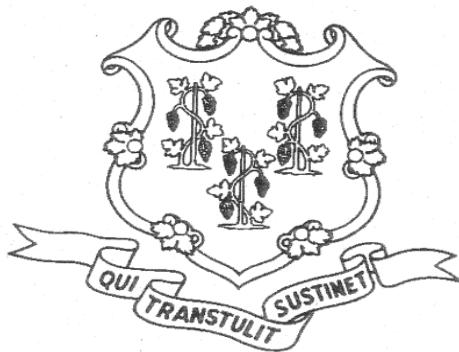


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

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	
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

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 9/30/2021	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, 2020 and ending September 30, 2021, 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) Rachel Demaida		Printed Name (Owner)	
Subscribed and Sworn to before me:	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 10/1/2020	To 9/30/2021
Address of Facility 2021 Albany Avenue, West Hartford CT 06117				
Report Prepared By Haley Gregory	Phone Number 734-343-6611	Date		
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 9/30/2021	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 <input checked="" type="checkbox"/> 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 Rachel DeMaida		Nursing Home Administrator's License No.:	18-89	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name None		License No.:		

General Information and Questionnaire Partners/Members

General Information and Questionnaire Corporate Owners

Name of Facility Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2021	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

Mercy Community Health Inc. (Saint Mary Home)

Attachment Page 3A

Board of Directors

Ann Kane, CSJ

Gagandeep Singh, MD

Janice Hamilton-Crawford (Ex-Officio)

Jean McGinty, RSM

Patricia McKeon, RSM

Peter Murphy , Board Chair

Shyamala Raman

William Healy (Ex-Officio)

General Information and Questionnaire

Individual Proprietorship

Name of Facility Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2021	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

General Information and Questionnaire

Related Parties*

Name of Facility Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2021			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes <input checked="" type="radio"/> 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?				<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the following information:				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party	
		Yes	No	%**				Description of Goods/Services Provided
Trinity Health	20555 Victor Pkwy, Livonia MI 48152	<input type="radio"/>	<input checked="" type="radio"/>		Loan	Pg. 33 A12, Pg. 34 B	9,409,442	9,409,442
Mercy Community Health	2021 Albany Avenue West Hartford, CT 06117	<input type="radio"/>	<input checked="" type="radio"/>		Management Services	Pg. 16 line m12	2,164,662	2,164,662
Trinity Health	20555 Victor Pkwy, Livonia MI 48152	<input type="radio"/>	<input checked="" type="radio"/>		Interest on loan	Pg. 26 line m13	366,089	366,089
Trinity Health		<input type="radio"/>	<input checked="" type="radio"/>		Intercompany Receivable	Pg. 33 line A12	2,175,303	2,175,303
St. Francis Medical Group		<input type="radio"/>	<input checked="" type="radio"/>		Medical Director and Physician Services	Pg. 13 Line 8	78,459	78,459
St. Francis Hospital		<input type="radio"/>	<input checked="" type="radio"/>		Employment Physicals	Pg. 16 Line M13	9,608	9,608
		<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.

** 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 9/30/2021	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 were 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.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-6 Rev. 9/2002

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

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

Name of Facility		License No.		Report for Year Ended			Page	of
Saint Mary Home		680-C		9/30/2021			6	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	12/20/16	60 months	8,296	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"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?		<input type="radio"/> Yes		<input 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 9/30/2021	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 2 3 4	Address (No. & Street, City, State, Zip Code)
---	---

Services Provided by This Firm (*describe fully*)

1	\$
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 See attached 2 3 4 5	Telephone Number
--	------------------

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

Services Provided by This Firm (*describe fully*)

1	See attached	\$
2		\$
3		\$
4		\$
5		\$

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

⊕ Yes ⊖ No

Name of Legal Firm or Independent Attorney Address

Armer Arbitration Association	
Goldman Gruder & Woods LLC	200 Connecticut Ave. Norwalk, CT 06854-1940
West Hartford Probate Court	50 S Main St West Hartford, CT 06107-2485
Pullman & Comley LLC	850 Main St. Bridgeport, CT 06601-7006
Robinson & Cole	
Wiggin and Diana	265 Church St. New Haven, CT 06510
Varnum Riddering Schmidt Howlett LLP	39500 High Pointe Blvd Novi, MI 48375

