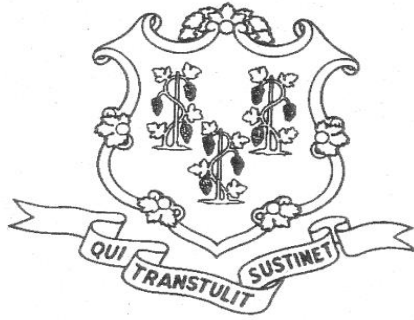


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2023

Name of Facility (as licensed) St Joseph's Residence	
Address (No. & Street, City, State, Zip Code) 1365 Enfield Street, Enfield CT 06082	
Type of Facility Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input checked="" type="checkbox"/> (Specify) <input checked="" type="checkbox"/> Residential Care Home	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 901-C	(Specify)	Residential Care Home 1678-HA	Medicare Provider 075272
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Medicaid Provider Numbers:	CCNH / RHNS 9019	(Specify)	Residential Care Home
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General Information

Name of Facility (as licensed) St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for St Joseph's Residence [facility name], for the cost report period beginning October 1, 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) Thomas Ranstrom			Printed Name (Owner) Little Sisters of the Poor		
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 St Joseph's Residence		Period Covered:	From 10/1/2022	To 9/30/2023
Address of Facility 1365 Enfield Street, Enfield CT 06082				
Report Prepared By Kevin P Kelleher CPA		Phone Number 860.677.8440	Date 2/12/2024	
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.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860.741.0791		Report for Year Ended 9/30/2023	Page 2	of 37
Name of Facility (as shown on license) St Joseph's Residence		Address (No. & Street, City, State, Zip) 1365 Enfield Street, Enfield CT 06082		
License Numbers:	CCNH / RHNS 901-C	(Specify)	Residential Care Home 1678-HA	Medicare Provider No. 075272
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input checked="" type="checkbox"/> (Specify) <input checked="" type="checkbox"/> Residential Care Home				
Type of Ownership (Check appropriate box) <input type="checkbox"/> Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> Partnership <input type="checkbox"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="checkbox"/> Government <input type="checkbox"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," explain fully.				
The RCH licensed capacity from July 1, 2022 was reduced by the State to 50 RCH beds. This was not noticed or reported on the 2022 prior year cost report.				
Administrator				
Name of Administrator Thomas Randstrom		Nursing Home Administrator's License No.:	1968	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name none		License No.:		

General Information and Questionnaire Related Parties*

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? 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	%**				
Little Sisters of the Poor	1365 Enfield St, Enfield CT 06082	<input type="radio"/>	<input checked="" type="radio"/>		lendor of funds	pg 26 / ln 12A1		n/a Motherhouse of Ord
Little Sisters of the Poor	1365 Enfield St, Enfield CT 06082	<input type="radio"/>	<input checked="" type="radio"/>		12 Sisters employed	pg 10 / ln var	422,066	n/a Motherhouse of Ord
Little Sisters of the Poor	1365 Enfield St, Enfield CT 06082	<input type="radio"/>	<input checked="" type="radio"/>		Computer IT and Human Resources Services	pg 16 / ln M13	12,000	12,000
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.
 ** Provide the percentage amount of revenue received from non-related parties.

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (<i>See listing page 13</i>)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.
 No changes from prior cost reporting periods. Related party is the Motherhouse of the Order of Roman Catholic Nuns.

