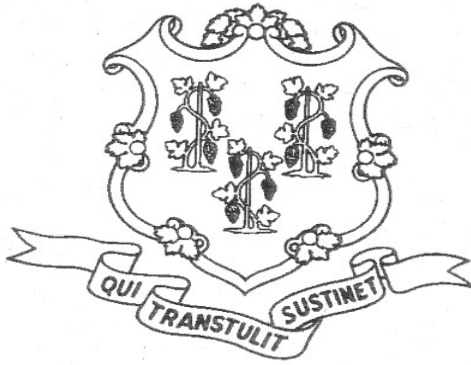


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as licensed) Saint Mary Home	
Address (No. & Street, City, State, Zip Code) 2021 Albany Avenue, West Hartford CT 06117	
Type of Facility Chronic and Convalescent Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input checked="" type="checkbox"/> Residential Care Home (CCNH) (RHNS)	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH 680-C	RHNS	Residential Care Home 1289	Medicare Provider 07-5085
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Medicaid Provider Numbers:	CCNH 75085	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

General Information

Name of Facility (as licensed) Saint Mary Home	License No. 680-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 Saint Mary Home [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) Eric Dana			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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State of Connecticut
Department of Social Services
 55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Saint Mary Home	Period Covered:	From 10/1/2017	To 9/30/2018	
Address of Facility 2021 Albany Avenue, West Hartford CT 06117				
Report Prepared By Pamela Latovick	Phone Number 734-343-6628	Date 2/15/2019		
Item	Total	CCNH	RHNS	Residential Care Home
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire

Type of Facility - Organization Structure

	Phone No. of Facility 860-570-8300	Report for Year Ended 9/30/2018	Page 2	of 37
Name of Facility (as shown on license) Saint Mary Home		Address (No. & Street, City, State, Zip) 2021 Albany Avenue, West Hartford CT 06117		
License Numbers:	CCNH 680-C	RHNS	Residential Care Home 1289	Medicare Provider No. 07-5085
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 checked="" type="checkbox"/> Residential Care Home				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Eric Dana		Nursing Home Administrator's License No.:	1447	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name None		License No.:		

**General Information and Questionnaire
 Related Parties***

Name of Facility Saint Mary Home	License No. 680-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	%**				
Sisters of Mercy Northeast	15 Highland View Road Cumberland, RI 02864	<input type="radio"/>	<input checked="" type="radio"/>		Pastoral Care	Pg. 13 line 12	1,613	1,613
Trinity Health	17410 College Parkway, Livonia MI 48152	<input type="radio"/>	<input checked="" type="radio"/>		Loan	Pg. 33 A12, Pg. 34 B	9,958,418	9,958,418
Mercy Community Health	2021 Albany Avenue West Hartford, CT 06117	<input type="radio"/>	<input checked="" type="radio"/>		Management Services	Pg. 16 line m12	3,072,926	3,072,926
McAuley	275 Steele Rd West Hartford, CT 06117	<input type="radio"/>	<input checked="" type="radio"/>		Revenue for CCRC Nursing Home patients	Pg. 30 line I4a	142,260	142,260
Sisters of Providence	1221 Main St. Suite 213 Holyoke, MA 01040	<input type="radio"/>	<input checked="" type="radio"/>		Outside Printing	Pg. 16 line m13	448	448
Trinity Health	17410 College Parkway, Livonia MI 48152	<input type="radio"/>	<input checked="" type="radio"/>		Interest on loan	Pg. 26 line m13	391,463	391,463
Mercy Community Health	2021 Albany Avenue West Hartford, CT 06117	<input type="radio"/>	<input checked="" type="radio"/>		Intercompany receivable	Pg. 33 line A12	94,140	94,140
McAuley	275 Steele Rd West Hartford, CT 06117	<input checked="" type="radio"/>	<input type="radio"/>		Intercompany receivable	Pg. 33 line A12	514,442	514,442
See attached		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Saint Mary Home	License No. 680-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.

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 salary costs of the residential care home was directly assigned.

