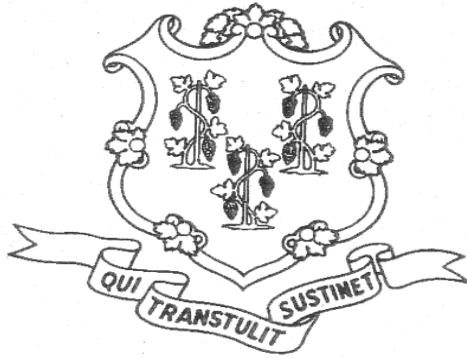


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2020

Name of Facility (as licensed) Saint Joseph Living Center LLC	
Address (No. & Street, City, State, Zip Code) 14 Club Rd. Windham, CT 06280	
Type of Facility Chronic and Convalescent                      Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH)    (RHNS)	
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

License Numbers:	CCNH 20397	RHNS	(Specify)	Medicare Provider 07-5321
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
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**For Department Use Only**

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

**General Information**

Name of Facility (as licensed) Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2020	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 Saint Joseph Living Center LLC [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Saint Joseph Living Center LLC	Period Covered:	From 10/1/2019	To 9/30/2020	
Address of Facility 14 Club Rd. Windham, CT 06280				
Report Prepared By CJLC LLC	Phone Number 860-610-9009	Date 2/15/2020		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (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 860-456-1107		Report for Year Ended 9/30/2020		Page 2	of 37
Name of Facility (as shown on license) Saint Joseph Living Center LLC			Address (No. & Street, City, State, Zip) 14 Club Rd. Windham, CT 06280		
License Numbers:		CCNH 20397	RHNS (Specify)	Medicare Provider No. 07-5321	
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input checked="" type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No   If "Yes," explain fully.					
<b>Administrator</b>					
Name of Administrator Ginny Person			Nursing Home Administrator's License No.:	001882	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		





### General Information and Questionnaire Individual Proprietorship

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2020	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

N/A



**General Information and Questionnaire  
 Related Parties\***

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2020	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	%**				
Diocese of Norwich		<input type="radio"/>	<input checked="" type="radio"/>		Heath Insurance	15/1a5	1,163,895	1,163,895
Diocese of Norwich		<input type="radio"/>	<input checked="" type="radio"/>		Auto Insurance	27/14b	4,158	4,158
Christian Brothers		<input type="radio"/>	<input checked="" type="radio"/>		Pension	15/1a7	155,059	155,059
See Attached List		<input type="radio"/>	<input checked="" type="radio"/>		Pastoral	13/B12	7,310	7,310
Diocese of Norwich		<input type="radio"/>	<input checked="" type="radio"/>		Advertising	16/m3	1,650	1,650
		<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 Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2020	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.

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

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

--
- Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)  Yes  No If "No," explain fully why such allocation was not made.  

--

### General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Saint Joseph Living Center LLC			License No. 20397	Report for Year Ended 9/30/2020			Page 6	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						
Pitney Bowes. PO Box 371887, Pittsburg PA 15250-7887	<input type="radio"/>	<input checked="" type="radio"/>	Postage Machine	12/20/18	12 months	3,448	3,448	
	<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"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes	<input checked="" type="radio"/> No
<b>Total ***</b>							3,448	

\* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

\*\* Attach copies of newly acquired leases.

\*\*\* Amount should agree to Page 22, Line 6e.

**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2020	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:  
 Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm 1 Blum, Shapiro & Co PC 2 CJLC LLC 3 4	Address (No. & Street, City, State, Zip Code) 29 South Main St West Hartford, Ct 06127-2000 225 Pitkin St Suite 200 East Hartford, Ct 06108
--	---

Services Provided by This Firm (*describe fully*)

1 Financial Consulting, Audited Financial Statements & Tax Form 990	\$ 30,165
2 Medicaid Cost Report	\$ 7,175
3	\$ .
4	\$
	Charge for Services Provided \$ 37,340

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    15/1d

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 Murtha Cullina LLP 2 Updike, Kelly & Spellacy, PC 3 Guarnaccia, Connors, Kalom & Zorn LLC 4 5	Telephone Number 860-240-6000 860-548-2600 860-423-6309
---	--

Address (*No. & Street, City, State, Zip Code*)  
 1 City Place 1 Asylum Street Hartford, Ct 06103  
 2 100 Pearl St, Hartford, CT 06103  
 3 25 Church St, Willimantic, CT 06226  
 4  
 5