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

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

General Information and Questionnaire
Other Lines of Business

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility.		0		
Outpatient Therapy				
Does the Facility provide outpatient therapy services?		No		
<i>If yes, please complete the following:</i>				
Square footage of therapy space.				
Meals on Wheels				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
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?			
<i>If yes, please state where costs are reported.</i>				
No	Are drivers for the program included in the facility's payroll?			
<i>If yes, please complete the following:</i>				
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		
<i>If yes, please complete the following:</i>				
Square footage of apartments				
Square footage of independent living				
Square footage of assisted living				
Please identify the services provided:				

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023	Page 7	of 37
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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:

Schedule of Resident Statistics

Name of Facility St Joseph's Residence			License No. 901-C		Report for Year Ended 9/30/2023				Page 8	of 37			
	Total All Levels	Total CCNH / RHNS Level	Total	Total Residential Care Home	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH / RHNS	(Specify)	Residential Care Home	Total	CCNH / RHNS	(Specify)	Residential Care Home	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	75	25		50	75	25		50					
B. On last day of THIS report period	75	25		50					75	25			50
2. Number of Residents													
A. As of midnight of PREVIOUS report period	68	24		44	68	24		44					
B. As of midnight of THIS report period	70	25		45					70	25			45
3. Total Number of Days Care Provided During Period													
A. Medicare	575	575			518	518			57	57			
B. Medicaid (Conn.)	8,384	8,384			6,190	6,190			2,194	2,194			
C. Medicaid (other states)													
D. Private Pay	1,186			1,186	753			753	433				433
E. State SSI for RCH	14,496			14,496	10,969			10,969	3,527				3,527
F. Other (Specify)													
G. Total Care Days During Period (3A thru F)	24,641	8,959		15,682	18,430	6,708		11,722	6,211	2,251			3,960
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days													
B. Other Bed Reserve Days													
5. Total Resident Days (3G + 4A + 4B)	24,641	8,959		15,682	18,430	6,708		11,722	6,211	2,251			3,960

Schedule of Resident Statistics (Cont'd)

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No
 If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH / RHNS	(Specify)	Residential Care Home	Lost			Gained			CCNH / RHNS	(Specify)	Residential Care Home	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	(Specify)	(Specify)		
07/01/2022			X			8						50	

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	2,234		3,966
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		25				8		37
Per Diem Rate								
a. One bed rm.		#####				175.00		150.76
b. Two bed rms.								
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					
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other					
D. Total Physical Therapy Treatments					

8. Total Number of Speech Therapy Treatments

	TOTAL	CCNH / RHNS	(Specify)	Outpatient	Residential Care Home
A. Medicare - Part B					
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other					
D. Total Speech Therapy Treatments					

9. Total Number of Occupational Therapy Treatments

	TOTAL	CCNH / RHNS	(Specify)	Outpatient	Residential Care Home
A. Medicare - Part B					
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other					
D. Total Occupational Therapy Treatments					

Annual Report of Long-Term Care Facility

CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility		License No.		Report for Year Ended			Page		of	
St Joseph's Residence		901-C		9/30/2023			10		37	
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No										
Total Cost and Hours										
Item	CCNH / 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)	48,063		758				84,129		1,326	
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)										
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	242,552	(66,084)	8,678				424,567	(115,673)	15,188	
5. Dietary Service										
a. Head Dietitian	28,685		771				49,822		1,349	
b. Food Service Supervisor	14,981		756				26,019		1,324	
c. Dietary Workers	191,983		10,706				340,786		19,484	
6. Housekeeping Service										
a. Head Housekeeper										
b. Other Housekeeping Workers										
7. Repairs & Maintenance Services										
a. Engineer or Chief of Maintenance	28,734		772				50,297		1,352	
b. Other Maintenance Workers	22,362		688				39,142		1,204	
8. Laundry Service										
a. Supervisor	16,142		674				28,254		1,179	
b. Other Laundry Workers	21,818		1,327				38,191		2,323	
9. Barber and Beautician Services										
10. Protective Services	27,945		1,405				48,915		2,460	
11. Accounting Services										
a. Head Accountant										
b. Other Accountants										
12. Professional Care of Residents										
a. Directors and Assistant Director of Nurses	131,583		2,192							
b. RN										
1. Direct Care	619,050		12,799							
2. Administrative**	20,105		433							
c. LPN										
1. Direct Care	212,191		5,598				61,219		1,748	
2. Administrative**										
d. Aides and Attendants	699,979		32,316				520,645		26,251	
e. Physical Therapists										
f. Speech Therapists										
g. Occupational Therapists										
h. Recreation Workers	27,630		774				91,370		4,007	
i. Physicians										
1. Medical Director										
2. Utilization Review										
3. Resident Care***										
4. Other (Specify)										
medical records	67,004		2,061							
j. Dentists										
k. Pharmacists										
l. Podiatrists										
m. Social Workers/Case Management	26,231		652				45,915		1,141	
n. Marketing										
o. Other (Specify)										
See Attached Schedule	17,982		1,071				31,476		1,876	
<i>A-13. Total Salary Expenditures</i>	<i>2,465,020</i>	<i>(66,084)</i>	<i>84,431</i>				<i>1,880,747</i>	<i>(115,673)</i>	<i>82,212</i>	

