

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) HBR Trumbull, LLC -d/b/a: St. Joseph's Manor	
Address (No. & Street, City, State, Zip Code) 6448 Main Street, Trumbull, CT 06611	
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 type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

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

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

General Information

Name of Facility (as licensed) HBR Trumbull, LLC -d/b/a: St. Joseph's Manor	License No. 2321-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 HBR Trumbull, LLC -d/b/a: St. Joseph's Manor [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) Byron, Helen			Printed Name (Owner) Diane Morris - VP Reimbursement	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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State of Connecticut
Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment				Page 1A	of 37
Name of Facility HBR Trumbull, LLC -d/b/a: St. Joseph's Manor	Period Covered:		From 10/1/2020	To 9/30/2021	
Address of Facility 6448 Main Street, Trumbull, CT 06611					
Report Prepared By Rick Fink	Phone Number 410-494-7657		Date 12/28/2021		
Item	Total	CCNH	RHNS	(Specify)	
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$	7,044,252	7,032,706	11,546	
5. All other wages paid	\$	1,499,402	1,394,444	104,958	
6. Total Wages Paid	\$	8,543,654	8,427,150	116,504	
7. Total salaries paid	\$	488,890	477,889	11,001	
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	9,032,544	8,905,039	127,505	

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

	Phone No. of Facility 203-268-6204	Report for Year Ended 9/30/2021	Page 2
Name of Facility (as shown on license) HBR Trumbull, LLC -d/b/a: St. Joseph's Manor		Address (No. & Street, City, State, Zip) 6448 Main Street, Trumbull, CT 06611	
License Numbers:	CCNH 2321-C	RHNS	(Specify)
Medicare Provider No. 07-5001			
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes <input checked="" type="radio"/> No	If "Yes," explain fully.
Administrator			
Name of Administrator Byron, Helen		Nursing Home Administrator's License No.:	1605
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name		License No.:	

General Information and Questionnaire Partners/Members

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**General Information and Questionnaire
Corporate Owners**

Name of Facility HBR Trumbull, LLC -d/b/a: St. Joseph's Manor	License No. 2321-C	Report for Year Ended 9/30/2021	Page of 3A 37
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation HBR Trumbull, LLC -d/b/a: St. Joseph's Manor	Business Address 101 East State Street, Kennett Square, PA 19348	State(s) in Which Incorporated DE
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Name of Directors, Officers See Attached	Business Address	Title	No. Shares Held by Each

Names of Stockholders Owning at Least 10% of Shares See Attached			

General Information and Questionnaire

Individual Proprietorship

Name of Facility HBR Trumbull, LLC -d/b/a: St. Joseph's Manor	License No. 2321-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:

Owner(s) of Facility

General Information and Questionnaire

Related Parties*

Name of Facility HBR Trumbull, LLC -d/b/a: St. Joseph's Manor	License No. 2321-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
Genesis Administrative Services LLC	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	1,225,208	1,225,208
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	730,691	730,691
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input type="radio"/>	<input checked="" type="radio"/>		Staffing Pool	Pg 10/A12, p15-1		
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Medical Director /NP	Pg 13/B8, Pg 10/A12		
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Outside Agency	Pg 13/B11 pg 10-12, 1		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>		Respiratory Therapy	Pg 13/B12, Pg 20/C5E	6,386	6,386
Genesis Healthcare Ins Program	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	534,192	534,192
		<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 HBR Trumbull, LLC -d/b/a: St. Joseph's Manor	License No. 2321-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.

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 ***

* 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 HBR Trumbull, LLC -d/b/a: St. Jos	License No. 2321-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 KPMG Peat Marwick 2 3 4	Address (No. & Street, City, State, Zip Code) 1600 Market Street, Philadelphia, PA 19103
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Services Provided by This Firm (*describe fully*)

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

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

Yes No Included in Management Fee pg. 16 m-12

Legal Services Information

Name of Legal Firm or Independent Attorney 1 2 3 4 5	Telephone Number
---	------------------

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

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$

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

Are These Charges Reflected in the Expenditure Portion of This Report? Legal Fees pg. 15 1-e

Schedule of Resident Statistics

Name of Facility HBR Trumbull, LLC -d/b/a: St. Joseph's Manor			License No. 2321-C				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												
A. On last day of PREVIOUS report period	292	269		23	292	269		23				
B. On last day of THIS report period	292	269		23					292	269		23
2. Number of Residents												
A. As of midnight of PREVIOUS report period	189	176		13	189	176		13				
B. As of midnight of THIS report period	186	171		15					186	171		15
3. Total Number of Days Care Provided During Period												
A. Medicare	2,451	2,451			2,024	2,024			427	427		
B. Medicaid (Conn.)	53,353	53,353			40,297	40,297			13,056	13,056		
C. Medicaid (other states)												
D. Private Pay	4,129	4,037		92	3,053	3,053			1,076	984		92
E. State SSI for RCH	4,801			4,801	3,579			3,579	1,222			1,222
F. Other (Specify)	3,322	3,322			2,595	2,595			727	727		
G. Total Care Days During Period (3A thru F)	68,056	63,163		4,893	51,548	47,969		3,579	16,508	15,194		1,314
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	108			108	63			63	45			45
B. Other Bed Reserve Days	45	45			20	20			25	25		
5. Total Resident Days (3G + 4A + 4B)	68,209	63,208		5,001	51,631	47,989		3,642	16,578	15,219		1,359

