p15-1		
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	85%	Medical Director /NP	Pg 13/B8, Pg 10/A12	46,520	46,520
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	91%	Outside Agency	Pg 13/B11 pg 10-12, 15		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>	40%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E2	10,800	10,800
Genesis Healthcare	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	528,079	528,079
Genesis Healthcare	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Capital Interest	Page 17, page 26-12A	100,491	100,491
		<input type="radio"/>	<input type="radio"/>					

\* Use additional sheets if necessary.

\*\* Provide the percentage amount of revenue received from non-related parties.

**General Information and Questionnaire**  
**Basis for Allocation of Costs**

Name of Facility St. Joseph's Manor Care and Rehabilitation Center	License No. 2321-C	Report for Year Ended 9/30/2018	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

- In the preparation of this Report, were all costs allocated as required?       Yes       No      If "No," explain fully why such allocation was not made.
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

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

### General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility St. Joseph's Manor Care and Rehabilitation Center			License No. 2321-C			Report for Year Ended 9/30/2018		Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed		
	Yes	No							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
Is a Mileage Log Book Maintained for All Leased Vehicles ?								<input type="radio"/> Yes	<input type="radio"/> No
								<b>Total ***</b>	

\* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

\*\* Attach copies of newly acquired leases.

\*\*\* Amount should agree to Page 22, Line 6e.

**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility St. Joseph's Manor Care and Rehab	License No. 2321-C	Report for Year Ended 9/30/2018	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:  
 Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm 1 KPMG Peat Marwick 2 3 4	Address (No. & Street, City, State, Zip Code) 1600 Market Street, Philadelphia, PA 19103
---	---

Services Provided by This Firm (*describe fully*)

1 Year end financial audit	\$
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$

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

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 GOLDMAN GRUDER & WOOD, LLC 2 Christopher Paoletti and Joan S. Mehlhorn State Marshal 3 STATE OF CT, PROBATE COURT 4 5	Telephone Number (203) 899-8900  (203) 452-5068
---	--

Address ( <i>No. &amp; Street, City, State, Zip Code</i> ) 1 200 Connecticut Ave. Norwalk, CT 06854 2 3301 Maine St Bridgeport, CT 06606 3 Town Hall, 5866 Main St., Trumbull, CT 06611 4 5
--

Services Provided by This Firm (*describe fully*)

1 Applications and affidavits of debt, Probate Court conferences and correspondence, review title search	\$
2 State Marshall fee for Citation Appointment of Conservator	\$ 2,723
3 Hearing Fees & Notices, Conservatorship Fees	\$
4	\$
5	\$
	Charge for Services Provided
	\$ 2,723

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    Legal Fees pg. 15 1-e

### Schedule of Resident Statistics

Name of Facility St. Joseph's Manor Care and Rehabilitation Center				License No. 2321-C		Report for Year Ended 9/30/2018				Page 8		of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	297	274		23	297	274		23	297	274			23
B. On last day of THIS report period	297	274		23	297	274		23	297	274			23
2. Number of Residents													
A. As of midnight of PREVIOUS report period	265	244		21	265	244		21	270	257			13
B. As of midnight of THIS report period	258	244		14	270	257		13	258	244			14
3. Total Number of Days Care Provided During Period													
A. Medicare	4,381	4,381			3,277	3,277			1,104	1,104			
B. Medicaid (Conn.)	78,144	78,144			58,207	58,207			19,937	19,937			
C. Medicaid (other states)													
D. Private Pay	4,588	4,588			3,599	3,599			989	989			
E. State SSI for RCH	4,780			4,780	3,485			3,485	1,295				1,295
F. Other (Specify)	3,029	3,029			2,268	2,268			761	761			
G. Total Care Days During Period (3A thru F)	94,922	90,142		4,780	70,836	67,351		3,485	24,086	22,791			1,295
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	351	1		350	351	1		350					
B. Other Bed Reserve Days	7	7			2	2			5	5			
5. <b>Total Resident Days (3G + 4A + 4B)</b>	95,280	90,150		5,130	71,189	67,354		3,835	24,091	22,796			1,295

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

Name of Facility St. Joseph's Manor Care and Rehabilitation C			License No. 2321-C			Report for Year Ended 9/30/2018			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <span style="float: right;"><input type="radio"/> Yes <input checked="" type="radio"/> No</span>													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare	Medicaid		Self-Pay			Other State Assisted						
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID					
No. of Residents	11	212		21			14						
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	555.18	248.41		539.15			94.00						
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									2,134	2,134			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									1,990	1,990			
C. Other									12,233	12,233			
D. <b>Total Physical Therapy Treatments</b>									16,357	16,357			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									604	604			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									293	293			
C. Other									1,686	1,686			
D. <b>Total Speech Therapy Treatments</b>									2,583	2,583			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									4,121	4,121			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									2,173	2,173			
C. Other									15,400	15,400			
D. <b>Total Occupational Therapy Treatments</b>									21,694	21,694			

### Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
St. Joseph's Manor Care and Rehabilitation Center	2321-C	9/30/2018	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	145,500	1,982			7,658	104
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	471,735	22,168			24,828	1,167
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers						
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	149,916	4,280			7,890	225
b. Other Maintenance Workers	269,326	14,800			14,175	779
8. Laundry Service						
a. Supervisor						
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	392,717	7,812				
b. RN						
1. Direct Care	1,403,715	39,593				
2. Administrative**	169,690	4,068				
c. LPN						
1. Direct Care	3,262,861	112,032				
2. Administrative**						
d. Aides and Attendants	4,184,009	242,665				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	333,130	18,598			17,533	979
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	321,670	12,725			16,930	670
n. Marketing						
o. Other (Specify) See Attached Schedule	147,774	8,257			7,778	435
<i>A-13. Total Salary Expenditures</i>	11,252,042	488,980			96,792	4,358

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

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

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





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

Name of Facility				License No.	Report for Year Ended			Page	of	
St. Joseph's Manor Care and Rehabilitation Center				2321-C	9/30/2018			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
St. Joseph's Manor Care and Rehabilitation Center				2321-C	9/30/2018			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Gaudioso, Marian	145,500		7,658		Management of Center	2,086	2			
<b>Section IV - Assistant Administrators</b>										
					Assists in overseeing facility operations		3			

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

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

\*\*\* If more than one Administrator is reported, include dates of employment for each.

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of		
St. Joseph's Manor Care and Rehabilitation Center	2321-C	9/30/2018	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian						
2. Dentist	24,218					
3. Pharmacist	25,443	636				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	740,333	12,339				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	60,110	192				
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	75,837	1,431				
b. Other						
10. Occupational Therapist						
a. Resident Care	204,660	3,790				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	26,829	591				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	48,688					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>1,206,118</b>	<b>18,979</b>				

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

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

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

## Report of Expenditures

### Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis\*

Name of Facility St. Joseph's Manor Care and Rehabilitation Center		License No. 2321-C	Report for Year Ended 9/30/2018	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
		<input checked="" type="radio"/>	<input type="radio"/>		
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
St. Joseph's Manor Care and Rehabilitation Center	2321-C	9/30/2018		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 509,100	504,009			5,091
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 122,802	121,574			1,228
4. Social Security (F.I.C.A.)	\$ 830,757	822,449			8,308
5. Health Insurance	\$ 1,163,483	1,151,848			11,635
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 478,759	473,971			4,788
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 395,818	376,027			19,791
d. Accounting and Auditing	\$				
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 2,723	2,587			136
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 34,649	32,917			1,732
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 31,073	29,519			1,554
2. Cellular Phones	\$ 1,780	1,691			89
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$				
k. Other Taxes ( <i>Not related to property - See Page 22</i> )					
1. Income*	\$				
2. Other ( <i>Specify</i> ) See Attached Schedule	\$ 1,312	1,246			66
3. Resident Day User Fee	\$ 1,343,371	1,343,371			
<b>Subtotal</b>	\$ 4,915,627	4,861,209			54,418

\* 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**

St. Joseph's Manor Care and Rehabilitation Center  
9/30/2018

Attachment Page 15

**Schedule of Other Employee Benefits**

Description		CCNH	RHNS	(Specify)
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
<b>Total</b>		\$ -	\$ -	\$ -

**Schedule of Other Taxes**

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	\$ 1,246	\$ -	\$ 66
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -		
<b>Total</b>		\$ 1,246	\$ -	\$ 66

0

0

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

Name of Facility	License No.	Report for Year Ended		Page	of
St. Joseph's Manor Care and Rehabilitation Center	2321-C	9/30/2018		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>	4,915,627	4,861,209		54,418	
<b>l. Travel and Entertainment</b>					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 3,417	3,246		171	
5. Education Expenses Related to Seminars and Conventions	\$ 1,181	1,122		59	
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$				
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
<b>m. Other Administrative and General Expenses</b>					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$				
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 17,696	16,811		885	
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	\$ 8,269	7,856		413	
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 22,024	20,923		1,101	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 531	504		27	
10. Contributions*** See Attached Schedule	\$ 3,612	3,612			
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$ 5,597	5,317		280	
12. Administrative Management Services**	\$ 1,067,260	1,013,897		53,363	
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 88,768	84,330		4,438	
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 6,133,982	6,018,827		115,155	

\* Do not include Subscriptions, which should go in item 9.

