State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2020

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 10/1/2019	Report for Year Ending 9/30/2020	

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	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, 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) 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)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility ST JOSEPH'S RESIDENCE	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 1365 ENFIELD ST, ENFIELD CT 06082				
Report Prepared By KEVIN P KELLEHER	Phone Number 860.677.8440		Date 02.11.2021	

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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860.741.0791	9/30/2020	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

License Numbers:	CCNH	RHNS	Residential Care Home	Medicare Provider No.
	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	

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General Information and Questionnaire
Partners/Members

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

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

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General Information and Questionnaire
Corporate Owners

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

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 PRES	N/A
SISTER JOANNA FRANCIS KEEBOY YO	1365 ENFIELD ST, ENFIELD CT 06082	SECT / TREAS	N/A
Names of Stockholders Owning at Least 10% of Shares			
NONE			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ⊙ Yes ○ No

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
LITTLE SISTERS OF THE POOR	1365 ENFIELD ST, ENFIELD CT 06082	○	⊙		LENDOR OF FUNDS	PG 26Y / LN 12A1		N/A MOTHERHOUSE
LITTLE SISTERS OF THE POOR	1365 ENFIELD ST, ENFIELD CT 06082	○	⊙		11 SISTERS EMPLOYED BY FACILITY	PG 10 / LN VAR	446,131	N/A MOTHERHOUSE
LITTLE SISTERS OF THE POOR	1365 ENFIELD ST, ENFIELD CT 06082	○	⊙		COMPUTER SOFTWARE INSTALLATIO	PG 16 / LN M13	12,000	
LITTLE SISTERS OF THE POOR	1365 ENFIELD ST, ENFIELD CT 06082	○	⊙		HUMAN RESOURCE SERVICES	PG 16 / LN M13	6,000	
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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.

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
COX CABLE COMMUNICATIONS, MANCHESTER CT	○	⊙	CABLE TELEVISION OUTLETS, INTERNET ACCESS, TELEPHONE	MONTH TO MONTH	MONTH TO MONTH	3,132	3,132
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 3,132

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 KELLEHER & COMPANY	11 MELROSE DR, 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	$ 50,996
2		$
3		$
4		$
		Charge for Services Provided $ 50,996

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

⊙ Yes ○ No PABGE 15 LINE 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 ANMD MEDICAID LEGAL SERVICES	$ 2,933
2	ESTATE AND PROBATE SERVICES AND CORPORATION FILING COMPLIANCE	$ 690
3		$
4		$
5		$
		Charge for Services Provided $ 3,623

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

⊙ Yes ○ No PAGE 15 LINE 1E

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	82	25		57	82	25		57				
B. As of midnight of THIS report period	77	25		52					77	25		52
3. Total Number of Days Care Provided During Period												
A. Medicare	203	203			149	149			54	54		
B. Medicaid (Conn.)	8,879	8,879			6,647	6,647			2,232	2,232		
C. Medicaid (other states)												
D. Private Pay	3,030			3,030	2,389			2,389	641			641
E. State SSI for RCH	17,662			17,662	13,240			13,240	4,422			4,422
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	29,774	9,082		20,692	22,425	6,796		15,629	7,349	2,286		5,063
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)**	29,774	9,082		20,692	22,425	6,796		15,629	7,349	2,286		5,063

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH (1)	RHNS (2)	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 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	1	23		1		6	46	
Per Diem Rate								
a. One bed rm.	593.00	251.00		400.00		150.00	133.00	
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***				

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Report of Expenditures - Salaries & Wages

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	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)	23,527	634			53,604	1,446
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	132,259	6,127			301,332	13,955
5. Dietary Service						
a. Head Dietitian	20,350	659			46,356	1,501
b. Food Service Supervisor	12,508	634			28,492	1,446
c. Dietary Workers	155,604	10,689			331,233	22,770
6. Housekeeping Service						
a. Head Housekeeper	11,284	619			25,709	1,409
b. Other Housekeeping Workers	41,257	2,982			111,869	7,383
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	21,195	668			48,290	1,523
b. Other Maintenance Workers	23,185	1,090			52,823	2,483
8. Laundry Service						
a. Supervisor	7,747	428			17,649	975
b. Other Laundry Workers	23,490	1,775			53,517	4,043
9. Barber and Beautician Services						
10. Protective Services	20,019	1,247			45,609	2,841
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	111,249	2,220				
b. RN						
1. Direct Care	388,959	10,289				
2. Administrative**	37,981	1,028				
c. LPN						
1. Direct Care	190,315	6,308			66,342	2,253
2. Administrative**						
d. Aides and Attendants	675,194	36,133			403,459	24,996
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	17,710	616			106,841	5,125
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
medical records	99,835	3,924				
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	13,353	429			30,422	979
n. Marketing						
o. Other (Specify)						
See Attached Schedule	23,657	1,268			53,901	2,892
A-13. Total Salary Expenditures	2,050,678	89,767			1,777,448	98,020