Services Provided by This Firm

Arbitration Services
Collections & Probate Fees - Disallowed
Probate Fees - Application Services - Disallowed
Site Visits
Union Negotiations
Bed Restructure
Labor Negotiations

Telephone Number

Charge for Service Provided

1,605
75,074
250
8,437
22,849
101
23,024
131,339

Schedule of Resident Statistics

Name of Facility Saint Mary Home			License No. 680-C				Report for Year Ended 9/30/2021				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				
B. On last day of THIS report period	353	256		97					353	256		97
2. Number of Residents												
A. As of midnight of PREVIOUS report period	238	157		81	238	157		81				
B. As of midnight of THIS report period	221	134		87					221	134		87
3. Total Number of Days Care Provided During Period												
A. Medicare	10,952	10,952			7,714	7,714			3,238	3,238		
B. Medicaid (Conn.)	62,620	33,823		28,797	46,559	25,240		21,319	16,061	8,583		7,478
C. Medicaid (other states)												
D. Private Pay	6,317	5,316		1,001	4,553	3,815		738	1,764	1,501		263
E. State SSI for RCH												
F. Other (Specify)	2,825	2,825			2,316	2,316			509	509		
G. Total Care Days During Period (3A thru F)	82,714	52,916		29,798	61,142	39,085		22,057	21,572	13,831		7,741
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	34			34	34			34				
B. Other Bed Reserve Days	58	58			58	58						
5. Total Resident Days (3G + 4A + 4B)	82,806	52,974		29,832	61,234	39,143		22,091	21,572	13,831		7,741

Schedule of Resident Statistics (Cont'd)

Name of Facility Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2021	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No

If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-MR
No. of Residents	13	94	84	17		3		
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	Residential Care Home
		2,405	2,405	
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	44	44		
2. Restorative Treatments				
C. Other	24,047	24,047		
D. Total Physical Therapy Treatments	26,496	26,496		

8. Total Number of Speech Therapy Treatments	TOTAL	CCNH	RHNS	Residential Care Home
		63	63	
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	2	2		
2. Restorative Treatments				
C. Other	1,040	1,040		
D. Total Speech Therapy Treatments	1,105	1,105		

9. Total Number of Occupational Therapy Treatments	TOTAL	CCNH	RHNS	Residential Care Home
		4,549	4,549	
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	152	152		
2. Restorative Treatments				
C. Other	37,036	37,036		
D. Total Occupational Therapy Treatments	41,737	41,737		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		680-C	9/30/2021	10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No			
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)	156,256	1,758			27,379 308
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	213,423	8,243			37,396 1,444
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor	24,457	1,214			13,773 684
c. Dietary Workers	659,895	35,571			371,616 20,032
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers	396,141	22,192			71,876 4,027
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	42,030	1,297			22,842 705
b. Other Maintenance Workers	408,147	21,496			221,814 11,682
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	133,592	7,093			75,231 3,995
9. Barber and Beautician Services					
10. Protective Services	174,881	9,428			95,042 5,124
11. Accounting Services					
a. Head Accountant					
b. Other Accountants					
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	283,169	4,016			
b. RN					
1. Direct Care	1,730,437	41,186			51,776 1,780
2. Administrative**	528,097	9,873			
c. LPN					
1. Direct Care	1,883,514	60,215			
2. Administrative**	83,867	1,976			
d. Aides and Attendants	3,256,577	173,638			405,563 37,833
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	152,334	5,753			26,692 1,008
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	125,581	4,196			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	110,518	3,814			19,365 668
<i>A-13. Total Salary Expenditures</i>	10,362,916	412,959			1,440,365 89,290

* 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)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility Saint Mary Home			License No. 680-C		Report for Year Ended 9/30/2021			Page 11	of 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							
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.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

**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		9/30/2021			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***										
Brian Nyberg	129,206		22,640	56,539	Administrator	1,680	A2			
Rachel DeMaida	27,047		4,739	11,833	Administrator	400	A2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2021		Page 13	of 37
Item	Total Cost and Hours				
	CCNH	Hours	RHNS	Hours	Residential Care Home
*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	21,109	DISALLOW			
3. Pharmacist					
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	732,531	12,209			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	78,459	624			
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	54,495	908			
b. Other					
10. Occupational Therapist					
a. Resident Care	767,207	12,787			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care					
2. Administrative***					
b. LPN					
1. Direct Care					
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify)					
See Attached Schedule	89,366				
B-13 Total Fees Paid in Lieu of Salaries	1,743,167	26,528			