Services Provided by This Firm (*describe fully*)

1 Various See Attached	\$ 20,961
2 Various See Attached	\$ 14,937
3 Mortgage Deed	\$ 313
4	\$
5	\$
	Charge for Services Provided \$ 36,211

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    15/1e

### Schedule of Resident Statistics

Name of Facility Saint Joseph Living Center LLC			License No. 20397		Report for Year Ended 9/30/2020				Page 8		of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	120	120			120	120			120	120		
B. On last day of THIS report period	120	120			120	120			120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	111	111			111	111			80	80		
B. As of midnight of THIS report period	76	76			80	80			76	76		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,827	1,827			1,735	1,735			92	92		
B. Medicaid (Conn.)	26,808	26,808			20,569	20,569			6,239	6,239		
C. Medicaid (other states)												
D. Private Pay	4,321	4,321			3,620	3,620			701	701		
E. State SSI for RCH												
F. Other (Specify) MA Plans & Contracts	1,787	1,787			1,706	1,706			81	81		
G. Total Care Days During Period (3A thru F)	34,743	34,743			27,630	27,630			7,113	7,113		
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	16	16			16	16						
5. <b>Total Resident Days (3G + 4A + 4B)</b>	34,759	34,759			27,646	27,646			7,113	7,113		

### Schedule of Resident Statistics (Cont'd)

Name of Facility Saint Joseph Living Center LLC			License No. 20397			Report for Year Ended 9/30/2020			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <span style="float: right;"><input type="radio"/> Yes <input checked="" type="radio"/> No</span>													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare	Medicaid		Self-Pay			Other State Assisted						
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR					
No. of Residents	1	69		6									
Per Diem Rate													
a. One bed rm.		227.66		445.00									
b. Two bed rms.		227.66		415.00									
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									1,632	1,632			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									9,650	9,650			
D. <b>Total Physical Therapy Treatments</b>									11,282	11,282			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									139	139			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									716	716			
D. <b>Total Speech Therapy Treatments</b>									855	855			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									1,521	1,521			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									9,589	9,589			
D. <b>Total Occupational Therapy Treatments</b>									11,110	11,110			

**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		
Saint Joseph Living Center LLC	20397	9/30/2020	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	145,257	2,316				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	447,475	15,175				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	53,261	1,760				
c. Dietary Workers	377,404	25,385				
6. Housekeeping Service						
a. Head Housekeeper	24,200	1,064				
b. Other Housekeeping Workers	213,717	15,102				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	118,648	5,508				
8. Laundry Service						
a. Supervisor	23,869	1,064				
b. Other Laundry Workers	174,136	8,683				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	240,787	4,568				
b. RN						
1. Direct Care	1,083,223	32,740				
2. Administrative**	430,528	17,123				
c. LPN						
1. Direct Care	661,288	24,376				
2. Administrative**						
d. Aides and Attendants	1,821,326	104,708				
e. Physical Therapists	311,069	7,194				
f. Speech Therapists	57,780	1,157				
g. Occupational Therapists	208,138	6,441				
h. Recreation Workers	154,609	7,746				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	114,466	4,003				
n. Marketing						
o. Other (Specify) See Attached Schedule	29,872	1,813				
<i>A-13. Total Salary Expenditures</i>	6,691,055	287,924				

\* 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)**

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Pastorial Wages	\$ 29,872	1,813				
<b>Total</b>	\$ 29,872	1,813	\$ -	-	\$ -	-

**Schedule of Other Fees (Page 13)**

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Pastoral Service	\$ 8,060	156				
<b>Total</b>	\$ 8,060	156	\$ -	-	\$ -	-



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

Name of Facility				License No.	Report for Year Ended			Page	of	
Saint Joseph Living Center LLC				20397	9/30/2020			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)							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

\* 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
Saint Joseph Living Center LLC				20397	9/30/2020				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)							
<b>Section III - Administrators***</b>										
Ginny Person	145,257			Standard	Responsible for daily operations of the facility	2,316	A2			
<b>Section IV - Assistant Administrators</b>										

\*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		
Saint Joseph Living Center LLC	20397	9/30/2020	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian	20,903	781				
2. Dentist	13,032	151				
3. Pharmacist	10,912	170				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other	60,000	240				
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	62,189	519				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	2,116	79				
2. Administrative***						
c. Aides	9,539	324				
d. Other						
12. Other (Specify)						
See Attached Schedule	8,060	156				
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>186,750</b>	<b>2,420</b>				

\* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

\*\* This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

\*\*\* Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

Name of Facility Saint Joseph Living Center LLC		License No. 20397		Report for Year Ended 9/30/2020		Page 14		of 37	
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship					
		Yes	No						
Margaret B. Higgins, 635 RT 197, Woodstock, CT 06281	Dietician	<input type="radio"/>	<input checked="" type="radio"/>						
HeathDrive Dental Group, 1 Prestidge Drive, Meriden, CT 06450	Dentist	<input type="radio"/>	<input checked="" type="radio"/>						
Omnicare Pharmacy Services, PO Box 715268, Columbus, OJ 53271-5268	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>						
Brenda Miller, 33 Gulliver Circle, Norwich, CT 06360	Dietician	<input type="radio"/>	<input checked="" type="radio"/>						
Michael Kilgannon, MD, 60 Fieldstone Dr., Storrs, CT 06268	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>						
Ralph J Laguardia, MD, 10 Higgins HWY STE 4, Mansfield CTR, CT, 06280	Medical Staff/Medical Director	<input type="radio"/>	<input checked="" type="radio"/>						
Elizabeth Visone, APRN, 1 Enders Rd., Windsor, CT 06095	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>						
See List Attached to Page 4	Pastoral Care	<input checked="" type="radio"/>	<input type="radio"/>	Affiliate Organization					
Facility Compliance Services, 221 West Main Street, Plantsville, CT 06479	Emergecy Prepardness & Risk Assessment	<input type="radio"/>	<input checked="" type="radio"/>						
Heathpro Management Services, 536 Old Howell Road, Greenville, SC 29615	Rehab Department Software & Consulting	<input type="radio"/>	<input checked="" type="radio"/>						
Northeast Med Staff, 221 Chelmsford st, Chelmsford, MA	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>						
Julia Tarbox, 11D Plumtree Drive, Norwich, CT 06360	Dietician	<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"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						

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

**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended		Page	of
Saint Joseph Living Center LLC	20397	9/30/2020		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 188,578	188,578			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 40,614	40,614			
4. Social Security (F.I.C.A.)	\$ 450,166	450,166			
5. Health Insurance	\$ 1,166,895	1,166,895			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 155,059	155,059			
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 5,503	5,503			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 182,797	182,797			
d. Accounting and Auditing	\$ 37,340	37,340			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 36,211	36,211			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 39,657	39,657			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 12,284	12,284			
2. Cellular Phones	\$ 528	528			
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	\$ 653,490	653,490			
<b>Subtotal</b>	\$ 2,969,121	2,969,121			

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

(Carry Subtotals forward to next page)



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

Name of Facility	License No.	Report for Year Ended		Page	of
Saint Joseph Living Center LLC	20397	9/30/2020		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>	2,969,121	2,969,121			
<b>l. Travel and Entertainment</b>					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 2,052	2,052			
5. Education Expenses Related to Seminars and Conventions	\$ 2,802	2,802			
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$ 3,839	3,839			
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
<b>m. Other Administrative and General Expenses</b>					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 15,886	15,886			
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 14,139	14,139			
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	\$ 3,377	3,377			
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 11,736	11,736			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 500	500			
9. Subscriptions	\$				
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> )	\$ 61,684	61,684			
12. Administrative Management Services**	\$				
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 116,425	116,425			
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 3,201,562	3,201,562			

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Business Promotion	\$ 6,479		
Advertising	\$ 7,660		
<b>Total Other Advertising</b>	\$ 14,139	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM	\$ 255		
AANAC	\$ 131		
CAHCF	\$ 350		
Leading Age	\$ 11,000		
<b>Total Dues</b>	\$ 11,736	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
<b>Total Contributions</b>	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
New Hire Expenses	\$ 2,916		
Employee Relations	\$ 19,897		
Breakroom Expense	\$ 2,402		
Licenses	\$ 2,908		
Service Charges - Bank	\$ 3,895		
Professional Fees	\$ 2,700		
Loss on Disposal of Asset	\$ 94		
Chapel Supplies	\$ 1,613		
Loss on Property Deposit	\$ 80,000		
<b>Total Other Administrative and General</b>	\$ 116,425	\$ -	\$ -



