State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2021

Name of Facility (as licensed) St Joseph's Residence		
Address (No. & Street, City, State, Zip Code) 1365 Enfield St., Enfield CT 06082		
Type of Facility ☐ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021	

License Numbers:	CCNH	RHNS	Residential Care Home	Medicare Provider
	901-C		1678-HA	075272

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	9019		

For Department Use Only

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for St Joseph's Residence [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Sister Genevieve Nugent			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)

Table of Contents

	General Information - Administrator's/Owner's Certification	1
	General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
	General Information and Questionnaire - Type of Facility - Organization Structure	2
	General Information and Questionnaire - Partners/Members	3
	General Information and Questionnaire - Corporate Owners	3A
	General Information and Questionnaire - Individual Proprietorship	3B
	General Information and Questionnaire - Related Parties	4
	General Information and Questionnaire - Basis for Allocation of Costs	5
	General Information and Questionnaire - Leases	6
	General Information and Questionnaire - Accounting Basis	7
	Schedule of Resident Statistics	8
	Schedule of Resident Statistics (Cont'd)	9
A.	Report of Expenditures - Salaries & Wages	10
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B.	Report of Expenditures - Professional Fees	13
	Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C.	Expenditures Other than Salaries - Administrative and General	15
C.	Expenditures Other than Salaries (Cont'd) - Administrative and General	16
	Schedule C-1 - Management Services	17
C.	Expenditures Other than Salaries (Cont'd) - Dietary	18
C.	Expenditures Other than Salaries (Cont'd) - Laundry	19
C.	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
	Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C.	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
	Depreciation Schedule	23
	Amortization Schedule	24
C.	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C.	Expenditures Other than Salaries (Cont'd) - Interest	26
C.	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D.	Adjustments to Statement of Expenditures	28
D.	Adjustments to Statement of Expenditures (Cont'd)	29
F.	Statement of Revenue	30
G.	Balance Sheet	31
G.	Balance Sheet (Cont'd)	32
G.	Balance Sheet (Cont'd)	33
G.	Balance Sheet (Cont'd)	34
G.	Balance Sheet (Cont'd) - Reserves and Net Worth	35
H.	Changes in Total Net Worth	36
I.	Preparer's/Reviewer's Certification	37

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1A Rev. 6/95

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 10/1/2020	To 9/30/2021
Address of Facility 1365 Enfield St., Enfield CT 06082				
Report Prepared By Kevin P Kelleher CPA	Phone Number 860.677.8440		Date 2/11/2022	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 10/2005

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860.741.0791	9/30/2021	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
St Joseph's Residence	1365 Enfield St., Enfield CT 06082

	CCNH	RHNS	Residential Care Home	Medicare Provider No.
License Numbers:	901-C		1678-HA	075272

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ○ Profit Corp. ◉ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Sister Genevieve Nugent		000695

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

Name	License No.:
none	

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	3	37

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

Name of Partners/Members	Business Address	Title	% Owned
n/a			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
St Joseph's Residence	1365 Enfield St., Enfield CT 06082	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Sister Genevieve Nugent	1365 Enfield St., Enfield CT 06082	President	n/a
Sister Regina Tamayo	1365 Enfield St., Enfield CT 06082	Vice President	n/a
Sister Joanna Keeboy Young	1365 Enfield St., Enfield CT 06082	ecretary/Treasur	n/a
Names of Stockholders Owning at Least 10% of Shares			
none			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	3B	37

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

Owner(s) of Facility
n/a

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	4	37

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Little Sisters of the Poor	1365 Enfield St., Enfield CT 06082	○	◉		Lendor of funds	pg 26 / ln 12A1		n/a motherhouse
Little Sisters of the Poor	1365 Enfield St., Enfield CT 06082	○	◉		10 Sisters employed by the facility	pg 10 / ln var	419,600	n/a motherhouse
Little Sisters of the Poor	1365 Enfield St., Enfield CT 06082	○	◉		Computer Software installation	pg 16 / ln m13		
Little Sisters of the Poor	1365 Enfield St., Enfield CT 06082	○	◉		Human Resource services	pg 16 / ln m13		
		○	◉					
		○	◉					
		○	◉					
		○	◉					
		○	◉					

* Use additional sheets if necessary.

