State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2023

Name of Facility (as licensed) Saint Joseph Living Center LLC		
Address (No. & Street, City, State, Zip Code) 14 Club Rd. Windham, CT 06280		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	20397			07-5321

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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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 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 Joseph Living Center LLC [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) Ginny Person			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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Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Saint Joseph Living Center LLC	Period Covered:		From 10/1/2022	To 9/30/2023
Address of Facility 14 Club Rd. Windham, CT 06280				
Report Prepared By RKL LLP	Phone Number 717-394-5666		Date	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$				
5. All other wages paid	$				
6. ***Total Wages Paid***	$				
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
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Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Saint Joseph Living Center LLC	14 Club Rd. Windham, CT 06280

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	20397			07-5321

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

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.:	
Ginny Person		001882

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC	20397	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

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

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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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	%**				
Diocese of Norwich	201 Broadway, Norwich, CT 06360	○	⊙		Health Insurance	15/1a5	959,541	959,541
Diocese of Norwich	201 Broadway, Norwich, CT 06360	○	⊙		Auto Insurance	27/14b	2,975	2,975
Christian Brothers	1205 Windham Parkway, Romeoville, IL 60446	○	⊙		Pension	15/Ia7	143,349	143,349
See Attached List		○	⊙		Pastoral	13/B12	14,300	14,300
Diocese of Norwich	201 Broadway, Norwich, CT 06360	○	⊙		Advertising	16/M3	10,338	198
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* 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.

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
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
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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, PO Box 371887, Pittsburgh, PA 15250-7887	○	⊙	Postage Machine	06/20/21	36 months	3,257	3,257
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	3,257

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No

* 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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General Information and Questionnaire
Accounting Basis

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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	Address (No. & Street, City, State, Zip Code)
1 CliftonLarsonAllen LLP	29 South Main St, West Hartford, CT 06127
2 RKL LLP	1800 Fruitville Pike, Lancaster, PA 17601
3	
4	

Services Provided by This Firm (*describe fully*)

1	Audited Financial Statements & Tax Form 990	$	42,026
2	Financial Consulting & Medicaid and Medicare Cost Reports	$	89,441
3		$	
4		$	

Charge for Services Provided: $ 131,467

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

◉ Yes ○ No — 15/1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha Cullina LLP	860-240-6000
2 Halloran & Sage	203-672-5432
3 Pulman & Comely LLC	860-424-4300
4 ReedSmith	469-680-4200
5	

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

1 City Place 1 Asylum Street, Hartford, CT 06103
2 265 Church Street Suite 802 New Haven, CT 06510
3 90 State House Square, Hartford, CT 06103
4 2850 N. Harwood Street Suite 1500 Dallas, TX 75201
5

Services Provided by This Firm (*describe fully*)

1	Review of contracts, response preparation, telephone conferences, various	$	50,331
2	CHRO complaint from employee	$	6,175
3	CHEFA's Loan payoff counsel	$	606
4	Loan payoff counsel	$	6,350
5		$	

Charge for Services Provided: $ 63,462

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

◉ Yes ○ No — 15/1e

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30 Total	Period 10/1 Thru 6/30 CCNH	Period 10/1 Thru 6/30 RHNS	Period 10/1 Thru 6/30 (Specify)	Period 7/1 Thru 9/30 Total	Period 7/1 Thru 9/30 CCNH	Period 7/1 Thru 9/30 RHNS	Period 7/1 Thru 9/30 (Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	120	120			120	120						
B. On last day of THIS report period	120	120							120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	84	84			84	84						
B. As of midnight of THIS report period	82	82							82	82		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,485	1,485			1,237	1,237			248	248		
B. Medicaid (Conn.)	20,653	20,653			15,661	15,661			4,992	4,992		
C. Medicaid (other states)												
D. Private Pay	4,020	4,020			2,765	2,765			1,255	1,255		
E. State SSI for RCH												
F. Other (Specify) MA Plans & Contracts	3,998	3,998			2,742	2,742			1,256	1,256		
G. Total Care Days During Period (3A thru F)	30,156	30,156			22,405	22,405			7,751	7,751		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	33	33			19	19			14	14		
B. Other Bed Reserve Days	16	16			4	4			12	12		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	30,205	30,205			22,428	22,428			7,777	7,777		

