



Annual Report of Long-Term Care Facility
Cost Year 2016

Name of Facility (as licensed) 23 Fair Streete Operations LLC	
Address (No. & Street, City, State, Zip Code) 23 Fair Street , Bristol, CT 06010	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> SLTC	
Report for Year Beginning 12/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH 2416	RHNS	SLTC	Medicare Provider 07-5198
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Medicaid Provider Numbers:	CCNH CT 000020164	RHNS	SLTC 520165
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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) 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2016	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 23 Fair Streete Operations LLC [facility name], for the cost report period beginning December 1, 2015 and ending September 30, 2016, 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) Dahl,James			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

State of Connecticut
Department of Social Services
 25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility 23 Fair Streete Operations LLC		Period Covered:	From 12/1/2015	To 9/30/2016
Address of Facility 23 Fair Street , Bristol, CT 06010				
Report Prepared By Thomas Farnan		Phone Number 978-247-5029	Date 12/21/2016	
Item	Total	CCNH	RHNS	SLTC
1. Dietary wages paid	\$ 270,151	229,628		40,523
2. Laundry wages paid	\$ 40,926	34,787		6,139
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$ 2,844,228	2,076,234		767,994
5. All other wages paid	\$ 328,532	276,774		51,758
6. Total Wages Paid	\$ 3,483,837	2,617,424		866,413
7. Total salaries paid	\$ 229,811	187,867		41,944
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$ 3,713,648	2,805,291		908,357

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 860-589-2923	Report for Year Ended 9/30/2016	Page 2	of 37
Name of Facility (as shown on license) 23 Fair Streete Operations LLC		Address (No. & Street, City, State, Zip) 23 Fair Street , Bristol, CT 06010			
License Numbers:	CCNH 2416	RHNS	SLTC	Medicare Provider No. 07-5198	
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 checked="" type="checkbox"/> SLTC					
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input 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.					
Administrator					
Name of Administrator Dahl,James			Nursing Home Administrator's License No.:	CT 1840	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		

**General Information and Questionnaire
 Corporate Owners**

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2016	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
23 Fair Streete Operations LLC	101 East State Street, Kennett Square, PA 19348	PA		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
N/A				
Names of Stockholders Owning at Least 10% of Shares				
N/A				

The related party transaction costs listed below are not related to the current year property additions.

**General Information and Questionnaire
 Related Parties***

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2016	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	%**				
Genesis Health Ventures	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	347,524	347,524
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	62%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	653,964	653,964
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	56%	Staffing Pool	Pg 10/A12	1,415	1,415
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	83%	Case Management	Pg 13/B8, Pg 10/A12	40,000	40,000
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	80%	Staffing Pool	Pg 13/B11 a,b,c	17,665	17,665
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>	51%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	709,644	709,644
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	157,737	157,737
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Capital Interest	Page 17, page 26-12A	32,308	32,308
		<input type="radio"/>	<input 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 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2016	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item	Method of Allocation			
Dietary	Number of meals served to residents			
Laundry	Number of pounds processed			
Housekeeping	Number of square feet serviced			
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants			
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (<i>See listing page 13</i>)			
Maintenance and operation of plant	Square feet			
Property costs (depreciation)	Square feet			
Employee health and welfare	Gross salaries			
Management services	Appropriate cost center involved			
All other General Administrative expenses	Total of Direct and Allocated Costs			
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.				
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)				
<input checked="" type="radio"/> Yes <input type="radio"/> 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 23 Fair Streete Operations LLC			License No. 2416		Report for Year Ended 9/30/2016		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						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?								<input type="radio"/> Yes <input type="radio"/> No
Total ***								

* 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 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2016	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 KPMG Peat Marwick 2 3 4	Address (No. & Street, City, State, Zip Code) 1600 Market Street, Philadelphia, PA 19103
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Services Provided by This Firm (*describe fully*)

1 Year end financial audit	\$
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$

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

- Yes No

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Marshal Arthur B Cyr 2 Treasure oState of CT 3 4 5	Telephone Number
--	------------------