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 Saint Mary Home			License No. 680-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						
Pitney Bowes, Box 371887, 500 Ross St, Suite 154-0470, Pittsburgh, PA 15262	<input type="radio"/>	<input checked="" type="radio"/>	Postage Machine	06/28/11	66 months	11,675	8,296	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input checked="" type="radio"/> No	Total ***
							8,296	

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

General Information and Questionnaire
Accounting Basis

Name of Facility Saint Mary Home	License No. 680-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	Address (No. & Street, City, State, Zip Code)
1 Robert Half Account Temps	12400 Collection Center Dr. Chicago, IL 60693-0124
2 Deloitte via Trinity Health	3805 W Chester Pike # 100, Newtown Square, PA 19073
3	
4	

Services Provided by This Firm (*describe fully*)

1 Temporary Labor - Accountants	\$ 3,576
2 External Audit and Form 990 prep	\$ 9,126
3	\$
4	\$
	Charge for Services Provided
	\$ 12,702

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 Harbor Robert	203-849-0863
2 Goldman, Gruder and Woods, LLC	203-899-8915
3 Robinson & Cole, LLP	860-275-8200
4 State of Connecticut	
5 Various	

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

1 70 New Canaan Avenue, Norwalk, CT 06850
2 200 Connecticut Ave, Norwalk, CT 06604
3 280 Trumbull Street, Hartford, CT 06103-3597
4 50 S. Main St, RM#318, Probate Court, West Hartford, CT 06107
5

Services Provided by This Firm (*describe fully*)

1 Recruiting	\$ 420
2 Collections - Disallowed	\$ 14,663
3 Labor Relations	\$ 43,359
4 Probate Fees - Disallowed	\$ 1,125
5 Collections - Disallowed	\$ 2,294
	Charge for Services Provided
	\$ 61,861

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

Schedule of Resident Statistics

Name of Facility Saint Mary Home			License No. 680-C		Report for Year Ended 9/30/2018				Page 8	of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	353	256		97	353	256		97	353	256		97
B. On last day of THIS report period	353	256		97	353	256		97	353	256		97
2. Number of Residents												
A. As of midnight of PREVIOUS report period	332	240		92	332	240		92	330	238		92
B. As of midnight of THIS report period	330	236		94	330	238		92	330	236		94
3. Total Number of Days Care Provided During Period												
A. Medicare	8,659	8,659			6,505	6,505			2,154	2,154		
B. Medicaid (Conn.)	58,466	58,466			43,481	43,481			14,985	14,985		
C. Medicaid (other states)												
D. Private Pay	11,173	10,128		1,045	8,883	7,930		953	2,290	2,198		92
E. State SSI for RCH	31,862			31,862	23,551			23,551	8,311			8,311
F. Other (Specify)	9,295	9,295			6,922	6,922			2,373	2,373		
G. Total Care Days During Period (3A thru F)	119,455	86,548		32,907	89,342	64,838		24,504	30,113	21,710		8,403
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	805	53		752	620	39		581	185	14		171
5. Total Resident Days (3G + 4A + 4B)	120,260	86,601		33,659	89,962	64,877		25,085	30,298	21,724		8,574

Schedule of Resident Statistics (Cont'd)

Name of Facility Saint Mary Home			License No. 680-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? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	Residential Care Home	Lost			Gained			CCNH	RHNS	Residential Care Home	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	Residential Care Home		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-MR				
No. of Residents	22		179		34		1	90					
Per Diem Rate													
a. One bed rm.			244.35		518.00			108.23					
b. Two bed rms.			244.35		469-493			108.23					
c. Three or more bed rms.			244.35		426.00			108.23					
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	Residential Care Home	
A. Medicare - Part B									7,365	7,365			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									1,278	1,278			
2. Restorative Treatments													
C. Other									43,261	43,261			
D. Total Physical Therapy Treatments									51,904	51,904			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									442	442			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									20	20			
2. Restorative Treatments													
C. Other									3,220	3,220			
D. Total Speech Therapy Treatments									3,682	3,682			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									4,520	4,520			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									1,242	1,242			
2. Restorative Treatments													
C. Other									42,067	42,067			
D. Total Occupational Therapy Treatments									47,829	47,829			