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

Name of Facility				License No.	Report for Year Ended			Page	of	
St Joseph's Residence				901-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).										
see attached page 11a with detail										

* 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.

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

Name of Facility (as licensed)				License No.	Report for Year Ended				Page	of
St Joseph's Residence				901-C	9/30/2023				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***										
Thomas Ranstrom	48,063		84,129	insurance, pension, wc	all in charge duties	2,084	a2	none		
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended					Page	of	
St Joseph's Residence	901-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	1,469		49				2,551		85
2. Dentist	1,200		26				1,200		26
3. Pharmacist									
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	30,889	(30,889)							
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	18,000		120						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**									
d. Administrative Services facility									
1. Infection Control Committee (Quarterly meetings)									
2. Pharmaceutical Committee (Quarterly meetings)									
3. Staff Development Committee (Once annually)									
e. Other (Specify)									
9. Speech Therapist									
a. Resident Care	5,456	(5,456)							
b. Other									
10. Occupational Therapist									
a. Resident Care	66,889	(66,889)							
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care									
2. Administrative***									
b. LPN									
1. Direct Care									
2. Administrative***									
c. Aides									
d. Other									
12. Other (Specify)									
See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	123,903	(103,234)	195				3,751		111

* 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.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended					Page	of
St Joseph's Residence	901-C	9/30/2023					15	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment	
I. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 91,993	52,181				39,812		
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 30,410	17,249				13,161		
4. Social Security (F.I.C.A.)	\$ 293,099	166,252				126,847		
5. Health Insurance	\$ 277,665	157,498				120,167		
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 106,245	60,265				45,980		
8. Uniform Allowance	\$							
9. Other (<i>Specify</i>) See Attached Schedule	\$ 13,670	7,754				5,916		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$							
c. Bad Debts*	\$							
d. Accounting and Auditing	\$ 48,406	25,825				22,581		
e. Legal (<i>Services should be fully described on Page 15b</i>)	\$ 250	133				117		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$							
g. Office Supplies	\$ 17,650	9,416				8,234		
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$ 61,271	35,526				31,064	(5,319)	
2. Cellular Phones	\$							
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$							
j. Corporation Business Taxes (<i>franchise tax</i>)	\$							
k. Other Taxes (<i>Not related to property - See Page 22</i>)								
1. Income*	\$							
2. Other (<i>Specify</i>) See Attached Schedule	\$							
3. Resident Day User Fee	\$ 176,085	176,085						
Subtotal	\$ 1,116,744	708,184				413,879	(5,319)	

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
STAFF EDUCATION	\$ 4,095				\$ 3,125	
PHYSICALS	\$ 3,659				\$ 2,791	
Total	\$ 7,754	\$ -	\$ -	\$ -	\$ 5,916	\$ -

Schedule of Other Taxes

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

General Information and Questionnaire
Accounting Basis

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023	Page 15b	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 Kelleher & Company 2 3 4	Address (No. & Street, City, State, Zip Code) 11 Melrose Dr, Farmington CT 06032
--	---

Services Provided by This Firm (*describe fully*)