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

1 17 Riverside Ave PO Box 302 Bristol, CT 06011-0302
2 240 Stafford Ave Bristol, CT 06010-4682
3
4
5

Services Provided by This Firm (*describe fully*)

1 State Marshall fees	\$	293
2 Probate Court fees for the Conservator	\$	869
3	\$	
4	\$	
5	\$	
	Charge for Services Provided	
	\$	1,162

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

- Yes No

Legal Fees pg. 15 1-e

Schedule of Resident Statistics

Name of Facility 23 Fair Streete Operations LLC				License No. 2416		Report for Year Ended 9/30/2016				Page 8	of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total SLTC	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	SLTC	Total	CCNH	RHNS	SLTC
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	120	104		16	120	104		16	120	104		16
B. On last day of THIS report period	120	104		16	120	104		16	120	104		16
2. Number of Residents												
A. As of midnight of PREVIOUS report period	89	75		14	89	75		14	90	78		12
B. As of midnight of THIS report period	82	75		7	90	78		12	82	75		7
3. Total Number of Days Care Provided During Period												
A. Medicare	2,223	2,077		146	1,498	1,413		85	725	664		61
B. Medicaid (Conn.)	20,562	16,962		3,600	14,555	11,860		2,695	6,007	5,102		905
C. Medicaid (other states)												
D. Private Pay	779	585		194	562	419		143	217	166		51
E. State SSI for RCH												
F. Other (Specify)	2,404	2,327		77	1,741	1,721		20	663	606		57
G. Total Care Days During Period (3A thru F)	25,968	21,951		4,017	18,356	15,413		2,943	7,612	6,538		1,074
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	33	33			32	32			1	1		
B. Other Bed Reserve Days	33	33			22	22			11	11		
5. Total Resident Days (3G + 4A + 4B)	26,034	22,017		4,017	18,410	15,467		2,943	7,624	6,550		1,074

Schedule of Resident Statistics (Cont'd)

Name of Facility 23 Fair Streete Operations LLC			License No. 2416			Report for Year Ended 9/30/2016			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	SLTC	Lost			Gained			CCNH	RHNS	SLTC	
	(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	SLTC		
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	SLTC		CCNH	RHNS	SLTC	R.C.H.	ICF-IID			
No. of Residents	9		57	7		9							
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	605.81		263.84			384.46			94.00				
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	SLTC	
A. Medicare - Part B									3,263	2,285		978	
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									2,274	1,382		892	
C. Other									7,810	7,132		678	
D. Total Physical Therapy Treatments									13,347	10,799		2,548	
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									398	320		78	
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									456	274		182	
C. Other									478	381		97	
D. Total Speech Therapy Treatments									1,332	975		357	
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									3,540	2,699		841	
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									2,791	1,508		1,283	
C. Other									8,629	7,943		686	
D. Total Occupational Therapy Treatments									14,960	12,150		2,810	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
23 Fair Streete Operations LLC	2416	9/30/2016	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	SLTC	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)	91,320	1,484			16,115	262
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	80,818	3,524			14,262	622
5. Dietary Service						
a. Head Dietitian	14,585	500			2,574	88
b. Food Service Supervisor	23,283	915			4,109	161
c. Dietary Workers	191,760	13,761			33,840	2,428
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	44,080	1,404			9,827	313
b. Other Maintenance Workers	18,648	1,408			4,157	314
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	34,787	2,695			6,139	476
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	96,547	2,127			25,829	550
b. RN						
1. Direct Care	369,052	10,038			195,078	5,750
2. Administrative**	45,485	1,144			20,323	573
c. LPN						
1. Direct Care	770,501	24,654			225,173	7,639
2. Administrative**						
d. Aides and Attendants	761,174	44,846			304,475	20,091
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	74,356	3,553			13,122	627
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	58,873	2,275			10,389	401
n. Marketing						
o. Other (Specify) See Attached Schedule	130,022	6,960			22,945	1,228
<i>A-13. Total Salary Expenditures</i>	2,805,291	121,286			908,357	41,525

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

Name of Facility				License No.	Report for Year Ended				Page	of
23 Fair Streete Operations LLC				2416	9/30/2016				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	SLTC							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

**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	
23 Fair Streete Operations LLC				2416	9/30/2016			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	SLTC							
Section III - Administrators***										
Dahl,James	91,320		16,115		Management of Center	1,746	2			
Section IV - Assistant Administrators										
Bewry,Nickeisha					Assists in overseeing facility operations		3			

*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.

