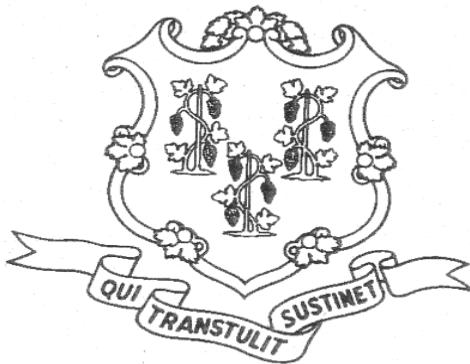


State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2021

Name of Facility (as licensed) Saint Joseph Living Center LLC	
Address (No. & Street, City, State, Zip Code) 14 Club Rd. Windham, CT 06280	
Type of Facility	
Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 20397	RHNS	(Specify)	Medicare Provider 07-5321
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Medicaid Provider Numbers:	CCNH	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 Joseph Living Center LLC	License No. 20397	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 Joseph Living Center LLC [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) Ginny Person		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 Joseph Living Center LLC	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 14 Club Rd. Windham, CT 06280				
Report Prepared By RKL LLP	Phone Number 717-394-5666	Date		
Item	Total	CCNH	RHNS	(Specify)
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	Report for Year Ended 9/30/2021	Page 2	of 37		
Name of Facility (as shown on license) Saint Joseph Living Center LLC	Address (No. & Street, City, State, Zip) 14 Club Rd. Windham, CT 06280					
License Numbers: Type of Facility (Check appropriate box(es))	CCNH 20397	RHNS	(Specify)	Medicare Provider No. 07-5321		
<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 type="checkbox"/> (Specify)						
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 Ginny Person <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Nursing Home Administrator's License No.:</td> <td style="width: 40%;">001882</td> </tr> </table>					Nursing Home Administrator's License No.:	001882
Nursing Home Administrator's License No.:	001882					
Other Operators/Owners who are assistant administrators (full or part time) of this facility.						
Name	License No.:					

General Information and Questionnaire Partners/Members

General Information and Questionnaire

Corporate Owners

Name of Facility Saint Joseph Living Center LLC	License No. 20397	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:

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3B Rev. 10/2005

**General Information and Questionnaire
Individual Proprietorship**

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2021	Page of 3B 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

N/A

General Information and Questionnaire

Related Parties*

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2021	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?	<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.
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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			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	%**				
Diocese of Norwich	201 Broadway, Norwich, CT 06360	<input type="radio"/>	<input checked="" type="radio"/>		Health Insurance	15/1a5	1,147,242	1,147,242
Diocese of Norwich	201 Broadway, Norwich, CT 06360	<input type="radio"/>	<input checked="" type="radio"/>		Auto Insurance	27/14b	4,033	4,033
Christian Brothers	1205 Windham Parkway, Romeoville, IL 60446	<input type="radio"/>	<input checked="" type="radio"/>		Pension	15/Ia7	153,920	153,920
See Attached List		<input type="radio"/>	<input checked="" type="radio"/>		Pastoral	13/B12	8,700	8,350
Diocese of Norwich	201 Broadway, Norwich, CT 06360	<input type="radio"/>	<input checked="" type="radio"/>		Advertising	16/M3	12,019	1,698
		<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.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Saint Joseph Living Center LLC	License No. 20397	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.

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.

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

○ No

Total ***

3,242

* 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 Joseph Living Center LLC	License No. 20397	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 Yes If "No," explain.
previous period? No

Independent Accounting Firm

Name of Accounting Firm 1 CliftonLarsonAllen LLP 2 RKL LLP 3 CJLC LLC 4	Address (No. & Street, City, State, Zip Code) 29 South Main St, West Hartford, CT 06127 1800 Fruitville Pike, Lancaster, PA 17601 225 Pitkin St, Suite 200, East Hartford, CT 06108
---	--

Services Provided by This Firm (*describe fully*)

1 Audited Financial Statements & Tax Form 990	\$ 9,568
2 Financial Consulting & Medicaid and Medicare Cost Reports	\$ 74,912
3 Medicaid and Medicare Cost Reports	\$ 6,500
4	\$
	Charge for Services Provided \$ 90,980