1 audited financial statements, cost report preparation, form 990 preparataion, audit representation	\$ 48,406
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 48,406

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

- Yes No page 15 line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Murtha Cullina 2 3 4 5	Telephone Number 860.240.6000
--	----------------------------------

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

1 280 Trumbul St, Hartford CT 06103 2 3 4 5

Services Provided by This Firm (*describe fully*)

1 Corporation filling services	\$ 250
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$ 250

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

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

Name of Facility	License No.	Report for Year Ended				Page	of
St Joseph's Residence	901-C	9/30/2023				16	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Subtotals Brought Forward:	1,116,744	708,184				413,879	(5,319)
l. Travel and Entertainment							
1. Resident Travel and Entertainment \$							
2. Holiday Parties for Staff \$							
3. Gifts to Staff and Residents \$							
4. Employee Travel \$	1,217	649				568	
5. Education Expenses Related to Seminars and Conventions \$							
6. Automobile Expense (<i>not purchase or depreciation</i>) \$	4,088	10,168	(7,987)			8,891	(6,984)
7. Other (<i>Specify</i>) See Attached Schedule \$							
m. Other Administrative and General Expenses							
1. Advertising Help Wanted (<i>all such expenses</i>) \$	4,794	2,558				2,236	
2. Advertising Telephone Directory (<i>all such expenses</i>)*** \$							
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule \$		6,187	(6,187)			5,410	(5,410)
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 \$	5,271	2,812				2,459	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule \$	8,643	4,611				4,032	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$							
9. Subscriptions \$	3,642	1,943				1,699	
10. Contributions*** See Attached Schedule \$							
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>) \$	14,356	8,343	(684)			7,295	(598)
12. Administrative Management Services** \$							
13. Other (<i>Specify</i>) See Attached Schedule \$	66,734	97,835	(62,233)			85,548	(54,416)
C-14 Total Administrative & General Expenditures \$	1,225,489	843,290	(77,091)			532,017	(72,727)

* 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 in 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
OTHER ADVERTISING	\$ 6,187	\$ (6,187)			\$ 5,410	\$ (5,410)
Total Other Advertising	\$ 6,187	\$ (6,187)	\$ -	\$ -	\$ 5,410	\$ (5,410)

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
VARIOUS	\$ 4,611				\$ 4,032	
Total Dues	\$ 4,611	\$ -	\$ -	\$ -	\$ 4,032	\$ -

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
LICENSES	\$ 2,625				\$ 2,296	
CONSULTING BILLING, IT AND HR SERVICES	\$ 12,696				\$ 11,101	
DATA PROCESSING PAYROLL FEES	\$ 8,545				\$ 7,472	
DATA PROCESSING SUPPLIES	\$ 5,513				\$ 4,821	
PROFESSIONAL BACKGROUND CHECKS, FINGERPRINTING	\$ 6,223				\$ 5,442	
MISCELLANEOUS	\$ 1,024	\$ (1,024)			\$ 895	\$ (895)
DEVELOPMENT MAILING SERVICE	\$ 9,618	\$ (9,618)			\$ 8,410	\$ (8,410)
DEVELOPMENT SUPPLIES AND EXPENSE	\$ 5,159	\$ (5,159)			\$ 4,511	\$ (4,511)
OTHER NON REIMBURESABLE	\$ 46,432	\$ (46,432)			\$ 40,600	\$ (40,600)
Total Other Administrative and General	\$ 97,835	\$ (62,233)	\$ -	\$ -	\$ 85,548	\$ (54,416)

Schedule C-1 - Management Services*

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
St Joseph's Residence		901-C	9/30/2023			18	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
2. Dietary							
a. In-House Preparation & Service							
1. Raw Food	\$ 227,962	117,537	(34,240)			204,130	(59,465)
2. Non-Food Supplies	\$ 18,068	6,602				11,466	
3. Other (Specify) _____	\$						
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$						
c. Other (Specify) _____ DIETARY EQUIPMENT REPAIRS	\$ 10,247	3,744				6,503	
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 256,277	127,883	(34,240)			222,099	(59,465)
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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No					
H. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)							
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input checked="" type="radio"/> Yes	<input type="radio"/> No			If yes, specify cost.	deminimus	
K. Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)							
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify cost.		
N. Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify amt.		
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)							