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

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

**Schedule of Other Travel and Entertainment**

Description		CCNH	RHNS	(Specify)
				0
				0
				0
				0
				0
				0
<b>Total Other Travel and Entertainment</b>		\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description		CCNH	RHNS	(Specify)
1020630020	Advertising	5,433.24	0	285.96
1020630330	Marketing Expense	9,212.04	0	484.844
3165630330	Marketing Expense	436.97	0	22.9985
1020630331	Marketing Exp- Corporate Spend	1,729.03	0	91.0015
0		0	-	0
0		0	-	0
0		0	-	0
0		0	-	0
<b>Total Other Advertising</b>		\$ 16,811	\$ -	\$ 885
		\$ -		\$ -

**Schedule of Dues**

Description		CCNH	RHNS	(Specify)
1020630310	Licenses and Certification fee	\$20,923.26	\$ -	\$1,101.22
0		\$ -	\$ -	\$ -
0		\$ -	\$ -	\$ -
0		\$ -	\$ -	\$ -
0		\$ -	\$ -	\$ -
0		\$ -	\$ -	\$ -



0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
<b>Total Dues</b>		\$ 20,923	\$ -	\$ 1,101
		\$ -	\$ -	\$ -

Schedule of Contributions

Description		CCNH	RHNS	(Specify)
1020630135	Political Contributions	3,611.82	-	-
<b>Total Contributions</b>		\$ 3,612	\$ -	\$ -
		\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description		CCNH	RHNS	(Specify)
0	0	\$ -	\$ -	\$ -
1020630060	Bank Service Charges	\$ 7,086.20	\$ -	\$ 372.96
1020630120	Collection Fees	\$30,215.26	\$ -	\$1,590.28
1020630140	Education Expense	\$ 4.85	\$ -	\$ 0.26
1020630180	Employee Physicals	\$12,687.66	\$ -	\$ 667.77
1020630200	Employee Relations	\$ 6,411.77	\$ -	\$ 337.46
1020630380	Printing	\$ 102.90	\$ -	\$ 5.42
1020630610	Training Expense	\$ 415.42	\$ -	\$ 21.86
1020630640	Uniforms	\$ 159.25	\$ -	\$ 8.38
1020640080	Fines & Penalties	\$22,600.50	\$ -	\$1,189.50
1020640090	Miscellaneous	\$ 590.91	\$ -	\$ 31.10
1020660080	Rental Expense	\$ 1,156.95	\$ -	\$ 60.89
1020660990	Accrued Expense Estimation	\$ 313.98	\$ -	\$ 16.53
1020720070	State Tax Annual Report Filing	\$ 304.00	\$ -	\$ 16.00
5095720090	Landlord Operating Taxes	\$ 2,280.00	\$ -	\$ 120.00
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
<b>Total Other Administrative and General</b>		\$ 84,330	\$ -	\$ 4,438
		0	0	0

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

Name of Facility St. Joseph's Manor Care and Rehabilitatio	License No. 2321-C	Report for Year Ended 9/30/2018	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Genesis Healthcare , 101 East St., Kennett Square, PA 19348	1,044,307	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Healthcare , 101 East St., Kennett Square, PA 19348	100,491	Capital Interest	pg 26 12-A-1

**\* In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.**

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Joseph's Manor Care and Rehabilitation Center	2321-C	9/30/2018	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 416,891	396,046		20,845
2. Non-Food Supplies	\$ 61,925	58,829		3,096
3. Other (Specify) _____ Contra Meal Exp T& E/Education Expense	\$ (22,627)	(21,496)		(1,131)
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 1,770,031	1,681,529		88,502
c. Other (Specify) _____	\$			
<b>2D. Total Dietary Expenditures (2a + b + c)</b>	<b>\$ 2,226,220</b>	<b>2,114,908</b>		<b>111,312</b>
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*				
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.				
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify cost.				
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.				
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify cost.				
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.				
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

\* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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

Name of Facility		License No.	Report for Year Ended		Page	of
St. Joseph's Manor Care and Rehabilitation Center		2321-C	9/30/2018		19	37
Item		Total	CCNH	RHNS	(Specify)	
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. \$	16,223	15,412		811
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. \$	23,716	22,530		1,186
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	601,078	571,024		30,054
c. Other (Specify)		\$				
<b>3D. Total Laundry Expenditures (3a + b + c)</b>		\$	<b>641,017</b>	<b>608,966</b>		<b>32,051</b>
3F. Laundry Questionnaire						
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				

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

All allocations should add to total recorded in 3E.

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
St. Joseph's Manor Care and Rehabilitation Center		2321-C	9/30/2018		20	37
Item		Total	CCNH	RHNS	(Specify)	
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	25,556	24,278		1,278
b.	Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	Sq. Ft. Serviced by Personnel				
		Amt. \$	903,032	857,880		45,152
c.	Other ( <i>Specify</i> )	\$				
4D.	<b>Total Housekeeping Expenditures (4a + b + c)</b>	\$	928,588	882,158		46,430
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	300,904	300,904		
b.	Medicine Cabinet Drugs	\$	64,794	64,794		
c.	Medical and Therapeutic Supplies	\$	297,640	297,640		
d.	Ambulance/Limousine***	\$	17,631	17,631		
e.	Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	24,813	24,813		
f.	X-rays and Related Radiological Procedures***	\$	17,824	17,824		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h.	Laboratory***	\$	55,109	55,109		
i.	Recreation	\$	44,311	42,095		2,216
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	192,027	182,425		9,601
5M.	<b>Total Resident Care Expenditures (5a - 5l)</b>	\$	1,015,053	1,003,235		11,817