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

Yes No 15/1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Murtha Cullina LLP 2 Updike, Kelly & Spellacy, PC 3 Pulman & Comely LLC 4 Treasurer State of CT 5	Telephone Number 860-240-6000 860-548-2600 860-424-4300 860-702-3000
---	--

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

1 City Place 1 Asylum Street, Hartford, CT 06103
2 100 Pearl St, Hartford, CT 06103
3 90 State House Square, Hartford, CT 06103
4 55 Elm St #2, Hartford, CT 06106
5

Services Provided by This Firm (*describe fully*)

1 Review of correspondence, response preparation, telephone conferences, various	\$ 6,713
2 Modification of revenue bonds	\$ 6,150
3 Bond counsel in connection with loan modification	\$ 3,800
4 Resident matter	\$ 33
5	\$
	Charge for Services Provided \$ 16,696

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

Yes No 15/1e

Schedule of Resident Statistics

Name of Facility Saint Joseph Living Center LLC			License No. 20397			Report for Year Ended 9/30/2021				Page 8 of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					120	120						
A. On last day of PREVIOUS report period	120	120										
B. On last day of THIS report period	120	120							120	120		
2. Number of Residents					76	76						
A. As of midnight of PREVIOUS report period	76	76										
B. As of midnight of THIS report period	87	87							87	87		
3. Total Number of Days Care Provided During Period					1,345	1,345				483	483	
A. Medicare	1,828	1,828										
B. Medicaid (Conn.)	22,493	22,493			16,280	16,280			6,213	6,213		
C. Medicaid (other states)												
D. Private Pay	2,568	2,568			1,964	1,964			604	604		
E. State SSI for RCH												
F. Other (Specify) MA Plans & Contracts	1,822	1,822			1,225	1,225			597	597		
G. Total Care Days During Period (3A thru F)	28,711	28,711			20,814	20,814			7,897	7,897		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	29	29			21	21			8	8		
B. Other Bed Reserve Days	39	39			19	19			20	20		
5. Total Resident Days (3G + 4A + 4B)	28,779	28,779			20,854	20,854			7,925	7,925		

Schedule of Resident Statistics (Cont'd)

Name of Facility Saint Joseph Living Center LLC	License No. 20397	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	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)		
				(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.

1st change	Change in Resident Days			CCNH	RHNS	(Specify)
2nd change						
3rd change						
4th change						

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	6	74		7				
Per Diem Rate								
a. One bed rm.		266.01		455.00				
b. Two bed rms.		266.01		425.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	TOTAL	CCNH	RHNS	(Specify)
	753	753		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	2,546	2,546		
D. Total Physical Therapy Treatments	3,299	3,299		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	43	43	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	105	105	
D. Total Speech Therapy Treatments	148	148	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	733	733	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	3,499	3,499	
D. Total Occupational Therapy Treatments	4,232	4,232	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2021		10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No			
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	150,488	2,008			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	348,141	19,321			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor	73,219	2,080			
c. Dietary Workers	413,491	39,859			
6. Housekeeping Service					
a. Head Housekeeper	26,880	1,152			
b. Other Housekeeping Workers	228,274	17,183			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance					
b. Other Maintenance Workers	114,361	6,900			
8. Laundry Service					
a. Supervisor	25,001	1,066			
b. Other Laundry Workers	179,618	18,434			
9. Barber and Beautician Services					
10. Protective Services					
11. Accounting Services					
a. Head Accountant					
b. Other Accountants					
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	246,973	4,442			
b. RN					
1. Direct Care	982,070	51,904			
2. Administrative**	445,411	17,194			
c. LPN					
1. Direct Care	706,581	40,262			
2. Administrative**					
d. Aides and Attendants	1,667,891	178,941			
e. Physical Therapists	335,615	8,223			
f. Speech Therapists	42,066	884			
g. Occupational Therapists	224,750	7,664			
h. Recreation Workers	160,047	8,639			
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	117,586	3,939			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	39,350	2,933			
<i>A-13. Total Salary Expenditures</i>	6,527,813	433,028			