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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

Name of Facility St Joseph's Residence		License No. 901-C	Report for Year Ended 9/30/2023				Page 19	of 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. \$	16,587	6,030			10,557	
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) LAUNDRY EQUIPMENT REPAIRS		\$	2,384	867			1,517	
3D. Total Laundry Expenditures (3a + b + c)		\$	18,971	6,897			12,074	
3E. Laundry Questionnaire								
F. Is cost of employee laundry included in 3D?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		If yes, specify cost.		
G. Did you receive revenue from employees?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report? (Page/Line Item)								
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		If yes, specify cost.		
J. Did you receive revenue from these people?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		If yes, specify amt.		
K. Where is the revenue received reported in the Cost Report? (Page/Line Item)								

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

*** Pounds of Laundry only required for multi-level facilities.

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

Name of Facility		License No.	Report for Year Ended				Page	of
St Joseph's Residence		901-C	9/30/2023				20	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
4.	Housekeeping							
	a. In-House Care	Sq. Ft. Serviced by Personnel						
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	25,957	9,437			16,520	
	b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel						
		Amt. \$	319,272	116,081			203,191	
	C. Other (<i>Specify</i>)	\$						
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	345,229	125,518			219,711	
5.	Resident Care (Supplies)**							
	a. Prescription Drugs***							
	1. Own Pharmacy	\$						
	2. Purchased from OMNICARE OF CT	\$		36,286	(36,286)			
	b. Medicine Cabinet Drugs	\$	9,266	9,266				
	c. Medical and Therapeutic Supplies	\$	59,932	59,796			136	
	d. Ambulance/Limousine***	\$						
	e. Oxygen							
	1. For Emergency Use	\$						
	2. Other***	\$						
	f. X-rays and Related Radiological Procedures***	\$		3,147	(3,147)			
	g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$						
	h. Laboratory***	\$		3,451	(3,451)			
	i. Recreation	\$	7,778	4,317			3,461	
	j. Direct Management Services*	\$						
	k. Indirect Management Services*	\$						
	l. Cable TV	\$	7,682	5,282			5,669	(3,269)
	m. Other (Specify)**** See Attached Schedule	\$	41,383	27,644			13,739	
	n. Physical Therapy Expense	\$						
	o. Speech Therapy Expense	\$						
5P.	Total Resident Care Expenditures (5a - 5o)	\$	126,041	149,189	(42,884)		23,005	(3,269)

* 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.

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

Name of Facility St Joseph's Residence			License No. 901-C		Report for Year Ended 9/30/2023				Page of 21 37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	Residential Care Home	Pg	Line
PERFORMANCE HEALTHCARE SERVICES INC	WELLESLEY, MA 02481	<input type="radio"/>	<input checked="" type="radio"/>		HOUSEKEEPING SERVICES	104,044		182,120	20	4b
ENVIRO SYSTEMS CORP	18 JANSEN CT, W HARTFORD, CT 06110	<input type="radio"/>	<input checked="" type="radio"/>		HVAC MAINTENANCE	5,636		9,864	22	6f
NALCO	PO BOX 70716, CHICAGO, IL 60673	<input type="radio"/>	<input checked="" type="radio"/>		WATER MANAGEMENT	5,058		8,854	22	6f
OTIS ELEVATOR COMPANY	PO BOX 13716, NEWARK, NJ 07188	<input type="radio"/>	<input checked="" type="radio"/>		ELEVATOR MAINTENANCE	7,690		13,460	22	6f
USA WASTE AND RECYCLING	PO BOX 728, EAST WINDSOR, CT 06088	<input type="radio"/>	<input checked="" type="radio"/>		WASTE MANAGEMENT	8,373		14,655	20	4b
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