* 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*

* 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
		9/30/2021		15	37
Item		Total	CCNH	RHNS	Residential Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$				
2. Disability Insurance	\$	42,181	37,034		5,147
3. Unemployment Insurance	\$	283,132	248,581		34,551
4. Social Security (F.I.C.A.)	\$	886,048	777,923		108,125
5. Health Insurance	\$	505,627	443,925		61,702
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	228,711	200,801		27,910
8. Uniform Allowance	\$	21,530	18,903		2,627
9. Other (<i>Specify</i>) See Attached Schedule	\$	2,429,529	2,131,296		298,233
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$				
d. Accounting and Auditing	\$				
e. Legal (<i>Services should be fully described on Page 7</i>)	\$	131,339	111,757		19,582
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$	22,071	18,780		3,291
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	27,278	23,211		4,067
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	\$	672,121	672,121		
Subtotal		5,249,567	4,684,332		565,235

* 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**

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
Other Benefits	\$ 481,143		\$ 68,875
Union Education	\$ 57,152		\$ 7,944
Union Insurance 671	\$ 394,659		\$ 54,854
Union Insurance 1199	\$ 1,198,342		\$ 166,560
Total	\$ 2,131,296	\$ -	\$ 298,233

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 9/30/2021		Page 16	of 37
Item		Total	CCNH	RHNS	Residential Care Home
	<i>Subtotals Brought Forward:</i>	5,249,567	4,684,332		565,235
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	1,565	1,332		233
5. Education Expenses Related to Seminars and Conventions	\$	16,525	14,061		2,464
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	302	257		45
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	\$	580	493		87
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	\$	18,712	15,922		2,790
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	31,490	20,146		11,344
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>)	\$	7,747	6,592		1,155
12. Administrative Management Services**	\$	2,164,662	1,841,921		322,741
13. Other (<i>Specify</i>) See Attached Schedule	\$	(8,645,865)	(7,356,808)		(1,289,057)
C-14 Total Administrative & General Expenditures	\$	(1,154,715)	(771,752)		(382,963)

* 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
Holy Family Passionate Retreat - Sponsorship	\$ 213		\$ 37
Moscarillos Garden Shoppe - Advertising	\$ 102		\$ 18
PJ Kenedy & Sons - Advertising	\$ 191		\$ 34
Taylor Communications	\$ 35		\$ 6
Mercy Medical Center	\$ (65)		\$ (11)
Miscellaneous	\$ 17		\$ 3
Total Other Advertising	\$ 493	\$ -	\$ 87

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
Hartford Courant	\$ 146		\$ 82
Leading Age Iowa	\$ 19,978		\$ 11,250
Miscellaneous	\$ 22		\$ 12
Total Dues	\$ 20,146	\$ -	\$ 11,344

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Employee Discounts and Awards	\$ 4,382		\$ 768
Data Lines	\$ 6,513		\$ 1,141
Permits and Licences	\$ 5,001		\$ 876
Bank Fees - Disallowed	\$ 8,320		\$ 1,458
Non Reimbursable Expense - Disallowed	\$ 494		\$ 87
Fines and Penalties - Disallowed	\$ 553		\$ 97
Miscellaneous - Disallowed	\$ (7,488)		\$ (1,312)
PPE Asset Impairment - Disallowed	\$ (7,518,799)		\$ (1,317,442)
Purchased Services	\$ 14,591		\$ 2,557
Software Maintenance & Data Service	\$ 14,834		\$ 2,599
Patient Transportation Ambulance - Disallowed	\$ 1,494		\$ 262
Recruiting	\$ 38,425		\$ 6,733
Billing Fees	\$ 38,644		\$ 6,771
Purchase Discounts	\$ (110,340)		\$ (19,334)
Other Supplies	\$ 19,112		\$ 3,349
IC Insurance	\$ 28,696		\$ 5,028
IC Other Integrated and Professional Liability	\$ 91,449		\$ 16,024
Temp Labor Services	\$ 7,311		\$ 1,281
Total Other Administrative and General	\$ (7,356,808)	\$ -	\$ (1,289,057)