**Schedule C-1 - Management Services\***

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2020	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
Saint Joseph Living Center LLC		20397	9/30/2020		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1. Raw Food	\$	281,970	281,970			
2. Non-Food Supplies	\$	48,209	48,209			
3. Other (Specify) _____	\$					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)						
c. Other (Specify) _____						
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>		\$	330,179	330,179		
2F. Dietary Questionnaire						
G. Resident Meals: Total no. of meals served per day:*			3	3		
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No						
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.						
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input checked="" type="radio"/> Yes <input type="radio"/> No                      If yes, specify cost.						
L. Is any revenue collected from these people? <input checked="" type="radio"/> Yes <input type="radio"/> No                      If yes, specify amt.                      \$735						
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)                      30/IV1						
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify cost.						
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.						
P. 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 Saint Joseph Living Center LLC		License No. 20397	Report for Year Ended 9/30/2020	Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1.	Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
2.	Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
		Amt. \$			
3.	Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
		Amt. \$			
4.	Repair and/or purchase of linens.***	Lbs.			
		Amt. \$	5,815	5,815	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Other (Specify) Laundry Supplies		\$	23,099	23,099	
<b>3D. Total Laundry Expenditures (3a + b + c)</b>		\$	28,914	28,914	
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
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 laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K. Did you receive revenue 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)			

\* 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 3E.

\*\*\* 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
Saint Joseph Living Center LLC		20397	9/30/2020		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	29,403	29,403		
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. \$				
	C. Other ( <i>Specify</i> )	\$				
4D.	<b>Total Housekeeping Expenditures (4a + b + c)</b>	\$	29,403	29,403		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	141,875	141,875		
	b. Medicine Cabinet Drugs	\$	25,094	25,094		
	c. Medical and Therapeutic Supplies	\$	178,968	178,968		
	d. Ambulance/Limousine***	\$	1,254	1,254		
	e. Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	32,279	32,279		
	f. X-rays and Related Radiological Procedures***	\$	11,148	11,148		
	g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
	h. Laboratory***	\$	16,703	16,703		
	i. Recreation	\$	20,944	20,944		
	j. Direct Management Services*	\$				
	k. Indirect Management Services*	\$				
	l. Other (Specify)**** See Attached Schedule	\$	50,455	50,455		
5M.	<b>Total Resident Care Expenditures (5a - 5j)</b>	\$	478,719	478,719		

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

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

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

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

**Schedule of Other Resident Care**

Description	CCNH	RHNS	(Specify)
Supplies - Patient Personal	\$ 192		
Physician Services Medicare	\$ 1,066		
Other - Nursing Admin Exp	\$ 4,645		
Supplies - PT	\$ 108		
Supplies - OT	\$ 1,915		
Purchased Services - ST	\$ 2,231		
DME Rental	\$ 8,281		
IV Therapy Consultant	\$ 1,085		
IV Therapy Supplies	\$ 5,388		
IV Therapy Supplies Insurance	\$ 11,102		
IV Therapy Supplies Medicare	\$ 14,440		
<b>Total Other Resident Care</b>	\$ 50,455	\$ -	\$ -

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

Name of Facility Saint Joseph Living Center LLC			License No. 20397	Report for Year Ended 9/30/2020	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)	Pg	Line
ADP	PO Box 842875, Boston, MA 02284	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	50,884			16	m11
CONN COMPUTER SERVICE INC	Box 35, Plantsville, CT 06479	<input type="radio"/>	<input checked="" type="radio"/>		Service Contracts	87,552			15\22	1g\6a
Hawthorne, Ryan	Mansfield Center, CT 06250	<input type="radio"/>	<input checked="" type="radio"/>		Grounds Maintenance	35,120			22	6f
MDI Acheieve/Matrixcare	PO Box 86, Minneapolis, MN 55486	<input type="radio"/>	<input checked="" type="radio"/>		Office Supplies, Nursing Supplies	16,045			var	var
Seventy Two Degrees	PO Box 692, Baltic, CT 06330	<input type="radio"/>	<input checked="" type="radio"/>		Repairs and Maintenance	12,103			22	6f
Willimantic Waste Paper	PO Box 239, Willimantic, CT 06226	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal	27,638			22	6f
OnShift Inc	PO Box 204856, Dallas, TX 75320-7856	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	10,800			16	m11
		<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	License No.	Report for Year Ended			Page	of
Saint Joseph Living Center LLC	20397	9/30/2020			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 60,523	60,523				
b. Heat	\$ 53,571	53,571				
c. Light & Power	\$ 109,971	109,971				
d. Water	\$ 27,698	27,698				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 3,448	3,448				
f. Other ( <i>itemize</i> )	\$ 164,712	164,712				
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	\$ 419,923	419,923				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 5,951	5,951				
b. Building & Building Improvements	\$ 216,546	216,546				
c. Non-Movable Equipment	\$ 35,622	35,622				
d. Movable Equipment	\$ 58,595	58,595				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	\$ 316,714	316,714				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$ 11,434	11,434				
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	\$ 11,434	11,434				
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	\$ 94	94				
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	\$ 328,242	328,242				

