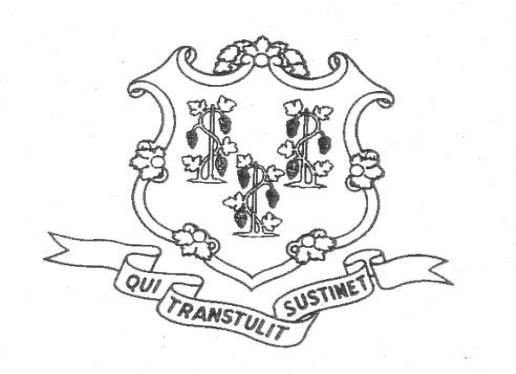
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2023

Name of Facility (as licensed) Saint Mary Home		
Address (No. & Street, City, State, Zip Code) 2021 Albany Avenue, West Hartford CT 06117		
Type of Facility ☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☑ (Specify)	☑ Residential Care Home
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023	

License Numbers:	CCNH / RHNS	(Specify)	Residential Care Home	Medicare Provider
	680-C		1289	07-5085

Medicaid Provider Numbers:	CCNH / RHNS	(Specify)	Residential Care Home
	75085		

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CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Saint Mary Home [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Rachel DeMaida			Printed Name (Owner)	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Saint Mary Home	Period Covered:		From 10/1/2022	To 9/30/2023
Address of Facility 2021 Albany Avenue, West Hartford CT 06117				
Report Prepared By Haley Gregory	Phone Number 734-343-6611		Date 2/15/2024	

Item		Total	CCNH / RHNS	(Specify)	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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-570-8300	9/30/2023	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Saint Mary Home	2021 Albany Avenue, West Hartford CT 06117

License Numbers:	CCNH / RHNS	(Specify)	Residential Care Home	Medicare Provider No.
	680-C		1289	07-5085

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined ☑ (Specify) ☑ Residential Care Home

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ○ Profit Corp. ◉ Non-Profit Corp. ○ Government ○ 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? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Rachel DeMaida		18-89

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:
None	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	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
Saint Mary Home, Inc.	2021 Albany Avenue, West Hartford CT	Connecticut

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
See attached			
Names of Stockholders Owning at Least 10% of Shares			

Mercy Community Health Inc. (Saint Mary Home)

Attachment Page 3A

Board of Directors
Patrick Johnson - Board Chair
Ann Kane, CSJ
Gagandeep Singh, MD
Jaclyn Harris (Ex-Officio)
Patricia McKeon, RSM
Peter Murphy - Board Secretary/Treasurer
Shyamala Raman
Mark Walker

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ⊙ Yes ○ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? ⊙ Yes ○ No

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Trinity Health	20555 Victor Parkway, Livonia MI 48152	○	⊙		Loan	Pg. 33 A12, Pg. 34 B	9,045,741	9,045,741
Trinity Health	20555 Victor Parkway, Livonia MI 48152	○	⊙		Management Services	Pg. 16 line m12	2,495,455	2,495,455
Trinity Health	20555 Victor Parkway, Livonia MI 48152	○	⊙		Interest on Loan (adj to underlying bond)	Pg. 26 line m13	373,925	226,609
St Francis Hospital d/b/a Trinity Health New England	114 Woodland Street, Hartford CT, 06112	○	⊙		Lab Services	PG. 20 Line 5H	11,655	11,655
St Francis Hospital d/b/a Trinity Health New England	114 Woodland Street, Hartford CT, 06112	○	⊙		Radiology Services	PG. 20 Line 5F	249	249
Trinity Health New England	114 Woodland Street, Hartford CT, 06112	○	⊙		Medical Director	Pg. 13 Line 8	81,782	81,782
Trinity Health New England	114 Woodland Street, Hartford CT, 06112	○	⊙		Ancillary Services	PG. 20 Line 5H	18,734	18,734
Sisters of Mercy of the Americas	15 Highland View Rd., Cumberland RI 02864	○	⊙		Pastoral Services	Pg. 16 line m13	6,211	6,211
		○	⊙					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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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 (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required? ○ Yes ◉ No If "No," explain fully why such allocation was not made.

Certain salary costs of the residental care home were directly assigned.

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

◉ Yes ○ No If "No," explain fully why such allocation was not made.

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General Information and Questionnaire
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	6	37

Square footage of entire facility.	71,695

Outpatient Therapy

Does the Facility provide outpatient therapy services?	No

If yes, please complete the following:

	Square footage of therapy space.