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Saint Mary Home	680-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	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)	132,023	1,822			18,673	258
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					69,344	2,080
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	314,979	13,962			44,549	1,975
5. Dietary Service						
a. Head Dietitian	38,389	1,829			14,921	711
b. Food Service Supervisor						
c. Dietary Workers	921,399	55,553			358,118	21,604
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	902,126	56,114			169,144	10,530
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	49,031	1,818			26,646	988
b. Other Maintenance Workers	72,844	4,128			39,588	2,243
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	168,668	9,768			65,556	3,799
9. Barber and Beautician Services						
10. Protective Services	218,532	12,385			118,765	6,730
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	254,216	4,160				
b. RN						
1. Direct Care	2,584,991	65,207				
2. Administrative**	230,740	4,433				
c. LPN						
1. Direct Care	2,168,409	80,766				
2. Administrative**						
d. Aides and Attendants	4,430,246	264,776			355,478	21,184
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	223,271	10,160			31,578	1,437
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	168,442	5,854				
n. Marketing	76,674	1,837			10,844	260
o. Other (Specify)						
See Attached Schedule	274,065	10,308			38,762	1,458
<i>A-13. Total Salary Expenditures</i>	13,229,045	604,880			1,361,966	75,257

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		Residential Care Home	
	\$	Hours	\$	Hours	\$	Hours
Pastoral Services	\$ 274,065	10,308			\$ 38,762	1,458
Total	\$ 274,065	10,308	\$ -	-	\$ 38,762	1,458

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		Residential Care Home	
	\$	Hours	\$	Hours	\$	Hours
Respiratory Therapy Services - Disallowed	\$ 63,166	1,053				
Pastoral Services	\$ 2,500	47			\$ 354	7
Total	\$ 65,666	1,100	\$ -	-	\$ 354	7

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

Name of Facility				License No.	Report for Year Ended				Page	of
Saint Mary Home				680-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	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.

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Saint Mary Home				680-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	Residential Care Home							
Section III - Administrators***										
Eric Dana	134,441		16,255	Administrator		2,080	A2			
Section IV - Assistant Administrators										
Patricia Cyphers			69,344	Director of Resident Services		2,080	A3			

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Saint Mary Home	680-C	9/30/2018	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	23,124	Disallow				
3. Pharmacist	18,483					
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	1,052,323	17,539				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	79,088	830				
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	181,426	3,024				
b. Other						
10. Occupational Therapist						
a. Resident Care	963,522	16,059				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	96,786	1,792				
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	65,666	1,100			354	7
B-13 Total Fees Paid in Lieu of Salaries	2,480,418	40,344			354	7

* 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 Saint Mary Home		License No. 680-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		
Health Drive Dental Group, 85 Old Barnes Rd, Wallingford, CT 06492	Dental Services	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Sisters of Mercy Northeast	Pastoral Services	<input checked="" type="radio"/>	<input type="radio"/>	Members are on the Board of Directors	
PharMerica, 1904 Campus Place, Louisville, KY 40299	Pharmacists	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Select Rehabilitation	PT/ST/OT	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Saint Francis Medical Group, 114 Woodland St, Hartford, CT 06105	Medical Director	<input checked="" type="radio"/>	<input type="radio"/>	Trinity Health Affiliate	
Symbria Rehab	Respiratory Services	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Celtic Consulting	MDS Coordinator, Pharmacy Consulting	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Sisters of Adoration	RN	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" 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
Saint Mary Home	680-C	9/30/2018		15	37
Item	Total	CCNH	RHNS	Residential Care Home	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 84,697	76,849			7,848
2. Disability Insurance	\$ 26,412	23,965			2,447
3. Unemployment Insurance	\$ 35,334	32,060			3,274
4. Social Security (F.I.C.A.)	\$ 1,105,076	1,002,681			102,395
5. Health Insurance	\$ 2,636,431	2,392,143			244,288
6. Life Insurance (employees only) (not-owners and not-operators)	\$ (1,793)	(1,627)			(166)
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 861,496	781,671			79,825
8. Uniform Allowance	\$ 57,012	51,729			5,283
9. Other (<i>Specify</i>) See Attached Schedule	\$ 75,186	68,219			6,967
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$				
d. Accounting and Auditing	\$ 12,702	11,525			1,177
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 61,861	56,129			5,732
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 35,266	31,998			3,268
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 1,774	1,610			164
2. Cellular Phones	\$				
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 1,185,977	1,185,977			
Subtotal	\$ 6,177,431	5,714,929			462,502