Schedule of Resident Statistics (Cont'd)

Name of Facility HBR Trumbull, LLC -d/b/a: St. Joseph's Mand	License No. 2321-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	(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)
	CCNH	RHNS	(Specify)	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	7	141		23			15	
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	691.07	280.46		579.97			94.00	
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

TOTAL CCNH RHNS (Specify)

A. Medicare - Part B	2,660	2,660	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	1,875	1,875	
C. Other			
D. Total Physical Therapy Treatments	4,535	4,535	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	471	471	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	246	246	
C. Other			
D. Total Speech Therapy Treatments	717	717	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	4,505	4,505	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	1,912	1,912	
C. Other			
D. Total Occupational Therapy Treatments	6,417	6,417	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		2321-C	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)
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	143,647	1,860			10,812 140
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	2,504	74			188 6
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	457,103	19,336			34,406 1,455
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor					
c. Dietary Workers					
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers					
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	132,253	3,582			9,955 270
b. Other Maintenance Workers	257,325	12,094			19,369 910
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers					
9. Barber and Beautician Services					
10. Protective Services					
11. Accounting Services					
a. Head Accountant					
b. Other Accountants					
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	331,739	5,662			
b. RN					
1. Direct Care	903,194	22,058	RN		
2. Administrative**	186,452	4,127	NUMD		
c. LPN					
1. Direct Care	2,645,183	82,658	LPN		
2. Administrative**			NLN1		
d. Aides and Attendants	3,144,483	161,383	PCA		
e. Physical Therapists			ACN1		
f. Speech Therapists			CNA		
g. Occupational Therapists					
h. Recreation Workers	288,015	14,415			21,679 1,085
i. Physicians					
1. Medical Director					
2. Utilization Review					
3. Resident Care***					
j. Dentists					
k. Pharmacists					
l. Podiatrists					
m. Social Workers/Case Management	259,746	8,316			19,551 626
n. Marketing					
o. Other (Specify) See Attached Schedule	153,394	7,892			11,546 594
A-13. Total Salary Expenditures	8,905,040	343,457			127,505 5,086

* 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)

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

Name of Facility HBR Trumbull, LLC -d/b/a: St. Joseph's Manor			License No. 2321-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	(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.

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**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
HBR Trumbull, LLC -d/b/a: St. Joseph's Manor				2321-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	(Specify)							
Section III - Administrators***										
Byron,Helen	143,647		10,812		Management of Center	2,000	2			
Section IV - Assistant Administrators										
Beard,Nicole Elizabeth	2,504		188		Assists in overseeing facility operations	80	3			

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended		Page	of
	2321-C	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					
2. Dentist	26,236				
3. Pharmacist	23,677	592			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	621,596	10,360			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	53,818	192			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**					
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
9. Speech Therapist					
a. Resident Care	54,344	1,025			
b. Other					
10. Occupational Therapist					
a. Resident Care	156,508	2,898			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	23,572	410			
2. Administrative***					
b. LPN					
1. Direct Care	9,413	207			
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify)					
See Attached Schedule	383,002				
B-13 Total Fees Paid in Lieu of Salaries	1,352,166	15,685			

* 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	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	516,757	511,589		5,168
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	88,684	87,797		887
4. Social Security (F.I.C.A.)	\$	662,025	655,405		6,620
5. Health Insurance	\$	1,066,757	1,056,089		10,668
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	638,978	632,588		6,390
8. Uniform Allowance	\$				
9. Other (Specify) See Attached Schedule	\$	59,723	59,126		597
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$	(161,544)	(150,236)		(11,308)
d. Accounting and Auditing	\$				
e. Legal (Services should be fully described on Page 7)	\$				
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$	23,438	21,797		1,641
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	25,325	23,552		1,773
2. Cellular Phones	\$	3,909	3,635		274
i. Appraisal (Specify purpose and attach copy)*	\$				
j. Corporation Business Taxes (franchise tax)	\$				
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$				
2. Other (Specify) See Attached Schedule	\$	717	667		50
3. Resident Day User Fee	\$	937,826	937,826		
Subtotal	\$	3,862,595	3,839,835		22,760

* 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

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
1020640110 Sales Tax	\$ 667	\$ -	\$ 50
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
Total	\$ 667	\$ -	\$ 50

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2021		16	37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		3,862,595	3,839,835		22,760
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	1,479	1,375		104
5. Education Expenses Related to Seminars and Conventions	\$				
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	282	262		20
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	15,295	14,225		1,071
4. Fund-Raising***	\$				
5. Medical Records	\$	598	556		42
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	10,379	9,652		727
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	20,345	18,921		1,424
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	125	116		9
10. Contributions*** See Attached Schedule	\$	1,632	1,517		114
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	7,904	7,351		553
12. Administrative Management Services**	\$	1,547,121	1,438,823		108,298
13. Other (<i>Specify</i>) See Attached Schedule	\$	85,779	79,774		6,005
<i>C-14 Total Administrative & General Expenditures</i>	\$	5,553,534	5,412,407		141,127