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Saint Mary Home	680-C	9/30/2021	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 #
Mercy Community Health	2,164,662	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	License No.	Report for Year Ended		Page of
	680-C	9/30/2021		18 37
Item	Total	CCNH	RHNS	Residential Care Home
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 702,608	449,484		253,124
2. Non-Food Supplies	\$ 65,429	41,857		23,572
3. Other (Specify) _____	\$ _____			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 603,886	386,328		217,558
c. Other (Specify) _____	\$ _____			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 1,371,923	877,669		494,254
2E. Dietary Questionnaire	Total	CCNH	RHNS	Residential Care Home
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No				
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 meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
K. Is any revenue collected 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)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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 9/30/2021		Page 19 37
Item	Total	CCNH	RHNS	Residential Care Home
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	126,106	80,675	45,431
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 (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (Specify)	\$			
3D. Total Laundry Expenditures (3a + b + c)	\$ 126,106	80,675		45,431
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

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

All allocations should add to total recorded in 3D.

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

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	9/30/2021		20	37
Item		Total	CCNH	RHNS	Residential Care Home
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 125,663	106,364		19,299
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
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.	\$ 35,458	30,013		5,445
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	161,121	136,377		24,744
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	430,769	430,769		
b. Medicine Cabinet Drugs	\$	7,106	7,106		
c. Medical and Therapeutic Supplies	\$	451,277	451,277		
d. Ambulance/Limousine***	\$	15,882	15,882		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	85,190	85,190		
f. X-rays and Related Radiological Procedures***	\$	22,673	22,673		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	64,168	64,168		
i. Recreation	\$				
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$				
5M. Total Resident Care Expenditures (5a - 5j)	\$	1,077,065	1,077,065		

* 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

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 9/30/2021				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
MJ Norton Security Inc.	Springfield, MA 01151-1326	<input type="radio"/>	<input checked="" type="radio"/>		Security	56,314		30,603	22	6F
Unidine Corporation	PO Box 360639, Pittsburg, PA 1154251	<input type="radio"/>	<input checked="" type="radio"/>		Dining Services	386,444		217,374	18	2b1
Sodexo, Inc.	PO Box 84019, Woburn, MA 01801	<input type="radio"/>	<input checked="" type="radio"/>		Janitoral Services	30,013		5,445	20	4b
Sodexo, Inc.	PO Box 84019, Woburn, MA 01801	<input type="radio"/>	<input checked="" type="radio"/>		Maintenance Services	235,349		127,900	22	6F
Quest Pest Control	PO Box 1512 Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Exterminating Services	20,214		10,986	22	6F
Plant Life	16 Seymour Rd. #9A, East Granby CT 06026	<input type="radio"/>	<input checked="" type="radio"/>		Lanscaping & Grounds	16,888		9,177	22	6F
Kone Inc	Floor Trumbull CT 06611	<input type="radio"/>	<input checked="" type="radio"/>		Elevator Maintenance	17,296		9,400	22	6F
Otis Mechanical LLC	87 Liberty Hill E., Weathersfield CT 06109	<input type="radio"/>	<input checked="" type="radio"/>		Heating and Cooling Maintenance	40,902		22,228	22	6F
All Waste Inc	PO Box 2472, Hartford, CT 06146	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal	35,822		19,467	22	6F
		<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"/>							

* 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 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	Residential Care Home	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	284,028	184,020			100,008
b. Heat	\$	157,857	102,274			55,583
c. Light & Power	\$	449,349	291,130			158,219
d. Water	\$	142,400	92,260			50,140
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	16,983	11,003			5,980
f. Other <i>(itemize)</i>	\$	856,670	555,030			301,640
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	1,907,287	1,235,717			671,570
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$	18,730	12,135			6,595
b. Building & Building Improvements	\$	(55,086)	(35,690)			(19,396)
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$	169,691	139,656			30,035
*7e. Total Depreciation Costs (7a + b + c + d)	\$	133,335	116,101			17,234
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	\$	138,157	89,511			48,646
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	271,492	205,612			65,880