* List all contracted services over \$10,000. Use additional sheets if necessary.
 ** Refer to Page 4 for definition of related.
 *** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023					Page 22	of 37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment	
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$ 233,987	87,444	(2,372)			153,065	(4,150)	
b. Heat	\$ 112,581	49,596	(8,664)			86,815	(15,166)	
c. Light & Power	\$ 72,536	28,481	(2,109)			49,855	(3,691)	
d. Water	\$ 44,528	16,964	(728)			29,693	(1,401)	
e. Equipment Lease (Provide detail on page 22b)	\$							
f. Other (itemize)	\$ 55,859	22,231	(1,922)			38,915	(3,365)	
See Attached Schedule								
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 519,491	204,716	(15,795)			358,343	(27,773)	
7. Depreciation (complete schedule page 23*)								
a. Land Improvements	\$ 20,374	7,408				12,966		
b. Building & Building Improvements	\$ 93,601	34,032				59,569		
c. Non-Movable Equipment	\$ 173,013	62,904				110,109		
d. Movable Equipment	\$ 47,054	23,190	(6,082)			40,591	(10,645)	
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 334,042	127,534	(6,082)			223,235	(10,645)	
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	\$ 1,295	471				824		
b. Real estate taxes paid by lessor	\$							
c. Personal property taxes	\$							
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 335,337	128,005	(6,082)			224,059	(10,645)	

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

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 St Joseph's Residence			License No. 901-C			Report for Year Ended 9/30/2023		Page 22b	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed		
	Yes	No							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input checked="" type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
							Total ***		

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.

Depreciation Schedule

Name of Facility St Joseph's Residence			License No. 901-C			Report for Year Ended 9/30/2023			Page 23	of 37			
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
A. Land Improvements													
1. Acquired prior to this report period			506,427		506,427	364,973	sl	var	17,748				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			44,496		44,496		sl	15	2,626				
A-4. Subtotal										20,374			
B. Building and Building Improvements													
1. Acquired prior to this report period			8,680,569		8,680,569	7,664,967	sl	var	93,601				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal										93,601			
C. Non-Movable Equipment													
1. Acquired prior to this report period			4,150,425		4,150,425	2,521,194	sl	var	164,149				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			114,742		114,742		sl	var	8,864				
C-4. Subtotal										173,013			
		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. 2011 Honda, Van, KIA, Ford Transi						175,775		175,775	167,084				
b. 2019 Honda Pilot,					9	2019	31,935		31,935	23,951	sl	4	7,984
c. 2022 Dodge Promaster Van					8	2022	54,507		54,507	2,271	sl	4	13,627
d. 2023 Pacifica Van					6	2023	62,000		62,000		sl	4	3,100
2. Movable Equipment													
a. Acquired prior to this report period							1,865,961		1,865,961	1,681,121	sl	var	39,032
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative							46,044		46,044		sl	var	38
d. Standard Resident													
e. Specialized Resident													
Total Acquired during this report period							46,044		46,044				38
D-3. Subtotal													63,781
E. Total Depreciation													350,769

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/17/2022	Sidewalks M&S	\$ 27,600	15	\$ 1,687
12/1/2022	Sidewalks Encore	\$ 16,896	15	\$ 939
Total additions for Land Improvements		\$ 44,496		\$ 2,626 *
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:				
Total additions for Building Improvements		\$ -		\$ - *
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:				
10/11/2022	Breaker Panel, Kitchen	\$ 17,460	15	\$ 1,067
4/6/2023	PTAC Fan Coil Unit	\$ 6,882	10	\$ 344
6/15/2023	Circuit Breaker Panel	\$ 20,400	15	\$ 453
9/12/2023	Lightning Project	\$ 70,000	10	\$ 7,000
Total additions for Non-Movable Equipment		\$ 114,742		\$ 8,864 *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
9/29/2023	ASG WiFi	Administrative	\$ 41,453	5	\$ -
9/6/2023	Refrigerator	Administrative	\$ 4,591	10	\$ 38
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipment			\$ 46,044		\$ 38 *
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