* 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)
1020630020 Advertising	\$ 7,179	\$ -	\$ 540
1020630330 Marketing Expense	\$ 3,991	\$ -	\$ 300
3165630330 Marketing Expense	\$ -	\$ -	\$ -
1020630331 Marketing Exp- Corporate Spend	\$ 3,055	\$ -	\$ 230
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
Total Other Advertising	\$ 14,225	\$ -	\$ 1,071

Schedule of Dues

Description	CCNH	RHNS	(Specify)
1020630310 Licenses and Certification fee	\$ 18,921	\$ -	\$ 1,424
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
Total Dues	\$ 18,921	\$ -	\$ 1,424

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
1020630135 Political Contributions	\$ 1,517	\$ -	\$ 114
1020630130 Contributions	\$ -	\$ -	\$ -
Total Contributions	\$ 1,517	\$ -	\$ 114

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
0 0	\$ -	\$ -	\$ -
1020630060 Bank Service Charges	\$ 6,329	\$ -	\$ 476
1020630120 Collection Fees	\$ 33,018	\$ -	\$ 2,485
1020630140 Education Expense	\$ -	\$ -	\$ -
1020630180 Employee Physicals	\$ 13,161	\$ -	\$ 991
1020630200 Employee Relations	\$ 8,840	\$ -	\$ 665
1020630380 Printing	\$ 429	\$ -	\$ 32
1020630610 Training Expense	\$ 181	\$ -	\$ 14
1020630640 Uniforms	\$ -	\$ -	\$ -
1020640080 Fines & Penalties	\$ 5,580	\$ -	\$ 420
1020640090 Miscellaneous	\$ 1,914	\$ -	\$ 144
1020660080 Rental Expense	\$ 198	\$ -	\$ 15
1020660990 Accrued Expense Estimation	\$ 1,959	\$ -	\$ 147
1020720070 State Tax Annual Report Filing	\$ 353	\$ -	\$ 27
5095720090 Landlord Operating Taxes	\$ -	\$ -	\$ -
7010800030 Non-recurring Charges	\$ -	\$ -	\$ -
7010730010 Interest Expense	\$ 7	\$ -	\$ 1
3080630441 Foreign Recruitment Cost	\$ 3,453	\$ -	\$ 260
3080630440 Recruiting Fees	\$ 642	\$ -	\$ 48
1020640060 Equipment Non-Capitalized	\$ 3,709	\$ -	\$ 279
Total Other Administrative and General	\$ 79,774	\$ -	\$ 6,005

Schedule C-1 - Management Services*

Name of Facility HBR Trumbull, LLC -d/b/a: St. Joseph's N	License No. 2321-C	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 #
Genesis Administrative Services LLC, 101 East St., Kennett Square, PA 19348	1,225,208	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12

*** 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
	2321-C	9/30/2021		18	37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$ 353,760	328,997			24,763
2. Non-Food Supplies	\$ 66,312	61,670			4,642
3. Other (Specify) _____	\$ (5,695)	(5,296)			(399)
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 1,824,365	1,696,659			127,706
c. Other (Specify) _____	\$				
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 2,238,742	2,082,030			156,712
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)	
F. Resident Meals: Total no. of meals served per day:*					
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 HBR Trumbull, LLC -d/b/a: St. Joseph's Manor	License No. 2321-C	Report for Year Ended 9/30/2021		Page of 19 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	14,171	13,179	992
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. \$	11,367	10,571	796
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	535,991	498,472	37,519
c. Other (Specify)	\$			
3D. Total Laundry Expenditures (3a + b + c)	\$	561,529	522,222	39,307
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
		9/30/2021		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 22,008	20,467		1,541
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.	\$ 814,837	757,798		57,039
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	836,845	778,265		58,580
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	186,810	186,810		
b. Medicine Cabinet Drugs	\$	44,661	44,661		
c. Medical and Therapeutic Supplies	\$	256,742	256,742		
d. Ambulance/Limousine***	\$	1,713	1,713		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	10,643	10,643		
f. X-rays and Related Radiological Procedures***	\$	14,329	14,329		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	85,738	85,738		
i. Recreation	\$	45,986	42,767		3,219
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	133,802	124,436		9,366
5M. Total Resident Care Expenditures (5a - 5j)	\$	780,424	767,839		12,585

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
3060610160 Incontinency	\$ 91,196	\$ -	\$ 6,864
3080630030 Advertising-Help Wanted	\$ 4,495	\$ -	\$ 338
3080630140 Education Expense	\$ 222	\$ -	\$ 17
3165630340 Meetings & Seminars	\$ -	\$ -	\$ -
3120630530 Supplies	\$ 669	\$ -	\$ 50
3155630530 Supplies	\$ 10,323	\$ -	\$ 777
3165630530 Supplies	\$ (17)	\$ -	\$ (1)
3090630535 Office Supplies	\$ -	\$ -	\$ -
3120630535 Office Supplies	\$ -	\$ -	\$ -
3170630530 Supplies	\$ -	\$ -	\$ -
3120660080 Rental Expense	\$ -	\$ -	\$ -
3155660080 Rental Expense	\$ 3,392	\$ -	\$ 255
3010610300 Consolidated Billing	\$ 14,213	\$ -	\$ 1,070
3080630080 Books, Dues & Subscriptions	\$ -	\$ -	\$ -
3080630630 Tuition Reimbursement	\$ -	\$ -	\$ -
3165630535 Office Supplies	\$ 246	\$ -	\$ 19
3080630310 Licenses & Certifications	\$ -	\$ -	\$ -
3060610161 Incontinency - Rebates	\$ (497)	\$ -	\$ (37)
3225630630 Tuition Reimbursement	\$ -	\$ -	\$ -
3165630550 T&E-Lodging/Transportation	\$ 193	\$ -	\$ 15
3080630550 T&E-Lodging/Transportation	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
Total Other Resident Care	\$ 124,436	\$ -	\$ 9,366