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

(Carry Subtotals forward to next page)

***** DO NOT Include Holiday Parties / Awards / Gifts to Staff**

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
Union Education	\$ 65,158		\$ 6,654
EAP	\$ 3,061		\$ 313
Total	\$ 68,219	\$ -	\$ 6,967

Schedule of Other Taxes

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

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

Name of Facility Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2018		Page 16	of 37
Item	Total	CCNH	RHNS	Residential Care Home	
Subtotals Brought Forward:	6,177,431	5,714,929		462,502	
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$				
5. Education Expenses Related to Seminars and Conventions	\$	12,092	10,594	1,498	
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	2,793	2,447	346	
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
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	\$	1,826	1,600	226	
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	\$	24,781	21,710	3,071	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	39,719	30,751	8,968	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	14,310	12,537	1,773	
12. Administrative Management Services**	\$	3,042,197	2,665,240	376,957	
13. Other (<i>Specify</i>) See Attached Schedule	\$	262,199	229,710	32,489	
C-14 Total Administrative & General Expenditures	\$	9,577,348	8,689,518	887,830	

* 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
Sales and Advertising	\$ 1,600		\$ 226
Total Other Advertising	\$ 1,600	\$ -	\$ 226

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
Leading Age - Connecticut	\$ 18,886		\$ 5,508
Leading Age - National	\$ 6,052		\$ 1,765
Allscripts and Subscription Fees - Disallowed	\$ 4,156		\$ 1,212
National Daycare Corporation	\$ 426		\$ 124
CT Associated of Residential Care Facilities	\$ 813		\$ 237
RFMS Fees	\$ 418		\$ 122
Total Dues	\$ 30,751	\$ -	\$ 8,968

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Recruitment	\$ 52,712		\$ 7,455
Bank service fees - Disallowed	\$ 7,821		\$ 1,106
License and Fees	\$ 8,516		\$ 1,205
Miscellaneous Expense - Disallowed	\$ 17,077		\$ 2,415
Gift Shop Purchases - Disallowed	\$ 14,420		\$ 2,040
Resident Services	\$ 575		\$ 81
Fines and Penalties - Dissallowed	\$ 124		\$ 18
Purchase Discounts	\$ (32,220)		\$ (4,557)
Intercompany Expense	\$ 160,685		\$ 22,726
Total Other Administrative and General	\$ 229,710	\$ -	\$ 32,489

Schedule C-1 - Management Services*

Name of Facility Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2018	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 #	
Mercy Community Health	30,729	Direct costs associated with the parent company including wages of the CEO, CFO, Administrative Asst, and the VP of HR and other directly non-allocated expenses	ADC cost not reported	
		such as insurance for the officers and financial consulting		
Mercy Community Health	3,042,197	Direct costs associated with the parent company including wages of the CEO, CFO, Administrative Asst, and the VP of HR and other directly non-allocated expenses	Pg. 16 line m12	
		such as insurance for the officers and financial consulting		
Trinity Health		Cash management and financing services including access to the bonding markets for financing, administrative services via a continuum care		
		management leadership, purchasing management services, legal services, corporate compliance, and quality.		

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

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

Name of Facility Saint Mary Home		License No. 680-C	Report for Year Ended 9/30/2018	Page 18	of 37
Item		Total	CCNH	RHNS	Residential Care Home
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 970,706	699,020		271,686
2.	Non-Food Supplies	\$ 90,292	65,021		25,271
3.	Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)					
c. Other (Specify) _____		\$			
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 1,621,861	1,167,927		453,934
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? <input type="radio"/> Yes <input checked="" type="radio"/> No					
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify cost.					
L. Is any revenue collected from these people? <input 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 Saint Mary Home		License No. 680-C	Report for Year Ended 9/30/2018	Page 19	of 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. \$	30,639	22,064		8,575
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)	\$	13,073	9,414		3,659
c. Other (Specify)	\$				
3D. Total Laundry Expenditures (3a + b + c)	\$	43,712	31,478		12,234
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
Saint Mary Home		680-C	9/30/2018		20	37
Item			Total	CCNH	RHNS	Residential Care Home
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	155,727	131,139		24,588
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. \$	75,855	63,878		11,977
C.	Other (<i>Specify</i>)	\$				
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	231,582	195,017		36,565
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from Pharmedica	\$	555,361	555,361		
b.	Medicine Cabinet Drugs	\$	3,454	3,454		
c.	Medical and Therapeutic Supplies	\$	471,356	471,356		
d.	Ambulance/Limousine***	\$	18,340	18,340		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	109,177	109,177		
f.	X-rays and Related Radiological Procedures***	\$	33,309	33,309		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	42,814	42,814		
i.	Recreation	\$				
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	1,398	1,398		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	1,235,209	1,235,209		

* 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.