Meals on Wheels

Does the facility provide Meals on Wheels?	No

If yes, please complete the following:

	Square footage of kitchen	
	Number of meals served per week	
No	Are meals included in meals served on page 18 of the Annual Report?	
No	Are direct costs included in the Annual Report?	
	If yes, please state where costs are reported.	
No	Are drivers for the program included in the facility's payroll?	
	If yes, please complete the following:	
		Amount Reported
		Annual Report page and line
	Please state the salary amounts of specific cooks and/or dietary aides	
	Please state where the cooks and/or dietary aides are reported in the Annual Report	

Apartments, Independent Living, Assisted Living

Does the facility have apartments, independent living, and/or assisted living?	No

If yes, please complete the following:

	Square footage of apartments
	Square footage of independent living
	Square footage of assisted living
	Please identify the services provided:

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General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
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Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care?	No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH / RHNS Level	Total	Total Residential Care Home	Period 10/1 Thru 6/30 Total	CCNH / RHNS	(Specify)	Residential Care Home	Period 7/1 Thru 9/30 Total	CCNH / RHNS	(Specify)	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	328	231		97	328	231		97				
B. On last day of THIS report period	328	231		97					328	231		97
2. Number of Residents												
A. As of midnight of PREVIOUS report period	249	158		91	249	158		91				
B. As of midnight of THIS report period	260	175		85					260	175		85
3. Total Number of Days Care Provided During Period												
A. Medicare	13,665	13,665			10,533	10,533			3,132	3,132		
B. Medicaid (Conn.)	69,164	38,414		30,750	50,979	27,994		22,985	18,185	10,420		7,765
C. Medicaid (other states)												
D. Private Pay	10,517	8,755		1,762	8,103	6,591		1,512	2,414	2,164		250
E. State SSI for RCH												
F. Other (Specify) Hospice & Insurance	3,262	3,262			2,237	2,237			1,025	1,025		
G. Total Care Days During Period (3A thru F)	96,608	64,096		32,512	71,852	47,355		24,497	24,756	16,741		8,015
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	1,171	4		1,167	772	2		770	399	2		397
B. Other Bed Reserve Days	55	1		54	54			54	1	1		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	97,834	64,101		33,733	72,678	47,357		25,321	25,156	16,744		8,412

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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)	Residential Care Home	Lost			Gained			CCNH / RHNS	(Specify)	Residential Care Home	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	Residential Care Home	R.C.H.	ICF-MR
No. of Residents	32	111		21		2	83	
Per Diem Rate								
a. One bed rm.	611.59	######		580-641		182.00	121.00	
b. Two bed rms.	611.59	######		527-580			121.00	
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	Residential Care Home
A. Medicare - Part B	2,381	2,381			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	131	131			
2. Restorative Treatments					
C. Other	29,137	29,137			
D. ***Total Physical Therapy Treatments***	31,649	31,649			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	59	59			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments	3	3			
C. Other	760	760			
D. ***Total Speech Therapy Treatments***	822	822			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	1,820	1,820			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	96	96			
2. Restorative Treatments					
C. Other	27,958	27,958			
D. ***Total Occupational Therapy Treatments***	29,874	29,874			

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	Residential Care Home	Adjustment	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)	192,270	(36,833)	2,080				83,025	(647)	2,079
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	686,872	(571)	17,680				102,866	(85)	2,648
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor									
c. Dietary Workers	716,176		36,113				376,886		19,005
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers	517,551		28,114				93,904		5,101
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance									
b. Other Maintenance Workers	427,247		22,276				232,194		12,106
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers	141,155		6,768				74,282		3,562
9. Barber and Beautician Services									
10. Protective Services	177,341		9,447				96,378		5,134
11. Accounting Services									
a. Head Accountant									
b. Other Accountants									
12. Professional Care of Residents									
a. Directors and Assistant Director of Nurses	315,493		4,152						
b. RN									
1. Direct Care	1,678,174		33,995						
2. Administrative**	658,437		11,912						
c. LPN									
1. Direct Care	2,501,168		69,917						
2. Administrative**									
d. Aides and Attendants	3,612,072		168,185				400,190		20,006
e. Physical Therapists									
f. Speech Therapists									
g. Occupational Therapists									
h. Recreation Workers	213,316		7,809						
i. Physicians									
1. Medical Director									
2. Utilization Review									
3. Resident Care***									
4. Other (Specify)									
j. Dentists									
k. Pharmacists									
l. Podiatrists									
m. Social Workers/Case Management	179,707		5,783						
n. Marketing	131,913	(131,913)	3,618				19,755	(19,755)	542
o. Other (Specify)									
See Attached Schedule	83,346		3,068				12,482		459
A-13. Total Salary Expenditures	12,232,238	(169,317)	430,917				1,491,962	(20,487)	70,642