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	Residential Care Home
Fuel Oil	\$ 2,698		\$ 1,466
Purchased Services	\$ 237,272		\$ 128,949
IC Occupancy	\$ 10,158		\$ 5,521
Temp Labor	\$ 56,028		\$ 30,449
Pest Control	\$ 20,214		\$ 10,986
Grounds	\$ 77,005		\$ 41,849
Other Utilites - TV Cable - Disallowed	\$ 64,769		\$ 35,200
Minor Equipment and Instruments - Disallowed	\$ 38,857		\$ 21,118
Waste Removal	\$ 48,029		\$ 26,102
Total Other Repairs and Maintenance	\$ 555,030	\$ -	\$ 301,640

Depreciation Schedule

Schedule of Land Improvements Acquired during this report period

*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:				
6/19/2020	Dishmachine Room Reno	\$ 148,272	144	\$ 12,356
5/20/2020	Chapel Fan	\$ 4,380	240	\$ 219
1/27/2021	Fire Doors	\$ 33,623	240	\$ 1,121
12/9/2020	Water Heater	\$ 5,531	120	\$ 461
11/9/2020	Flooring 182	\$ 2,100	120	\$ 193
1/21/2021	UTO 182	\$ 8,389	120	\$ 559
11/9/2020	Flooring 354	\$ 2,300	120	\$ 211
1/6/2021	UTO 354	\$ 8,229	120	\$ 549
1/6/2021	UTO 461	\$ 7,406	120	\$ 494
5/3/2021	Flooring 2 Flr/Common Halls	\$ 49,300	120	\$ 2,054
9/9/2019	Flooring 255 FWT	\$ 3,300	120	\$ 330
Total additions for Building Improvement:		\$ 272,830		\$ 18,546
Deletions:				
Total deletions for Building Improvement		\$ -		\$ -

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

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

				ttachment Pages 23 24
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

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

**Ties to Page 24, Line C2

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-23 Rev. 10/2006

Depreciation Schedule

D. Movable Equipment Attachment	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value
	Yes	No	Month	Year		
1. Motor Vehicles (Specify name, model and year of each vehicle)					236,329	
fully depreciated						
2015 Ford Truck F-350			11	2016	73,770	
2017 Ford Transit Shuttle Bus			9	2017	84,664	
2017 Ford F350			9	2017	68,092	
2018 Ford Transit Van			12	2017	47,131	
d. ATTACHED SCHEDULE TOTAL	X	0	var	var	509,986	

Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year
236,329	236,329	SL	various	0
73,770	71,465	SL	48	2,305
84,664	64,380	SL	48	20,284
68,092	51,778	SL	48	16,314
47,131	32,894	SL	48	11,783
509,986	456,846	SL	Various	50,686

*Self-Disallowed - Additional de

*Self-Disallowed - Additional de

preciation in excess of 28,000 to be disallowed.

preciation in excess of 28,000 to be disallowed.

Amortization Schedule*

Name of Facility Saint Mary Home			License No. 680-C		Report for Year Ended 9/30/2021			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:

- Minimum of 5 years or 60 months.
- Life of mortgage; OR
- Remaining Life of Lease; OR
- 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 9/30/2021	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility
or leased from a Related Party?

Yes

No

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

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

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity				
6. Square Footage	353			
7. Acquisition Cost				
a. Land	211,856			
b. Building				

Part B - Owner and Related Parties

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed	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 _____	7,691,834	1,893,450		

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	License No.	Report for Year Ended 9/30/2021			Page 26	of 37
Item		Total	CCNH	RHNS	Residential Care Home	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage		\$ 356945	231,262			125,683
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount		\$				
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$ 356,945	231,262			125,683

(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
		9/30/2021			27	37
Item			Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:			356,945	231,262		125,683
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$				
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$	356,945	231,262		125,683
14. Insurance						
a. Insurance on Property (buildings only)		\$	23,939	15,510		8,429
b. Insurance on Automobiles		\$	13,437	8,706		4,731
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$				
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$				
14d. Total Insurance Expenditures (14a + b + c)		\$	37,376	24,216		13,160
15. Total All Expenditures (A-13 thru C-14)		\$	17,701,048	15,202,924		2,498,124