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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 (1)	RHNS (2)	(Specify) (3)	Lost (1)	Lost (2)	Lost (3)	Gained (1)	Gained (2)	Gained (3)	CCNH	RHNS	(Specify)	

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)
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	(Specify)	R.C.H.	ICF-MR
No. of Residents	4	56		22				
Per Diem Rate								
a. One bed rm.		274.21		470.00				
b. Two bed rms.		274.21		440.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	1,012	1,012		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	8,636	8,636		
D. ***Total Physical Therapy Treatments***	9,648	9,648		
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				
C. Other	397	397		
D. ***Total Speech Therapy Treatments***	456	456		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,360	1,360		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	10,160	10,160		
D. ***Total Occupational Therapy Treatments***	11,520	11,520		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	152,085	2,032				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	333,917	9,929				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	34,457	1,064				
c. Dietary Workers	331,212	16,044				
6. Housekeeping Service						
a. Head Housekeeper	20,563	754				
b. Other Housekeeping Workers	143,254	7,116				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	117,283	4,084				
8. Laundry Service						
a. Supervisor	18,490	678				
b. Other Laundry Workers	123,406	5,929				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	250,198	3,792				
b. RN						
1. Direct Care	799,813	13,915				
2. Administrative**	404,155	13,406				
c. LPN						
1. Direct Care	932,364	22,662				
2. Administrative**						
d. Aides and Attendants	1,721,225	68,271				
e. Physical Therapists	82,607	1,671				
f. Speech Therapists	20,627	291				
g. Occupational Therapists	104,853	2,960				
h. Recreation Workers	133,547	6,200				
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	109,826	3,075				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	32,841	1,533				
A-13. Total Salary Expenditures	5,866,723	185,406				

* 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)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Pastoral Wages	$ 32,841	1,533				
Total	$ 32,841	1,533	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Pastoral Service	$ 14,300	146				
Total	$ 14,300	146	$ -	-	$ -	-

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

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

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Ginny Person	152,085			Standard	Responsible for daily operations of the facility	2,032	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 Joseph Living Center LLC	20397	9/30/2023	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	25,840	598				
2. Dentist	13,032	79				
3. Pharmacist	14,847	175				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	60,000	527				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	35,883	550				
2. Administrative***						
b. LPN						
1. Direct Care	163,530	2,841				
2. Administrative***						
c. Aides	63,970	1,897				
d. Other						
12. Other (Specify)						
See Attached Schedule	14,300	146				
B-13 Total Fees Paid in Lieu of Salaries	391,402	6,813				

* 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.

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

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Saint Joseph Living Center LLC	20397	9/30/2023	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Margaret B Higgins, 635 RT 197, Woodstock ,CT 06281	Dietician	○	⊙	
HealthDrive Dental Group, 1 Prestige Dr, Meriden, CT 06450	Dentist	○	⊙	
Omnicare Pharmacy Services, PO Box 715268, Columbus, OH 43271	Pharmacist	○	⊙	
Michael Kilgannon, MD, 60 Fieldstone Drive, Storrs, CT 06268	Medical Director	○	⊙	
Elizabeth Visone, APRN, 1 Enders Rd, Windsor, CT 06095	Medical Director	○	⊙	
See List Attached to Page 4	Pastoral Care	⊙	○	Affiliate Organization
Facility Compliance Services, 221 West Main St, Plantsville, CT 06479	Emergency Preparedness & Risk Assessment	○	⊙	
All American Healthcare Services, Inc, 484 Broad St, Suite 302, Newark, NJ 07102	Agency Nursing	○	⊙	
Genie Healthcare, Suite 100, Monroe, NJ 08831	Agency Nursing	○	⊙	
Jireh Medical Staffing, 4 Collins Road, Bethany, CT 06524	Agency Nursing	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* 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 Joseph Living Center LLC	20397	9/30/2023	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	182,942	182,942		
2. Disability Insurance	$				
3. Unemployment Insurance	$	61,150	61,150		
4. Social Security (F.I.C.A.)	$	388,177	388,177		
5. Health Insurance	$	959,541	959,541		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	143,349	143,349		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	8,632	8,632		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	25,294	25,294		
d. Accounting and Auditing	$	131,467	131,467		
e. Legal (*Services should be fully described on Page 7)*	$	41,632	41,632		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	19,025	19,025		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	6,242	6,242		
2. Cellular Phones	$	838	838		
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	$	538,154	538,154		
Subtotal	$	2,506,443	2,506,443		