\* 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	(Specify)
3060610160	Incontinency	138,075.52	-	7,267.13
3080630030	Advertising-Help War	326.59	-	17.19
3080630140	Education Expense	2,665.06	-	140.27
3165630340	Meetings & Seminars	-	-	-
3120630530	Supplies	4,098.18	-	215.69
3155630530	Supplies	17,755.61	-	934.51
3165630530	Supplies	21.95	-	1.16
3090630535	Office Supplies	191.25	-	10.07
3120630535	Office Supplies	-	-	-
3080630610	Training Expense	-	-	-
3120660080	Rental Expense	-	-	-
3155660080	Rental Expense	12,640.56	-	665.29
3010610300	Consolidated Billing	5,594.83	-	294.46
3080630080	Books, Dues & Subscr	140.13	-	7.38
3080630630	Tuition Reimbursemer	874.00	-	46.00
3165630535	Office Supplies	41.80	-	2.20
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	0.00	0.00	0.00
0	0	0.00	0.00	0.00
0	0	0.00	0.00	0.00
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
<b>Total Other Resident Care</b>		\$ 182,425	\$ -	\$ 9,601
		0		0

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

Name of Facility St. Joseph's Manor Care and Rehabilitation Center			License No. 2321-C		Report for Year Ended 9/30/2018			Page of 21   37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Laundry Purchased Services	601,078			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	903,032			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Dietary Purchased Services	1,770,030			18	2b
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
St. Joseph's Manor Care and Rehabilitation Center	2321-C	9/30/2018			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 488,815	464,374		24,441		
b. Heat	\$ 295,168	280,410		14,758		
c. Light & Power	\$ 395,452	375,679		19,773		
d. Water	\$ 389,234	369,772		19,462		
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$					
f. Other ( <i>itemize</i> )	\$					
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	\$ 1,568,669	1,490,235		78,434		
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 30,985	29,436		1,549		
b. Building & Building Improvements	\$ 129,657	123,174		6,483		
c. Non-Movable Equipment	\$ 32,363	30,745		1,618		
d. Movable Equipment	\$ 48,338	45,921		2,417		
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	\$ 241,343	229,276		12,067		
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 2,810,504	2,669,979		140,525		
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 227,643	216,261		11,382		
c. Personal property taxes	\$					
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	\$ 3,279,490	3,115,516		163,974		

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





### Depreciation Schedule

Name of Facility St. Joseph's Manor Care and Rehabilitation Center			License No. 2321-C			Report for Year Ended 9/30/2018			Page 23	of 37				
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals				
<b>A. Land Improvements</b>														
1. Acquired prior to this report period			6,132		6,132	2,015	S/L	Various	1,175					
2. Disposals (attach schedule)														
3. Acquired during this report period (attach schedule)			204,971		204,971				29,810					
A-4. Subtotal										30,985				
<b>B. Building and Building Improvements</b>														
1. Acquired prior to this report period			689,914			206,527			103,811					
2. Disposals (attach schedule)														
3. Acquired during this report period (attach schedule)			410,726		410,726				25,846					
B-4. Subtotal										129,657				
<b>C. Non-Movable Equipment</b>														
1. Acquired prior to this report period			284,650		284,650	135,281	S/L	Various	32,363					
2. Disposals (attach schedule)														
3. Acquired during this report period (attach schedule)														
C-4. Subtotal										32,363				
			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								
<b>D. Movable Equipment</b>														
1. Motor Vehicles (Specify name, model and year of each vehicle)														
a. Motor Vehicles (attach schedule)					8,930		8,930	8,930	S/L	Various				
b. Disposals (attach schedule)														
c. Acquired during this report period (attach schedule)														
d.														
2. Movable Equipment														
a. Acquired prior to this report period					413,405		413,405	194,783	S/L	Various	44,588			
b. Disposals (attach schedule)														
c. Acquired during this report period (attach schedule)					53,448		53,448					3,750		
D-3. Subtotal														48,338
<b>E. Total Depreciation</b>														241,344

St. Joseph's Manor Care and Rehabilitation Center  
9/30/2018

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
10/31/2017	Labor & materials to pave main roadw	200,543	06 02	29,810
5/31/2018	Sales Tax for invoice 495818	4,428	05 07	264
<b>Total additions for Land Improvements</b>		\$ 204,971		\$ 30,075 *
<b>Deletions:</b>				
<b>Total deletions for Land Improvements</b>		\$ -		\$ - **