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		680-C	9/30/2021	28 37	
			Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
<i>Page 10 - Salaries and Wages</i>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<i>Page 13 - Professional Fees</i>							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$	767,207	767,207	
7.			Other - See attached Schedule	\$	95,173	95,173	
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.			Accounting	\$			
10a.			Legal	\$	75,324	64,094	11,230
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	\$	11,377	9,681	1,696
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	M3	Unallowable Advertising *	\$	581	494	87
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$	(8,832,276)	(7,515,426)	(1,316,850)
<i>Page 18 - Dietary Expenditures</i>							
24.			Meals to employees, guests and others who are not residents	\$			
<i>Page 19 - Laundry Expenditures</i>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<i>Page 20 - Housekeeping Expenditures</i>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$	(7,882,614)	(6,578,777)		(1,303,837)

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	M13	Bank Service Fees	\$ 8,320		\$ 1,458
16	M13	Non Allowable Expense	\$ 494		\$ 87
16	M13	Miscellaneous	\$ (7,488)		\$ (1,312)
16	M13	Fines and Penalties	553		97
16	M13	Transportation	1494		262
16	M13	Asset Impairment	-7518799		-1317442
Total Other A&G Adjustments			\$ (7,515,426)	\$ -	\$ (1,316,850)

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

Name of Facility Saint Mary Home			License No. 680-C	Report for Year Ended 9/30/2021		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward	\$ (7,882,614)	(6,578,777)		(1,303,837)
			Page 20 - Resident Care Supplies***				
27.	20	5a2	Prescription Drugs	\$ 430,769	430,769		
28.	20	5d	Ambulance/Limousine	\$ 15,882	15,882		
29.	20	5f	X-rays, etc	\$ 22,673	22,673		
30.	20	5h	Laboratory	\$ 64,168	64,168		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 85,190	85,190		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$			
			Page 22 - Maintenance and Property				
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.	22	7d	Depreciation on Unallowable Motor Vehicles	\$ 14,088	11,552		2,536
37.	22	10c	Unallowable Property and Real Estate Taxes	\$ 138,157	89,511		48,646
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	\$ 160,307	103,868		56,439
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
			Not For Profit Providers Only				
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49.	Total Amount of Decrease (Items 1 - 48)		\$	(6,951,380)	(5,755,164)		(1,196,216)

*** 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

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

Total Unallowable Building Interest	\$ -	\$ -	\$ -
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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 30 37
Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 16,741,739	16,741,739			
b. Medicaid Room and Board Contractual Allowance **	\$ (7,368,833)	(7,368,833)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 5,892,531	5,892,531			
b. Medicare Room and Board Contractual Allowance **	\$ (1,869,219)	(1,869,219)			
4. a. Private-Pay Residents and Other	\$ 7,240,486	3,891,861			3,348,625
b. Private-Pay Room and Board Contractual Allowance **	\$ (819,100)	(812,921)			(6,179)
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 367,239	367,239			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (367,239)	(367,239)			
c. Prescription Drugs - Non-Medicare	\$ 24,417	24,417			
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	\$ 3,008,067	3,008,067			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (3,008,067)	(3,008,067)			
c. Physical Therapy - Non-Medicare	\$ 264,772	264,772			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 225,477	225,477			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (225,477)	(225,477)			
c. Speech Therapy - Non-Medicare	\$ 104,257	104,257			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 4,220,387	4,220,387			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (4,220,387)	(4,220,387)			
c. Occupational Therapy - Non-Medicare	\$ 416,849	416,849			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (<i>Specify</i>) - Medicare	\$				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 1,843,298	1,843,298			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 22,471,197	19,128,751			3,342,446
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 70	70			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$ (70)	(70)			
8. Other (<i>Specify</i>)	\$ 1,070,632	1,064,347			6,286
V. Total Other Revenue (1 thru 8)	\$ 1,070,632	1,064,347			6,286
VI. Total All Revenue (III +V)	\$ 23,541,829	20,193,098			3,348,732

* 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	Lab - Medicare	\$ 46,123		
30, II6a	Lab - Medicare C/A	\$ (46,123)		
30, II6a	X-Ray - Medicare	\$ 18,740		
30, II6a	X-Ray - Medicare C/A	\$ (18,740)		
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue**Related Exp**