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

* 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 HBR Trumbull, LLC -d/b/a: St. Joseph's Mand	License No. 2321-C	Report for Year Ended 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	514,322	478,319			36,003
b. Heat	\$	224,971	209,223			15,748
c. Light & Power	\$	283,540	263,692			19,848
d. Water	\$	476,912	443,528			33,384
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$					
f. Other <i>(itemize)</i>	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	1,499,745	1,394,762			104,983
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$	86	80			6
b. Building & Building Improvements	\$	48,569	45,169			3,400
c. Non-Movable Equipment	\$	289,375	269,119			20,256
d. Movable Equipment	\$	37,560	34,931			2,629
*7e. Total Depreciation Costs (7a + b + c + d)	\$	375,590	349,299			26,291
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	\$	875,440	814,159			61,281
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	231,322	215,129			16,193
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	1,482,352	1,378,587			103,765

* 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	(Specify)
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
Total Other Repairs and Maintenance	\$ -	\$ -	\$ -

Depreciation Schedule

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
5/31/2021	Tree and Stump Removal for planting of n	\$ 1,170	07 07	\$ 51
5/31/2021	Weeping Cherry Tree	\$ 798	07 07	\$ 35
Total additions for Land Improvement		\$ 1,967		\$ 86 *
Deletions:				
			-	
Total deletions for Land Improvement		\$ -		\$ - **

*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:				
2/28/2021	New Nurse Call System - 50% Deposit	\$ 36,147	07 10	\$ 2,692
5/31/2021	Memory Care Unit Space Design Development Cost	\$ 1,812	07 07	\$ 80
6/30/2021	New Nurse Call System - Final Pmt	\$ 36,147	07 06	\$ 1,205
6/30/2021	New Feed, Breaker, Disconnect, & Wiring for new dishwasher	\$ 2,670	07 06	\$ 89
9/30/2021	New 400A Panel installation	\$ 18,611	07 03	\$ -
8/31/2021	Lock Out Key Switch for Elevator	\$ 11,985	00 01	\$ 11,985
4/30/2021	Johnsonite Rubber Radial Flooring Tile	\$ 574	07 08	\$ 31
5/31/2021	New Flooring for Fireside Lounge	\$ 4,117	07 07	\$ 181
5/31/2021	Johnsonite inflection mill work base for Fireside Lounge	\$ 2,361	07 07	\$ 104
7/31/2021	New Mag Lock System for 2nd Floor - 50% Deposit	\$ 8,536	00 01	\$ 8,536
Total additions for Building Improvement		\$ 122,962		\$ 24,902
Deletions:				
9/30/2020	September 2020 Accrual	\$ (691)		
Total deletions for Building Improvement		\$ (691)		\$ -

*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**

Amortization Schedule*

Name of Facility HBR Trumbull, LLC -d/b/a: St. Joseph's Manor			License No. 2321-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 HBR Trumbull, LLC -d/b/a: St. Joseph	License No. 2321-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	292			
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				

Part B - Owner and Related Parties

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				

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
GMF-CT	Facility Lease	7/1/2019-12/31	10 years	875,440
650 Madison Avenue New York, NY 10022				

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	(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. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$				

(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 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
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)		\$				
14. Insurance						
a. Insurance on Property (buildings only)		\$ 48,636	45,231			3,405
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$ 485,556	451,567			33,989
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$				
14d. Total Insurance Expenditures (14a + b + c)		\$ 534,192	496,798			37,394
15. Total All Expenditures (A-13 thru C-14)		\$ 23,872,073	23,090,116			781,958

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		2321-C	9/30/2021	28 37	
			Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<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	\$ 19,559	18,190		1,369
<i>Page 13 - Professional Fees</i>							
5.	13	8-c	Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 844,623	844,623		
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ (161,544)	(150,236)		(11,308)
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m-2	Unallowable Advertising *	\$ 15,295	14,225		1,071
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 1,632	1,517		114
21.			Unallowable Management Fees	\$ 321,913	299,379		22,533
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 276,001	274,110		1,891
<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)			\$ 1,317,478	1,301,808			15,670

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	2	Administrator's salary disallowed	\$ 18,190	\$ -	\$ 1,369
Total Other Salaries Adjustment			\$ 18,190	\$ -	\$ 1,369