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

Name of Facility Saint Mary Home			License No. 680-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	Residential Care Home	Pg	Line
Sodexo, Inc.	PO Box 84019, Woburn, MA 01801	<input type="radio"/>	<input checked="" type="radio"/>		Maintenance Services	163,977		89,116	22	6f
Sodexo, Inc.	PO Box 84019, Woburn, MA 01801	<input type="radio"/>	<input checked="" type="radio"/>		Housekeeping Services	63,878		11,977	20	4b
Sodexo, Inc.	PO Box 84019, Woburn, MA 01801	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Services	9,414		3,659	19	3b
AEGIS Energy Services	PO Box 2511, Springfield, MA 01101	<input type="radio"/>	<input checked="" type="radio"/>		CoGeneration	10,217		5,553	22	6f
All Waste	PO Box 2472, Hartford, CT 06146	<input type="radio"/>	<input checked="" type="radio"/>		Waste Disposals/Removal	36,372		19,767	22	6f
Comcast	PO Box 1577, Newark, NJ 07101-1577	<input type="radio"/>	<input checked="" type="radio"/>		Cable TV	41,413		22,507	22	6f
Holy Family Passionist Retreat	303 Tunxis Rd, West Hartford, CT 06117	<input type="radio"/>	<input checked="" type="radio"/>		Clergy Services Mass Celebration	12,828		1,537	16	m13
Mobilex USA	PO Box 222430, Chantilly, VA 20153	<input type="radio"/>	<input checked="" type="radio"/>		Radiology Services	25,158			20	5f
Quest Pest Control	PO Box 1512 Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Extermination Services	40,645		22,089	22	6f
Saint Francis Hospital	114 Woodland Street, Hartford, CT 06112	<input checked="" type="radio"/>	<input type="radio"/>	Trinity Health Affiliate	Employment Physicals	25,205		3,019	16	m13
Siemens	Carol Stream, IL, 60132-2134	<input type="radio"/>	<input checked="" type="radio"/>		Contract Service - Alarm	15,339		8,336	22	6f
Otis Mechanical	87 Liberty Hill E., Weathersfield, CT 06109	<input type="radio"/>	<input checked="" type="radio"/>		Elevator Maintenance	52,101		28,315	22	6a
Unidine Corporation	PO Box 360639, Pittsburg, PA 1154251	<input type="radio"/>	<input checked="" type="radio"/>		Dining Services	491,026		63,615	18	2b
		<input type="radio"/>	<input checked="" 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 Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2018			Page 22	of 37
Item	Total	CCNH	RHNS	Residential Care Home		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 422,556	273,771			148,785	
b. Heat	\$ 180,366	116,858			63,508	
c. Light & Power	\$ 467,758	303,057			164,701	
d. Water	\$ 152,680	98,920			53,760	
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 2,074	1,344			730	
f. Other (<i>itemize</i>)	\$ 892,167	578,029			314,138	
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 2,117,601	1,371,979			745,622	
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 18,100	11,727			6,373	
b. Building & Building Improvements	\$ 830,245	537,910			292,335	
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 258,181	167,274			90,907	
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 1,106,526	716,911			389,615	
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$ 38,869	25,183			13,686	
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,145,395	742,094			403,301	