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility St Joseph's Residence			License No. 901-C		Report for Year Ended 9/30/2023			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*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	75				
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of _____					
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility St Joseph's Residence		License No. 901-C	Report for Year Ended 9/30/2023				Page 26	of 37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
12. Interest								
A. Building, Land Improvement & Non-Movable Equipment								
1. First Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
2. Second Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
3. Third Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
4. Fourth Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
B. CHEFA Loan Information								
1. Original Loan Amount		\$						
2. Loan Origination Date								
3. Interest Rate %								
4. Term								
5. CHEFA Interest Expense								
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$						

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended				Page	of	
St Joseph's Residence		901-C		9/30/2023				27	37	
Item				Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Residential Care Home	Adjustment
Subtotals Brought Forward:										
12. C. Movable Equipment										
1. Automotive Equipment				\$						
A. Item		Rate	Amount							
Lender										
Address of Lender										
2. Other (Specify)				\$						
A. Item		Rate	Amount							
Lender										
Address of Lender										
B. Item		Rate	Amount							
Lender										
Address of Lender										
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$						
12. D. Other Interest Expense (Specify)				\$						
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$						
14. Insurance										
a. Insurance on Property (buildings only)				\$ 25,459	9,256				16,203	
b. Insurance on Automobiles				\$ 4,420	4,552	(2,945)			7,968	(5,155)
c. Insurance other than Property (as specified above)										
1. Umbrella (Blanket Coverage)				\$						
2. Fire and Extended Coverage				\$ 24,008	8,729				15,279	
3. Other (Specify)				\$ 534	194				340	
SURETY BOND										
14d. Total Insurance Expenditures (14a + b + c)				\$ 54,421	22,731	(2,945)			39,790	(5,155)
15. Total All Expenditures (A-13 thru C-14)				\$ 7,069,686	4,197,152	(348,355)			3,515,596	(294,707)

F. Statement of Revenue

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023			Page 30	of 37
Item	Total	CCNH / RHNS	(Specify)	Residential Care Home		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 5,706,775	3,353,600		2,353,175		
b. Medicaid Room and Board Contractual Allowance **	\$ (977,068)	(879,608)		(97,460)		
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 584,693	584,693				
b. Medicare Room and Board Contractual Allowance **	\$ (115,475)	(115,475)				
4. a. Private-Pay Residents and Other	\$ 194,750			194,750		
b. Private-Pay Room and Board Contractual Allowance **	\$ (1,171)			(1,171)		
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$					
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$					
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$					
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$					
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 5,392,504	2,943,210		2,449,294		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 16,173	5,880		10,293		
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$ 4,989	1,814		3,175		
8. Other (<i>Specify</i>)	\$ 1,861,734	676,891		1,184,843		
V. Total Other Revenue (1 thru 8)	\$ 1,882,896	684,585		1,198,311		
VI. Total All Revenue (III +V)	\$ 7,275,400	3,627,795		3,647,605		

* 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
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	Residential Care Home
Total Other Resident Revenue		\$ -	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	Residential Care Home
30	BANK INTEREST		\$ 5,880		\$ 10,293
Total Interest Income			\$ 5,880	\$ -	\$ 10,293

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	Residential Care Home
30	UNRESTRICTED CONTRIBUTIONS	\$ 542,779		\$ 950,091
30	DONATED FOODS	\$ 23,215		\$ 40,635
30	FESTIVALS AND EVENTS, NET OF EXPENSES	\$ 110,665		\$ 193,711
30	RECYCLING INCOME	\$ 232		\$ 406
Total Other Revenue		\$ 676,891	\$ -	\$ 1,184,843