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	\$ 170,950	\$ -	\$ -
13	5	Rehabilitation Services	\$ 450,646	\$ -	\$ -
13	9	Speech Therapist	\$ 54,344	\$ -	\$ -
13	10	Occupational Therapist	\$ 156,508	\$ -	\$ -
13	12	Other	\$ 2,600	\$ -	\$ -
13	12	Other	\$ 3,094	\$ -	\$ -
13	12	Respiratory Purchased Services	\$ 6,480	\$ -	\$ -
Total Other Fees Adjustments			\$ 844,623	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-8a	1020630310	\$ -	\$ -	\$ -
16	m-13	1020630120	\$ 33,018	\$ -	\$ 2,485
16	m-13	1020660990	\$ 1,959	\$ -	\$ 147
16	m-13	7010800030	\$ -	\$ -	\$ -
16	m-13	1020640080	\$ 5,580	\$ -	\$ 420
0	0		0	\$ -	\$ -
15	1a3		0	\$ -	\$ -
15	1a4		0	\$ -	\$ -
15	1-a-1	adj workers comp	\$ (115,044)	\$ -	\$ (1,162)
13	B12	adj to SNAP Strike Cost (disallowable)	\$ 348,597	\$ -	\$ -
Total Other A&G Adjustments			\$ 274,110	\$ -	\$ 1,891

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

Name of Facility			License No.	Report for Year Ended		Page of	
HBR Trumbull, LLC -d/b/a: St. Joseph's Manor			2321-C	9/30/2021		29 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 1,317,478	1,301,808		15,670
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs	\$ 186,810	186,810		
28.	20	5-d	Ambulance/Limousine	\$ 1,713	1,713		
29.	20	5-f	X-rays, etc	\$ 14,329	14,329		
30.	20	5-h	Laboratory	\$ 85,738	85,738		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 10,643	10,643		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 30,030	30,030		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation				
			See Attached Schedule	\$ (27,634)	(27,634)		
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	\$ 433,376	403,040		30,336
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$ 34,822	32,384		2,438
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 22,080	22,080		
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)				\$ 2,109,384	2,060,940		48,444

*** 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	5-j	Consolidated Billing	\$ 15,283	\$ -	\$ -
20	5-j	Respiratory Supplies	\$ 11,100	\$ -	\$ -
20	5-j	Respiratory Rental	\$ 3,647	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
Total Other Ancillary Costs			\$ 30,030	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Page 22	7a	Land Imp	\$ (21,599)	\$ -	\$ -
Page 22	7b	Bldg Imp	\$ (170,686)	\$ -	\$ -
Page 22	7c	Non Movable Equip	\$ 208,766	\$ -	\$ -
Page 22	7d	Movable Equip	\$ (44,115)	\$ -	\$ -
0	0		0	\$ -	\$ -
Total Excess Movable Equipment Depreciation			\$ (27,634)	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 c1	General liability Insurance Adjust	\$ 403,040	\$ -	\$ 30,336
Total Other Property Adjustments			\$ 403,040	\$ -	\$ 30,336

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6b		0	\$ -	\$ -
22	6c		0	\$ -	\$ -
22	6d		0	\$ -	\$ -
22	6a	Teresian Towers Misc Revenue - Maint Dept	\$ 7,891	\$ -	\$ -
22	6b	Teresian Towers Misc Revenue- Electricity revenue	\$ 14,189	\$ -	\$ -
Total Other Adjustments			\$ 22,080	\$ -	\$ -

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>)		\$ (29,645,039)	(28,459,237)			(1,185,802)
b. Medicaid Room and Board Contractual Allowance **		\$ 14,236,532	13,667,071			569,461
2. a. Medicaid (<i>All other states</i>)		\$				
b. Other States Room and Board Contractual Allowance **		\$				
3. a. Medicare Residents (<i>all inclusive</i>)		\$ (1,353,225)	(1,353,225)			
b. Medicare Room and Board Contractual Allowance **		\$ 221,402	221,402			
4. a. Private-Pay Residents and Other		\$ (4,247,066)	(4,247,066)			
b. Private-Pay Room and Board Contractual Allowance **		\$ 807,789	807,789			
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare		\$ (78,787)	(78,787)			
b. Prescription Drugs - Medicare Contractual Allowance **		\$ 12,890	12,890			
c. Prescription Drugs - Non-Medicare		\$ (132,521)	(123,245)			(9,276)
d. Prescription Drugs - Non-Medicare Contractual Allowance **		\$ 29,038	27,005			2,033
2. a. Medical Supplies - Medicare		\$ (320)	(320)			
b. Medical Supplies - Medicare Contractual Allowance **		\$ 52	52			
c. Medical Supplies - Non-Medicare		\$ (626)	(582)			(44)
d. Medical Supplies - Non-Medicare Contractual Allowance **		\$ 301	280			21
3. a. Physical Therapy - Medicare		\$ (324,880)	(324,880)			
b. Physical Therapy - Medicare Contractual Allowance **		\$ 53,154	53,154			
c. Physical Therapy - Non-Medicare		\$ (388,783)	(361,568)			(27,215)
d. Physical Therapy - Non-Medicare Contractual Allowance **		\$ 100,332	93,309			7,023
4. a. Speech Therapy - Medicare		\$ (96,099)	(96,099)			
b. Speech Therapy - Medicare Contractual Allowance **		\$ 15,723	15,723			
c. Speech Therapy - Non-Medicare		\$ (133,530)	(124,183)			(9,347)
d. Speech Therapy - Non-Medicare Contractual Allowance **		\$ 32,785	30,490			2,295
5. a. Occupational Therapy - Medicare		\$ (457,917)	(457,917)			
b. Occupational Therapy - Medicare Contractual Allowance **		\$ 74,920	74,920			
c. Occupational Therapy - Non-Medicare		\$ (471,824)	(438,796)			(33,028)
d. Occupational Therapy - Non-Medicare Contractual Allowance **		\$ 118,866	110,545			8,321
6. a. Other (<i>Specify</i>) - Medicare		\$ (56,138)	(52,208)			(3,930)
b. Other (<i>Specify</i>) - Non-Medicare		\$ (246,206)	(228,972)			(17,234)
III. Total Resident Revenue (Section I. thru Section II.)		\$ (21,929,177)	(21,232,455)			(696,722)
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		\$ (21,535)	(20,028)			(1,507)
5. Interest Income (<i>Specify</i>)		\$ 136	136			
6. Private Duty Nurses' Fees		\$				
7. Barber, Coffee, Beauty and Gift shops		\$ (3,448)	(3,207)			(241)
8. Other (<i>Specify</i>)		\$ (698,875)	(698,875)			
V. Total Other Revenue (1 thru 8)		\$ (723,722)	(721,974)			(1,748)
VI. Total All Revenue (III +V)		\$ (22,652,899)	(21,954,429)			(698,470)