Annual Report of Long-Term Care Facility

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
23 Fair Streete Operations LLC	2416	9/30/2016	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	SLTC	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	58,746	1,588				
2. Dentist	35,830	245				
3. Pharmacist	4,842	99				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	331,125	4,536			78,128	1,070
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	20,000	104			20,000	150
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	49,093	629			17,975	230
b. Other						
10. Occupational Therapist						
a. Resident Care	149,913	2,054			34,671	475
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	14,105	235				
2. Administrative***						
b. LPN						
1. Direct Care	41,573	967				
2. Administrative***						
c. Aides	3,223	132				
d. Other						
12. Other (Specify)						
See Attached Schedule	6,385				433,904	
B-13 Total Fees Paid in Lieu of Salaries	714,834	10,589			584,679	1,926

* 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 23 Fair Streete Operations LLC		License No. 2416		Report for Year Ended 9/30/2016	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Genesis Eldercare Hospitality Services, 101 East State Street, Kennett Square, PA 19348	Dietary Services	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input 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
23 Fair Streete Operations LLC	2416	9/30/2016	15	37
Item	Total	CCNH	RHNS	SLTC
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 169,235	128,619		40,616
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 122,702	93,254		29,448
4. Social Security (F.I.C.A.)	\$ 278,838	211,917		66,921
5. Health Insurance	\$ 336,737	255,920		80,817
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 213,362	181,358		32,004
d. Accounting and Auditing	\$			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 1,162	988		174
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 19,211	16,329		2,882
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 29,908	25,422		4,486
2. Cellular Phones	\$ 2,412	2,050		362
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	\$ 525	446		79
3. Resident Day User Fee	\$ 491,006	409,638		81,368
Subtotal	\$ 1,665,098	1,325,941		339,157

* 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**

23 Fair Streete Operations LLC
9/30/2016

Attachment Page 15

Schedule of Other Employee Benefits

Description		CCNH	RHNS	SLTC
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
0	0	\$ -	\$ -	
Total		\$ -	\$ -	\$ -

Schedule of Other Taxes

Description		CCNH	RHNS	SLTC
1020640110	Sales Tax	\$ 446	\$ -	\$ 79
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -		
Total		\$ 446	\$ -	\$ 79

0

0

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

Name of Facility	License No.	Report for Year Ended	Page	of	
23 Fair Streete Operations LLC	2416	9/30/2016	16	37	
Item		Total	CCNH	RHNS	SLTC
Subtotals Brought Forward:		1,665,098	1,325,941		339,157
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	176	150		26
5. Education Expenses Related to Seminars and Conventions	\$	225	191		34
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>)	\$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$				
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)***	\$	5,281	4,489		792
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	\$	2,956	2,513		443
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>)	\$	8,078	6,866		1,212
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	800	680		120
9. Subscriptions	\$	307	261		46
10. Contributions***	\$	1,256	1,256		
See Attached Schedule					
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	3,579	3,042		537
12. Administrative Management Services**	\$	336,559	286,075		50,484
13. Other (<i>Specify</i>)	\$	41,969	35,673		6,295
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$	2,066,283	1,667,137		399,146

* 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 C-1 - Management Services*

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2016	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 #
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	347,524	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	32,308	Capital Interest	pg 26 12-A-1

*** 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
23 Fair Streete Operations LLC		2416	9/30/2016		18	37
Item		Total	CCNH	RHNS	SLTC	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 151,068	128,408		22,660	
2.	Non-Food Supplies	\$ 26,411	22,449		3,962	
3.	Other (<i>Specify</i>) _____	\$ (1,585)	(1,347)		(238)	
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)						
c. Management Services**						
d. Other (<i>Specify</i>) _____						
2E. Total Dietary Expenditures (2a + b + c + d)		\$ 175,934	149,544		26,390	
2F. Dietary Questionnaire		Total	CCNH	RHNS	SLTC	
G. Resident Meals: Total no. of meals served per day:*						
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 type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.						
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.						
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
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.

