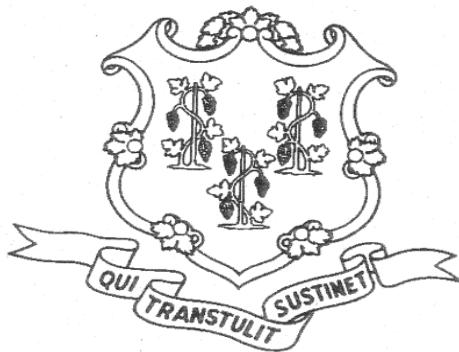


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) St Joseph's Residence	
Address (No. & Street, City, State, Zip Code) 1365 Enfield Street, Enfield, CT 06082	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022

License Numbers:	CCNH 901-C	RHNS	Residential Care Home 1678-HA	Medicare Provider 075272
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Medicaid Provider Numbers:	CCNH 9019	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) St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for St Joseph's Residence [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, 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) Thomas Ranstrom		Printed Name (Owner) Little Sisters of the Poor	
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 St Joseph's Residence	Period Covered:		From 10/1/2021	To 9/30/2022
Address of Facility 1365 Enfield Street, Enfield, CT 06082				
Report Prepared By Kevin P Kelleher CPA	Phone Number 860.677.8440	Date 2/10/2022		
Item	Total	CCNH	RHNS	Residential Care Home
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

	Phone No. of Facility 860-741-0791	Report for Year Ended 9/30/2022	Page 2
Name of Facility (as shown on license) St Joseph's Residence		Address (No. & Street, City, State, Zip) 1365 Enfield Street, Enfield, CT 06082	
License Numbers:	CCNH 901-C	RHNS	Residential Care Home 1678-HA
Medicare Provider No. 075272			
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes	<input checked="" type="radio"/> No
		If "Yes," explain fully.	
Administrator Name of Administrator Thomas Ranstrom			
		Nursing Home Administrator's License No.:	1968
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name none		License No.:	

General Information and Questionnaire Partners/Members

General Information and Questionnaire

Corporate Owners

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022	Page of 3A 37
If this facility is owned or operated as a corporation, provide the following information:			
Legal Name of Corporation	Business Address	State(s) in Which Incorporated	
St Joseph's Residence	1365 Enfield St Enfield CT 06082	CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Sister Maureen Weiss	1365 Enfield St Enfield CT 06082	President	n/a
Sister Regina Tamayo	1365 Enfield St Enfield CT 06082	Vice President	n/a
Sister Joanna Keeboy Young	1365 Enfield St Enfield CT 06082	Secretary/Treasurer	n/a
Names of Stockholders Owning at Least 10% of Shares			
none			

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022	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 St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input checked="" type="radio"/> Yes <input 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
Little Sisters of the Poor	1365 Enfield St., Enfield CT 06082	<input type="radio"/>	<input checked="" type="radio"/>		Lendor of funds	pg 26 / ln 12A1		n/a Motherhouse of Ord
Little Sisters of the Poor	1365 Enfield St., Enfield CT 06082	<input type="radio"/>	<input checked="" type="radio"/>		12 sisters employed by the organization	pg 10 / ln var	432,150	n/a Motherhouse of Ord
Little Sisters of the Poor	1365 Enfield St., Enfield CT 06082	<input type="radio"/>	<input checked="" type="radio"/>		Computer Software maintenance services	pg 16 / ln m13	12,000	12,000
Little Sisters of the Poor	1365 Enfield St., Enfield CT 06082	<input type="radio"/>	<input checked="" type="radio"/>		Human Resource services	pg 16 / ln m13	4,500	4,500
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022	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.

No changes from prior cost reporting periods. Related party is the Motherhouse of the Order of Roman Catholic Nuns.