* 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)
II-6-a	Medicare-X-Ray	\$ (7,958)	\$ -	\$ (599)
II-6-a	Medicare-Laboratory	\$ (36,964)	\$ -	\$ (2,782)
II-6-a	Medicare-Respiratory Therapy & Supplies	\$ (1,575)	\$ -	\$ (119)
II-6-a	Medicare-Nursing Treatment Supplies	\$ -	\$ -	\$ -
II-6-a	Medicare-Audiology	\$ (34)	\$ -	\$ (3)
II-6-a	Medicare-Incontinency	\$ -	\$ -	\$ -
II-6-a	Medicare-Oxygen & Supplies	\$ -	\$ -	\$ -
II-6-a	Medicare-Physician Visit	\$ -	\$ -	\$ -
II-6-a	Medicare-Ambulance	\$ (1,799)	\$ -	\$ (60)
II-6-a	Medicare-Flu Shot	\$ (15,090)	\$ -	\$ (11,36)
II-6-a	Medicare-Capitation Contracts	\$ -	\$ -	\$ -
II-6-a	Medicare-Radiology Service	\$ -	\$ -	\$ -
II-6-a	Medicare-Outpatient Therapy Program	\$ -	\$ -	\$ -
II-6-a	Medicare-Case Management	\$ -	\$ -	\$ -
II-6-a	Contractual-Medicare-X-Ray	\$ 1,302	\$ -	\$ 98
II-6-a	Contractual-Medicare-Laboratory	\$ 6,048	\$ -	\$ 455
II-6-a	Contractual-Medicare-Audiology	\$ 2,258	\$ -	\$ 19
II-6-a	Contractual-Medicare-Nursing Treatment Supplies	\$ 1	\$ -	\$ -
II-6-a	Contractual-Medicare-Audiology	\$ -	\$ -	\$ -
II-6-a	Contractual-Medicare-Incontinency	\$ -	\$ -	\$ -
II-6-a	Contractual-Medicare-Oxygen & Supplies	\$ -	\$ -	\$ -
II-6-a	Contractual-Medicare-Physician Visit	\$ -	\$ -	\$ -
II-6-a	Contractual-Medicare-Ambulance	\$ 131	\$ -	\$ 10
II-6-a	Contractual-Medicare-Flu Shot	\$ 2,469	\$ -	\$ 186
II-6-a	Contractual-Medicare-Capitation Contracts	\$ -	\$ -	\$ -
II-6-a	Contractual-Medicare-Radiology Service	\$ -	\$ -	\$ -
II-6-a	Contractual-Medicare-Outpatient Therapy Program	\$ -	\$ -	\$ -
II-6-a	Contractual-Medicare-Case Management	\$ -	\$ -	\$ -
Total Other Resident Revenue - Medicare		\$ (52,208)	\$ -	\$ (3,930)