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
11/30/2017	Lift gate elevator for kitchen	32,356	06 01	4,432
12/31/2017	Floor mounted toilet combo	746	06 00	93
12/31/2017	Jeron Provider 68+	86,992	06 00	10,874
1/31/2018	12 Panic Bars and Closures	7,338	05 11	827
5/31/2018	Toilet	667	05 07	40
5/31/2018	Rental Boiler While Waiting for New	71,190	05 07	4,250
5/31/2018	New Roof	42,438	05 07	2,534
7/31/2018	Boiler and ot Water Storage Tank Re	46,684	05 05	1,436
8/31/2018	New Circuit Board for Elevator	16,169	05 04	253
8/31/2018	Boiler Plant Upgrade (First Billing)	70,858	05 04	1,107
9/30/2018	Vinyl Flooring	8,576	05 03	-
9/30/2018	Boiler Rental- September	13,355	05 03	-
9/30/2018	Boiler Rental- August	13,355	05 03	-

<b>Total additions for Building Improvements</b>		\$ 410,726		\$ 25,846 *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

**Schedule of Non-Movable Equipment Acquired during this report period**

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

\*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
<b>Additions:</b>				
3/31/2018	Add a Data Drop	770.00	05 09	66.96
3/31/2018	DermaFloat Alternating Pressure Air	2,143.14	03 00	357.19
3/31/2018	Direct Choice Heated Plate Dispense	1,680.31	05 09	146.11
5/31/2018	(7) DermaFloat Mattress/ Foam Matt	21,238.77	03 00	2,359.86
5/31/2018	(2) Tracer Wheelchair	453.42	05 07	27.07
5/31/2018	9XT Wheelchair	507.56	05 07	30.30

5/31/2018	Slip-Top Overbed Table	578.52	05 07	34.54
5/31/2018	Bariatric Bed	2,640.67	03 00	293.41
6/30/2018	(2) DermaFLoat Mattress	5,217.49	03 00	434.79
9/30/2018	60 - Mattresses	14,485.51	03 00	-
9/30/2018	3 - Mattresses	1,027.65	03 00	-
9/30/2018	5 - LED Tv's	2,220.69	05 03	-
9/30/2018	Refrigerator 18 cu ft	483.95	05 03	-
<b>Total additions for Movable Equipment</b>		<b>\$ 53,448</b>		<b>\$ 3,750</b> *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		<b>\$ -</b>		<b>\$ -</b> **

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

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

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

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility St. Joseph's Manor Care and Rehabilitation Center			License No. 2321-C		Report for Year Ended 9/30/2018			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

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

Name of Facility St. Joseph's Manor Care and Rehabilitt	License No. 2321-C	Report for Year Ended 9/30/2018	Page 25	of 37	
<b>11. Property Questionnaire</b>					
<b>Part A</b>					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If <b>NOT</b> Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	297				
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of _____					
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	
SABRA, 101 Sun Ave. NE, Albuquerque, NM 87109	Facility Lease	11/15/10 - 6/30	127 months	2,669,979	

**Note:** Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

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

Name of Facility		License No.	Report for Year Ended			Page	of
St. Joseph's Manor Care and Rehabil		2321-C	9/30/2018			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$ 100,491	95,466			5,025	
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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$ 100,491	95,466			5,025	

(Carry Subtotals forward to next page)



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

Name of Facility	License No.	Report for Year Ended	Page	of		
St. Joseph's Manor Care and Rehabil	2321-C	9/30/2018	27	37		
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:			100,491	95,466		5,025
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. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>			\$ 100,491	95,466		5,025
14. Insurance						
a. Insurance on Property (buildings only)			\$ 29,994	28,494		1,500
b. Insurance on Automobiles			\$			
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)			\$ 498,085	473,181		24,904
2. Fire and Extended Coverage			\$			
3. Other (Specify)			\$			
14d. <b>Total Insurance Expenditures (14a + b + c)</b>			\$ 528,079	501,675		26,404
15. <b>Total All Expenditures (A-13 thru C-14)</b>			\$ 28,976,542	28,289,148		687,394

### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
St. Joseph's Manor Care and Rehabilitation Center				2321-C	9/30/2018	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 26,324	25,008		1,316
<b>Page 13 - Professional Fees</b>							
5.	13	8-c	Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 1,068,946	1,068,946		
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 395,818	376,027		19,791
10.			Accounting	\$			
10a.			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.	16	m-2 &	Unallowable Advertising *	\$ 17,696	16,811		885
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 3,612	3,612		
21.			Unallowable Management Fees	\$ 22,953	21,805		1,148
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 347,757	342,042		5,715
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
<b>Subtotal (Items 1 - 26)</b>				\$ 1,883,106	1,854,252		28,854

\* All except "Help Wanted".