* 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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

	CCNH / RHNS			(Specify)			Residential Care Home		
Position	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
Pastoral Care	$ 83,346		3,068				$ 12,482		459
Total	$ 83,346	$ -	3,068	$ -	$ -	-	$ 12,482	$ -	459

Schedule of Other Fees (Page 13)

	CCNH / RHNS			(Specify)			Residential Care Home		
Service	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
IV Consultant	$ 20,435								
Total	$ 20,435	$ -	-	$ -	$ -	-	$ -	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	Residential Care Home							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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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
Saint Mary Home	680-C	9/30/2023	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)	Residential Care Home							
Section III - Administrators* **										
Rachel DeMaida	192,270			26,228	Administrator	2,080	A2			
Shanowa Gaye			83,025	11,326	RCH RN	2,079	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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	13	37

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	Residential Care Home	Adjustment	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	21,109	(21,109)							
3. Pharmacist									
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	794,542								
b. Other									
6. Social Worker	42,019		560						
7. Recreation Worker	6,329		56						
8. Physicians									
a. Medical Director (entire facility)	81,782		638						
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	49,094								
b. Other									
10. Occupational Therapist									
a. Resident Care	708,432								
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	20,435								
B-13 Total Fees Paid in Lieu of Salaries	1,723,742	(21,109)	1,254						

* 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 in the Adjustment column.

*** 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.

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CSP-14 Rev. 6/95

Report of Expenditures
Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis*

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Health Drive Dental Group, 85 Old Barnes Rd, Wellingford CT 06402	Dental Services	○	⊙	N/A
Select Rehabilitation, PO Box 71985, Chicago IL 60694	PT/ST/OT	○	⊙	N/A
Trinity Health New England, 114 Woodland St, Hartford CT 06105	Medical Director	⊙	○	Trinity Health Affiliate
Omnicare of Sourthern Michigan, 525 Knotter Dr, Cheshire CT 06410	IV Consultant	○	⊙	N/A
		○	⊙	
		○	⊙	
		○	⊙	
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* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended					Page	of
Saint Mary Home	680-C	9/30/2023					15	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$							
2. Disability Insurance	$	3,992	3,558				434	
3. Unemployment Insurance	$	67	60				7	
4. Social Security (F.I.C.A.)	$	1,005,078	895,816				109,262	
5. Health Insurance	$	2,365,182	2,108,062				257,120	
6. Life Insurance (employees only) (not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	847,326	755,213				92,113	
8. Uniform Allowance	$	15,137	13,491				1,646	
9. Other (*Specify*) See Attached Schedule	$	60,558	53,975				6,583	
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$							
d. Accounting and Auditing	$							
e. Legal (*Services should be fully described on Page 15b)*	$	37,068	58,160	(25,920)			8,710	(3,882)
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	14,834	12,902				1,932	
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	34,197	29,743				4,454	
2. Cellular Phones	$							
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	$							
3. Resident Day User Fee	$	813,808	813,808					
Subtotal	$	5,197,247	4,744,788	(25,920)			482,261	(3,882)

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

Name of Legal Firm or Independent Attorney	Address
Goldman Gruder & Woods LLC	200 Connecticut Ave., Norwalk, CT 06854
Pullman & Comley LLC	850 Main St., Bridgeport, CT 06601
Varnium Riddering	39500 High Pointe Blvd., Novi, MI 48375
Treasurer State of CT Probate	250 Constitution Plaza, Hartford, CT 06103
Saint Mary Home	2021 Albany Ave., West Hartford, CT 06117
West Hartford Probate Court	50 S Main St., West Hartford, CT 06107

Services Provided by This Firm
Collection Fees
Tax Assessment
Union Matters
Removal of Fiduciary
Conservatorship
Conservatorship

Are these charges reflected in the expenditure portion of this report? If Yes, specify expe

Telephone Number
203-899-8900
203-330-2000
248-597-7400
860-757-9150
586-772-4300
860-561-7940

Charge for Service Provided
29,801
9,311
26,634
504
310
310

nse classification and line number.