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

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:				
2017-09-27	ASBESTOS SURVEY	\$ 17,965	5	\$ 3,743
2017-09-28	MTU - DINING/KITCHEN/AUDITORIUM	\$ 281,303	20	\$ 19,535
2017-10-05	VINYL FLOORING - APT #484	\$ 3,562	5	\$ 683
2017-11-09	FWT #275 VINYL FLOOR	\$ 1,700	5	\$ 297
2017-11-06	G116 HEAT PUMP	\$ 3,710	10	\$ 325
2017-11-17	FWT #463 VINYL FLOOR	\$ 3,975	5	\$ 696
2017-10-31	HEAT PUMPS	\$ 37,350	10	\$ 3,579
2017-11-02	HEAT PUMP G114	\$ 3,710	10	\$ 325
2017-12-14	CARPET APT #180	\$ 1,125	5	\$ 178
2018-02-01	HEAT PUMPS	\$ 7,530	10	\$ 471
2017-11-08	Heat Pump	\$ 3,710	10	\$ 325
Total additions for Building Improvements		\$ 365,640		\$ 30,156 *
Deletions:				
Total deletions for Building Improvements		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

Total deletions for Non-Movable Equipment		\$	-	\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
2017-10-25	CS7 ELECTRIC BEDS	\$ 12,825	10	\$ 1,024
2017-10-21	SNOW TRACTOR WITH BUCKET	\$ 41,883	10	\$ 4,014
2017-10-21	SNOW BLOWER	\$ 5,900	10	\$ 1,131
2017-10-21	SNOW DROP SPREADER	\$ 4,865	10	\$ 932
2017-11-28	MATTRESSES	\$ 2,100	10	\$ 367
2017-11-12	STEAM KETTLE	\$ 18,405	10	\$ 1,074
2017-11-29	OVERBED TABLE	2100	10	122.51
2017-11-29	MATRESSES	4600	10	805.01
2017-09-18	ELECTRIC CS7 BEDS&POSITIONING	12825	10	1113.27
2018-04-06	Bed and furniture	12342.61	10	565.72
Total additions for Movable Equipment		\$ 117,846		\$ 11,149 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Saint Mary Home			License No. 680-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							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2018	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description		Total		
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		353		
6. Square Footage		211,856		
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)		Fixed	Fixed	
b. Date Mortgage Obtained		2014	2014	
c. Interest Rate for the Cost Year		405.00%	405.00%	
d. Term of Mortgage (number of years)		35	35	
e. Amount of Principal Borrowed		8,934,956	2,180,000	
f. Principal balance outstanding as of 9/30/2018		8,133,857	2,002,259	
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.

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

Name of Facility Saint Mary Home		License No. 680-C	Report for Year Ended 9/30/2018			Page 26	of 37
Item		Total	CCNH	RHNS	Residential Care Home		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$ 391463	314,292			77,171	
Name of Lender Trinity Health		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)		\$ 391,463	314,292			77,171	

(Carry Subtotals forward to next page)

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

Name of Facility Saint Mary Home		License No. 680-C		Report for Year Ended 9/30/2018		Page 27 37	
Item				Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:				391,463	314,292		77,171
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (<i>Specify</i>)				\$			
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 (<i>Specify</i>)				\$			
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 391,463	314,292		77,171
14. Insurance							
a. Insurance on Property (buildings only)				\$ 25,651	16,619		9,032
b. Insurance on Automobiles				\$ 9,709	6,290		3,419
c. Insurance other than Property (as specified above)							
1. Umbrella (<i>Blanket Coverage</i>)				\$			
2. Fire and Extended Coverage				\$			
3. Other (<i>Specify</i>)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$ 35,360	22,909		12,451
15. Total All Expenditures (A-13 thru C-14)				\$ 33,471,314	29,479,886		3,991,428

D. Adjustments to Statement of Expenditures

Name of Facility Saint Mary Home				License No. 680-C	Report for Year Ended 9/30/2018	Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.	10	A12n	Salaries not related to Resident Care	\$ 87,518	76,674		10,844
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 86,290	86,290		
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 963,523	963,523		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.	15	Le	Accounting	\$ 18,082	15,842		2,240
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.	16	L5	Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$ 12,092	10,594		1,498
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.	16	M12	Unallowable Management Fees	\$ 2,156,005	1,888,876		267,129
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 62,077	53,785		8,292
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)				\$ 3,385,587	3,095,584		290,003

* 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
13	B2	Dentist	\$ 23,124		
13	B12.03	Respiratory Services	\$ 63,166		
Total Other Salaries Adjustment			\$ 86,290	\$ -	\$ -