(Carry Subtotal forward to next page)

\*\* Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

**Schedule of Other Salaries Adjustment**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	2	Administrator's salary disallowed	0 \$ 25,008	0	1316.218124
10	a12o		0 \$ -	0	0
10	a12o		0 \$ -	0	0
0	0		0 \$ -	0	0
0	0		0 \$ -	0	0
0	0		0 \$ -	0	0
<b>Total Other Salaries Adjustment</b>			\$ 25,008	\$ -	\$ 1,316

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020 \$ 140,637	0	0
13	5	Rehabilitation Services	3195620020 \$ 599,695	0	0
13	9	Speech Therapist	3170620020 \$ 75,837	0	0
13	10	Occupational Therapist	3105620020 \$ 204,660	0	0
13	12	Other	3010620020 \$ 1,580	0	0
13	12	Other	3015620020 \$ 40,669	0	0
13	12	Respiratory Purchased Servies	3155620020 \$ 5,868	0	0
				0	0
				0	0
				0	0
				0	0
				0	0
<b>Total Other Fees Adjustments</b>			\$ 1,068,946	\$ -	\$ -
			\$ -		

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-8a	1020630310	Chamber of Commer	-	-
16	m-13	1020630120	Collection Fees	30,215.26	1,590.28
16	m-13	1020660990	Estimated Accrual	313.98	16.53
16	m-13	7010800030	Non-recurring charge	-	-
16	m-13	1020640080	Penalty	22,600.50	1,189.50
-	-	-	-	-	-
15	1a3	-	-	-	-
15	1a4	-	-	-	-
15	1-a-1	adj workers comp	-	288,912.73	2,918.31
-	-	-	-	-	-
<b>Total Other A&amp;G Adjustments</b>			\$ 342,042	\$ -	\$ 5,715

0.00

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

Name of Facility				License No.	Report for Year Ended	Page	of
St. Joseph's Manor Care and Rehabilitation Center				2321-C	9/30/2018	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,883,106	1,854,252		28,854
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5-a-2	Prescription Drugs	\$ 300,904	300,904		
28.	20	5-d	Ambulance/Limousine	\$ 17,631	17,631		
29.	20	5-f	X-rays, etc	\$ 17,824	17,824		
30.	20	5-h	Laboratory	\$ 55,109	55,109		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 24,813	24,813		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 37,885	37,885		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 23,632	23,632		
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$ 26,816	25,476		1,341
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 470,474	446,950		23,524
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 2,858,194	2,804,475		53,719

\*\*\* 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.

St. Joseph's Manor Care and Rehabilitation Center  
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**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	\$ 5,889	\$ -	\$ -
20	5-j	Respiratory Supplies	\$ 18,690	\$ -	\$ -
20	5-j	Respiratory Rental	\$ 13,306	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
<b>Total Other Ancillary Costs</b>			<b>\$ 37,885</b>	<b>\$ -</b>	<b>\$ -</b>
			\$ -		

**Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
-	-	-	\$ -	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
-	-	-	\$ -	\$ -	\$ -
<b>Total Excess Movable Equipment Depreciation</b>			<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6b	-	-	-	-
22	6c	-	-	-	-
22	6d	-	-	-	-
22	6a	Teresian Towers Misc Revenue - Maint Dept	7,848	-	-
22	6b	Teresian Towers Misc Revenue- Electricity revenue	15,784	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
<b>Total Other Property Adjustments</b>			<b>\$ 23,632</b>	<b>\$ -</b>	<b>\$ -</b>
			\$ -		

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 c1	General liability Insurance Adjust	446,950	-	23,524
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
<b>Total Other - Miscellaneous Administrative</b>			<b>\$ 446,950</b>	<b>\$ -</b>	<b>\$ 23,524</b>
			<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
<b>Total Unallowable Building Interest</b>			<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Other - Miscellaneous - Other Indirect

Page Ref	Line Ref	Description	CCNH	RHNS	i
20	5-i	Cable TV	25,476	allow \$3600	1,341
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
<b>Total Other - Miscellaneous - Other Indirect</b>			<b>\$ 25,476</b>	<b>\$ -</b>	<b>\$ 1,341</b>

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended			Page	of
St. Joseph's Manor Care and Rehabilitation	2321-C	9/30/2018			30	37
Item	Total	CCNH	RHNS	(Specify)		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 41,748,374	39,660,955		2,087,419		
b. Medicaid Room and Board Contractual Allowance **	\$ (21,792,560)	(20,702,932)		(1,089,628)		
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 2,342,275	2,342,275				
b. Medicare Room and Board Contractual Allowance **	\$ (690,460)	(690,460)				
4. a. Private-Pay Residents and Other	\$ 3,977,604	3,977,604				
b. Private-Pay Room and Board Contractual Allowance **	\$ (976,587)	(976,587)				
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 166,891	166,891				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (49,196)	(49,196)				
c. Prescription Drugs - Non-Medicare	\$ 143,596	136,416		7,180		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (43,671)	(41,487)		(2,184)		
2. a. Medical Supplies - Medicare	\$ 12	12				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (3)	(3)				
c. Medical Supplies - Non-Medicare	\$ 582	553		29		
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (304)	(289)		(15)		
3. a. Physical Therapy - Medicare	\$ 490,194	490,194				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (144,500)	(144,500)				
c. Physical Therapy - Non-Medicare	\$ 380,213	361,202		19,011		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (123,765)	(117,577)		(6,188)		
4. a. Speech Therapy - Medicare	\$ 173,892	173,892				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (51,260)	(51,260)				
c. Speech Therapy - Non-Medicare	\$ 144,097	136,892		7,205		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (45,428)	(43,157)		(2,271)		
5. a. Occupational Therapy - Medicare	\$ 697,879	697,879				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (205,722)	(205,722)				
c. Occupational Therapy - Non-Medicare	\$ 530,257	503,744		26,513		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (164,769)	(156,531)		(8,238)		
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 181,518	172,442		9,076		
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 426,774	405,435		21,339		
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 27,115,933	26,046,685		1,069,248		
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$ 4,102	3,897		205		
5. Interest Income ( <i>Specify</i> )	\$ 105	105				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$ 43,389	41,220		2,169		
8. Other ( <i>Specify</i> )	\$ 53,957	53,957				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 101,553	99,179		2,374		
<b>VI. Total All Revenue</b> (III +V)	\$ 27,217,486	26,145,864		1,071,622		