* 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 Joseph Living Center LLC				License No. 20397		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	(Specify)							
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 Joseph Living Center LLC				20397		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	(Specify)							
Section III - Administrators***										
Ginny Person	150,488			Standard	Responsible for daily operations of the facility	2,008	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	License No.	Report for Year Ended		Page	of
	20397	9/30/2021		13	37
	Total Cost and Hours				
Item	CCNH	Hours	RHNS	Hours	(Specify) 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	14,849	480			
2. Dentist	13,032	104			
3. Pharmacist	9,740	111			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	60,000	390			
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					
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	440	8			
2. Administrative***					
b. LPN					
1. Direct Care	56,281	1,020			
2. Administrative***					
c. Aides	24,492	894			
d. Other					
12. Other (Specify)					
See Attached Schedule	8,700	167			
B-13 Total Fees Paid in Lieu of Salaries	187,534	3,174			

* 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 Joseph Living Center LLC		License No. 20397	Report for Year Ended 9/30/2021		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Margaret B Higgins, 635 RT 197, Woodstock ,CT 06281	Dietician	<input type="radio"/>	<input checked="" type="radio"/>			
Julia Tabox, 11D Plumtree Drive, Norwich, CT 06360	Dietician	<input type="radio"/>	<input checked="" type="radio"/>			
HealthDrive Dental Group, 1 Prestige Dr, Meriden, CT 06450	Dentisit	<input type="radio"/>	<input checked="" type="radio"/>			
Omnicare Pharmacy Services, PO Box 715268, Columbus, OH 43271	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>			
Michael Kilgannon, MD, 60 Fieldstone Drive, Storrs, CT 06268	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Elizabeth Visone, APRN, 1 Enders Rd, Windsor, CT 06095	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
See List Attached to Page 4	Pastoral Care	<input checked="" type="radio"/>	<input type="radio"/>	Affiliate Organization		
Facility Compliance Services, 221 West Main St, Plantsville, CT 06479	Emergency Preparedness & Risk Assessment	<input type="radio"/>	<input checked="" type="radio"/>			
All American Healthcare Services, Inc, 484 Broad St, Suite 302, Newark, NJ 07102	Agency Nursing	<input type="radio"/>	<input checked="" type="radio"/>			
Genie Healthcare, Suite 100, Monroe, NJ 08831	Agency Nursing	<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"/>			
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		<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 Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2021	Page 15	of 37
Item		Total	CCNH	RHNS
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 223,948	223,948		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 39,442	39,442		
4. Social Security (F.I.C.A.)	\$ 431,844	431,844		
5. Health Insurance	\$ 1,147,242	1,147,242		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 153,920	153,920		
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 746	746		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 107,638	107,638		
d. Accounting and Auditing	\$ 90,980	90,980		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 16,696	16,696		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 27,732	27,732		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 20,703	20,703		
2. Cellular Phones	\$ 937	937		
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	\$ 536,409	536,409		
Subtotal	\$ 2,798,237	2,798,237		

* 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	(Specify)
Employee Physicals	\$ 746		
Total	\$ 746	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Total	\$ -	\$ -	\$ -

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

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2021		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		2,798,237	2,798,237		
I. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	724	724		
5. Education Expenses Related to Seminars and Conventions	\$	3,980	3,980		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	109	109		
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	25,702	25,702		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	12,019	12,019		
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	\$	3,282	3,282		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	11,170	11,170		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	200	200		
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>)	\$	66,669	66,669		
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$	39,941	39,941		
C-14 Total Administrative & General Expenditures	\$	2,962,033	2,962,033		

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Business Promotion	\$ 4,637		
Advertising	7,382		
Total Other Advertising	\$ 12,019	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM	\$ 170		
LeadingAge CT	11,000		
Total Dues	\$ 11,170	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Total Contributions	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
New Hire Expenses	\$ 6,099		
Employee Relations	17,328		
Professional Fees	2,700		
Breakroom Expense	2,794		
Licenses	3,529		
Miscellaneous Expense	208		
Service Charges - Bank	5,236		
Chapel Supplies	2,047		
Total Other Administrative and General	\$ 39,941	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2021	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