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	5	37

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.

Related party expenses were allocated using the standard departmental allocations. 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 9/2002

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
St Joseph's Residence	901-C	9/30/2021	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	7	37

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Kelleher & Company	11 Melrose Drive, Ste 200, Farmington, CT 06032
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	audited financial statements, cost report preparation, form 990 preparation, audit representation	$ 61,864
2		$
3		$
4		$
		Charge for Services Provided $ 61,864

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

⊙ Yes ○ No page 15 ln 1d

Legal Services Information

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

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Nursing and related Medicare and Medicaid legal services	$ 3,200
2	Estate and Probate services	$ 1,923
3		$
4		$
5		$
		Charge for Services Provided $ 5,123

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	83	25		58	83	25		58				
B. On last day of THIS report period	83	25		58					83	25		58
2. Number of Residents												
A. As of midnight of PREVIOUS report period	77	25		52	77	25		52				
B. As of midnight of THIS report period	78	25		53					78	25		53
3. Total Number of Days Care Provided During Period												
A. Medicare	46	46			46	46						
B. Medicaid (Conn.)	8,872	8,872			6,594	6,594			2,278	2,278		
C. Medicaid (other states)												
D. Private Pay	1,249	134		1,115	1,086	134		952	163			163
E. State SSI for RCH	16,303			16,303	12,447			12,447	3,856			3,856
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	26,470	9,052		17,418	20,173	6,774		13,399	6,297	2,278		4,019
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)**	26,470	9,052		17,418	20,173	6,774		13,399	6,297	2,278		4,019

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	9	37

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)	Residential Care Home (3)	Lost (1)	Lost (2)	Lost (3)	Gained (1)	Gained (2)	Gained (3)	CCNH	RHNS	Residential Care Home	

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-MR
No. of Residents		24		1		5		48
Per Diem Rate								
a. One bed rm.		295.00		400.00		150.00		140.00
b. Two bed rms.								
c. Three or more bed rms.								

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	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)	27,358	711			52,642	1,369
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	170,328	6,976			327,747	13,421
5. Dietary Service						
a. Head Dietitian	24,437	726			46,108	1,396
b. Food Service Supervisor	14,202	711			26,798	1,369
c. Dietary Workers	176,836	11,157			326,463	20,654
6. Housekeeping Service						
a. Head Housekeeper	7,573	384			14,573	739
b. Other Housekeeping Workers	33,096	2,398			35,478	2,558
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	33,166	1,028			63,819	1,979
b. Other Maintenance Workers	18,598	637			35,787	1,226
8. Laundry Service						
a. Supervisor	13,212	621			25,422	1,196
b. Other Laundry Workers	22,217	1,527			42,749	2,938
9. Barber and Beautician Services						
10. Protective Services	25,906	1,479			49,849	2,846
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	128,033	2,288				
b. RN						
1. Direct Care	478,439	11,054				
2. Administrative**	75,042	1,604				
c. LPN						
1. Direct Care	185,089	5,524			52,759	1,780
2. Administrative**						
d. Aides and Attendants	688,427	34,983			496,007	28,212
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	62,835	1,983			57,197	3,566
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
medical reords	117,009	4,028				
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	6,999	209			13,467	403
n. Marketing						
o. Other (Specify)						
See Attached Schedule	23,138	1,422			44,520	2,738
A-13. Total Salary Expenditures	2,331,940	91,450			1,711,385	88,390

* 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		Residential Care Home	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Pastoral Care Salaries	$ 23,138	1,422			$ 44,520	2,738
Total	$ 23,138	1,422	$ -	-	$ 44,520	2,738

Schedule of Other Fees (Page 13)

	CCNH		RHNS		Residential Care Home	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-11 Rev. 10/2005

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	9/30/2021	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	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 Schedule Page 11a										

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
Section III - Administrators* **										
Sister Genevieve Nugent	27,358		52,642	none	all in charge duties	2,080	2	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	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	1,413	47			2,667	89
2. Dentist	820	18			1,579	35
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	41,634					
b. Other						
6. Social Worker	350	14				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	18,000	120				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	3,008					
b. Other						
10. Occupational Therapist						
a. Resident Care	64,925					
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	130,150	199			4,246	124