\* 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.





II-6-b	Contractuals-Medicaid	Radiology Service	-	-	-
II-6-b	Contractuals-Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Contractuals-Medicaid	Daycare	-	-	-
II-6-b	Private,insurance, other	X-Ray	10,302.76	-	542.25
II-6-b	Private,insurance, other	Laboratory	56,517.45	-	2,974.60
II-6-b	Private,insurance, other	Respiratory Therapy & Supplie	2,668.07	-	140.42
II-6-b	Private,insurance, other	Nursing Treatment Supplies	-	-	-
II-6-b	Private,insurance, other	Audiology	-	-	-
II-6-b	Private,insurance, other	Incontinency	-	-	-
II-6-b	Private,insurance, other	Oxygen & Supplies	-	-	-
II-6-b	Private,insurance, other	Physician Visit	-	-	-
II-6-b	Private,insurance, other	Ambulance	-	-	-
II-6-b	Private,insurance, other	Flu Shot	-	-	-
II-6-b	Private,insurance, other	Capitation Contracts	464,149.10	-	24,428.90
II-6-b	Private,insurance, other	Radiology Service	-	-	-
II-6-b	Private,insurance, other	Outpatient Therapy Program	-	-	-
II-6-b	Private,insurance, other	Daycare	-	-	-
II-6-b	Contractuals-Non-Medicaid	X-Ray	(2,529.55)	-	(133.13)
II-6-b	Contractuals-Non-Medicaid	Laboratory	(13,876.25)	-	(730.33)
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplie	(655.07)	-	(34.48)
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Contractuals-Non-Medicaid	Audiology	-	-	-
II-6-b	Contractuals-Non-Medicaid	Incontinency	-	-	-
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Contractuals-Non-Medicaid	Physician Visit	-	-	-
II-6-b	Contractuals-Non-Medicaid	Ambulance	-	-	-
II-6-b	Contractuals-Non-Medicaid	Flu Shot	-	-	-
II-6-b	Contractuals-Non-Medicaid	Capitation Contracts	(113,958.60)	-	(5,997.82)
II-6-b	Contractuals-Non-Medicaid	Radiology Service	-	-	-
II-6-b	Contractuals-Non-Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Contractuals-Non-Medicaid	Daycare	-	-	-
0	0	0	-	-	-
0	0	0	-	-	-
<b>Total Other Resident Revenue</b>			\$ 405,435	\$ -	\$ 21,339
			\$ -		\$ -

**Interest Income**

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
IV-5	Interest on Overdue Accts	Interest	\$104.82	0	0
-	-	-	\$0.00	0	0
-	-	-	\$0.00	0	0
<b>Total Interest Income</b>			\$ 105	\$ -	\$ -
			\$ -		

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
IV-8	Tmobile basement rent	\$ 48,373	\$ -	\$ -
IV-8	Security-Maint employees r	\$ 1,196	\$ -	\$ -
IV-8	Vendor Machine	\$ -	\$ -	\$ -
IV-8	Reclass to contra meal	\$ -	\$ -	\$ -
IV-8	Medical Records	\$ 93	\$ -	\$ -
IV-8	teresian towers utilities	\$ 761	\$ -	\$ -
IV-8	Donation	\$ 33	\$ -	\$ -
IV-8	Hair Dresser	\$ 392	\$ -	\$ -
IV-8	Reclass	\$ 730	\$ -	\$ -
IV-8	SETTLEMENT - REHABC	\$ 600	\$ -	\$ -
IV-8	UHC Optum Care Plus Part	\$ 1,780	\$ -	\$ -
<b>Total Other Revenue</b>		\$ 53,957	\$ -	\$ -
		\$ (0)		

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
St. Joseph's Manor Care and Rehabilitat	2321-C	9/30/2018	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	27,804
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,478,195
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(48,749)
4. Inventories			\$	101,687
5. Prepaid Expenses			\$	11,264
a. Prepaid Expenses				
b. Prepaid Property Tax	4,677			
c. Prepaid Escrow Real Estate				
d. Prepaid Personal Property Tax	6,587			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
_____				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	2,570,199
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	211,103		
	Accum. Depreciation	33,001		
	Net		\$	178,102
3. Buildings	*Historical Cost	1,100,639		
	Accum. Depreciation	336,184		
	Net		\$	764,455
4. Leasehold Improvements	*Historical Cost			
	Accum. Depreciation			
	Net		\$	
5. Non-Movable Equipment	*Historical Cost	284,650		
	Accum. Depreciation	167,645		
	Net		\$	117,005
6. Movable Equipment	*Historical Cost	466,853		
	Accum. Depreciation	243,121		
	Net		\$	223,732
7. Motor Vehicles	*Historical Cost	8,930		
	Accum. Depreciation	8,930		
	Net		\$	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
PPE CIP				
_____				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	1,283,294