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 St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022	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 Kelleher & Company 2 3 4	Address (No. & Street, City, State, Zip Code) 11 Melrose Drive, Ste 200, Farmington CT 06032
--	---

Services Provided by This Firm (*describe fully*)

1	audited financial statements, cost report preparation, form 990 preparation, audit representation	\$ 53,328
2		\$
3		\$
4		\$
		Charge for Services Provided
		\$ 53,328

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

Yes No page 15 line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Garfunkel Wild PC	516.393.2200
2 Murtha Cullina LLP	860.240.6000
3	
4	
5	

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

Address (Av. & Street, City, State, Zip Code)
1 11 Great Neck Rd, Great Neck NY 11021
2 280 Trumbul St, Hartford CT 06103
3
4
5

Services Provided by This Firm (*describe fully*)

1	Nursing and related Medicare and Medicaid legal services	\$	1,333
2	Estate and Probate legal services	\$	7,823
3		\$	
4		\$	
5		\$	
		Charge for Services Provided	
		\$	9,156

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

page 15 line 1e

Schedule of Resident Statistics

Name of Facility St Joseph's Residence			License No. 901-C				Report for Year Ended 9/30/2022				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	83	25		58	83	25		58				
B. On last day of THIS report period	83	25		58					83	25		58
2. Number of Residents												
A. As of midnight of PREVIOUS report period	78	25		53	78	25		53				
B. As of midnight of THIS report period	68	24		44					68	24		44
3. Total Number of Days Care Provided During Period												
A. Medicare	185	185			121	121			64	64		
B. Medicaid (Conn.)	8,738	8,738			6,568	6,568			2,170	2,170		
C. Medicaid (other states)												
D. Private Pay	1,399			1,399	1,070			1,070	329			329
E. State SSI for RCH	14,224			14,224	10,587			10,587	3,637			3,637
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	24,546	8,923		15,623	18,346	6,689		11,657	6,200	2,234		3,966
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	24,546	8,923		15,623	18,346	6,689		11,657	6,200	2,234		3,966

Schedule of Resident Statistics (Cont'd)

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No

If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-MR
No. of Residents	1	23				4	40	
Per Diem Rate								
a. One bed rm.	400.00	288.47				150.00	149.00	
b. Two bed rms.								
c. Three or more bed rms.								

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

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

9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. Total Occupational Therapy Treatments				

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		901-C	9/30/2022	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
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	40,556	747			71,007
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	220,542	8,269			386,141
5. Dietary Service					
a. Head Dietitian	26,734	771			48,387
b. Food Service Supervisor	14,591	756			26,409
c. Dietary Workers	181,478	10,952			328,885
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers					
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	27,331	771			47,853
b. Other Maintenance Workers	20,800	681			36,419
8. Laundry Service					
a. Supervisor	13,653	591			23,904
b. Other Laundry Workers	23,385	1,546			40,944
9. Barber and Beautician Services					
10. Protective Services	26,953	1,455			47,191
11. Accounting Services					
a. Head Accountant					
b. Other Accountants					
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	127,790	2,128			
b. RN					
1. Direct Care	568,644	12,316			
2. Administrative**	13,199	263			
c. LPN					
1. Direct Care	195,205	5,604			35,678
2. Administrative**					
d. Aides and Attendants	693,843	33,301			526,522
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	24,657	726			103,752
i. Physicians					
1. Medical Director					
2. Utilization Review					
3. Resident Care***					
4. Other (Specify)					
medical records	121,074	3,974			
j. Dentists					
k. Pharmacists					
l. Podiatrists					
m. Social Workers/Case Management	8,753	228			15,325
n. Marketing					398
o. Other (Specify)					
See Attached Schedule	17,979	1,071			31,479
A-13. Total Salary Expenditures	2,367,167	86,150			1,769,896
					82,833

* 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)

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

Name of Facility St Joseph's Residence			License No. 901-C		Report for Year Ended 9/30/2022			Page 11	of 37
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS							
Section I - Operators/Owners									
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).									
See Attached Schedule Page 11a									