* 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**

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Employee Physicals	$ 8,427		
Employee Benefits- Other	$ 205		
Total	$ 8,632	$ -	$ -

Schedule of Other Taxes

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

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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 Joseph Living Center LLC	20397	9/30/2023	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,506,443	2,506,443		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	948	948		
5. Education Expenses Related to Seminars and Conventions	$	7,340	7,340		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	49,361	49,361		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	10,338	10,338		
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	$	5,688	5,688		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	13,030	13,030		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	510	510		
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)*	$	122,811	122,811		
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	179,297	179,297		
C-14 Total Administrative & General Expenditures	$	2,895,766	2,895,766		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Business Promotion	$ 5,203		
Advertising	5,135		
Total Other Advertising	$ 10,338	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM	$ 190		
Leading Age	11,000		
CT-LTMAP	350		
Verathon	1,350		
BJS	140		
Total Dues	$ 13,030	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
G&A -Professional Fees	$ 152,700		
G&A-Copier Equipment	128		
G&A -Licenses	3,545		
G&A -Licenses	5,623		
G&A -Taxes - General	255		
G&A -Breakroom Expense	1,298		
G&A -Service Charges- Bank	5,493		
G&A- State of CT Treasurer	500		
G&A-Hair Services	55		
G&A-Misc	147		
G&A-Business Cards	50		
G&A -Bank Reconciliation Adjustments	(712)		
G&A -Citations/Fines	2,416		
G&A- Disallowed Board Meeting Exp	238		
Pastoral Services-Supplies	1,064		
Pastoral Services-Restricted Chapel	262		
Employee Benefits-New Hire Expenses	3,191		
Employee Benefits-Employee Relations	3,044		
Total Other Administrative and General	$ 179,297	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2023	Page 17 | of 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 #
Legacy Lifecare Consulting 240 Lynnfield Street Peabody, MA 01960	150,000	Legacy provided operational, clinical, and financial services to SJLC to increase performance and financial results.	16M13

*** 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 Joseph Living Center LLC	20397	9/30/2023	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	254,423	254,423		
2. Non-Food Supplies	$	36,507	36,507		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	350,777	350,777		
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	641,707	641,707		

2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals:	Total no. of meals served per day:*	3	3		

G.	Is cost of employee meals included in 2D?	○ 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
Saint Joseph Living Center LLC	20397	9/30/2023	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
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. $	10,754	10,754		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Laundry Supplies	$	79,137	79,137		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	89,891	89,891		

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 Joseph Living Center LLC	20397	9/30/2023	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	27,830	27,830		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*) Contracted Housekeeping		$	131,961	131,961		
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	159,791	159,791		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	219,967	219,967		
b. Medicine Cabinet Drugs		$	23,133	23,133		
c. Medical and Therapeutic Supplies		$	127,285	127,285		
d. Ambulance/Limousine***		$	5,763	5,763		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	30,198	30,198		
f. X-rays and Related Radiological Procedures***		$	7,532	7,532		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	12,649	12,649		
i. Recreation		$	12,703	12,703		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	332,908	332,908		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	772,138	772,138		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Nursing-Supplies - Patient Personal	$ 71		
Nursing-Physician Service	1,102		
Nursing-COVID Vaccine Expenses	326		
PT-Supplies	72		
PT-Other - Management Fee	30,000		
PT-Purchased Services	109,680		
OT-Supplies	902		
OT-Purchased Services	154,267		
ST-Purchased Services	15,579		
Medical Supplies-IV Therapy Supplies	883		
Medical Supplies-IV Therapy Supplies Me	1,344		
Medical Supplies-IV Therapy Supplies In	8,872		
Medical Supplies-IV Therapy Consultant	2,010		
Medical Supplies-DME Rental	7,800		
Total Other Resident Care	$ 332,908	$ -	$ -