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Union Education Fund	$ 53,975				$ 6,583	
Total	$ 53,975	$ -	$ -	$ -	$ 6,583	$ -

Schedule of Other Taxes

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Total	$ -	$ -	$ -	$ -	$ -	$ -

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	15b	37

The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? ⊙ Yes ○ No — If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1	
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	$
2	$
3	$
4	$
	Charge for Services Provided $

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

⊙ Yes ○ No

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Goldman Gruder & Woods LLC	203-899-8900
2 Pullman & Comley LLC	203-330-2000
3 Varnium Riddering	248-597-7400
4 Treasurer State of CT Probate	860-757-9150
5 See attached	

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

1 200 Connecticut Ave., Norwalk, CT 06854
2 850 Main St., Bridgeport, CT 06601
3 39500 High Pointe Blvd., Novi, MI 48375
4 250 Constitution Plaza, Hartford, CT 06103
5

Services Provided by This Firm (*describe fully*)

1	Collection Fees	$ 29,801
2	Tax Assessment	$ 9,311
3	Union Matters	$ 26,634
4	Removal of Fiduciary	$ 504
5	Conservatorship	$ 620
		Charge for Services Provided $ 66,870

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

⊙ Yes ○ No

Page 15, Line 1E

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

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	16	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Subtotals Brought Forward:		5,197,247	4,744,788	(25,920)			482,261	(3,882)
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$							
3. Gifts to Staff and Residents	$							
4. Employee Travel	$	5,390	4,688				702	
5. Education Expenses Related to Seminars and Conventions	$	1,310	2,708	(1,569)			406	(235)
6. Automobile Expense (*not purchase or depreciation*)	$	379	330				49	
7. Other (*Specify*)	$							
See Attached Schedule								
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (*all such expenses*)	$							
2. Advertising Telephone Directory (*all such expenses*)***	$							
3. Advertising Other (*Specify*)***	$	(1)	661	(661)			99	(100)
See Attached Schedule								
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	$	6,797	5,912				885	
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	24,404	21,225				3,179	
See Attached Schedule								
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$							
10. Contributions***	$							
See Attached Schedule								
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$							
12. Administrative Management Services**	$	2,495,454	2,170,414				325,040	
13. Other (*Specify*)	$	325,279	332,776	(49,866)			49,838	(7,469)
See Attached Schedule								
C-14 Total Administrative & General Expenditures	$	8,056,259	7,283,502	(78,016)			862,459	(11,686)

* 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 expensein the Adjustment column.

Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Total Other Travel and Entertainment	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Promtional Advertising	$ 661	$ (661)			$ 99	$ (100)
Total Other Advertising	$ 661	$ (661)	$ -	$ -	$ 99	$ (100)

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
CT Assoc of Health Care Facilities Inc	$ 913				$ 137	
Leading Age	$ 14,786				$ 2,214	
NRC Allocation	$ 5,381				$ 806	
Workday Reimbursement	$ 145				$ 22	
Total Dues	$ 21,225	$ -	$ -	$ -	$ 3,179	$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Total Contributions	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Employee Discounts	$ 1,370				$ 205	
Admin Purchased Service	$ 5,185				$ 776	
Miscellaneous Supplies	$ 1,344				$ 201	
Discount and Rebates	$ (122,446)				$ (18,337)	
Patient Transporation	$ 699	$ (699)			$ 105	$ (105)
Pastoral Care	$ 5,402				$ 809	
Software	$ 17,828				$ 2,670	
Billing Fees	$ 33,907				$ 5,078	
Record Storage	$ 2,395				$ 359	
Recruiting	$ 52,315				$ 7,835	
Social Services Purchased Services	$ 23,872				$ 3,575	
Data Lines	$ 13,928				$ 2,086	
IC Professional Liability	$ 44,564	$ 44,603			$ 6,674	$ 6,680
License & Certifications	$ 644				$ 96	
Sales Tax	$ 292				$ 44	
Fines & Penalties	$ 20,553	$ (20,553)			$ 3,078	$ (3,078)
Bank Fees	$ 9,559	$ (9,559)			$ 1,432	$ (1,432)
Loss on Sale of Equipment	$ 127,270				$ 19,060	
Non Reimburseable	$ 272	$ (272)			$ 41	$ (41)
Miscellaneous Expense	$ 16,311	$ (17,876)			$ 2,443	$ (2,677)
IC Insurance Other	$ 77,512	$ (45,510)			$ 11,608	$ (6,816)
Total Other Administrative and General	$ 332,776	$ (49,866)	$ -	$ -	$ 49,838	$ (7,469)

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Schedule C-1 - Management Services*

Name of Facility Saint Mary Home	License No. 680-C	Report for Year Ended 9/30/2023	Page 17 | 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Mercy Community Health	2,495,455	Direct costs associated with the parent company including wages of the CEO, CFO, Addministrative Asst, and the VP of HR and other directly non-allocated expenses	Pg. 16 line m12
		such as insurance for the officers and financial	
Trinity Health		consulting. Cash management and financing services including access to the bonding markets for financing,	
		administrative services via a continuum care	
		management leadership, purchasing management services, legal services, corporate compliance, and quality.	