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
16	m13	Bank service fees	\$ 7,821		\$ 1,106
16	m13	Miscellaneous expenses	\$ 17,077		\$ 2,415
16	m13	Gift shop purchases	\$ 14,420		\$ 2,040
16	m13	Fines and penalties	124		18
16	m8	Allscript subscription fees	4156		1212
16	m13	Marketing Consulting	1600		226
16	m13	Marketing Benefits	8587		1275
Total Other A&G Adjustments			\$ 53,785	\$ -	\$ 8,292

Marketing Benefits Disallowed Calculation:

Marketing Salaries	87,518
Total Salaries	14,591,011
% Marketing Salaries	0.60%
Total Benefits pg 15 1a1-1a9	4,932,609
Marketing Benefits Disallowance (33.33% of Marketing Benefits)	9,862

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Saint Mary Home			680-C	9/30/2018	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward				\$ 3,385,587	3,095,584		290,003
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$ 555,362	555,362		
28.			Ambulance/Limousine	\$ 18,340	18,340		
29.			X-rays, etc	\$ 33,309	33,309		
30.			Laboratory	\$ 42,814	42,814		
31.			Medical Supplies	\$ 471,356	471,356		
32.			Oxygen (non emergency)	\$ 109,177	109,177		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 1,398	1,398		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$ 21,166	17,822		3,344
37.			Unallowable Property and Real Estate Taxes	\$ 38,869	32,728		6,141
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$ 163,464	114,139		49,325
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$ 33,315	33,315		
49. Total Amount of Decrease (Items 1 - 48)				\$ 4,874,157	4,525,344		348,813

*** 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.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
20	5J.06	PT Supplies	\$ 1,353		
20	5J.07	OT Supplies	\$ 45		
Total Other Ancillary Costs			\$ 1,398	\$ -	\$ -

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
Total Other Property Adjustments			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
22	6f	Cable TV	\$ 41,414		\$ 22,507
22	6f	Medical Equipment Rental	\$ 40,006		\$ 21,742
30	IV8	Gift Shop Revenue	\$ 13,751		
30	IV8	Other Revenue	\$ 7,837		
various	various	Outpatient Therapy Program	\$ 273		\$ 136
		Fair Rent for Adult Day Care Revenue	\$ 10,858		\$ 4,940
Total Other Adjustments			\$ 114,139	\$ -	\$ 49,325

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
26	12B7	Mortgage interest in excess of CON	\$ 33,315		
Total Unallowable Building Interest			\$ 33,315	\$ -	\$ -

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Saint Mary Home	680-C	9/30/2018			30	37
Item	Total	CCNH	RHNS	Residential Care Home		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 30,160,050	26,642,257				3,517,793
b. Medicaid Room and Board Contractual Allowance **	\$ (12,419,020)	(10,970,496)				(1,448,524)
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 6,542,702	6,542,702				
b. Medicare Room and Board Contractual Allowance **	\$ 106,083	106,083				
4. a. Private-Pay Residents and Other	\$ 7,049,960	6,924,724				125,236
b. Private-Pay Room and Board Contractual Allowance **	\$ (2,490,083)	(2,494,931)				4,848
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 334,511	334,511				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (334,511)	(334,511)				
c. Prescription Drugs - Non-Medicare	\$ 272,146	272,146				
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	\$ 961,325	961,325				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (961,325)	(961,325)				
c. Physical Therapy - Non-Medicare	\$ 1,106,145	1,106,145				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 180,378	180,378				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (180,378)	(180,378)				
c. Speech Therapy - Non-Medicare	\$ 193,580	193,580				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 1,057,854	1,057,854				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (1,057,854)	(1,057,854)				
c. Occupational Therapy - Non-Medicare	\$ 872,760	872,760				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$ (1,312,075)	(1,312,075)				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 30,082,248	27,882,895				2,199,353
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$ (390)	185				(575)
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 40	40				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$ 13,751	13,751				
8. Other (<i>Specify</i>)	\$ 29,180	7,837				21,343
V. Total Other Revenue (1 thru 8)	\$ 42,581	21,813				20,768
VI. Total All Revenue (III +V)	\$ 30,124,829	27,904,708				2,220,121