*** 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 Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2021		Page 18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 274,620	274,620		
2. Non-Food Supplies	\$ 45,155	45,155		
3. Other (Specify) _____	\$ _____			
b. Purchased Services (by contract other than through Management Services) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ _____			
c. Other (Specify) _____	\$ _____			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 319,775	319,775		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	3	3		
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" 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 Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2021		Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$				
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. \$	9,352	9,352		
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$				
c. Other (Specify) Laundry Supplies	\$	12,568	12,568		
3D. Total Laundry Expenditures (3a + b + c)	\$	21,920	21,920		
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 Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2021		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 35,529	35,529		
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt.	\$			
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	35,529	35,529		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	127,810	127,810		
b. Medicine Cabinet Drugs	\$	21,089	21,089		
c. Medical and Therapeutic Supplies	\$	200,970	200,970		
d. Ambulance/Limousine***	\$	2,349	2,349		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	23,223	23,223		
f. X-rays and Related Radiological Procedures***	\$	8,283	8,283		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	9,806	9,806		
i. Recreation	\$	12,742	12,742		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	91,444	91,444		
5M. Total Resident Care Expenditures (5a - 5j)	\$	497,716	497,716		

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Supplies - Patient Personal	\$ 118		
Physician Services Medicare	2,907		
COVID Vaccine Expenses	420		
Other - Nursing Admin Expense	375		
Supplies - PT	1,169		
Other - Management Fee	63,700		
Supplies - OT	1,407		
Purchased Services - ST	2,145		
Billable Non-Direct	225		
DME Rental	9,940		
IV Therapy Consultant	360		
IV Therapy Supplies	164		
IV Therapy Supplies Insurance	1,782		
IV Therapy Supplies Medicare	6,732		
Total Other Resident Care	\$ 91,444	\$ -	\$ -

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

Name of Facility Saint Joseph Living Center LLC				License No. 20397	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	(Specify)	Pg	Line
ADP	PO Box 8242875, Boston, MA 02284	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	44,436			16	m11
Conn Computer Service Inc	Box 35, Plantsville, CT 06479	<input type="radio"/>	<input checked="" type="radio"/>		Service Contracts	65,345			15/22	1g/6a
Hawthorne, Ryan	Mansfield Center, CT 06250	<input type="radio"/>	<input checked="" type="radio"/>		Grounds Maintenance	37,520			22	6f
Willimantic Waste Paper	PO Box 239, Willimantic, CT 06226	<input type="radio"/>	<input checked="" type="radio"/>		Trash Removal	35,616			22	6f
PAETEC	250 Constitution Plz, Hartford, CT 06103	<input type="radio"/>	<input checked="" type="radio"/>		Telephone	14,542			15	1h1
Healthpro Management Services	536 Old Howell Rd, Greenville, SC 29615	<input type="radio"/>	<input checked="" type="radio"/>		Rehab Department Software & Consulting	63,700			20	51
		<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"/>							

* 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 Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2021			Page 22 37
Item	Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 84,164	84,164			
b. Heat	\$ 53,622	53,622			
c. Light & Power	\$ 104,891	104,891			
d. Water	\$ 29,220	29,220			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 3,242	3,242			
f. Other (<i>itemize</i>)	\$ 196,501	196,501			
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 471,640	471,640			
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$ 4,576	4,576			
b. Building & Building Improvements	\$ 71,035	71,035			
c. Non-Movable Equipment	\$ 26,447	26,447			
d. Movable Equipment	\$ 64,108	64,108			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 166,166	166,166			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)					
a. Organization Expense	\$ 11,434	11,434			
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$				
d. Other (<i>Specify</i>)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$ 11,434	11,434			
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	\$ 8	8			
b. Real estate taxes paid by lessor	\$				
c. Personal property taxes	\$ 143	143			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 177,751	177,751			

* 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

Depreciation Schedule

Name of Facility Saint Joseph Living Center LLC				License No. 20397			Report for Year Ended 9/30/2021				Page 23	of 37
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
A. Land Improvements												
1. Acquired prior to this report period				163,049		163,049	125,058	SL	Various	4,576		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal											4,576	
B. Building and Building Improvements												
1. Acquired prior to this report period				8,004,673		8,004,673	11,598,334	SL	Various	70,819		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)				10,568		10,568				216		
B-4. Subtotal											71,035	
C. Non-Movable Equipment												
1. Acquired prior to this report period				747,349		747,349	606,809	SL	Various	26,015		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)				24,145		24,145				432		
C-4. Subtotal											26,447	
	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. Movable Equipment												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. Senator Bus	x		12	2001	44,405		44,405	44,405				
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					2,067,546		2,067,546	1,048,152			54,733	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					206,388						9,375	
D-3. Subtotal											64,108	
E. Total Depreciation											166,166	