* 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	$ 23,657	1,268			$ 53,901	2,892
Total	$ 23,657	1,268	$ -	-	$ 53,901	2,892

Schedule of Other Fees (Page 13)

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

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	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.

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	Residential Care Home							
Section III - Administrators* **										
SISTER GENEVIEVE NUGENT	23,527		53,604	MED INS $1,748	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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	1,263	43			2,877	96
2. Dentist	732	30			1,668	35
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	37,238					
b. Other						
6. Social Worker	300	12			300	12
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	16,500	98				
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	10,244					
b. Other						
10. Occupational Therapist						
a. Resident Care	66,123					
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	132,400	183			4,845	143

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

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

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

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

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

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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	9/30/2020	15	37

Item		Total	CCNH	RHNS	Residential Care Home
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	88,455	47,384		41,071
2. Disability Insurance	$				
3. Unemployment Insurance	$	32,891	17,619		15,272
4. Social Security (F.I.C.A.)	$	221,844	118,839		103,005
5. Health Insurance	$	364,890	195,467		169,423
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	87,522	46,885		40,637
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	302	162		140
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	50,996	25,569		25,427
e. Legal (*Services should be fully described on Page 7)*	$	3,623	1,817		1,806
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	13,793	6,916		6,877
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	61,227	30,699		30,528
2. Cellular Phones	$	5,297	2,656		2,641
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	$	186,699	186,699		
Subtotal	$	1,117,539	680,712		436,827

* 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	$ 129		$ 111
STAFF PHYSICALS	$ 33		$ 29
Total	$ 162	$ -	$ 140

Schedule of Other Taxes

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

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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	9/30/2020	16	37

Item		Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:		1,117,539	680,712		436,827
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	1,334	669		665
5. Education Expenses Related to Seminars and Conventions	$				
6. Automobile Expense (*not purchase or depreciation*)	$	9,623	4,825		4,798
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	8,348	4,186		4,162
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	11,329	5,680		5,649
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	5,957	2,987		2,970
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	8,562	4,293		4,269
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	72	36		36
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	10,230	5,129		5,101
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	193,314	96,928		96,386
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,366,308	805,445		560,863

* 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	$ 5,680		$ 5,649
Total Other Advertising	$ 5,680	$ -	$ 5,649

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
LEADING AGE	$ 3,449		$ 3,430
CT ASSN HEALTH CARE FACILITIES	$ 175		$ 175
AMAZON PRIME	$ 84		$ 84
COSTCO	$ 157		$ 156
CREDIT CARDS	$ 23		$ 22
CHAMBER OF COMMERCE	$ 263		$ 261
ACADEMY OF NUTRITION AND DIETETICS	$ 117		$ 117
STAPLES	$ 25		$ 24
Total Dues	$ 4,293	$ -	$ 4,269

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
LICENSES	$ 2,046		$ 2,034
CONSULTING SERVICES, BILLING SERVICES	$ 48,064		$ 47,796
DATA PROCESSING PAYROLL FEES	$ 8,386		$ 8,339
DATA PROCESSING SUPPLIES	$ 9,500		$ 9,447
PROFESSIONA;L BACKGROUND CHECKS	$ 2,375		$ 2,362
BAD DEBTS	$ 147		$ 146
MISCELLANEOUS	$ 1,184		$ 1,178
DEVELOPMENT MAILING SERVICE	$ 8,628		$ 8,580
DEVELOPMENT EXPENSES	$ 277		$ 276
OTHER NON-REIMBURSEABLE	$ 13,393		$ 13,317
BACKUP INTERNET SERVICE	$ 1,148		$ 1,141
MEDICARE BILLING SOFTWARE	$ 1,780		$ 1,770
Total Other Administrative and General	$ 96,928	$ -	$ 96,386

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	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.**

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

Name of Facility	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	18 | 37

Item		Total	CCNH	RHNS	Residential Care Home
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	347,628	106,052		241,576
2. Non-Food Supplies	$	31,193	9,516		21,677
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	$	6,523	1,990		4,533
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	385,344	117,558		267,786

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.