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

**Schedule of Other Repairs and Maintenance**

Description	CCNH	RHNS	(Specify)
Trash Removal	\$ 29,240		
Service Contracts	\$ 95,174		
Grounds Maintenance	\$ 35,140		
Rent - Storage	\$ 2,208		
Equipment Rental	\$ 2,950		
<b>Total Other Repairs and Maintenance</b>	\$ 164,712	\$ -	\$ -

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### Depreciation Schedule

Name of Facility Saint Joseph Living Center LLC			License No. 20397			Report for Year Ended 9/30/2020			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					
<b>A. Land Improvements</b>													
1. Acquired prior to this report period	163,049		163,049	119,107	SL	Various	5,951						
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)					SL	Various							
A-4. Subtotal								5,951					
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period	8,000,250		8,000,250	11,381,788	SL	Various	216,356						
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)	4,423						190						
B-4. Subtotal								216,546					
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period	713,271		713,271	574,102		Various	34,067						
2. Disposals (attach schedule)	(2,915)			(2,915)									
3. Acquired during this report period (attach schedule)	36,993						1,556						
C-4. Subtotal								35,622					
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost	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	Exclusive of Land							
<b>D. Movable Equipment</b>													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a. Senator Bus		x		12	2001	44,405		44,405	44,405				
b. 2010 Nissan Xterra		x		12	2009	25,580		25,580	25,580				
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period						2,050,593		2,050,593	1,006,809			53,878	
b. Disposals (attach schedule)						(17,252)			(17,252)				
c. Acquired during this report period (attach schedule)						34,205						4,717	
D-3. Subtotal													58,595
<b>E. Total Depreciation</b>													316,714

Saint Joseph Living Center LLC  
9/30/2020

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Land Improvements</b>		\$ -		\$ -
<b>Deletions:</b>				
<b>Total deletions for Land Improvements</b>		\$ -		\$ -

\*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
<b>Additions:</b>				
2/18/2020	CT Roofing	\$ 2,555	10	\$ 128
6/30/2020	Park Roway	\$ 1,868	15	\$ 62
<b>Total additions for Building Improvements</b>		\$ 4,423		\$ 190
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ -

\*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
<b>Additions:</b>				
9/30/2020	Exterior Additions	\$ 9,861	10	\$ 493
9/30/2020	Generator Repairs	\$ 22,408	12	\$ 934
9/30/2020	Compressor - Walkin Cooler	2,115.00	15	\$ 71
9/30/2020	Relocate Duct per DPH - ST Ann B	1252	20	\$ 31
9/30/2020	SPRINKLER SYSTEM REPAIRS - Leaky Pipe-Supply Storage Closet Basement	1,356.79	25	\$ 27

<b>Total additions for Non-Movable Equipment</b>		\$ 36,993		\$ 1,556
<b>Deletions:</b>				
	COURTYARD AWNING - HALF	\$ 1,458	10	
	COURTYARD AWNING - HALF	\$ 1,458	10	
<b>Total deletions for Non-Movable Equipment</b>		\$ (2,915)		\$ -

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2



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### Amortization Schedule\*

Name of Facility Saint Joseph Living Center LLC			License No. 20397		Report for Year Ended 9/30/2020			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							
<b>A. Organization Expense</b>									
1. Insurance Costs	6	2016	87 months	82,897	37,160	SL		11,434	
2.									
3.									
<b>A-4. Subtotal</b>									11,434
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
<b>B-4. Subtotal</b>									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
<b>C-4. Subtotal</b>									
<b>D. Total Amortization</b>									11,434

\* 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 Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2020	Page 25	of 37
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**11. Property Questionnaire**