* 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
30, II6a	Laboratory - Medicare Revenue	\$ 49,884		
30, II6a	Laboratory - Medicare C/A	\$ (49,884)		
30, II6a	Radiology - Medicare Revenue	\$ 5,083		
30, II6a	Radiology - Medicare C/A	\$ (5,083)		
30, II6a	Oxygen - Medicare	\$ 7,254		
30, II6a	Oxygen - Medicare C/A	\$ (7,254)		
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
30, 116b	Laboratory Revenue	\$ 24,798		
30, 116b	Radiology Revenue	\$ 6,838		
30, 116b	Oxygen Revenue	\$ 29,947		
30, 116b	Ancillary Contractual Allowances	\$ (1,373,658)		
Total Other Resident Revenue		\$ (1,312,075)	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	Residential Care Home
30, IV5	Interest Income Operations		\$ 40		
Total Interest Income			\$ 40	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
30, IV8	Contributions	\$ (14,242)		
30, IV8	Miscellaneous Revenue	\$ 22,079		
30, IV8	Adult Day Care Revenue			\$ 21,343
Total Other Revenue		\$ 7,837	\$ -	\$ 21,343

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2018	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	14,293,864
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	4,862,943
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	17,903
4. Inventories			\$	121,829
5. Prepaid Expenses			\$	35,204
a. Other Prepaid Expense	35,204			
b. _____				
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	26,415
Escrow- Teamsters 671 Med	21,427			
Dental Prefund	2,760			
FSA Prefund	2,228			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	19,358,158
B. Fixed Assets				
1. Land			\$	100,982
2. Land Improvements	*Historical Cost	444,267	\$	444,267
	Accum. Depreciation			Net
3. Buildings	*Historical Cost	25,966,209	\$	7,756,362
	Accum. Depreciation	18,209,847		Net
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation			Net
5. Non-Movable Equipment	*Historical Cost		\$	
	Accum. Depreciation			Net
6. Movable Equipment	*Historical Cost	5,896,164	\$	1,343,794
	Accum. Depreciation	4,552,370		Net
7. Motor Vehicles	*Historical Cost	532,231	\$	197,734
	Accum. Depreciation	334,497		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	1,653,298
Construction in Progress	1,653,298			
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	11,496,437

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2018	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 30,854,595	
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 (<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>)			\$ 451,614	
Investments		451,614		
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 451,614	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 31,306,209	

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

G. Balance Sheet (cont'd)

Name of Facility Saint Mary Home		License No. 680-C	Report for Year Ended 9/30/2018	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	2,371,333
2. Notes Payable (<i>itemize</i>)				\$	

See Schedule					
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>)				\$	929,517
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	136,813
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>)				\$	6,995,234
Resident Trust Funds		300,607	Miscellaneous Current Li	96,416	
Current Portion of Debt - Intercompa		177,697			
Accrued Retirement Expenses		(7,920)			
Intercompany Payable, net		6,428,434	See Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	10,432,897

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2018		Page 34	of 37
Account				Amount	
Total Brought Forward:				10,432,897	
Liabilities (cont'd)					
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>)				\$ 9,958,418	
Intercompany Debt - Long term		9,958,418			
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 9,958,418	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 20,391,315	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2018	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 (<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			\$	265,000
6. Total Reserves			\$	265,000
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	13,996,381
6. Gain or Loss for Period			\$	(3,346,487)
				10/1/2017 thru 9/30/2018
7. Total Net Worth			\$	10,649,894
C. Total Reserves and Net Worth			\$	10,914,894
D. Total Liabilities, Reserves, and Net Worth			\$	31,306,209

H. Changes in Total Net Worth

Name of Facility Saint Mary Home	License No. 680-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			\$	13,969,820
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	30,124,828
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	33,471,314
D. Net Income or Deficit			\$	(3,346,486)
E. Balance			\$	10,623,334
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
Other Entity Loss not Included	26,561			
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	26,561
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. Balance at End of Period			\$	10,649,895

I. Preparer's/Reviewer's Certification

Name of Facility Saint Mary Home	License No. 680-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 checked="" type="checkbox"/> Residential Care Home		
Preparer/Reviewer Certification				
<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				
Pamela Latovick				
Address Address			Phone Number	
17410 College Parkway Suite 200, Livonia, MI 48152			734-343-6628	