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

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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
Saint Mary Home	680-C	9/30/2023	18	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	926,767	607,219				319,548	
2. Non-Food Supplies	$	90,409	59,236				31,173	
3. Other (*Specify*)_____	$							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	729,317	477,850				251,467	
c. Other (*Specify*)_____	$							
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	1,746,493	1,144,305				602,188	

2E. Dietary Questionnaire	Total	CCNH / RHNS	(Specify)	Residential Care Home
F. Resident Meals: Total no. of meals served per day:*				

G.	Is cost of employee meals included in 2D?	○ Yes	⊙ No	
H.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⊙ 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	19	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
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. $	31,157	20,414				10,743	
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.							
	Amt. $							
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.							
	Amt. $							
4. Repair and/or purchase of linens.***	Lbs.							
	Amt. $							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*)	$							
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	31,157	20,414				10,743	

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ 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.

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

Name of Facility	License No.	Report for Year Ended					Page	of
Saint Mary Home	680-C	9/30/2023					20	37

Item			Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
4. Housekeeping	Sq. Ft. Serviced by Personnel								
a. In-House Care									
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	111,542	94,412				17,130	
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel								
	Amt.	$	312,817	264,776				48,041	
C. Other (*Specify*)		$							
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	424,359	359,188				65,171	
5. Resident Care (Supplies)**									
a. Prescription Drugs***									
1. Own Pharmacy		$							
2. Purchased from		$		569,134	(569,134)				
b. Medicine Cabinet Drugs		$	2,898	2,898					
c. Medical and Therapeutic Supplies		$	444,710	459,858	(15,148)				
d. Ambulance/Limousine***		$		15,719	(15,719)				
e. Oxygen									
1. For Emergency Use		$							
2. Other***		$		63,380	(63,380)				
f. X-rays and Related Radiological Procedures***		$		26,632	(26,632)				
g. Dental (*Not dentists who should be included under salaries or fees)*		$							
h. Laboratory***		$		103,410	(103,410)				
i. Recreation		$	33,011	33,461	(450)				
j. Direct Management Services*		$							
k. Indirect Management Services*		$							
l. Cable TV		$							
m. Other (Specify)**** See Attached Schedule		$							
n. Physical Therapy Expense		$							
o. Speech Therapy Expense		$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)		$	480,619	1,274,492	(793,873)				

* 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 in the Adjustment column.

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

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Total Other Resident Care	$ -	$ -	$ -	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	Residential Care Home	Pg	Line
All Waste Inc	PO Box 2472, Hartford, CT 06146	○	⊙	N/A	Rubbish Removal	39,653		21,550	22	6F
American Medical Response CT	PO Box 100296, Atlanta, GA 30384	○	⊙	N/A	Ambulance	10,454			20	5D
David Cinquegrani	303 Tunxis Rd., West Hartford, CT 06107	○	⊙	N/A	Religious Services	11,676		1,774	16	M13
Comcast	PO Box 70219, Philadelphia, PA 19176	○	⊙	N/A	Cable	33,924		18,437	22	6F
Data Facts	PKWY, Suite 400, Cordova, TN 38018	○	⊙	N/A	Recruiting Fees	9,781		1,486	16	M13
Mark Elkins	117 Chestnut Circle, West Suffield, CT 06093	○	⊙	N/A	Maintenance - Paint Project	13,509		7,341	22	6A
Kone, Inc	Floor Trumbull CT 06611	○	⊙	N/A	Elevator Maintenance	19,405		10,546	22	6A
Norton and Associates, Inc	PO Box 310, Cohasset, MA 02025	○	⊙	N/A	Social Services Consultant	42,019			13	B6
Otis Mechanical LLC	87 Liberty Hill E., Weathersfield CT 06109	○	⊙	N/A	Heating and Cooling Maintenance	36,210		19,679	22	6A
Quest Pest Control LLC	PO Box 1512 Avon, CT 06001	○	⊙	N/A	Exterminating Services	20,214		10,986	22	6F
Sodexo Affiliates	PO Box 84019, Woburn, MA 01801	○	⊙	N/A	Janitoral Services	338,509		61,419	20	4b
Sodexo Affiliates	PO Box 84019, Woburn, MA 01801	○	⊙	N/A	Maintenance Services	190,894		103,744	22	6F
Unidine Corporation	PO Box 360639, Pittsburg, PA 1154251	○	⊙	N/A	Dining Services	477,850		251,467	18	2b
		○	⊙							

* 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).