**Part A**  
 Is the property either owned by the Facility or leased from a Related Party?\*

Yes  No

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

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

Description	Total			
1. Date Land Purchased	02/17/94			
2. Date Structure Completed	09/01/88			
3. If <b>NOT</b> Original Owner, Date of Purchase				
4. Date of Initial Licensure	10/12/88			
5. Total Licensed Bed Capacity	120			
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building	6,458,157			

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	06/15/16			
c. Interest Rate for the Cost Year	3.32%			
d. Term of Mortgage (number of years)	10			
e. Amount of Principal Borrowed	2,840,000			
f. Principal balance outstanding as of 9/30/20	2,513,000			
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
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	License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC	20397	9/30/2020	26	37
Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
2. Second Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
3. Third Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
4. Fourth Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount	\$ 2,840,000			
2. Loan Origination Date	06/15/16			
3. Interest Rate %	3.32%			
4. Term	10			
5. CHEFA Interest Expense	135,109	135,109		
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)	\$ 135,109	135,109		

*(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
Saint Joseph Living Center LLC		20397		9/30/2020		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				135,109	135,109		
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. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$ 135,109	135,109		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 195,884	195,884		
b. Insurance on Automobiles				\$ 4,158	4,158		
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$ 200,041	200,041		
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$ 12,029,899	12,029,899		

### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC				20397	9/30/2020	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	a12g	Occupational Therapy	\$ 208,138	208,138		
4.			Other - See attached Schedule	\$			
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 154,297	154,297		
10.			Accounting	\$			
10a.			Legal	\$ 32,603	32,603		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$ 14,139	14,139		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 99,026	99,026		
<b>Page 18 - Dietary Expenditures</b>							
24.	30	iv8	Meals to employees, guests and others who are not residents	\$ 909	909		
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 509,112	509,112		

\* All except "Help Wanted".

(Carry Subtotal forward to next page )

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

**Schedule of Other Salaries Adjustment**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Fees Adjustments</b>			\$ -	\$ -	\$ -

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	8a	Chamber of Commerce Dues	\$ 500		
30	IV8	Restricted Revenue	\$ 1,075		
30	IV8	Chapel-Restricted Revenue	\$ 2,670		
30	IV8	Rec-Restricted Revenue	\$ 500		
30	IV8	Eden-Restricted Revenue	\$ 251		
16	m13	Employee Relations	\$ 13,936		
16	m13	Loss on Property	\$ 80,094		
<b>Total Other A&amp;G Adjustments</b>			\$ 99,026	\$ -	\$ -

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

Name of Facility Saint Joseph Living Center LLC				License No. 20397	Report for Year Ended 9/30/2020	Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 509,112	509,112		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 141,875	141,875		
28.	20	d	Ambulance/Limousine	\$ 1,254	1,254		
29.	20	f	X-rays, etc	\$ 11,148	11,148		
30.	20	j	Laboratory	\$ 16,703	16,703		
31.			Medical Supplies	\$			
32.	20	5e	Oxygen (non emergency)	\$ 32,279	32,279		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 45,808	45,808		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 685	685		
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 146	146		
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.	27	14a	Property Insurance	\$ 69	69		
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 759,078	759,078		

\*\*\* 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.

Saint Joseph Living Center LLC  
9/30/2020

#### Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Supplies - Patient Personal	\$ 192		
20	5j	Physician Services Medicare	\$ 1,066		
20	5j	Supplies - PT	\$ 108		
20	5j	Supplies - OT	\$ 1,915		
20	5j	Purchased Services - ST	\$ 2,231		
20	5j	DME Rental	\$ 8,281		
21	5j	IV Therapy Consultant	\$ 1,085		
22	5j	IV Therapy Supplies	\$ 5,388		
23	5j	IV Therapy Supplies Insurance	\$ 11,102		
24	5j	IV Therapy Supplies Medicare	\$ 14,440		
<b>Total Other Ancillary Costs</b>			\$ 45,808	\$ -	\$ -

#### Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7c	Depreciation of Chapel Video System 12/31/14	\$ 386		
22	7c	Depreciation of Install Box Camera/Tested Audio for PA Systems 1/31/15	\$ 227		
22	7b	Depreciation on Wire Runs To Basement/Chapel Camera 1/31/15	\$ 72		
<b>Total Excess Movable Equipment Depreciation</b>			\$ 685	\$ -	\$ -

#### Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22		Outpatient Therapy Adjustment	\$ 146		
<b>Total Other Property Adjustments</b>			\$ 146	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -



**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended			Page	of
Saint Joseph Living Center LLC	20397	9/30/2020			30	37
Item	Total	CCNH	RHNS	(Specify)		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 11,073,460	11,073,460				
b. Medicaid Room and Board Contractual Allowance **	\$ (4,919,946)	(4,919,946)				
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 763,205	763,205				
b. Medicare Room and Board Contractual Allowance **	\$ 494,985	494,985				
4. a. Private-Pay Residents and Other	\$ 2,657,650	2,657,650				
b. Private-Pay Room and Board Contractual Allowance **	\$ (31,167)	(31,167)				
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 75,247	75,247				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 103,643	103,643				
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	\$ 235,630	235,630				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 245,920	245,920				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 48,125	48,125				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 59,566	59,566				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 203,695	203,695				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 301,780	301,780				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (570,498)	(570,498)				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (381,068)	(381,068)				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 10,360,228	10,360,228				
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others	\$ 735	735				
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income ( <i>Specify</i> )	\$ 27,488	27,488				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 1,167,832	1,167,832				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 1,196,055	1,196,055				
<b>VI. Total All Revenue</b> (III +V)	\$ 11,556,283	11,556,283				

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

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

**Schedule of Other Resident Revenue - Medicare**

**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6a	Medicare A - IV Therapy	\$ 20,918		
30/II6a	Medicare A - X-Ray	\$ 9,419		
30/II6a	Medicare A - Physician Care	\$ 120		
30/II6a	Medicare A - Lab	\$ 14,472		
30/II6a	Medicare A - Contractual Adjustment	\$ (453,011)		
30/II6a	Insurance - Contractual Adjustment	\$ (31,975)		
30/II6a	Medicare B - Vaccines	\$ 2,365		
30/II6a	Medicare B - Contractual Adjustment	\$ (44,423)		
30/II6a	Managed Care B - Lab	\$ 12,666		
30/II6a	Managed Care B - Contractual Adjustment	\$ (101,339)		
30/II6a	Insurance B - Vaccines	\$ 61		
30/II6a	Medicare A - Prior Year Adjustment	\$ 229		
<b>Total Other Resident Revenue - Medicare</b>		\$ (570,498)	\$ -	\$ -

**Schedule of Other Non-Medicare Resident Revenue**

**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6b	Medicaid - Contractual Adjustment	\$ (1,280)		
30/II6b	Managed Care - IV Therapy	\$ 17,419		
30/II6b	Managed Care - X-Ray	\$ 9,394		
30/II6b	Managed Care - Physician Care	\$ 45		
30/II6b	Managed Care - Lab	\$ 3,799		
30/II6b	Managed Care - Contractual Adjustment	\$ (416,840)		
30/II6b	Insurance - X-Ray	\$ 135		
30/II6b	Managed Care B - Vaccines	\$ 6,260		
<b>Total Other Resident Revenue</b>		\$ (381,068)	\$ -	\$ -

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/IV5	Interest Income		\$ 27,488		
<b>Total Interest Income</b>			\$ 27,488	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
30?IV8	Charitable Donations	\$ 11,094		
30?IV8	Recovery Of Bad Debt	\$ 72,779		
30?IV8	Small Balance Adjustments	\$ (828)		
30?IV8	Discounts Earned	\$ 37,360		
30?IV8	Restricted Revenue	\$ 1,075		
30?IV8	Chapel Offering Box	\$ 804		
30?IV8	Chapel-Restricted Revenue	\$ 2,670		
30?IV8	Rec-Restricted Revenue	\$ 500		
30?IV8	Eden-Restricted Revenue	\$ 251		
30?IV8	HHS Cares Act Revenue	\$ 775,260		
30?IV8	CRF Revenue	\$ 266,867		
<b>Total Other Revenue</b>		\$ 1,167,832	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC	20397	9/30/2020	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	4,696,313
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	696,197
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	77,208
5. Prepaid Expenses			\$	47,896
a. _____				
b. _____				
c. _____				
d. See Schedule		47,896		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	2,660
_____				
_____				
See Schedule		2,660		
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	5,520,273
B. Fixed Assets				
1. Land			\$	1,220,000
2. Land Improvements	*Historical Cost	163,049		
	Accum. Depreciation	125,058		
	Net		\$	37,990
3. Buildings	*Historical Cost	8,004,673		
	Accum. Depreciation	11,598,334		
	Net		\$	(3,593,661)
4. Leasehold Improvements	*Historical Cost			
	Accum. Depreciation			
	Net		\$	
5. Non-Movable Equipment	*Historical Cost	747,349		
	Accum. Depreciation	606,809		
	Net		\$	140,540
6. Movable Equipment	*Historical Cost	2,067,546		
	Accum. Depreciation	1,048,152		
	Net		\$	1,019,394
7. Motor Vehicles	*Historical Cost	69,985		
	Accum. Depreciation	69,985		
	Net		\$	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	3,216,272
_____				
See Schedule		3,216,272		
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	2,040,535