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

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

Name of Facility 23 Fair Streete Operations LLC		License No. 2416	Report for Year Ended 9/30/2016		Page 19	of 37
Item		Total	CCNH	RHNS	SLTC	
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. \$	992	843		149
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. \$	80,967	68,822		12,145
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	69,335	58,935		10,400
c. Management Services**		\$				
d. Other (Specify)		\$				
3E. Total Laundry Expenditures (3a + b + c + d)		\$	151,294	128,600		22,694
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.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 *** 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
23 Fair Streete Operations LLC		2416	9/30/2016		20	37
Item			Total	CCNH	RHNS	SLTC
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.)</i>	Amt.	\$	30,958	25,314		5,644
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.	\$	78,634	64,299		14,335
c. Management Services*		\$				
d. Other (<i>Specify</i>)		\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)		\$	109,592	89,613		19,979
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		\$				
2. Purchased from		\$	185,978	185,978		
b. Medicine Cabinet Drugs		\$	45,971	45,971		
c. Medical and Therapeutic Supplies		\$	192,559	192,559		
d. Ambulance/Limousine****		\$	2,952	2,952		
e. Oxygen						
1. For Emergency Use		\$				
2. Other****		\$	39,593	23,472		16,121
f. X-rays and Related Radiological Procedures****		\$	6,790	6,790		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$				
h. Laboratory****		\$	11,957	11,957		
i. Recreation		\$	34,681	28,359		6,322
j. Other (<i>Specify</i>)**** See Attached Schedule		\$	293,342	50,441		242,901
5K. Total Resident Care Expenditures (5a - 5j)		\$	813,823	548,479		265,344

* 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	SLTC
3010610300	Consolidated Billing	12.33	-	-
3060610160	Incontinency	23,917.69	-	-
3080630030	Advertising-Help War	350.00	-	-
3080630030	Advertising-Help War	521.42	-	-
3080630030	Advertising-Help War	281.12	-	-
3080630030	Advertising-Help War	123.46	-	-
3080630140	Education Expense	458.12	-	-
3120630530	Supplies	1,609.24	-	-
3120630530	Supplies	(340.16)	-	-
3120660080	Rental Expense	2,440.55	-	-
3155630530	Supplies	17,482.80	-	117,835.40
0	0	-	-	-
3155660080	Rental Expense	3,506.43	-	125,065.33
3155660080	Rental Expense	-	-	-
3165630530	Supplies	49.00	-	-
3170630530	Supplies	29.22	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	0.00	0.00	0.00
0	0	0.00	0.00	0.00
0	0	0.00	0.00	0.00
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
Total Other Resident Care		\$ 50,441	\$ -	\$ 242,901
		0		0

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

Name of Facility 23 Fair Streete Operations LLC			License No. 2416		Report for Year Ended 9/30/2016			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	SLTC	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	<input checked="" type="radio"/>	<input type="radio"/>	Vendor Contracted	Laundry Purchased Services	69,335			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input checked="" type="radio"/>	<input type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	78,634			20	4b
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input 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
23 Fair Streete Operations LLC	2416	9/30/2016			22	37
Item	Total	CCNH	RHNS	SLTC		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 128,758	105,285		23,473		
b. Heat	\$ 24,402	19,954		4,448		
c. Light & Power	\$ 69,701	56,995		12,706		
d. Water	\$ 12,695	10,381		2,314		
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 235,556	192,615		42,941		
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 522	427		95		
b. Building & Building Improvements	\$ 1,356	1,109		247		
c. Non-Movable Equipment	\$ 182	149		33		
d. Movable Equipment	\$ 187,192	153,067		34,125		
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 189,252	154,752		34,500		
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 584,773	478,169		106,604		
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 127,597	104,336		23,261		
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 901,622	737,257		164,365		