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:				
6/9/2021	5 Fire Rated Resident Doors	\$ 8,908	5	\$ 198
7/28/2021	5 Doors Installed	1,660	5	\$ 18
Total additions for Building Improvements		\$ 10,568		\$ 216 *
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

***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:				
11/23/2020	Washer #2 Clogged Tubes	\$ 419	15	\$ 23
12/31/2020	C19 Labor For Laptops LR & JP Work From Home	688	3	172
1/19/2021	C 19 LT/Dock Stat/monitor/Keybrd BO & PR	2,635	3	586
1/19/2021	C 19 LT/Dock Stat/monitor/Keybrd BO & PR	2,635	3	586
6/10/2021	Deposit Srvr,PC,LT	105,134	5	7009
6/1/2021	0621 Monly Cntrct/ Tele Srvr Upgrade	5,552	5	370
6/22/2021	0621 PC, Wireless Upgrade	8,845	5	442
7/15/2021	Bal Of Tel/Svr Upgrade	57	5	2
7/27/2021	Tele Srvr Syst Upgrade	4,542	5	151
8/18/2021	0821 PC/LT Wireless Upgrade	172	5	3
8/26/2021	0821 PC/LT Wireless Upgrade	1,238	5	21
9/23/2021	Matrix AP Upgrade (portal Install DM)	104	5	0
9/27/2021	Tel Srv For Sys Upgrade	4,730	5	0
9/20/2021	Srvr/LT/PCWrls Upgrade	1,990	5	0
9/30/2021	Srvr/LT/PC/Wrls Upgrade	269	5	0
9/30/2021	Srvr/LT/PC/Wrls Upgrade	660	5	0
9/30/2021	Svr/PC/LT/Wrls Upgrade Bal Pay 2of2	66,525	5	0
6/25/2021	Tele System Upgrade/Server	193	5	10
Total additions for Movable Equipment				
		\$ 206,388		\$ 9,375 *
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 Joseph Living Center LLC			License No. 20397		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. Insurance Costs	6	2016	87 months	83,919	48,595	SL		11,434	
2.									
3.									
A-4. Subtotal									11,434
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									11,434

* 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 Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2021	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.	
<p>*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.</p>					
Description		Total			
1. Date Land Purchased		02/17/94			
2. Date Structure Completed		09/01/88			
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure		10/12/88			
5. Total Licensed Bed Capacity		120			
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building		6,458,157			
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)		Fixed			
b. Date Mortgage Obtained		06/15/16			
c. Interest Rate for the Cost Year		3.32%			
d. Term of Mortgage (number of years)		10			
e. Amount of Principal Borrowed		2,840,000			
f. Principal balance outstanding as of 9/30/21		2,429,000			
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 of 26 37
Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage		\$			
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		\$ 2,840,000			
2. Loan Origination Date		06/15/16			
3. Interest Rate %		3.32%			
4. Term		10			
5. CHEFA Interest Expense		\$ 38,752	38,752		
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$ 38,752	38,752		