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

Name of Facility	License No.	Report for Year Ended					Page	of
Saint Mary Home	680-C	9/30/2023					22	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	250,859	162,530				88,329	
b. Heat	$	237,004	153,553				83,451	
c. Light & Power	$	330,675	216,909	(2,667)			117,882	(1,449)
d. Water	$	195,683	127,072	(290)			69,059	(158)
e. Equipment Lease (*Provide detail on page 22b*)	$	2,053	1,330				723	
f. Other (*itemize*)	$	489,623	384,981	(66,778)			209,224	(37,804)
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	1,505,897	1,046,375	(69,735)			568,668	(39,411)
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$	25,021	16,211				8,810	
b. Building & Building Improvements	$	279,134	180,849				98,285	
c. Non-Movable Equipment	$							
d. Movable Equipment	$	112,618	92,685				19,933	
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	416,773	289,745				127,028	
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$							
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$							
9. Rental payments on leased real property less real estate taxes included in item 10b	$							
10. Property Taxes								
a. Real estate taxes paid by owner	$							
b. Real estate taxes paid by lessor	$							
c. Personal property taxes	$		(359,953)	359,953			(195,622)	195,622
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	416,773	(70,208)	359,953			(68,594)	195,622

* 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	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Maintenance Supplies	$ 714	$ (16)			$ 388	$ (8)
Minor Equipment	$ 36,712	$ (17,088)			$ 19,952	$ (9,287)
Contracted Services	$ 164,109				$ 89,187	
Grounds	$ 55,704				$ 30,273	
Pest Control	$ 20,214				$ 10,986	
Fuel Oil	$ 1,349				$ 733	
Waste Removal	$ 49,305				$ 26,796	
Cable TV	$ 56,874	$ (49,674)			$ 30,909	$ (28,509)
Total Other Repairs and Maintenance	$ 384,981	$ (66,778)	$ -	$ -	$ 209,224	$ (37,804)

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	22b	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Pitney Bowes, Box 371887, 500 Ross St. Suite 154-0470, Pittsburgh, PA 15262	○	⊙	Postage Machine	06/01/22	60 months	2,053	2,053
	⊙	○					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No **Total ***** 2,053

* 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.

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CSP-23 Rev. 10/2022

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	651,251		651,251	362,838	SL	various	25,021	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								25,021
B. **Building and Building Improvements**								
1. Acquired prior to this report period	29,876,657		29,876,657	20,026,852	SL	various	266,901	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	119,405						12,233	
B-4. Subtotal								279,134
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. 2015 Ford F-350		X	9	2014	73,770		73,770	73,770	SL			
b. 2017 Ford Transit Shuttle Bus		X	11	2016	84,664		84,664	84,664	SL			
c. 2017 Ford F-350		X	6	2015	68,092		68,092	68,092	SL			
d. Various Fully Depreciated - Full List		X			283,461		283,461	283,461	SL			
2. Movable Equipment												
a. Acquired prior to this report period					6,382,568		6,382,568	5,108,047	SL	various	110,519	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative												
d. Standard Resident					15,054						2,099	
e. Specialized Resident												
Total Acquired during this report period					15,054						2,099	
D-3. Subtotal												112,618
E. ***Total Depreciation***												416,773

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Land Improvements		$ -		$ -	*
Deletions:					
Total deletions for Land Improvements		$ -		$ -	**