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
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		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	

* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 9/2018

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	9/30/2021	15	37

Item		Total	CCNH	RHNS	Residential Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	93,954	54,187		39,767
2. Disability Insurance	$				
3. Unemployment Insurance	$	3,180	1,834		1,346
4. Social Security (F.I.C.A.)	$	245,270	141,457		103,813
5. Health Insurance	$	317,765	183,267		134,498
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	104,312	60,161		44,151
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	1,638	944		694
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	61,864	33,363		28,501
e. Legal (*Services should be fully described on Page 7)*	$	5,123	2,763		2,360
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	10,881	5,868		5,013
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	80,800	43,576		37,224
2. Cellular Phones	$	5,767	3,110		2,657
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	$	189,055	189,055		
Subtotal	$	1,119,609	719,585		400,024

* 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	Residential Care Home
Staff Education	$ 520		$ 382
Staff Physicals	$ 424		$ 312
Total	$ 944	$ -	$ 694

Schedule of Other Taxes

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-16 Rev. 9/2002

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	9/30/2021	16	37

Item		Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:		1,119,609	719,585		400,024
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$				
5. Education Expenses Related to Seminars and Conventions	$				
6. Automobile Expense (*not purchase or depreciation*)	$	11,726	6,324		5,402
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	4,639	2,502		2,137
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	15,170	8,181		6,989
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	$	8,297	4,475		3,822
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	8,368	4,513		3,855
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	612	330		282
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	10,467	5,645		4,822
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	334,424	180,354		154,070
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,513,312	931,909		581,403

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	Residential Care Home
Other Advertising	$ 8,181		$ 6,989
Total Other Advertising	$ 8,181	$ -	$ 6,989

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
Leading Age	$ 3,710		$ 3,170
CT Association Health Care Facilities	$ 189		$ 161
Visa Credit Cards	$ 93		$ 79
Amazon Prime	$ 112		$ 96
Academy pof Nutrition and Dietitics	$ 126		$ 108
Chamber of Commerce	$ 283		$ 241
Total Dues	$ 4,513	$ -	$ 3,855

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Licenses	$ 787		$ 672
Consulting, Billing Services	$ 17,241		$ 14,728
Data Processing Payroll Fees	$ 7,836		$ 6,694
Data Processing Supplies	$ 10,879		$ 9,294
Professional Background Checks	$ 3,348		$ 2,860
Bad Debts / Charity Care	$ 83,232		$ 71,101
Miscellaneous	$ 342		$ 292
Development Mailing Service	$ 9,488		$ 8,105
Other Non-Reimburseable	$ 47,201		$ 40,324
Total Other Administrative and General	$ 180,354	$ -	$ 154,070

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
St Joseph's Residence	901-C	9/30/2021	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.**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 9/2018

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	9/30/2021	18 | 37

Item		Total	CCNH	RHNS	Residential Care Home
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	273,204	94,637		178,567
2. Non-Food Supplies	$	19,350	6,703		12,647
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____ Equipment Repairs	$	11,986	4,152		7,834
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	304,540	105,492		199,048

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

G.	Is cost of employee meals included in 2D?	○ 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. deminimous
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 9/2018

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 9/30/2021		Page of 19 | 37
Item	Total	CCNH	RHNS	Residential Care Home
3. Laundry a. In-House Processing* — Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.*** — Amt. $	16,794	5,743		11,051
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. $	2,448	837		1,611
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)* — $				
c. Other (*Specify*) Equipment repairs — $	3,309	1,132		2,177
3D. ***Total Laundry Expenditures*** (3a + b + c) — $	22,551	7,712		14,839

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 9/2018

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	9/30/2021	20	37

Item			Total	CCNH	RHNS	Residential Care Home
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	20,299	6,941		13,358
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	171,839	58,764		113,075
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	192,138	65,705		126,433
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Omnicare of CT		$	4,991	4,991		
b. Medicine Cabinet Drugs		$	8,979	8,471		508
c. Medical and Therapeutic Supplies		$	83,280	83,280		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$	2,492	2,492		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	1,434	1,434		
i. Recreation		$	4,444	2,309		2,135
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	44,625	25,253		19,372
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	150,245	128,230		22,015