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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	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	19 | 37

Item		Total	CCNH	RHNS	Residential Care Home
3. Laundry					
a. In-House Processing*					
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $	16,668	5,084		11,584
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. $	513	157		356
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) EQUIPMENT REPAIRS	$	4,402	1,343		3,059
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	21,583	6,584		14,999

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
H.	Where is the revenue received reported in the Cost Report?			(Page/Line Item)
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
K.	Where is the revenue received reported in the Cost Report?			(Page/Line Item)

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	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.	$	32,463	9,902		22,561
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	23,217	7,082		16,135
C. Other (*Specify*)		$	138	42		96
REPAIRS HOUSEKEEPING EQUIPMENT						
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	55,818	17,026		38,792
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	31,306	31,306		
OMNICARE OF CONNECTICUT						
b. Medicine Cabinet Drugs		$	12,095	10,928		1,167
c. Medical and Therapeutic Supplies		$	72,118	71,837		281
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$	5,064	5,064		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	1,862	1,862		
i. Recreation		$	7,824	2,387		5,437
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)****		$	36,981	21,361		15,620
See Attached Schedule						
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	167,250	144,745		22,505

* 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	$ 476		
INFECTOUS WASTE	$ 14,030		
RELIGIOUS SUPPLIES	$ 2,890		$ 6,585
PASTORAL CARE FELICIAN SISTERS	$ 3,965		$ 9,035
Total Other Resident Care	$ 21,361	$ -	$ 15,620

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

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	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
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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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	9/30/2020	22 | 37

Item		Total	CCNH	RHNS	Residential Care Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	216,250	65,963		150,287
b. Heat	$	94,489	28,822		65,667
c. Light & Power	$	155,242	47,354		107,888
d. Water	$	113,541	34,634		78,907
e. Equipment Lease (*Provide detail on page 6*)	$	3,132	955		2,177
f. Other (*itemize*)	$	35,795	10,919		24,876
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	618,449	188,647		429,802
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	6,200	1,891		4,309
b. Building & Building Improvements	$	135,569	41,353		94,216
c. Non-Movable Equipment	$	104,191	31,781		72,410
d. Movable Equipment	$	71,418	21,785		49,633
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	317,378	96,810		220,568
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)	$	317,378	96,810		220,568

* 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	$ 10,919		$ 24,876
Total Other Repairs and Maintenance	$ 10,919	$ -	$ 24,876

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	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	338,597	sl	var	6,200	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								6,200
B. **Building and Building Improvements**								
1. Acquired prior to this report period	8,622,711		8,622,711	7,271,563	sl	var	134,008	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	25,808		25,808				1,561	
B-4. Subtotal								135,569
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	2,921,078		2,921,078	2,120,443	sl	var	89,769	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	292,921		292,921				14,422	
C-4. Subtotal								104,191

	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 ODYSSE	1		6	2011	70,878		70,878	65,577	sl	10	3,029	
b. 2015 DODGE, 2007 TOYTOA, 2015	1		6	2015	129,561		129,561	127,963	sl	4	1,128	
c. 2018 KIA, 2018 FORD TRANSIT	1		8	2018	52,072		52,072	8,654	sl	4	13,019	
d. 2019 HONDA PILOT	1		9	2019	31,935		31,935		sl	4	7,984	
2. Movable Equipment												
a. Acquired prior to this report period					1,821,554		1,821,554	1,550,007	sl	var	45,228	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					14,746		14,746				1,030	
D-3. Subtotal												71,418
E. ***Total Depreciation***												317,378

Schedule of Land Improvements Acquired during this report peri

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

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

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

Schedule of Building Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
1/21/2020	100 NEW FAUCETS	$ 16,243	10	$ 1,083	
4/2/2020	BASEMENT WATERPROOFING	$ 9,565	10	$ 478	
Total additions for Building Improvemen		$ 25,808		$ 1,561	*
Deletions:					
Total deletions for Building Improvement		$ -		$ -	**