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

Depreciation Schedule

Name of Facility 23 Fair Streete Operations LLC			License No. 2416			Report for Year Ended 9/30/2016			Page 23	of 37			
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
A. Land Improvements													
1. Acquired prior to this report period							S/L	Various	(0)				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			43,821		43,821				522				
A-4. Subtotal										522			
B. Building and Building Improvements													
1. Acquired prior to this report period									(0)				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			107,746		107,746				1,356				
B-4. Subtotal										1,356			
C. Non-Movable Equipment													
1. Acquired prior to this report period							S/L	Various	(0)				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			4,370		4,370				182				
C-4. Subtotal										182			
		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. Motor Vehicles (attach schedule)									S/L	Various			
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)													
d.													
2. Movable Equipment													
a. Acquired prior to this report period									S/L	Various		0	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						688,227		688,227				187,192	
D-3. Subtotal													187,192
E. Total Depreciation													189,252

23 Fair Streete Operations LLC
9/30/2016

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
07/31/16	60 new trees	\$ 7,396	20	\$ 62
08/31/16	Landscapinf work	\$ 7,086	20	\$ 30
03/31/16	Exterior signage allocated from 10808	\$ 417	10	\$ 21
04/30/16	Asphalt installation	\$ 5,075	10	\$ 211
08/31/16	Replace walkway	\$ 23,847	10	\$ 199
Total additions for Land Improvements		\$ 43,821		\$ 522
Deletions:		AR page 23		
Total deletions for Land Improvements		\$ -		\$ -

WP
300.1

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
03/31/16	Time Allocation Property Management	\$ 8,477	20	\$ 212
04/30/16	Property Management Time Allocation	\$ 5,534	20	\$ 115
04/30/16		\$ 500	20	\$ 10
04/30/16	Architectual Services	\$ 8,517	20	\$ 177
05/31/16	Property Management Time Allocation	\$ 7,512	20	\$ 125
06/30/16	Property Management Time Allocation	\$ 7,972	20	\$ 100
06/30/16	Sofit repairs	\$ 16,850	20	\$ 211
06/30/16	Architectual Services	\$ 1,625	20	\$ 20
06/30/16	2 grab bars	\$ 366	20	\$ 5
07/31/16	Property Management Time Allocation	\$ 5,962	20	\$ 50
07/31/16	Air balancing study first installment	\$ 4,084	20	\$ 34
07/31/16	50% deposit on project	\$ 23,847	20	\$ 199
07/31/16	Architectual Services	\$ 4,030	20	\$ 34
08/31/16	Plumberex Pro Extreme ADA Covers	\$ 396	20	\$ 2

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Total additions for Building Improvements		\$ 107,746	\$ 1,356
Deletions:		AR page 23	
Total deletions for Building Improvements		\$ -	\$ -

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
04/30/16	Replaced 119 Gallon storage tank	\$ 4,370	10	\$ 182
Total additions for Non-Movable Equipment		\$ 4,370		\$ 182
Deletions:		AR page 23		
Total deletions for Non-Movable Equipment		\$ -		\$ -

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
02/29/16	Medium Duty Slicer, 12i Blade	\$ 1,451	10	\$ 85
03/31/16	replaced hatco hot water booster in kitche	\$ 5,113	10	\$ 256
03/31/16	Floor Model Mixer 20 Qt wire whip dough	\$ 2,915	10	\$ 146
03/31/16	BATTER BEATER PADDLE	\$ 157	10	\$ 8
06/30/16	Conveyor Toaster 1000 Slices Per Hour	\$ 1,257	10	\$ 31
11/30/15	Revera Valuation - Equipment	\$ 672,000	3	\$ 186,667

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09/30/16	Destroyit paper shredder	\$ 5,334	10	\$ -
Total additions for Movable Equipment		\$ 688,227		\$ 187,192
Deletions:		AR page 23		
Total deletions for Movable Equipment		\$ -		\$ -