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

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St. Joseph's Manor Care and Rehabilitat	2321-C	9/30/2018	32	37
<b>Account</b>			<b>Amount</b>	
Total Brought Forward:			\$ 3,853,493	
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				
\$				
2. Land Improvements				
*Historical Cost _____				
Accum. Depreciation _____ Net				
\$				
3. Buildings				
*Historical Cost _____				
Accum. Depreciation _____ Net				
\$				
4. Non-Movable Equipment				
*Historical Cost _____				
Accum. Depreciation _____ Net				
\$				
5. Movable Equipment				
*Historical Cost _____				
Accum. Depreciation _____ Net				
\$				
6. Motor Vehicles				
*Historical Cost _____				
Accum. Depreciation _____ Net				
\$				
7. Minor Equipment-Not Depreciable				
\$				
C-8 <b>Total Leasehold or Like Properties</b> (C1 thru 7)				
\$				
D. Investment and Other Assets				
1. Deferred Deposits				
\$				
2. Escrow Deposits				
\$				
3. Organization Expense				
*Historical Cost _____				
Accum. Depreciation _____ Net				
\$				
4. Goodwill (Purchased Only)				
\$				
5. Investments Related to Resident Care ( <i>itemize</i> )				
\$				
6. Loans to Owners or Related Parties ( <i>itemize</i> )				
\$				
Name and Address		Amount	Loan Date	
7. Other Assets ( <i>itemize</i> )				
\$ (1,947,514)				
O L/T A Suspense				
Identifiable Intangible Assets				
694,985				
Intercompany				
(2,642,500)				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)				
\$ (1,947,514)				
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)				
\$ 1,905,979				

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

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of	
St. Joseph's Manor Care and Rehabilitation Center	2321-C	9/30/2018	33	37	
Account			Amount		
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable			\$	1,147,159	
2. Notes Payable ( <i>itemize</i> )			\$		
_____					
_____					
_____					
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )			\$		
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )			\$	601,306	
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$		
6. Accrued Payroll Taxes Payable			\$	120	
7. Medicare Final Settlement Payable			\$		
8. Medicare Current Financing Payable			\$		
9. Mortgage Payable ( <i>Current Portion</i> )			\$		
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )			\$		
11. Accrued Income Taxes*			\$		
12. Other Current Liabilities ( <i>itemize</i> )			\$	670,982	
A/R Credit Gross Up Liability		239,022	Accr Exp Other 29,000		
Accr Exp Water and Sewer		6,061	Deferred Revenue 21,670		
Accr Exp Gas		10,731	Accrued Provider/Bed Tax 338,440		
Accr Exp Electricity		6,639	Accr Gross Rec Tax 19,419		
A-13. <b>Total Current Liabilities</b> (Lines A1 thru 12)			\$	2,419,567	

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

(Carry Total forward to next page)

### G. Balance Sheet (cont'd)

Name of Facility St. Joseph's Manor Care and Rehabilitation	License No. 2321-C	Report for Year Ended 9/30/2018	Page 34	of 37
Account				Amount
Total Brought Forward:				2,419,567
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 519,480
LT Debt-Financing Obligation		517,752		
Escheatable Funds		1,728		
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 519,480
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 2,939,047

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Joseph's Manor Care and Rehabilit	2321-C	9/30/2018	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	725,993
6. Gain or Loss for Period	10/1/2017	thru 9/30/2018	\$	(1,759,062)
7. Total Net Worth			\$	(1,033,069)
<b>C. Total Reserves and Net Worth</b>			\$	(1,033,069)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	1,905,978

### H. Changes in Total Net Worth

Name of Facility St. Joseph's Manor Care and Rehabilitati	License No. 2321-C	Report for Year Ended 9/30/2018	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2017			\$	725,987
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	27,217,483
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	28,976,539
D. Net Income or Deficit			\$	(1,759,056)
E. Balance			\$	(1,033,069)
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
2. Other ( <i>itemize</i> )				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )			\$	
Name and Address ( <i>No., City, State, Zip</i> )		Title	Amount	
2. Other Withdrawings ( <i>Specify</i> )			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	(1,033,069)

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

Name of Facility St. Joseph's Manor Care and Rehabilitation	License No. 2321-C	Report for Year Ended 9/30/2018	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
Thomas Farnan Title -Sr. Director of Reimbursement				
Address Address		Phone Number		
200 Brickstone Square, Andover, MA 01810		978-247-5029		