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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 Joseph Living Center LLC	20397	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)	Pg	Line
ADP	PO Box 8242875, Boston, MA 02284	○	⊙		Payroll Processing	37,910			16	m11
Conn Computer Service Inc	Box 35, Plantsville, CT 06479	○	⊙		Service Contracts	66,584			15/22	1g/6a
Healthpro Management Services	536 Old Howell Rd, Greenville, SC 29615	○	⊙		Rehab Department Software & Consulting	30,000			20	5l
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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 Joseph Living Center LLC	20397	9/30/2023	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	81,332	81,332		
b. Heat	$	68,854	68,854		
c. Light & Power	$	106,451	106,451		
d. Water	$	24,784	24,784		
e. Equipment Lease (*Provide detail on page 6*)	$	3,257	3,257		
f. Other (*itemize*)	$	253,598	253,598		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	538,276	538,276		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	4,143	4,143		
b. Building & Building Improvements	$	61,956	61,956		
c. Non-Movable Equipment	$	18,718	18,718		
d. Movable Equipment	$	105,203	105,203		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	190,020	190,020		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$	11,384	11,384		
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	11,384	11,384		
9. Rental payments on leased real property less real estate taxes included in item 10b	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$	8	8		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	201,412	201,412		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
POM-Service Contracts	$ 160,770		
POM-Trash Removal	38,406		
POM-Internet Serivces	1,379		
POM-Grounds Maintenance	46,375		
POM-Grounds Landscaping	5,770		
POM-Other	180		
POM-Rent - Storage	718		
Total Other Repairs and Maintenance	$ 253,598	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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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	166,319		166,319	133,857	SL	Various	4,143	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								4,143
B. **Building and Building Improvements**								
1. Acquired prior to this report period	8,034,468		8,168,731	11,733,233	SL	Various	57,390	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	134,263						4,566	
B-4. Subtotal								61,956
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	803,245		803,245	674,328	SL	Various	18,718	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								18,718

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. Senator Bus	x		12	2001	44,405		44,405	44,405				
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					2,225,366		2,239,773	2,333,404			100,732	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					14,407						4,471	
D-3. Subtotal												105,203
E. ***Total Depreciation***												190,020

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life
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
Additions:			
10/1/2022	Roof	$ 126,000	30
12/14/2022	Toilets	1,580	15
12/28/2022	Cracked Heater 72 Degrees	6,683	20
Total additions for Building Improvements		$ 134,263	
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
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	Cost	Useful Life
Additions:			
10/1/2022	MatrixCare Software	$ 8,075	2
5/16/2023	CS Bases	3,006	5
6/20/2023	Clothing Label	2,165	5
8/8/2023	Pressure Machine	1,161	5
Total additions for Movable Equipment		$ 14,407	
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
Additions:			
Total additions for Leasehold Improvement		$ -	
Deletions:			
Total deletions for Leasehold Improvement		$ -	

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

Depreciation	
$	-
$	- *
$	- **

Depreciation	
	4,200
	88
	278
$	4,566 *
$	- **

Depreciation	
$	- *

$ -	**

Depreciation	
4,038	
250	
144	
39	
$ 4,471	*
$ -	**

Depreciation	
$ -	*
$ -	**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC	20397	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. Insurance Costs	6	2016	87 months	83,919	71,513	SL		11,384	
2.									
3.									
A-4. Subtotal									11,384
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									11,384

* 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 Joseph Living Center LLC	20397	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	02/17/94
2. Date Structure Completed	09/01/88
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	10/12/88
5. Total Licensed Bed Capacity	120
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	6,458,157

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	06/15/16			
c. Interest Rate for the Cost Year	3.32%			
d. Term of Mortgage (number of years)	10			
e. Amount of Principal Borrowed	2,840,000			
f. Principal balance outstanding as of ___9/30/23_	2,240,000			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

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

Name of Facility	License No.	Report for Year Ended	Page of
Saint Joseph Living Center LLC	20397	9/30/2023	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage	$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	$	2,840,000			
2. Loan Origination Date		06/15/16			
3. Interest Rate %		3.32%			
4. Term		10			
5. CHEFA Interest Expense		77,474	77,474		
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)	$	77,474	77,474		