\* 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	License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC	20397	9/30/2020	32	37
<b>Account</b>			<b>Amount</b>	
Total Brought Forward:			\$	7,560,808
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 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	82,897		
	Accum. Depreciation	48,595	Net	\$ 34,302
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. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	34,302
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	7,595,110

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Prepaid-Expenses	\$ 18,776
31	A5	Prepaid-Insurance	\$ 29,120
<b>Total Prepaid Expenses</b>			<b>\$ 47,896</b>

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

Page Ref	Line Ref	Description	
31	A8	Refundable Deposits	\$ 2,660
<b>Total Other Current Assets (Itemize)</b>			<b>\$ 2,660</b>

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

Page Ref	Line Ref	Description	
31	B9	Book Vs Cost	\$ 3,216,272
<b>Total Other Other Fixed Assets (Itemize)</b>			<b>\$ 3,216,272</b>

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
<b>Total Other Assets</b>			<b>\$ -</b>

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			<b>\$ -</b>

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

Page Ref	Line Ref	Description	
33	A12	Accrued Expense Other	\$ 87,332
33	A12	Bonds Payable Non-Taxable - ST	\$ 84,000
33	A12	PPP Loan-SBA - ST	\$ 714,763
33	A12	Accrued Provider Tax	\$ 145,879
33	A12	Resident Refunds & Exchange	\$ 125,874
33	A12	Resident Trust	\$ 38,297
33	A12	Due To Residents	\$ 228,609
33	A12	Deferred Revenue	\$ 370
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ 1,425,124</b>

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

Page Ref	Line Ref	Description	
33	B4	Interest Rate Swap Obligation	\$ 119,594
33	B4	PPP Loan-SBA - LT	\$ 1,010,898
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ 1,130,492</b>

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of	
Saint Joseph Living Center LLC	20397	9/30/2020	33	37	
Account			Amount		
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable			\$	230,828	
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> )			\$	930,911	
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$		
6. Accrued Payroll Taxes Payable			\$	16,744	
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> )			\$	6,957	
11. Accrued Income Taxes*			\$		
12. Other Current Liabilities ( <i>itemize</i> )			\$	1,425,124	
_____					
_____					
See Schedule				1,425,124	
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)			\$	<b>2,610,563</b>	

\* 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 Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2020	Page 34	of 37
Account				Amount
Total Brought Forward:				2,610,563
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$ 2,429,000
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> )				\$ 1,130,492
See Schedule		1,130,492		
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 3,559,492
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 6,170,055

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

Name of Facility	License No.	Report for Year Ended	Page	of
Saint Joseph Living Center LLC	20397	9/30/2020	35	37
Account			Amount	
<b>A. Reserves</b>				
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>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	1,898,672
6. Gain or Loss for Period			\$	(473,616)
	10/1/2019	thru 9/30/2020		
7. Total Net Worth			\$	1,425,056
<b>C. Total Reserves and Net Worth</b>			\$	1,425,056
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	7,595,111



### H. Changes in Total Net Worth

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2020	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2019			\$	1,898,672
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	11,556,283
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	12,029,899
D. Net Income or Deficit			\$	(473,616)
E. Balance			\$	1,425,056
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. <b>Balance at End of Period</b>		09/30/20	\$	1,425,056

### I. Preparer's/Reviewer's Certification

Name of Facility Saint Joseph Living Center LLC	License No. 20397	Report for Year Ended 9/30/2020	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<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				
CJLC LLC				
Address Address		Phone Number		
225 Pitkin St., East Hartford, CT 06108		860-610-9009		
Annual Report Contact		Phone Number		
CJLC		860-610-9009		
Annual Report Contact Email Address				
annualreports@cjlc.com				