* 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
St Joseph's Residence				901-C		9/30/2022			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
Section III - Administrators***										
Sister Genevieve Nugent	14,541		25,459	none	all in charge duties	1,040	a2	none		
Patricia Salisbury	11,604		20,316	none	all in charge duties	456	a2			
Thomas Ranstrom	14,411		25,232	none	all in charge duties	560	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 St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022		Page 13	of 37
Item	Total Cost and Hours				
	CCNH	Hours	RHNS	Hours	Residential Care Home
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)					
1. Dietitian	1,403	47			2,647
2. Dentist	1,200	26			1,200
3. Pharmacist					
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	30,837				
b. Other					
6. Social Worker	350	14			
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	18,000	120			
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	1,246				
b. Other					
10. Occupational Therapist					
a. Resident Care	65,677				
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care					
2. Administrative***					
b. LPN					
1. Direct Care					
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify)					
See Attached Schedule					
B-13 Total Fees Paid in Lieu of Salaries	118,713	207			3,847
					115

* 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 St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022		Page 15	of 37
Item		Total	CCNH	RHNS	Residential Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 100,463	57,483			42,980
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 3,308	1,893			1,415
4. Social Security (F.I.C.A.)	\$ 276,711	158,330			118,381
5. Health Insurance	\$ 318,158	182,045			136,113
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 115,574	66,130			49,444
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 16,068	9,194			6,874
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$				
d. Accounting and Auditing	\$ 53,328	28,386			24,942
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 9,156	4,874			4,282
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 21,499	11,444			10,055
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 79,727	42,439			37,288
2. Cellular Phones	\$ 6,063	3,227			2,836
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	\$ 183,778	183,778			
Subtotal	\$ 1,183,833	749,223			434,610

* 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	Residential Care Home
Total	\$ -	\$ -	\$ -

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

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022		Page 16	of 37
Item		Total	CCNH	RHNS	Residential Care Home
	<i>Subtotals Brought Forward:</i>	1,183,833	749,223		434,610
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	500	266		234
5. Education Expenses Related to Seminars and Conventions	\$				
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	13,918	7,409		6,509
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	2,000	1,065		935
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	11,424	6,081		5,343
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	8,564	4,559		4,005
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	8,506	4,527		3,979
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	2,768	1,473		1,295
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>)	\$	10,878	5,790		5,088
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$	193,685	103,099		90,586
<i>C-14 Total Administrative & General Expenditures</i>	\$	1,436,076	883,492		552,584

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	Residential Care Home
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Residential Care Home
Other Advertising	\$ 6,081		\$ 5,343
Total Other Advertising	\$ 6,081	\$ -	\$ 5,343

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
Leading Age	\$ 3,726		\$ 3,274
CAHCF	\$ 186		\$ 164
Chamber of Commerce	\$ 279		\$ 246
Academy of Nutrition and Dietetics	\$ 125		\$ 109
Amazon Prime	\$ 146		\$ 128
Visa Credit Card	\$ 53		\$ 47
other	\$ 12		\$ 11
Total Dues	\$ 4,527	\$ -	\$ 3,979

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Licenses	\$ 2,315		\$ 2,034
Consulting, Billing Services	\$ 19,798		\$ 17,396
Data Processing Payroll fees	\$ 7,430		\$ 6,529
Data Processing Supplies	\$ 9,790		\$ 8,601
Professional Background checks, Fingerprinting	\$ 4,310		\$ 3,787
Bad Debts / Charity Care	\$ 14,472		\$ 12,716
Miscellaneous	\$ 1,089		\$ 956
Development Mailing Service	\$ 10,414		\$ 9,150
Development supplies	\$ 366		\$ 322
Other Non Reimbursable	\$ 33,115		\$ 29,095
Total Other Administrative and General	\$ 103,099	\$ -	\$ 90,586