(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 9/30/2021			Page of 27 37	
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:			38,752	38,752		
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						
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)			\$ 38,752	38,752		
14. Insurance						
a. Insurance on Property (buildings only)			\$ 199,703	199,703		
b. Insurance on Automobiles			\$ 4,033	4,033		
c. Insurance other than Property (as specified above)						
1. Umbrella (<i>Blanket Coverage</i>)			\$			
2. Fire and Extended Coverage			\$			
3. Other (Specify)			\$			
14d. Total Insurance Expenditures (14a + b + c)			\$ 203,736	203,736		
15. Total All Expenditures (A-13 thru C-14)			\$ 11,444,199	11,444,199		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of
Item No.	Page No.	Line No.		CCNH	RHNS	28 37
			Item Description	Total Amount of Decrease		
<i>Page 10 - Salaries and Wages</i>						
1.			Outpatient Service Costs	\$		
2.			Salaries not related to Resident Care	\$		
3.			Occupational Therapy	\$ 224,750	224,750	
4.			Other - See attached Schedule	\$		
<i>Page 13 - Professional Fees</i>						
5.			Resident Care Physicians **	\$		
6.			Occupational Therapy	\$		
7.			Other - See attached Schedule	\$		
<i>Pages 15 & 16 - Administrative and General</i>						
8.			Discriminatory Benefits	\$		
9.			Bad Debts	\$ 107,638	107,638	
10.			Accounting	\$		
10a.			Legal	\$ 3,199	3,199	
11.			Telephone	\$		
12.			Cellular Telephone	\$		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$		
14.			Gifts, flowers and coffee shops	\$		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$		
17.			Automobile Expense (e.g. personal use)	\$		
18.			Unallowable Advertising *	\$ 12,019	12,019	
19.			Income Tax / Corporate Business Tax	\$		
20.			Fund Raising / Contributions	\$		
21.			Unallowable Management Fees	\$		
22.			Barber and Beauty	\$		
23.			Other - See attached Schedule	\$ 21,874	21,874	
<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)			\$ 369,480	369,480		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Fees Adjustments			\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	8a	Dues to Chamber of Commerce	\$ 200		
30	IV8	Restricted Revenue	2,225		
30	IV8	Chapel-Restricted Revenue	512		
30	IV8	Rec-Restricted Revenue	1,210		
30	IV8	Eden-Restricted Revenue	191		
16	m3	Employee Relations	17,328		
16	m3	Miscellaneous Expense	208		
Total Other A&G Adjustments			\$ 21,874	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended		Page of
Item No.	Page No.	Line No.	20397	9/30/2021		29 37
Item Description			Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward			\$ 369,480	369,480		
Page 20 - Resident Care Supplies***						
27.			Prescription Drugs	\$ 127,810	127,810	
28.			Ambulance/Limousine	\$ 2,349	2,349	
29.			X-rays, etc	\$ 8,283	8,283	
30.			Laboratory	\$ 9,806	9,806	
31.			Medical Supplies	\$ 23,223	23,223	
32.			Oxygen (non emergency)	\$		
33.			Occupational Therapy	\$		
34.			Other - See Attached Schedule	\$ 26,724	26,724	
Page 22 - Maintenance and Property						
35.			Excess Movable Equipment Depreciation			
			See Attached Schedule	\$ 72	72	
36.			Depreciation on Unallowable Motor Vehicles	\$		
37.			Unallowable Property and Real Estate Taxes	\$		
38.			Rental of Building Space or Rooms	\$		
39.			Other - See Attached Schedule	\$		
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	\$		
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)			\$ 567,747	567,747		

*** 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	(Specify)
20	51	Supplies - Patient Personal	\$ 118		
20	51	Physician Services Medicare	2,907		
20	51	Supplies - PT	1,169		
20	51	Supplies - OT	1,407		
20	51	Purchased Services - ST	2,145		
20	51	DME Rental	9,940		
20	51	IV Therapy Consultant	360		
20	51	IV Therapy Supplies	164		
20	51	IV Therapy Supplies Insurance	1,782		
20	51	IV Therapy Supplies Medicare	6,732		
Total Other Ancillary Costs			\$ 26,724	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7b	Depreciation on Wire Runs To Basement/Chapel Camera 1/31/15	\$ 72		
Total Excess Movable Equipment Depreciation			\$ 72	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total 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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 30	of 37
		Item	Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)		\$ 9,393,445	9,393,445			
b. Medicaid Room and Board Contractual Allowance **		\$ (3,844,230)	(3,844,230)			
2. a. Medicaid (<i>All other states</i>)		\$				
b. Other States Room and Board Contractual Allowance **		\$				
3. a. Medicare Residents (<i>all inclusive</i>)		\$ 771,700	771,700			
b. Medicare Room and Board Contractual Allowance **		\$ 445,333	445,333			
4. a. Private-Pay Residents and Other		\$ 1,940,220	1,940,220			
b. Private-Pay Room and Board Contractual Allowance **		\$ 2,860	2,860			
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare		\$ 75,453	75,453			
b. Prescription Drugs - Medicare Contractual Allowance **		\$				
c. Prescription Drugs - Non-Medicare		\$ 59,857	59,857			
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		\$ 184,265	184,265			
b. Physical Therapy - Medicare Contractual Allowance **		\$				
c. Physical Therapy - Non-Medicare		\$ 228,325	228,325			
d. Physical Therapy - Non-Medicare Contractual Allowance **		\$				
4. a. Speech Therapy - Medicare		\$ 21,615	21,615			
b. Speech Therapy - Medicare Contractual Allowance **		\$				
c. Speech Therapy - Non-Medicare		\$ 32,330	32,330			
d. Speech Therapy - Non-Medicare Contractual Allowance **		\$				
5. a. Occupational Therapy - Medicare		\$ 168,400	168,400			
b. Occupational Therapy - Medicare Contractual Allowance **		\$				
c. Occupational Therapy - Non-Medicare		\$ 250,445	250,445			
d. Occupational Therapy - Non-Medicare Contractual Allowance **		\$				
6. a. Other (<i>Specify</i>) - Medicare		\$ (397,757)	(397,757)			
b. Other (<i>Specify</i>) - Non-Medicare		\$ (414,619)	(414,619)			
III. Total Resident Revenue (Section I. thru Section II.)		\$ 8,917,642	8,917,642			
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		\$ (20,262)	(20,262)			
5. Interest Income (<i>Specify</i>)		\$ 752	752			
6. Private Duty Nurses' Fees		\$				
7. Barber, Coffee, Beauty and Gift shops		\$				
8. Other (<i>Specify</i>)		\$ 2,075,409	2,075,409			
V. Total Other Revenue (1 thru 8)		\$ 2,055,899	2,055,899			
VI. Total All Revenue (III +V)		\$ 10,973,541	10,973,541			