***Ties to Page 23, Line A3**

****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
9/7/2022	HVAC Rooftop	$ 10,223	10	$ 1,022	
6/20/2022	UTO 472	$ 12,571	10	$ 1,256	
6/17/2022	Flooring 472	$ 2,700	10	$ 270	
8/8/2022	UTO 465	$ 10,459	10	$ 1,046	
6/17/2022	Flooring 465	$ 3,500	10	$ 350	
8/25/2022	Baggot Street Bath Tile	$ 4,700	10	$ 470	
3/28/2022	Heat Pumps Fitz/Cal	$ 53,864	10	$ 5,386	
8/18/2022	East 1 Call Bell	$ 5,474	10	$ 547	
9/22/2022	Flooring FWT 180	$ 645	5	$ 129	
9/21/2022	East 3 Call Bell	$ 4,361	10	$ 436	
11/15/2022	CoGen Lenze	$ 3,156	10	$ 276	
4/29/2021	UTO 361 FWT	$ 1,094	10	$ 109	
12/8/2021	UTO FWT 450	$ 688	5	$ 138	
2/2/2022	UTO FWT 170	$ 995	5	$ 199	
2/7/2022	UTO FWT 275	$ 995	5	$ 199	
3/29/2022	UTO 473	$ 995	10	$ 100	
3/28/2022	UTO 363	$ 995	10	$ 100	
3/30/2022	UTO 471	$ 995	10	$ 100	
3/28/2022	UTO 258	$ 995	10	$ 100	
Total additions for Building Improvements		$ 119,405		$ 12,233	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

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

****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				

Total additions for Non-Movable Equipment		$ -		$ -	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line C3**

****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
6/30/2022	Microwave 472	Standard Resident	$ 180	5	$ 36	
6/6/2022	Mini Refrigerator 472	Standard Resident	$ 275	5	$ 55	
9/1/2022	Microwave 465	Standard Resident	$ 189	5	$ 38	
6/6/2022	Mini Refrigerator 465	Standard Resident	$ 275	5	$ 55	
8/1/2022	Lifts	Standard Resident	$ 8,816	10	$ 882	
5/19/2022	Air Mattress	Standard Resident	$ 5,019	5	$ 1,003	
7/7/2022	Bariatric Beds	Standard Resident	$ 300	10	$ 30	
Total additions for Movable Equipment			$ 15,054		$ 2,099	*
Deletions:						
Total deletions for Movable Equipment			$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report period

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

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	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
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	25	37

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	328
6. Square Footage	
7. Acquisition Cost	
a. Land	211,856
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Variable			
b. Date Mortgage Obtained	12/21/17			
c. Interest Rate for the Cost Year	4.00%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	7,727,037			
f. Principal balance outstanding as of _____	4,675,828			
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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	26	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
12. Interest								
A. Building, Land Improvement & Non-Movable Equipment								
1. First Mortgage	$	225289	242,264	(96,301)			131,662	(52,336)
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)	$	373,926	242,264	(96,301)			131,662	(52,336)

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	27	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Subtotals Brought Forward:	373,926	242,264	(96,301)			131,662	(52,336)
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) $	225,289	242,264	(96,301)			131,662	(52,336)
14. Insurance							
a. Insurance on Property (buildings only) $	37,258	29,658	(6,886)			16,118	(1,632)
b. Insurance on Automobiles $							
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*) $							
2. Fire and Extended Coverage $							
3. Other (*Specify*) $							
14d. ***Total Insurance Expenditures (14a + b + c)*** $	37,258	29,658	(6,886)			16,118	(1,632)
15. ***Total All Expenditures (A-13 thru C-14)*** $	28,161,133	25,285,970	(875,284)			3,680,377	70,070

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Saint Mary Home	680-C	9/30/2023	30 | 37

Item		Total	CCNH / RHNS	(Specify)	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	24,209,920	20,473,085		3,736,835
b. Medicaid Room and Board Contractual Allowance **	$	(9,145,167)	(9,145,167)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	6,285,162	6,285,162		
b. Medicare Room and Board Contractual Allowance **	$	(156,006)	(156,006)		
4. a. Private-Pay Residents and Other	$	9,182,663	8,712,054		470,609
b. Private-Pay Room and Board Contractual Allowance **	$	(1,360,029)	(1,360,029)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	169,406	169,406		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(169,406)	(169,406)		
c. Prescription Drugs - Non-Medicare	$	315,046	315,046		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$	4,654	4,654		
b. Medical Supplies - Medicare Contractual Allowance **	$	(4,654)	(4,654)		
c. Medical Supplies - Non-Medicare	$	31,035	31,035		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	1,151,830	1,151,830		
b. Physical Therapy - Medicare Contractual Allowance **	$	(1,151,830)	(1,151,830)		
c. Physical Therapy - Non-Medicare	$	2,606,254	2,606,254		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	87,049	87,049		
b. Speech Therapy - Medicare Contractual Allowance **	$	(87,049)	(87,049)		
c. Speech Therapy - Non-Medicare	$	154,244	154,244		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	1,207,172	1,207,172		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(1,207,172)	(1,207,172)		
c. Occupational Therapy - Non-Medicare	$	2,458,604	2,458,604		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	(5,352,828)	(5,352,828)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	29,228,898	25,021,454		4,207,444
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	135	135		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	(292)	(292)		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	19,117	19,117		
8. Other (*Specify*)	$	462,351	458,172		4,179
V. Total Other Revenue (1 thru 8)	$	481,311	477,132		4,179
VI. Total All Revenue (III +V)	$	29,710,209	25,498,586		4,211,623