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022	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	License No.	Report for Year Ended		Page of
St Joseph's Residence	901-C	9/30/2022		18 37
Item	Total	CCNH	RHNS	Residential Care Home
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 276,470	95,768		180,702
2. Non-Food Supplies	\$ 11,033	3,822		7,211
3. Other (Specify) _____	\$ _____			
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ _____			
c. Other (Specify) _____ Equipment Repairs	\$ 6,976	2,416		4,560
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 294,479	102,006		192,473
2E. Dietary Questionnaire	Total	CCNH	RHNS	Residential Care Home
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input 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 checked="" type="radio"/> Yes <input type="radio"/> No				If yes, specify cost. deminimous
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 St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022		Page 19 37
Item	Total	CCNH	RHNS	Residential Care Home
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	14,082	4,816	9,266
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. \$	72	25	47
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (<i>Specify</i>) Equipment Repairs	\$	4,296	1,469	2,827
3D. Total Laundry Expenditures (3a + b + c)	\$	18,450	6,310	12,140
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 St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022		Page 20	of 37
Item		Total	CCNH	RHNS	Residential Care Home
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 17,368	5,939		11,429
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.	\$ 310,231	106,090		204,141
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	327,599	112,029		215,570
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Omnicare of CT	\$	17,790	17,790		
b. Medicine Cabinet Drugs	\$	10,578	10,578		
c. Medical and Therapeutic Supplies	\$	59,829	59,730		99
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$				
f. X-rays and Related Radiological Procedures***	\$	714	714		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	901	901		
i. Recreation	\$	5,175	2,588		2,587
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	37,553	23,238		14,315
5M. Total Resident Care Expenditures (5a - 5j)	\$	132,540	115,539		17,001

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

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

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

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

Schedule of Other Resident Care

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

* 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 St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022			Page 22	of 37
Item		Total	CCNH	RHNS	Residential Care Home	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	158,562	54,224			104,338
b. Heat	\$	120,218	41,111			79,107
c. Light & Power	\$	123,360	42,186			81,174
d. Water	\$	61,265	20,951			40,314
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$					
f. Other <i>(itemize)</i>	\$	53,545	18,311			35,234
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	516,950	176,783			340,167
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$	14,575	4,984			9,591
b. Building & Building Improvements	\$	123,539	42,247			81,292
c. Non-Movable Equipment	\$	152,654	52,203			100,451
d. Movable Equipment	\$	59,455	20,332			39,123
*7e. Total Depreciation Costs (7a + b + c + d)	\$	350,223	119,766			230,457
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$	201	69			132
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	350,424	119,835			230,589

* 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

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/20/2021	Asphalt Sidewalks	\$ 25,900	8	\$ 2,968
7/13/2022	Asphalt Parking Lot	\$ 28,400	8	\$ 888
10/12/2021	Tree	\$ 3,886	20	\$ 194
11/9/2021	Statute Base and Trees	\$ 7,518	20	\$ 345
1/28/2022	Fire Hydrant	\$ 5,410	20	\$ 180
12/17/2021	Tree Removal	\$ 6,000	20	\$ 225
5/9/2022	Tree Removal	\$ 1,500	20	\$ 31
Total additions for Land Improvement		\$ 78,614		\$ 4,831
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:				
Total additions for Building Improvement		\$ -		\$ -
Deletions:				
Total deletions for Building Improvement		\$ -		\$ -

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
11/30/2021	Water Softening unit	\$ 3,669	10	\$ 306
3/22/2022	Circuit Breaker Replacement	\$ 39,000	15	\$ 1,300
7/21/2022	Kitchen Refrigeration Project	\$ 72,858	15	\$ 810
9/29/2022	PTAC Units Phase 2	\$ 87,070	10	\$ -
12/30/2021	Motors and Wheels	\$ 14,595	10	\$ 1,095
Total additions for Non-Movable Equipment		\$ 217,192		\$ 3,511
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ -

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
1/12/2022	Hospital Bed	Standard Resident	\$ 2,149	15	\$ 107
1/12/2022	Furniture	Standard Resident	\$ 2,191	15	\$ 110
6/13/2022	Laundry Labeler	Administrative	\$ 2,171	10	\$ 72
9/22/2022	2 Snowblowers	Administrative	\$ 3,600	5	\$ -
10/21/2021	Organ	Administrative	\$ 2,000	10	\$ 183
10/15/2021	Buffet Cart	Administrative	\$ 3,002	10	\$ 300
8/31/2022	Refrigerator	Administrative	\$ 5,135	10	\$ 43
Total additions for Movable Equipment			\$ 20,248		\$ 815
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 Improvements		\$ -		\$ -
Deletions:				
Total deletions for Leasehold Improvements		\$ -		\$ -