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

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

Schedule of Non-Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/28/2019	NEW HEAT PUMPS	$ 93,010	10	$ 8,526	
11/30/2019	VALVE INSTALLATION	$ 5,700	5	$ 950	
12/20/2019	NEW SPRINKLER LINE	$ 7,215	20	$ 271	
7/14/2020	AC PTAC UNITS	$ 186,996	10	$ 4,675	
Total additions for Non-Movable Equipmen		$ 292,921		$ 14,422	*
Deletions:					
Total deletions for Non-Movable Equipmen		$ -		$ -	**

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

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Dat	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
5/23/2020	DELL LAPTOP	$ 1,648	4	$ 110	
6/30/2020	12 CHAPEL ARM CHAIRS	$ 5,328	15	$ 89	
12/12/2019	10 72" ROUND TABLES	$ 2,561	10	$ 213	
11/27/2019	KATOM REFRIGERATOR	$ 2,449	10	$ 204	
12/30/2019	PJL HEATER - LAUNDRY	$ 2,760	5	$ 414	
Total additions for Movable Equipmen		$ 14,746		$ 1,030	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report peri

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

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

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Amortization Schedule*

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

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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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	9/30/2020	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.

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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	9/30/2020	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*)

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

Name of Facility	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	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)		$	25,476	7,771		17,705
b. Insurance on Automobiles		$	13,924	4,248		9,676
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*)		$				
2. Fire and Extended Coverage		$	14,118	4,306		9,812
3. Other (*Specify*) SURETY BOND		$	700	214		486
14d. ***Total Insurance Expenditures (14a + b + c)***		$	54,218	16,539		37,679
15. ***Total All Expenditures (A-13 thru C-14)***		$	6,951,719	3,576,432		3,375,287

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	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 $	109,616	33,436		76,180
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $	66,123	66,123		
7.			Other - See attached Schedule $	47,482	47,482		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.			Accounting $				
10a.			Legal $	3,623	1,817		1,806
11.			Telephone $				
12.	15	1H2	Cellular Telephone $	5,297	2,656		2,641
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) $	8,063	4,040		4,023
18.	16	M3	Unallowable Advertising * $	11,329	5,680		5,649
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	50,676	25,409		25,267
Page 18 - Dietary Expenditures							
24.	18	2A1,	Meals to employees, guests and others who are not residents $	43,351	13,225		30,126
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) $	345,560	199,868		145,692

* 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	$ 37,238		
13	B9A	SPEECH THERAPY	$ 10,244		
Total Other Fees Adjustments			$ 47,482	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	M13	BAD DEBTS	$ 147		$ 146
16	M13	MISCELLANEOUS	$ 1,184		$ 1,178
16	M13	DEVELOPMENT MAILING SERVICE	$ 8,628		$ 8,580
16	M13	DEVELOPMENT EXPENSES	$ 277		$ 276
16	M13	OTHER NON-REIMBURSEABLE	$ 13,393		$ 13,317
16	M13	MEDICARE SOFTWARE	$ 1,780		$ 1,770
Total Other A&G Adjustments			$ 25,409	$ -	$ 25,267

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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	9/30/2020	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
			Subtotals Brought Forward $	345,560	199,868		145,692
Page 20 - Resident Care Supplies***							
27.	20	5A2	Prescription Drugs $	31,306	31,306		
28.			Ambulance/Limousine $				
29.	20	5F	X-rays, etc $	5,064	5,064		
30.	20	5H	Laboratory $	1,862	1,862		
31.			Medical Supplies $				
32.			Oxygen (non emergency) $				
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	476	476		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.	22	7D	Depreciation on Unallowable Motor Vehicles $	17,176	5,239		11,937
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $	76,050	23,198		52,852
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $				
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49.	***Total Amount of Decrease (Items 1 - 48)***		$	477,494	267,013		210,481

*** 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 EXPENSE	$ 476		
Total Other Ancillary Costs			$ 476	$ -	$ -

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)	$ 6,762		$ 15,407
22	6C	LIGHT AND POWER (NON FACILITY UTILIZATION)	$ 1,909		$ 4,349
22	6D	WATER AND SEWER (NON FACILITY UTILIZATION)	$ 2,362		$ 5,382
22	6A	MAINTENANCE (NON FACILITY UTILIZATION)	$ 10,574		$ 24,090
22	6F	ELEVATORT MAINTENANCE (NON FACILITY UTILIZATION)	$ 1,591		$ 3,624
Total Other Property Adjustments			$ 23,198	$ -	$ 52,852