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
II-6-b	Medicaid-X-Ray	\$ (144)	\$ -	\$ (11)
II-6-b	Medicaid-Laboratory	\$ (932)	\$ -	\$ (70)
II-6-b	Medicaid-Respiratory Therapy & Supplies	\$ (2,575)	\$ -	\$ (194)
II-6-b	Medicaid-Nursing Treatment Supplies	\$ -	\$ -	\$ -
II-6-b	Medicaid-Audiology	\$ -	\$ -	\$ -
II-6-b	Medicaid-Incontinency	\$ -	\$ -	\$ -
II-6-b	Medicaid-Oxygen & Supplies	\$ -	\$ -	\$ -
II-6-b	Medicaid-Physician Visit	\$ -	\$ -	\$ -
II-6-b	Medicaid-Ambulance	\$ -	\$ -	\$ -
II-6-b	Medicaid-Flu Shot	\$ -	\$ -	\$ -
II-6-b	Medicaid-Capitation Contracts	\$ -	\$ -	\$ -
II-6-b	Medicaid-Radiology Service	\$ -	\$ -	\$ -
II-6-b	Medical	\$ -	\$ -	\$ -
II-6-b	Contractual-Medicaid-X-Ray	\$ 69	\$ -	\$ 5
II-6-b	Contractual-Medicaid-Respiratory Therapy & Supplies	\$ 447	\$ -	\$ 34
II-6-b	Contractual-Medicaid-Nursing Treatment Supplies	\$ 1,236	\$ -	\$ 93
II-6-b	Contractual-Medicaid-Audiology	\$ -	\$ -	\$ -
II-6-b	Contractual-Medicaid-Incontinency	\$ -	\$ -	\$ -
II-6-b	Contractual-Medicaid-Oxygen & Supplies	\$ -	\$ -	\$ -
II-6-b	Contractual-Medicaid-Physician Visit	\$ -	\$ -	\$ -
II-6-b	Contractual-Medicaid-Ambulance	\$ -	\$ -	\$ -
II-6-b	Contractual-Medicaid-Flu Shot	\$ -	\$ -	\$ -
II-6-b	Contractual-Medicaid-Capitation Contracts	\$ -	\$ -	\$ -
II-6-b	Contractual-Medicaid-Radiology Service	\$ -	\$ -	\$ -
II-6-b	Contractual-Medicaid-Outpatient Therapy Program	\$ -	\$ -	\$ -
II-6-b	Contractual-Medicaid-Daycare	\$ -	\$ -	\$ -
II-6-b	Private Insurance	\$ (5,427)	\$ -	\$ (499)
II-6-b	Private insurance, other-Laboratory	\$ (21,640)	\$ -	\$ (16,29)
II-6-b	Private insurance, other-Respiratory Therapy & Supplies	\$ (3,229)	\$ -	\$ (243)
II-6-b	Private insurance, other-Nursing Treatment Supplies	\$ -	\$ -	\$ -
II-6-b	Private insurance, other-Audiology	\$ -	\$ -	\$ -
II-6-b	Private insurance, other-Incontinency	\$ -	\$ -	\$ -
II-6-b	Private insurance, other-Oxygen & Supplies	\$ -	\$ -	\$ -
II-6-b	Private insurance, other-Physician Visit	\$ -	\$ -	\$ -
II-6-b	Private insurance, other-Ambulance	\$ -	\$ -	\$ -
II-6-b	Private insurance, other-Flu Shot	\$ -	\$ -	\$ -
II-6-b	Private insurance, other-Capitation Contracts	\$ (250,111)	\$ -	\$ (18,826)
II-6-b	Private insurance, other-Radiology Service	\$ -	\$ -	\$ -
II-6-b	Private insurance, other-Outpatient Therapy Program	\$ -	\$ -	\$ -
II-6-b	Private insurance, other-Daycare	\$ -	\$ -	\$ -
II-6-b	Contractual-Non-Medicaid-X-Ray	\$ 1,032	\$ -	\$ 78
II-6-b	Contractual-Non-Medicaid-Laboratory	\$ 4,116	\$ -	\$ 310
II-6-b	Contractual-Non-Medicaid-Respiratory Therapy & Supplies	\$ 614	\$ -	\$ 46
II-6-b	Contractual-Non-Medicaid-Nursing Treatment Supplies	\$ -	\$ -	\$ -
II-6-b	Contractual-Non-Medicaid-Audiology	\$ -	\$ -	\$ -
II-6-b	Contractual-Non-Medicaid-Incontinency	\$ -	\$ -	\$ -
II-6-b	Contractual-Non-Medicaid-Oxygen & Supplies	\$ -	\$ -	\$ -
II-6-b	Contractual-Non-Medicaid-Physician Visit	\$ -	\$ -	\$ -
II-6-b	Contractual-Non-Medicaid-Ambulance	\$ -	\$ -	\$ -
II-6-b	Contractual-Non-Medicaid-Flu Shot	\$ -	\$ -	\$ -
II-6-b	Contractual-Non-Medicaid-Capitation Contracts	\$ 47,571	\$ -	\$ 3,581
II-6-b	Contractual-Non-Medicaid-Radiology Service	\$ -	\$ -	\$ -
II-6-b	Contractual-Non-Medicaid-Outpatient Therapy Program	\$ -	\$ -	\$ -
II-6-b	Contractual-Non-Medicaid-Daycare	\$ -	\$ -	\$ -
Total Other Resident Revenue		\$ (228,972)	\$ -	\$ (17,234)

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
IV-8	Interest on Overdue Accts	430035	\$ 136	\$ -	\$ -
Total Interest Income		\$ 136	\$ -	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
IV-8	Elm Basic Healthcare Revenue	\$ 606,098	\$ -	\$ -
IV-8	Fed Stim - Phase II	\$ (9,739)	\$ -	\$ -
IV-8	Federal Stimulus 4	\$ (552,175)	\$ -	\$ -
IV-8	State COVID Support - Other	\$ (688,384)	\$ -	\$ -
IV-8	Timbale Rental Fee	\$ (47,595)	\$ -	\$ -
IV-8	Rehab Settlement	\$ (1,080)	\$ -	\$ -
IV-8	Project ECHO	\$ (6,000)	\$ -	\$ -
IV-8		0	\$ -	\$ -
IV-8		0	\$ -	\$ -
IV-8		0	\$ -	\$ -
Total Other Revenue		\$ (698,875)	\$ -	\$ -