(*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 Joseph Living Center LLC	20397	9/30/2023	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	77,474	77,474		
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) $	77,474	77,474		
14. Insurance				
a. Insurance on Property (buildings only) $	220,677	220,677		
b. Insurance on Automobiles $	2,975	2,975		
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)*** $	223,652	223,652		
15. ***Total All Expenditures (A-13 thru C-14)*** $	11,858,232	11,858,232		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
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Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $	104,853	104,853		
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $	25,294	25,294		
10.			Accounting $				
10a.			Legal $	12,279	12,279		
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.			Unallowable Advertising * $	10,338	10,338		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	18,862	18,862		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	171,626	171,626		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	8a	G&A - Dues & Membership	$ 13,030		
30	IV8	Other Revenue-Restricted Revenue	105		
30	IV8	Other Revenue-Chapel-Restricted Revenue	1,344		
30	IV8	Other Revenue-Rec-Restricted Revenue	1,150		
30	IV8	Other Revenue-Pet Therapy Restricted Re	149		
16	m3	Employee Benefits-Employee Relations	3,044		
16	m3	G&A -Miscellaneous Expense	752		
16	m3	G&A -Bank Reconciliation Adjustments	(712)		
Total Other A&G Adjustments			$ 18,862	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Saint Joseph Living Center LLC	20397	9/30/2023	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	171,626	171,626		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $	126,037	126,037		
28.			Ambulance/Limousine $	7,368	7,368		
29.			X-rays, etc $	8,638	8,638		
30.			Laboratory $	10,679	10,679		
31.			Medical Supplies $	26,385	26,385		
32.			Oxygen (non emergency) $				
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	37,752	37,752		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $				
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49.			***Total Amount of Decrease (Items 1 - 48)*** $	388,485	388,485		

*** 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.

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5l	Nursing-Supplies - Patient Personal	$ 71		
20	5l	Nursing-Physician Service	1,102		
20	5l	PT-Supplies	72		
20	5l	OT-Supplies	902		
20	5l	ST-Purchased Services	15,579		
20	5l	Medical Supplies-DME Rental	7,800		
20	5l	Medical Supplies-IV Therapy Consultant	2,010		
20	5l	Medical Supplies-IV Therapy Supplies Me	1,344		
20	5l	Medical Supplies-IV Therapy Supplies In	8,872		
Total Other Ancillary Costs			$ 37,752	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Saint Joseph Living Center LLC	20397	9/30/2023	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	9,208,798	9,208,798		
b. Medicaid Room and Board Contractual Allowance **	$	(3,560,361)	(3,560,361)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	650,382	650,382		
b. Medicare Room and Board Contractual Allowance **	$	(16,262)	(16,262)		
4. a. Private-Pay Residents and Other	$	3,209,374	3,209,374		
b. Private-Pay Room and Board Contractual Allowance **	$	212,229	212,229		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	87,578	87,578		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	224,439	224,439		
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	$	123,914	123,914		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	234,519	234,519		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	14,471	14,471		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	29,101	29,101		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	141,099	141,099		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	310,215	310,215		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	(11,141)	(11,141)		
b. Other *(Specify)* - Non-Medicare	$	(678,036)	(678,036)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	10,180,319	10,180,319		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$	1,590	1,590		
4. Rental of Television and Cable Services	$	(26,644)	(26,644)		
5. Interest Income *(Specify)*	$	7,529	7,529		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	98,241	98,241		
V. Total Other Revenue (1 thru 8)	$	80,716	80,716		
VI. Total All Revenue (III +V)	$	10,261,035	10,261,035		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6a	Medicare Part A-X-Ray	$ 3,284		
30/II6a	Medicare Part A-Physician Care	370		
30/II6a	Medicare Part A-Lab	5,821		
30/II6a	Medicare Part A-Contractual Adjustment	(6,322)		
30/II6a	Medicare B-Vaccines	1,639		
30/II6a	Medicare B-Contractual Adjustment	(15,933)		
Total Other Resident Revenue - Medicare		$ (11,141)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6b	Private-Physician Care	$ (19)		
30/II6b	Medicaid-Contractual Adjustment	(3,891)		
30/II6b	Managed Care-X-Ray	7,430		
30/II6b	Managed Care-Physician Care	1,196		
30/II6b	Managed Care-Lab	7,674		
30/II6b	Managed Care-Contractual Adjustment	(643,799)		
30/II6b	Managed Care B-Vaccines	279		
30/II6b	Managed Care B-Contractual Adjustment	(46,906)		
30/II6b	Insurance B-Contractual Adjustment	-		
Total Other Resident Revenue		$ (678,036)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/IV5	Interest Income		$ 7,529		
Total Interest Income			$ 7,529	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30/IV8	Other Revenue-Restricted Revenue	$ 105		
30/IV8	Other Revenue-Chapel-Restricted Revenue	1,344		
30/IV8	Other Revenue - Rehab- Retricted Revenu	4,911		
30/IV8	Other Revenue-Rec-Restricted Revenue	1,150		
30/IV8	Other Revenue-Pet Therapy Restricted Re	149		
30/IV8	Other Revenue-AR Transfer/Suspense	399		
30/IV8	Other Revenue-Fundraising Revenue	250		
30/IV8	Other Revenue-Charitable Donations	5,945		
30/IV8	Other Revenue-Misc. Income	41,146		
30/IV8	Other Revenue-Recovery Of Bad Debt	2,766		
30/IV8	Other Revenue-Small Balance Adjustments	34		
30/IV8	Other Revenue-Discounts Earned	40,042		
Total Other Revenue		$ 98,241	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC	20397	9/30/2023	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 990,082
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,368,773
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 82,625
5. Prepaid Expenses				$ 104,715
a.				
b.				
c.				
d. See Schedule		104,715		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 2,660
See Schedule		2,660		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,548,855
B. Fixed Assets				
1. Land				$ 1,220,000
2. Land Improvements	*Historical Cost	166,319		$ 28,319
	Accum. Depreciation	138,000	Net	
3. Buildings	*Historical Cost	8,168,731		$ (3,626,458)
	Accum. Depreciation	11,795,189	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	803,245		$ 110,199
	Accum. Depreciation	693,046	Net	
6. Movable Equipment	*Historical Cost	2,239,773		$ (198,834)
	Accum. Depreciation	2,438,607	Net	
7. Motor Vehicles	*Historical Cost	44,405		$
	Accum. Depreciation	44,405	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 4,622,102
See Schedule		4,622,102		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 2,155,328