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	$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	30 | 37

Item		Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	5,987,150	3,551,600		2,435,550
b. Medicaid Room and Board Contractual Allowance **	$	(1,391,866)	(1,334,671)		(57,195)
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	307,006	307,006		
b. Medicare Room and Board Contractual Allowance **	$	210,114	210,114		
4. a. Private-Pay Residents and Other	$	454,500			454,500
b. Private-Pay Room and Board Contractual Allowance **	$	(32,682)			(32,682)
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.)	$	5,534,222	2,734,049		2,800,173
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)*	$	63,915	19,496		44,419
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	2,545	776		1,769
8. Other (*Specify*)	$	1,381,362	421,358		960,004
V. Total Other Revenue (1 thru 8)	$	1,447,822	441,630		1,006,192
VI. Total All Revenue (III +V)	$	6,982,044	3,175,679		3,806,365

* *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

		Account			
Page Ref	**Account**	**Balance**	**CCNH**	**RHNS**	**Residential Care Home**
30	BANK INTEREST		$ 19,496		$ 44,419
Total Interest Income			$ 19,496	$ -	$ 44,419

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
30	UNRESTRICTED CONTRIBUTIONS	$ 379,590		$ 864,841
30	DONATED FOODS	$ 21,761		$ 49,578
30	FESTIVALS AND EVENTS, NET OF EXPENSES	$ 19,110		$ 43,540
30	MMISCELLANEOUS, RECYCLING, EXHIBITIONS	$ 897		$ 2,045
Total Other Revenue		$ 421,358	$ -	$ 960,004

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 2,302,635
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 478,362
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 69,450
a.				
b.				
c.				
d. See Schedule		69,450		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,850,447
B. Fixed Assets				
1. Land				$ 598,500
2. Land Improvements	*Historical Cost	382,713		$ 37,916
	Accum. Depreciation	344,797	Net	
3. Buildings	*Historical Cost	8,648,519		$ 1,241,387
	Accum. Depreciation	7,407,132	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	3,213,999		$ 989,365
	Accum. Depreciation	2,224,634	Net	
6. Movable Equipment	*Historical Cost	1,836,300		$ 240,035
	Accum. Depreciation	1,596,265	Net	
7. Motor Vehicles	*Historical Cost	284,446		$ 57,092
	Accum. Depreciation	227,354	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 549,861
See Schedule		549,861		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 3,714,156

* 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	5	PREPAID INSURANCE AND MAINTENANCE	$ 69,450
Total Prepaid Expenses			$ 69,450

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

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

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

Page Ref	Line Ref	Description	
31	B9	CONSTRUCTION IN PROGRESS	$ 549,861
Total Other Other Fixed Assets (Itemize)			$ 549,861

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	A4	ACCRUED EXPENSES	$ 47,185
Total Other Current Liabilities (Itemize)			$ 47,185

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

Page Ref	Line Ref	Description	
34	B4	DUE TO LITTLE SISTERS OF THE POOR	$ 571,918
34	B4	PPP LOAN PAYABLE	$ 651,583
Total Other Current Liabilities (Itemize)			$ 1,223,501

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	32	37

Account				Amount
			Total Brought Forward:	$ 6,564,603
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)				$ 6,564,603

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 286,483
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*)				$ 100,354
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*)				$ 47,185
See Schedule 47,185				
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 434,022

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	34	37

Account	Amount
Total Brought Forward:	434,022
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*)		$ 1,223,501
See Schedule	1,223,501	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 1,223,501
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 1,657,523

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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	9/30/2020	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 10/1/2019 thru 9/30/2020	$
	7. Total Net Worth	$ 4,907,080
C.	***Total Reserves and Net Worth***	$ 4,907,080
D.	***Total Liabilities, Reserves, and Net Worth***	$ 6,564,603

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	36	37

Account	Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2019	$ 2,376,755
B. Total Revenue (*From Statement of Revenue Page 30*)	$ 6,982,044
C. Total Expenditures (*From Statement of Expenditures Page 27*)	$ (6,951,719)
D. Net Income or Deficit	$ 30,325
E. Balance	$ 2,407,080
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***	09/30/20	$ 2,407,080

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
ST JOSEPH'S RESIDENCE	901-C	9/30/2020	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. 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