* 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	(Specify)
30/II6a	Medicare A - IV Therapy	\$ 9,647		
30/II6a	Medicare A - X-Ray	5,775		
30/II6a	Medicare A - Physician Care	461		
30/II6a	Medicare A - Lab	9,919		
30/II6a	Medicare A - Contractual Adjustment	(404,948)		
30/II6a	Medicare B - Vaccines	2,223		
30/II6a	Medicare B - Contractual Adjustment	(20,850)		
30/II6a	Managed Care B - Lab	16		
Total Other Resident Revenue - Medicare		\$ (397,757)	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6b	Medicaid - Vaccines	\$ 79		
30/II6b	Medicaid - Contractual Adjustment	(7,849)		
30/II6b	Managed Care - IV Therapy	2,375		
30/II6b	Managed Care - X-Ray	15,662		
30/II6b	Managed Care - Physician Care	174		
30/II6b	Managed Care - Lab	3,548		
30/II6b	Managed Care - Contractual Adjustment	(331,988)		
30/II6b	Insurance - X-Ray	1,227		
30/II6b	Insurance - Lab	324		
30/II6b	Insurance - Contractual Adjustment	(16,124)		
30/II6b	Hospice - Contractual Adjustment	(5,020)		
30/II6b	Managed Care B - Vaccines	7,421		
30/II6b	Managed Care B - Contractual Adjustment	(84,439)		
30/II6b	Insurance Care B - Contractual Adjustment	(9)		
Total Other Resident Revenue		\$ (414,619)	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/IV5	Interest Income	\$ 752			
Total Interest Income		\$ 752	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30/IV8	Charitable Donations	\$ 16,350		
30/IV9	Miscellaneous Income	20,906		
30/IV10	Recovery of Bad Debt	1,397		
30/IV11	Small Balance Adjustments	(279)		
30/IV12	Discounts Earned	81,035		
30/IV13	Restricted Revenue	2,225		
30/IV14	End of Life Suite Restricted Revenue	490		
30/IV15	Chapel - Restricted Revenue	512		
30/IV16	Rec - Restricted Revenue	1,210		
30/IV17	Eden - Restricted Revenue	191		
30/IV18	HHS Cares Act Revenue	1,950,492		
30/IV19	AR Transfer/Suspense	880		
Total Other Revenue		\$ 2,075,409	\$ -	\$ -

G. Balance Sheet

Name of Facility Saint Joseph Living Center LLC	License No. 20397	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>)		\$ 3,538,207		
2. Resident Accounts Receivable (Less Allowance for Bad Debts)		\$ 1,032,024		
3. Other Accounts Receivable (Excluding Owners or Related Parties)		\$		
4. Inventories		\$ 120,076		
5. Prepaid Expenses		\$ 45,881		
a. _____				
b. _____				
c. _____				
d. See Schedule		45,881		
6. Interest Receivable		\$		
7. Medicare Final Settlement Receivable		\$		
8. Other Current Assets (<i>itemize</i>)		\$ 2,660		