G. Balance Sheet

Name of Facility HBR Trumbull, LLC -d/b/a: St. Joseph's	License No. 2321-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>)			\$ 7,244	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,907,252	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$ (321,317)	
4. Inventories			\$ 134,257	
5. Prepaid Expenses			\$ #VALUE!	
a. _____				
b. _____				
c. Prepaid Escrow Real Estate				
d. See Schedule			#VALUE!	
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$ #VALUE!	
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	1,967	\$ 1,881	
	Accum. Depreciation	86 Net		
3. Buildings	*Historical Cost	342,505	\$ 269,642	
	Accum. Depreciation	72,863 Net		
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation	Net		
5. Non-Movable Equipment	*Historical Cost	343,689	\$ 53,264	
	Accum. Depreciation	290,425 Net		
6. Movable Equipment	*Historical Cost	264,988	\$ 209,662	
	Accum. Depreciation	55,326 Net		
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
PPE CIP				
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$ 534,449	

* 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	
31	A5	Prepaid Expenses	145010
31	A5	Prepaid Prop Taxes	145040
31	A5	Prepaid Personal Property Tax	145310
31	A5		#VALUE!
Total Prepaid Expenses			#VALUE!

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	
		Total Other Other Fixed Assets (Itemize)	\$ <input type="text" value="-"/>

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	ROU Bldg Asset-Open Lease	150510
32	D7	AccumAmort-ROU Bldg OprLease	150511
32	D7	O LT A Suspense	180050
32	D7	Elimination Intercompany	190010
32	D7	I/C Due to/Due From GHCLLC	198000
32	D7	I/C Due to/Due From GHCLLC PR	198010
32	D7	I/C Due to/Due From GHCLLC A/P	198020
32	D7	I/C Due to/Due From GHCLLC EX	198030
32	D7	I/C Due to/Due From GHCLLC AR	198040
32	D7	I/C Due to/Due From GHCLLC IN	198050
32	D7		#VALUE!
Total Other Assets			#VALUE!

Schedule of Notes Payable (Itemize) Page 33 Line A2

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

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 HBR Trumbull, LLC -d/b/a: St. Joseph'	License No. 2321-C	Report for Year Ended 9/30/2021	Page 32	of 37
Account		Amount		
Total Brought Forward:			\$	#VALUE!
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>)			\$	#VALUE!
ROU Bldg Asset-Oper Lease				
AccumAmort-ROU Bldg OprLease				
See Schedule	#VALUE!			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	#VALUE!
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	#VALUE!

* 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 HBR Trumbull, LLC -d/b/a: St. Joseph's Mand	License No. 2321-C	Report for Year Ended 9/30/2021	Page 33	of 37					
Account				Amount					
Liabilities									
A. Current Liabilities									
1. Trade Accounts Payable				\$ 1,035,911					
2. Notes Payable (<i>itemize</i>)				\$					
See Schedule									
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$					
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding: 2px;">Name of Lender</th> <th style="text-align: left; padding: 2px;">Purpose</th> <th style="text-align: left; padding: 2px;">Amount</th> <th style="text-align: left; padding: 2px;">Date Due</th> <th style="text-align: left; padding: 2px;"></th> </tr> </thead> </table>					Name of Lender	Purpose	Amount	Date Due	
Name of Lender	Purpose	Amount	Date Due						
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$ 274,540					
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$					
6. Accrued Payroll Taxes Payable				\$ 4,666					
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>)				\$ #VALUE!					
See Schedule				#VALUE!					
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ #VALUE!					

* 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 HBR Trumbull, LLC -d/b/a: St. Joseph's Ma	License No. 2321-C	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			#VALUE!	
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>)			\$	3,885,677
LT Debt-Financing Obligation		3,883,949		
Escheatable Funds		1,728		
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	3,885,677
C. Total All Liabilities (Lines A-13 + B-5)			\$	#VALUE!

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

Name of Facility	License No.	Report for Year Ended	Page of
HBR Trumbull, LLC -d/b/a: St. Joseph	2321-C	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			\$
6. Total Reserves			\$
B. Net Worth			
1. Owner's Capital			\$
2. Capital Stock			\$
3. Paid-in Surplus			\$
4. Treasury Stock			\$
5. Cumulated Earnings			\$ (2,267,631)
6. Gain or Loss for Period 10/1/2020 thru 9/30/2021			\$ (1,219,173)
7. Total Net Worth			\$ (3,486,804)
C. Total Reserves and Net Worth			\$ (3,486,804)
D. Total Liabilities, Reserves, and Net Worth			\$ #VALUE!

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
HBR Trumbull, LLC -d/b/a: St. Joseph's	2321-C	9/30/2021	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ (2,267,630)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 22,652,899
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 23,872,073
D. Net Income or Deficit				\$ (1,219,174)
E. Balance				\$ (3,486,804)
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	09/30/21			\$ (3,486,804)

I. Preparer's/Reviewer's Certification

Name of Facility HBR Trumbull, LLC -d/b/a: St. Joseph's	License No. 2321-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 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	Title	Date Signed
Printed Name of Preparer		
Rick Fink		
Address		Phone Number
200 Brickstone Square, Andover, MA 01810		410-494-7657
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Rick Fink		410-494-7657
Contact Email Address		
Rick.Fink@genesishcc.com		