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

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Amortization Schedule*

Name of Facility St Joseph's Residence			License No. 901-C		Report for Year Ended 9/30/2022			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 St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022	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	83			
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

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 St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022			Page 26 37
Item		Total	CCNH	RHNS	Residential Care Home
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 St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022			Page 27	of 37
Item			Total	CCNH	RHNS	Residential Care Home
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)		\$ 26,035	8,903			17,132
b. Insurance on Automobiles		\$ 14,717	5,033			9,684
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$				
2. Fire and Extended Coverage		\$ 17,230	5,892			11,338
3. Other (Specify)		\$ 366	125			241
Surety Bond						
14d. Total Insurance Expenditures (14a + b + c)		\$ 58,348	19,953			38,395
15. Total All Expenditures (A-13 thru C-14)		\$ 7,394,489	4,021,827			3,372,662

D. Adjustments to Statement of Expenditures

Name of Facility St Joseph's Residence			License No. 901-C	Report for Year Ended 9/30/2022		Page 28 of 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
<i>Page 10 - Salaries and Wages</i>							
1.			Outpatient Service Costs	\$			
2.	10	a4	Salaries not related to Resident Care	\$ 160,812	58,459		102,353
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<i>Page 13 - Professional Fees</i>							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 65,677	65,677		
7.			Other - See attached Schedule	\$ 32,083	32,083		
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.			Accounting	\$			
10a.			Legal	\$ 9,156	4,874		4,282
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.	16	L6	Automobile Expense (e.g. personal use)	\$ 12,804	6,816		5,988
18.	16	m3	Unallowable Advertising *	\$ 11,424	6,081		5,343
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 112,959	60,129		52,830
<i>Page 18 - Dietary Expenditures</i>							
24.	18	2a1	Meals to employees, guests and others who are not residents	\$ 89,686	31,067		58,619
<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)			\$ 494,601	265,186			229,415

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	m13	Bad Debts / Charity Care	\$ 14,472		\$ 12,716
16	m13	Miscellaneous	\$ 1,089		\$ 956
16	m13	Development Mailing Service	\$ 10,414		\$ 9,150
16	m13	Development Supplies	\$ 366		\$ 322
16	m13	Other Non Reimbursable	\$ 33,115		\$ 29,095
16	m11	Development Software	673		591
Total Other A&G Adjustments			\$ 60,129	\$ -	\$ 52,830

State of Connecticut

Annual Report of Long-Term Care Facility

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

Name of Facility St Joseph's Residence			License No. 901-C	Report for Year Ended 9/30/2022		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward	\$ 494,601	265,186		229,415
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 7,576	7,576		
28.			Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 714	714		
30.	20	5h	Laboratory	\$ 901	901		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 388	388		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.	22	7d	Depreciation on Unallowable Motor Vehicles	\$ 10,254	3,506		6,748
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 40,853	13,970		26,883
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.	27	14b	Property Insurance	\$ 10,208	3,491		6,717
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)				\$ 565,495	295,732		269,763

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Schedule of Other Ancillary Costs

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
22	6b	Heat (non facility utilization)	\$ 8,975		\$ 17,271
22	6c	Light & Power (non facility utilization)	\$ 1,702		\$ 3,274
22	6d	Water (non facility utilization)	\$ 728		\$ 1,401
22	6a	Maintenance (non facility utilization)	\$ 938		\$ 1,806
22	6f	Elevator Maintenance (non facility utilization)	\$ 1,627		\$ 3,131
Total Other Property Adjustments			\$ 13,970	\$ -	\$ 26,883

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

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

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022			Page 30 37
Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 5,628,800	3,495,200			2,133,600
b. Medicaid Room and Board Contractual Allowance **	\$ (1,015,639)	(922,105)			(93,534)
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 324,263	324,263			
b. Medicare Room and Board Contractual Allowance **	\$ (65,280)	(65,280)			
4. a. Private-Pay Residents and Other	\$ 209,850				209,850
b. Private-Pay Room and Board Contractual Allowance **	\$ (24,576)				(24,576)
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$				
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$				
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	\$				
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$				
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$				
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (<i>Specify</i>) - Medicare	\$				
b. Other (<i>Specify</i>) - Non-Medicare	\$				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 5,057,418	2,832,078			2,225,340
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 13,305	4,550			8,755
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$ 7,483	2,559			4,924
8. Other (<i>Specify</i>)	\$ 3,030,553	1,036,363			1,994,190
V. Total Other Revenue (1 thru 8)	\$ 3,051,341	1,043,472			2,007,869
VI. Total All Revenue (III +V)	\$ 8,108,759	3,875,550			4,233,209