See Schedule		2,660		
A-9. Total Current Assets (Lines A1 thru 8)		\$ 4,738,848		
B. Fixed Assets				
1. Land		\$ 1,220,000		
2. Land Improvements	*Historical Cost 163,049	\$ 33,415		
	Accum. Depreciation 129,634	Net		
3. Buildings	*Historical Cost 8,015,241	\$ (3,654,128)		
	Accum. Depreciation 11,669,369	Net		
4. Leasehold Improvements	*Historical Cost _____	\$		
	Accum. Depreciation _____	Net		
5. Non-Movable Equipment	*Historical Cost 771,494	\$ 138,238		
	Accum. Depreciation 633,256	Net		
6. Movable Equipment	*Historical Cost 2,273,934	\$ 1,161,674		
	Accum. Depreciation 1,112,260	Net		
7. Motor Vehicles	*Historical Cost 44,405	\$		
	Accum. Depreciation 44,405	Net		
8. Minor Equipment-Not Depreciable		\$		
9. Other Fixed Assets (<i>itemize</i>)		\$ 3,224,349		
See Schedule		3,224,349		
B-10. Total Fixed Assets (Lines B1 thru 9)		\$ 2,123,548		

* 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

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

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

Page Ref	Line Ref	Description	
31	B9	Book vs. Cost	\$ 3,224,349
Total Other Other Fixed Assets (Itemize)			\$ 3,224,349

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

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

Page Ref	Line Ref	Description	
33	A12	Due to Residents	\$ 92,785
33	A12	Accrued Expense Other	93,247
33	A12	Bonds Payable Non-Taxable - ST	93,000
33	A12	PPP Loan - SBA - ST	415,909
33	A12	W/H Life Insurance	(98)
33	A12	W/H Vision Insurance	710
33	A12	Accrued Provider Tax	147,350
33	A12	Garnishments	70
33	A12	Resident Refunds & Exchange	120,463
33	A12	Resident Trust	46,984
33	A12	Due to Residents	48,746
Total Other Current Liabilities (Itemize)			\$ 1,059,166

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

G. Balance Sheet (cont'd)

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2021	Page of 32 37
Account		Amount	
Total Brought Forward:		\$ 6,862,396	
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	83,919 60,029 Net	\$ 23,890
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>)		\$	
See Schedule			
D-8. Total Investments and Other Assets (Lines D1 thru 7)		\$ 23,890	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)		\$ 6,886,286	

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2021	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	335,661
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>)			\$	789,672
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	37,362
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>)			\$	6,724
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities (<i>itemize</i>)			\$	1,059,166
See Schedule			1,059,166	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	2,228,585

* 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 Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			2,228,585	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$ 2,336,000	
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>)			\$ 1,393,300	
See Schedule	1,393,300			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$ 3,729,300	
C. Total All Liabilities (Lines A-13 + B-5)			\$ 5,957,885	

G. Balance Sheet (cont'd)

Reserves and Net Worth

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2021	Page 35	of 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		\$		
6. Total Reserves		\$		
B. Net Worth				
1. Owner's Capital		\$		
2. Capital Stock		\$		
3. Paid-in Surplus		\$		
4. Treasury Stock		\$		
5. Cumulated Earnings		\$	1,425,059	
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ (496,658)
7. Total Net Worth			\$	928,401
C. Total Reserves and Net Worth			\$	928,401
D. Total Liabilities, Reserves, and Net Worth			\$	6,886,286

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Saint Joseph Living Center LLC	20397	9/30/2021	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ 1,425,059		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 10,947,541		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 11,444,199		
D. Net Income or Deficit				\$ (496,658)		
E. Balance				\$ 928,401		
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				\$ 928,401		

I. Preparer's/Reviewer's Certification

Name of Facility Saint Joseph Living Center LLC	License No. 20397	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 type="checkbox"/> (Specify)		

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 See Attached Compilation Report	Title	Date Signed
Printed Name of Preparer RKL LLP		
Address Address 1800 Fruitville Pike, Lancaster, PA 17601		Phone Number 717-394-5666
Contacted Person Regarding Additional Information Needed Regarding This Report Nick Hoefel		Phone Number 717-394-5666
Contact Email Address nhoefel@rklcpa.com		