* 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	Residential Care Home
Other Medicare A expense	$ 63		
Infectous Waste	$ 15,089		
Religious supplies	$ 1,876		$ 3,597
Pastoral Care Felician Sisters	$ 8,225		$ 15,775
Total Other Resident Care	$ 25,253	$ -	$ 19,372

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	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	Residential Care Home	Pg	Line
Performance Healthcare Services	47 River St, Wellesley, MA 02481	○	⊙	none	Housekeeping	50,306		96,800	20	4b
USA Waste and Recycling	15 Mullen Rd, Enfield CT 06082	○	⊙	none	Waste Removal	7,740		14,893	20	4b
EcoChoice Termite & Pest Control LLC	84 Spring St, Windsor Locks CT 06096	○	⊙	none	Pest Control	718		1,382	20	4b
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
St Joseph's Residence	901-C	9/30/2021	22 | 37

Item		Total	CCNH	RHNS	Residential Care Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	157,573	53,886		103,687
b. Heat	$	103,260	35,312		67,948
c. Light & Power	$	135,266	46,257		89,009
d. Water	$	83,197	28,451		54,746
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	41,057	14,040		27,017
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	520,353	177,946		342,407
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	5,601	1,915		3,686
b. Building & Building Improvements	$	134,296	45,925		88,371
c. Non-Movable Equipment	$	143,906	49,212		94,694
d. Movable Equipment	$	68,089	23,285		44,804
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	351,892	120,337		231,555
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	351,892	120,337		231,555

* 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	Residential Care Home
Contracted Maintenance services	$ 14,040		$ 27,017
Total Other Repairs and Maintenance	$ 14,040	$ -	$ 27,017

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	382,713		382,713	344,797	sl	var	5,376	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	45,100		45,100		sl	var	225	
A-4. Subtotal								5,601
B. **Building and Building Improvements**								
1. Acquired prior to this report period	8,648,519		8,648,519	7,407,132	sl	var	133,762	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	32,050		32,050		sl	5	534	
B-4. Subtotal								134,296
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	3,213,999		3,213,999	2,224,634	sl	var	118,465	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	719,234		719,234		sl	var	25,441	
C-4. Subtotal								143,906

	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. 2003 Turtle Top, 2011 Odyssey	1		6	2011	70,878		70,878	68,606	sl	10	2,272	
b. 2015 Dodge, 2007 Toyota Handicap	1		6	2015	129,561		129,561	129,091	sl	4	470	
c. 2018 KIA, 2018 Ford Transit	1		8	2018	52,072		52,072	21,673	sl	4	13,018	
d. 2019 Honda Pilot	1		9	2019	31,935		31,935	7,984	sl	4	7,984	
2. Movable Equipment												
a. Acquired prior to this report period					1,836,300		1,836,300	1,596,265	sl	var	43,108	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					9,413		9,413		sl	3	1,237	
D-3. Subtotal												68,089
E. ***Total Depreciation***												351,892

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
1/12/2021	Tree Removal	$ 3,000	10	$ 225	
9/24/2021	Parking Lot Renovations	$ 42,100	8	$ -	
Total additions for Land Improvements		$ 45,100		$ 225	*
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:					
8/31/2021	1st Floor Hallways flooring	$ 32,050	5	$ 534	
Total additions for Building Improvements		$ 32,050		$ 534	*
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:					
8/2/2021	Simplex Locks	$ 2,292	10	$ 38	
12/31/2020	Aegis Boiler Project	$ 610,000	20	$ 22,875	
6/15/2021	Aegis Boiler Project Engineering	$ 32,971	20	$ 550	
8/26/2021	ARC Study PJ Lodola	$ 11,687	10	$ 97	
9/22/2021	IR Survey Powerhawk	$ 4,758	10	$ -	
1/26/2021	Salt Water System Bypass	$ 4,852	10	$ 323	
2/10/2021	4th Floor Tub	$ 12,708	10	$ 847	
7/31/2021	PTAC Units	$ 38,162	10	$ 636	
4/20/2021	Compressor	$ 1,804	10	$ 75	
Total additions for Non-Movable Equipment		$ 719,234		$ 25,441	*
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	Depreciation	
Additions:					
4/23/2021	Computer	$ 3,531	3	$ 490	
4/12/2021	Computer	$ 2,382	3	$ 397	
10/7/2020	COVID Kiosk	$ 3,500	10	$ 350	
Total additions for Movable Equipment		$ 9,413		$ 1,237	*
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**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	83
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