* *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)	Residential Care Home
PG 30 II6a	LTC Revenue - Lab	$ 18,862		
PG 30 II6a	LTC C/A - Lab	$ (18,862)		
PG 30 II6a	LTC Revenue - X Ray	$ 5,760		
PG 30 II6a	LTC C/A - X Ray	$ (5,760)		
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	Residential Care Home
PG 30 II6b	LTC Lab Service Revenue	$ 29,972		
PG 30 II6b	LTC X Ray Service Revenue	$ 9,350		
PG 30 II6b	LTC Ancillary C/A	$ (5,392,150)		
Total Other Resident Revenue		$ (5,352,828)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	Residential Care Home
PG 30 IV5	Non Op Mkt Sec CMP Interest		$ (292)		
Total Interest Income			$ (292)	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	Residential Care Home
PG 30 IV8	LTC Transportation Services	$ 330		
PG 30 IV8	LTC Speciality Equipment	$ 26,375		
PG 30 IV8	Provider Incentive Revenue	$ (13,795)		
PG 30 IV8	State Funds - RCP Grant	$ 360,445		
PG 30 IV8	Unrestricted Contributions	$ 25,300		
PG 30 IV8	Rental Income - AT&T	$ 51,814		
PG 30 IV8	Miscellaneous Income	$ 17,124		$ 4,179
PG 30 IV8	MCH SWAP Cash Payments	$ (9,421)		
Total Other Revenue		$ 458,172	$ -	$ 4,179

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 222,223
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 4,359,997
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 830,718
4 Inventories				$ 114,217
5. Prepaid Expenses				$ 10,360
a. Prepaid Expense - Property Tax		10,360		
b.				
c.				
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 21,427
Deposits		21,427		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 5,558,942
B. Fixed Assets				
1. Land				$ 100,982
2. Land Improvements	*Historical Cost	651,251		$ 263,392
	Accum. Depreciation	387,859	Net	
3. Buildings	*Historical Cost	29,996,062		$ 9,690,076
	Accum. Depreciation	20,305,986	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	6,397,622		$ 1,176,957
	Accum. Depreciation	5,220,665	Net	
7. Motor Vehicles	*Historical Cost	509,987		$
	Accum. Depreciation	509,987	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 499,508
Construction in Progress		499,508		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 11,730,915

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	32	37

Account				Amount
			Total Brought Forward:	$ 17,289,857
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 (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 80,051
IC Other AR		40,701		
LT Other Assets Gross 1		39,350		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 80,051
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 17,369,908

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 1,593,762
	2. Notes Payable (*itemize*)				$
	See Schedule				
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
	Name of Lender	Purpose	Amount	Date Due	
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 1,619,039
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 3,872,135
	ST Asset Reitrement Obligation	2,808,575	Older Prior Year Medica	15,699	
	IC Current Portion of LT	185,116			
	AP Patient Credit Balance LTC	677,160			
	Other Custodial Funds	185,585	See Schedule		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 7,084,936

* 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	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	34	37

Account	Amount
Total Brought Forward:	7,084,936
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 9,045,741
IC LT Debt Net of Current Portion	9,045,741	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 9,045,741
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 16,130,677

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

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	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 (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$ 265,000
	6. Total Reserves	$ 265,000
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 230,367
	6. Gain or Loss for Period 10/1/2022 thru 9/30/2023	$ 743,864
	7. Total Net Worth	$ 974,231
C.	***Total Reserves and Net Worth***	$ 1,239,231
D.	***Total Liabilities, Reserves, and Net Worth***	$ 17,369,908

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2022			$ 211,661
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 29,710,209
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 28,966,345
D.	Net Income or Deficit			$ 743,864
E.	Balance			$ 955,525
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Temp Restricted Net Assets Released		18,706	
	2. Other (*itemize*)			
F-3.	Total Additions			$ 18,706
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/23		$ 974,231

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Mary Home	680-C	9/30/2023	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☑ (Specify)	☑ Residential Care Home

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Haley Gregory

Addres Address	Phone Number
20555 Victor Parkway	734-343-6611

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Pamela Latovick	734-343-6628

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