Page Ref	Description	CCNH	RHNS	Residential Care Home
30, II6b	Lab Revenue	\$ 3,458		
30, II6b	X Ray Revenue	\$ 1,775		
30, II6b	Ancillary Contractual Allowances	\$ 1,838,065		
Total Other Resident Revenue		\$ 1,843,298	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	Residential Care Home
30, IV5	Interest Income Operations	\$ 70			
Total Interest Income		\$ 70	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
30, IV8	Restricted Net Assets Released	\$ 7,478		\$ 1,180
30, IV8	Provider Incentive	\$ 16,268		
30, IV8	State & Other Cares Act	\$ 348,968		
30, IV8	Federal CARES Act Awards	\$ 683,514		
30, IV8	Unrestricted Contributions	\$ 28,125		
30, IV8	Miscellaneous Revenue	\$ 13,109		\$ 5,105
30, IV8	IC Derivatives Cash Payment	\$ (33,115)		
Total Other Revenue		\$ 1,064,347	\$ -	\$ 6,286

G. Balance Sheet

Name of Facility Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2021	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$ 384,778	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 2,706,071	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$ 46,932	
4. Inventories			\$ 82,699	
5. Prepaid Expenses			\$ 34,047	
a. Prepaid Expense		34,047		
b. _____				
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$ 21,427	
Deposits		21,427		

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$ 3,275,954	
B. Fixed Assets				
1. Land			\$ 100,982	
2. Land Improvements	*Historical Cost	557,113	\$ 544,155	
	Accum. Depreciation	12,958	Net	
3. Buildings	*Historical Cost	29,088,331	\$ 9,017,934	
	Accum. Depreciation	20,070,397	Net	
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost		\$	
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	6,126,653	\$ 1,141,435	
	Accum. Depreciation	4,985,218	Net	
7. Motor Vehicles	*Historical Cost	509,987	\$ 2,455	
	Accum. Depreciation	507,532	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$ 660,864	
Construction in Progress		660,864		
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$ 11,467,825	

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref Line Ref Description

Total Prepaid Expenses		\$ -

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref Line Ref Description

Total Other Current Assets (Itemize)		\$ -

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref Line Ref Description

Total Other Other Fixed Assets (Itemize)		\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

Total Other Assets		\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref Line Ref Description

Total Notes Payable		\$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)		\$ -

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)		\$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
		9/30/2021	32 37
Account		Amount	
		Total Brought Forward:	\$ 14,743,779
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>)			\$ 6,057,466
LT Other Assets	39,350		
IC Other AR	6,018,116		
See Schedule			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 6,057,466
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 20,801,245

* 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 9/30/2021	Page 33	of 37
Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 4,602,837
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>)				\$ 1,462,472
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$
6. Accrued Payroll Taxes Payable				\$ 15,868
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>)				\$ 3,667,674
IC current portion of LT		186,342	Other Custodial Funds	346,604
AP vendor Infection Control		28,800	Other Accrued Liabilities	118
AP patient credit balance LTC		887,342	Older PY Medicare Paya	34,252
IC AP		2,184,216	See Schedule	
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 9,748,851

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

G. Balance Sheet (cont'd)

Name of Facility Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			9,748,851	
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>)			\$	9,409,442
IC LT Debt	9,409,442			
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	9,409,442
C. Total All Liabilities (Lines A-13 + B-5)			\$	19,158,293

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

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2021	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			\$	(4,465,527)
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ 5,843,479
7. Total Net Worth			\$	1,377,952
C. Total Reserves and Net Worth				\$ 1,642,952
D. Total Liabilities, Reserves, and Net Worth				\$ 20,801,245

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2021	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ 6,880,210
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 23,541,829
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 17,701,048
D. Net Income or Deficit				\$ 5,840,781
E. Balance				\$ 12,720,991
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 (No., City, State, Zip)	Title	Amount		
2. Other Withdrawings (<i>Specify</i>)				\$
Purpose	Amount			
3. Total Deductions				\$
H. Balance at End of Period				\$ 12,720,991

I. Preparer's/Reviewer's Certification

Name of Facility Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2021	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

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Haley Gregory		
Address		Phone Number
20555 Victor Parkway, Livonia MI 48152		734-343-6611
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Pamela Latovick		734-343-6628
Contact Email Address		
latovicp@trinity-health.org		