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2023	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	1,793,173
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	447,255
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	64,121
a. _____				
b. _____				
c. _____				
d. See Schedule		64,121		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	46,825

See Schedule		46,825		
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,351,374
B. Fixed Assets				
1. Land			\$	598,500
2. Land Improvements	*Historical Cost	550,923	\$	165,576
	Accum. Depreciation	385,347	Net	
3. Buildings	*Historical Cost	8,680,569	\$	922,001
	Accum. Depreciation	7,758,568	Net	
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
5. Non-Movable Equipment	*Historical Cost	4,265,167	\$	1,570,960
	Accum. Depreciation	2,694,207	Net	
6. Movable Equipment	*Historical Cost	1,912,005	\$	191,814
	Accum. Depreciation	1,720,191	Net	
7. Motor Vehicles	*Historical Cost	324,217	\$	106,200
	Accum. Depreciation	218,017	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	3,555,051

* 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	A5a	PREPAID INSURANCE	\$ 52,662
31	A5a	PREPAID MAINTENANCE	\$ 11,459
Total Prepaid Expenses			\$ 64,121

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

Page Ref	Line Ref	Description	
31	A8	DEPOSIT	\$ 46,825
Total Other Current Assets (Itemize)			\$ 46,825

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

Page Ref	Line Ref	Description	
33	A12	DUE TO LSP CONVENT	\$ 15,069
Total Other Current Liabilities (Itemize)			\$ 15,069

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

Page Ref	Line Ref	Description	
34	B4	WORKING CAPITAL LOANS PAYABLE PROVINCE	\$ 21,918
Total Other Current Liabilities (Itemize)			\$ 21,918

G. Balance Sheet (cont'd)

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 5,906,425	
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			\$	
*Historical Cost _____ Accum. Depreciation _____ Net				
3. Buildings			\$	
*Historical Cost _____ Accum. Depreciation _____ Net				
4. Non-Movable Equipment			\$	
*Historical Cost _____ Accum. Depreciation _____ Net				
5. Movable Equipment			\$	
*Historical Cost _____ Accum. Depreciation _____ Net				
6. Motor Vehicles			\$	
*Historical Cost _____ Accum. Depreciation _____ Net				
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			\$	
*Historical Cost _____ Accum. Depreciation _____ Net				
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	

See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 5,906,425	

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

G. Balance Sheet (cont'd)

Name of Facility St Joseph's Residence		License No. 901-C	Report for Year Ended 9/30/2023	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	197,555
2. Notes Payable (<i>itemize</i>)				\$	

See Schedule					
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	151,251
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	15,069

See Schedule					15,069
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	363,875

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023		Page 34	of 37
Account				Amount	
Total Brought Forward:				363,875	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
				\$	
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 21,918	
See Schedule				21,918	
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 21,918	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 385,793	

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

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-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 (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	2,500,000
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	3,457,980
6. Gain or Loss for Period			\$	(437,348)
	10/1/2022	thru	9/30/2023	
7. Total Net Worth			\$	5,520,632
C. Total Reserves and Net Worth			\$	5,520,632
D. Total Liabilities, Reserves, and Net Worth			\$	5,906,425

H. Changes in Total Net Worth

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	5,957,980
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	7,275,400
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	(7,712,748)
D. Net Income or Deficit			\$	(437,348)
E. Balance			\$	5,520,632
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	5,520,632
				09/30/23

I. Preparer's/Reviewer's Certification

Name of Facility St Joseph's Residence	License No. 901-C	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> Home (CCNH) & RHNS Combined	<input checked="" type="checkbox"/> (Specify)	<input checked="" type="checkbox"/> Residential Care Home		
Preparer/Reviewer Certification				
<p>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.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Kevin P Kelleher CPA				
Address Address			Phone Number	
11 Melrose Dr, Suite 200, Farmington CT 06032			860.677.8440	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Kevin P Kelleher CPA			860.677.8440	
Contact Email Address				
kevin@kellehercpa.com				