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Resident Revenue		\$ -	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	Residential Care Home
30	Bank interest		\$ 4,550		\$ 8,755
Total Interest Income			\$ 4,550	\$ -	\$ 8,755

Schedule of Other Revenue

G. Balance Sheet

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$ 2,207,610	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 420,575	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$ 70,072	
a. _____				
b. _____				
c. _____				
d. See Schedule		70,072		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$ 1,000	

See Schedule		1,000		
A-9. Total Current Assets (Lines A1 thru 8)			\$ 2,699,257	
B. Fixed Assets				
1. Land			\$ 598,500	
2. Land Improvements	*Historical Cost	506,427	\$ 141,454	
	Accum. Depreciation	364,973	Net	
3. Buildings	*Historical Cost	8,680,569	\$ 1,015,602	
	Accum. Depreciation	7,664,967	Net	
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
5. Non-Movable Equipment	*Historical Cost	4,150,425	\$ 1,629,231	
	Accum. Depreciation	2,521,194	Net	
6. Movable Equipment	*Historical Cost	1,865,961	\$ 184,840	
	Accum. Depreciation	1,681,121	Net	
7. Motor Vehicles	*Historical Cost	262,217	\$ 68,911	
	Accum. Depreciation	193,306	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$ 3,638,538	

* 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 Insurance and Maintenance	\$ 70,072
Total Prepaid Expenses			\$ 70,072

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

Page Ref	Line Ref	Description	
31	A8	Due From LSP Convent	\$ 1,000
Total Other Current Assets (Itemize)			\$ 1,000

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

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

Page Ref	Line Ref	Description	
33	A12	Accrued Expenses	\$ 45,719
33	A12	Due to LSP Convent	\$ 12,037
Total Other Current Liabilities (Itemize)			\$ 57,756

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

Page Ref	Line Ref	Description	
34	B4	Working Capital Loans Payable Province	\$ 21,918
Total Other Current Liabilities (Itemize)			\$ 21,918

G. Balance Sheet (cont'd)

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	6,337,795
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>)			\$	
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	6,337,795

* 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 St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022	Page 33	of 37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$ 165,622	
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>)			\$ 134,519	
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	
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>)			\$ 57,756	
See Schedule			57,756	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$ 357,897	

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022	Page 34	of 37
Account			Amount	
Total Brought Forward:			357,897	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)			\$	21,918
See Schedule		21,918		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	21,918
C. Total All Liabilities (Lines A-13 + B-5)			\$	379,815

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

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022	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			\$	2,500,000
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	2,743,710
6. Gain or Loss for Period	10/1/2021	thru	9/30/2022	\$ 714,270
7. Total Net Worth			\$	5,957,980
C. Total Reserves and Net Worth			\$	5,957,980
D. Total Liabilities, Reserves, and Net Worth			\$	6,337,795

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
St Joseph's Residence	901-C	9/30/2022	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ 5,268,710		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 8,108,759		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 7,394,489		
D. Net Income or Deficit				\$ 714,270		
E. Balance				\$ 5,982,980		
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>)				\$ 25,000		
Purpose		Amount				
Distribution to General in France		25,000				
3. Total Deductions				\$ 25,000		
H. Balance at End of Period				\$ 5,957,980		

I. Preparer's/Reviewer's Certification

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2022	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> Residential Care Home		

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Kevin P Kelleher CPA		
Address		Phone Number
11 Melrose Dr. Ste 200, Farmington CT 06032		860.677.8440
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Kevin P Kelleher CPA		860.677.8440
Contact Email Address		
kevin@kellehercpa.com		