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Prepaid Expenses	$ 33,982
31	A5	Prepaid Insurance	69,312
31	A5	Prepaid Accounting Fees	1,421
Total Prepaid Expenses			$ 104,715

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

Page Ref	Line Ref	Description	
31	A8	Refundable Deposits	$ 2,660
Total Other Current Assets (Itemize)			$ 2,660

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

Page Ref	Line Ref	Description	
31	B9	Book vs. Cost	$ 4,622,102
Total Other Other Fixed Assets (Itemize)			$ 4,622,102

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	Accr Exp- Provider Tax	267,879
33	A12	Cur Liab -Advance Billing	92,785
33	A12	Res Rel Liab-Resident Trust	22,003
Total Other Current Liabilities (Itemize)			$ 382,667

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

Page Ref	Line Ref	Description	
34	B4	Interest Rate Swap Obligation	(27,522)
Total Other Current Liabilities (Itemize)			$ (27,522)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC	20397	9/30/2023	32	37

	Account				Amount
			Total Brought Forward:	$	4,704,183
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	83,919		
		Accum. Depreciation	82,897 Net	$	1,022
	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*)			$	
	See Schedule				
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)			$	1,022
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	4,705,205

* 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 Joseph Living Center LLC	20397	9/30/2023	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 418,940
	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*)				$ 557,898
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 14,902
	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*)				$ 6,408
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 382,667
	See Schedule			382,667	
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 1,380,815

* 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 Joseph Living Center LLC	20397	9/30/2023	34	37

Account	Amount
Total Brought Forward:	1,380,815
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$ 2,240,000
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$ (27,522)
See Schedule (27,522)	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 2,212,478
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 3,593,293

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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 Joseph Living Center LLC	20397	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	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 2,709,159
	6. Gain or Loss for Period 10/1/2022 thru 9/30/2023	$ (1,597,247)
	7. Total Net Worth	$ 1,111,912
C.	***Total Reserves and Net Worth***	$ 1,111,912
D.	***Total Liabilities, Reserves, and Net Worth***	$ 4,705,205

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC	20397	9/30/2023	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2022			$ 2,603,157
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 10,261,035
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 11,858,282
D.	Net Income or Deficit			$ (1,597,247)
E.	Balance			$ 1,111,912
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
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			$ 1,111,912

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC	20397	9/30/2023	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer	
RKL LLP	
Addres Address	Phone Number
1800 Fruitville Pike, Lancaster, PA 17601	717-394-5666
Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Viola Youssif	717-394-5666
Contact Email Address	
vyoussif@rklcpa.com	