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

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
St Joseph's Residence	901-C	9/30/2021	26 | 37

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

(*Carry Subtotals forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 6/95

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	9/30/2021	27 | 37

Item				Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment			$				
A. Item	Rate	Amount					
Lender							
Address of Lender							
2. Other (*Specify*)			$				
A. Item	Rate	Amount					
Lender							
Address of Lender							
B. Item	Rate	Amount					
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			$				
12. D. Other Interest Expense (*Specify*)			$				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$				
14. Insurance							
a. Insurance on Property (buildings only)			$	25,756	8,808		16,948
b. Insurance on Automobiles			$	15,500	5,301		10,199
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*)			$				
2. Fire and Extended Coverage			$	17,103	5,849		11,254
3. Other (*Specify*) Surety Bond			$	700	239		461
14d. ***Total Insurance Expenditures (14a + b + c)***			$	59,059	20,197		38,862
15. ***Total All Expenditures (A-13 thru C-14)***			$	7,291,811	4,019,618		3,272,193

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2018

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
St Joseph's Residence	901-C	9/30/2021	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.	10	A4	Salaries not related to Resident Care $	140,889	48,180		92,709
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	B10a	Occupational Therapy $	64,925	64,925		
7.			Other - See attached Schedule $	44,642	44,642		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.			Accounting $				
10a.			Legal $	5,123	2,763		2,360
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.	16	l6	Automobile Expense (e.g. personal use) $	10,126	5,461		4,665
18.	16	m3	Unallowable Advertising * $	15,170	8,181		6,989
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	261,294	140,676		120,618
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents $	92,305	31,974		60,331
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) $	634,474	346,802		287,672

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
13	B5a	Physical Therapy - Medicare	$ 41,634		
13	B9a	Speech Therapy - Medicare	$ 3,008		
Total Other Fees Adjustments			$ 44,642	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	m11	Development Software	$ 413		$ 796
16	m13	Bad Debts / Charity Care	$ 83,232		$ 71,101
16	m13	Miscellaneous	$ 342		$ 292
16	m13	Development Mailing	$ 9,488		$ 8,105
16	m13	Other Non-Reimburseable	$ 47,201		$ 40,324
Total Other A&G Adjustments			$ 140,676	$ -	$ 120,618

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 9/2018

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

Name of Facility	License No.	Report for Year Ended	Page of
St Joseph's Residence	901-C	9/30/2021	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward $	634,474	346,802		287,672
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	4,991	4,991		
28.			Ambulance/Limousine $				
29.	20	5f	X-rays, etc $	2,492	2,492		
30.	20	5h	Laboratory $	1,434	1,434		
31.			Medical Supplies $				
32.			Oxygen (non emergency) $				
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	63	63		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.	22	7d	Depreciation on Unallowable Motor Vehicles $	15,760	5,389		10,371
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $	40,051	13,697		26,354
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.	27	14b	Property Insurance $	10,714	3,664		7,050
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)***		$	709,979	378,532		331,447

*** 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	Residential Care Home
20	5l	Other Medicare A	$ 63		
Total Other Ancillary Costs			$ 63	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
22	6b	Heat (non facility utilization)	$ 7,549		$ 14,526
22	6c	Light & Power (non facility utilization)	$ 1,308		$ 2,516
22	6d	Water (non facility utilization)	$ 2,731		$ 5,255
22	6a	Maintenance (non facility utilization)	$ 279		$ 536
22	6f	Elevator maintenance (non facility utilization)	$ 1,830		$ 3,521
Total Other Property Adjustments			$ 13,697	$ -	$ 26,354

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Adjustments			$ -	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home

Total Unallowable Building Interest			$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
St Joseph's Residence	901-C	9/30/2021	30 | 37

Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	5,994,250	3,548,800		2,445,450
b. Medicaid Room and Board Contractual Allowance **	$	(1,354,622)	(1,116,078)		(238,544)
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	263,152	263,152		
b. Medicare Room and Board Contractual Allowance **	$	(59,367)	(59,367)		
4. a. Private-Pay Residents and Other	$	220,850	53,600		167,250
b. Private-Pay Room and Board Contractual Allowance **	$				
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 *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	5,064,263	2,690,107		2,374,156
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 *(Specify)*	$	2,366	811		1,555
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	2,448	839		1,609
8. Other (*Specify*)	$	2,584,364	885,965		1,698,399
V. Total Other Revenue (1 thru 8)	$	2,589,178	887,615		1,701,563
VI. Total All Revenue (III +V)	$	7,653,441	3,577,722		4,075,719

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	Residential Care Home
30	Bank Interest		$ 811		$ 1,555
Total Interest Income			$ 811	$ -	$ 1,555

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
30	Payroll Protection Program Revenue	$ 223,309		$ 428,274
30	Recycling Revenue	$ 393		$ 755
30	Festivals and Events, net of expenses	$ 33,396		$ 64,048
30	Donated Foods	$ 24,332		$ 45,911
30	Unrestricted Contributions	$ 604,535		$ 1,159,411
Total Other Revenue		$ 885,965	$ -	$ 1,698,399

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 2,115,771
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 381,549
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 76,697
a.				
b.				
c.				
d. See Schedule		76,697		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 3,193
See Schedule		3,193		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,577,210
B. Fixed Assets				
1. Land				$ 598,500
2. Land Improvements	*Historical Cost	427,813		$ 77,415
	Accum. Depreciation	350,398	Net	
3. Buildings	*Historical Cost	8,680,569		$ 1,139,141
	Accum. Depreciation	7,541,428	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	3,933,233		$ 1,564,693
	Accum. Depreciation	2,368,540	Net	
6. Movable Equipment	*Historical Cost	1,845,713		$ 205,103
	Accum. Depreciation	1,640,610	Net	
7. Motor Vehicles	*Historical Cost	284,446		$ 33,348
	Accum. Depreciation	251,098	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 3,618,200

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Prepaid Insurance and Maintenance	$ 76,697
Total Prepaid Expenses			$ 76,697

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

Page Ref	Line Ref	Description	
31	A8	Deposit on equipment	$ 3,193
Total Other Current Assets (Itemize)			$ 3,193

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description	
33	A12	Accrued Expense - user fee	$ 47,884
33	A12	Payable to Sisters Building Fund	$ 15,037
Total Other Current Liabilities (Itemize)			$ 62,921

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

Page Ref	Line Ref	Description	
34	B4	Working Capital Loans Payable Province	$ 571,918
Total Other Current Liabilities (Itemize)			$ 571,918

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	32	37

Account				Amount
			Total Brought Forward:	$ 6,195,410
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 6,195,410

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 171,843
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*)	$ 120,018
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$
7. Medicare Final Settlement Payable	$
8. Medicare Current Financing Payable	$
9. Mortgage Payable (*Current Portion*)	$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)	$
11. Accrued Income Taxes*	$
12. Other Current Liabilities (*itemize*)	$ 62,921
See Schedule 62,921	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 354,782

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	34	37

Account				Amount
			Total Brought Forward:	354,782
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (*itemize*)				$ 571,918
See Schedule	571,918			
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 571,918
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 926,700

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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	9/30/2021	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*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	$ 2,500,000
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 2,407,080
	6. Gain or Loss for Period 10/1/2020 thru 9/30/2021	$ 361,630
	7. Total Net Worth	$ 5,268,710
C.	***Total Reserves and Net Worth***	$ 5,268,710
D.	***Total Liabilities, Reserves, and Net Worth***	$ 6,195,410

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2020			$ 4,907,080
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 7,653,441
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ (7,291,811)
D.	Net Income or Deficit			$ 361,630
E.	Balance			$ 5,268,710
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***	09/30/21		$ 5,268,710

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
St Joseph's Residence	901-C	9/30/2021	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Kevin P Kelleher CPA

Addres Address	Phone Number
11 Melrose Dr. Ste 200, Farmington CT 06032	860.677.8440

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Kevin P Kelleher CPA	860.677.8440

Contact Email Address
kevin@kellehercpa.com