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility 23 Fair Streete Operations LLC			License No. 2416		Report for Year Ended 9/30/2016			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2016	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description		Total		
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		120		
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd 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
Well Tower /Healthcare REIT, Inc	Building and Equipment	12/01/15	20	478,169
Address: One Seagate Suite 1500				
Toledo, OH 43603-1475				

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
23 Fair Streete Operations LLC		2416	9/30/2016			26	37
Item		Total	CCNH	RHNS	SLTC		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$ 32,308	26,418			5,890	
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)		\$ 32,308	26,418			5,890	

(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
23 Fair Streete Operations LLC		2416		9/30/2016			27	37
Item				Total	CCNH	RHNS	SLTC	
Subtotals Brought Forward:				32,308	26,418		5,890	
12. C. Movable Equipment								
1. Automotive Equipment				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
2. Other (<i>Specify</i>)				\$				
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 (<i>Specify</i>)				\$				
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 32,308	26,418		5,890	
14. Insurance								
a. Insurance on Property (buildings only)				\$ 12,197	9,973		2,224	
b. Insurance on Automobiles				\$				
c. Insurance other than Property (as specified above)								
1. Umbrella (<i>Blanket Coverage</i>)			\$ 145,541	119,009		26,532		
2. Fire and Extended Coverage			\$					
3. Other (<i>Specify</i>)			\$					
14d. Total Insurance Expenditures (14a + b + c)				\$ 157,738	128,982		28,756	
15. Total All Expenditures (A-13 thru C-14)				\$ 9,657,311	7,188,770		2,468,541	

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
23 Fair Streete Operations LLC			2416	9/30/2016	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	SLTC
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 14,917	14,917		
Page 13 - Professional Fees							
5.	13	8-c	Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 666,947	666,947		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 213,362	181,358		32,004
10.			Accounting & Legal	\$			
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	m-2 &	Unallowable Advertising *	\$ 5,281	4,489		792
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 1,256	1,256		
21.			Unallowable Management Fees	\$ 368,867	312,493		56,374
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 163,344	163,344		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 1,433,974	1,344,804		89,170

* 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	SLTC
10	2	Administrator's salary disallowed	0	\$ 14,917	0
10	a12o	0	0	\$ -	0
10	a12o	0	0	\$ -	0
0	0	0	0	\$ -	0
0	0	0	0	\$ -	0
0	0	0	0	\$ -	0
Total Other Salaries Adjustment				\$ 14,917	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	SLTC
13	5	Rehabilitation Services	3120620020	\$ 154,046	0
13	5	Rehabilitation Services	3195620020	\$ 255,207	0
13	9	Speech Therapist	3170620020	\$ 67,068	0
13	10	Occupational Therapist	3105620020	\$ 184,584	0
13	12	Other	3010620020	\$ 6,043	0
13	12	Other	3015620020	\$ -	0
13	12	Respiratory Purchased Servies	3155620020	\$ -	0
				0	0
				0	0
				0	0
				0	0
				0	0
Total Other Fees Adjustments				\$ 666,947	\$ -
				\$ -	

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	SLTC
16	m-8a	1020630310	Chamber of Commerce	\$ 800	0
16	m-13	1020630120	Collection Fees	\$ 1,735	0
16	m-13	1020660990	Estimated Accrual	\$ 15,953	0
16	m-13	7010800030	Non-recurring charges	\$ -	0
16	m-13	1020640080	Penalty	\$ 3,031	0
0	0	0	0	\$ -	0
15	1a3	0	0	\$ -	0
15	1a4	0	0	\$ -	0
15	1-a-1	adj workers comp	0	141,825	0
0	0	0	0	0	0
Total Other A&G Adjustments				\$ 163,344	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
23 Fair Streete Operations LLC				2416	9/30/2016	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	SLTC
Subtotals Brought Forward				\$ 1,433,974	1,344,804		89,170
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs	\$ 185,978	185,978		
28.	20	5-d	Ambulance/Limousine	\$ 2,952	2,952		
29.	20	5-f	X-rays, etc	\$ 6,790	6,790		
30.	20	5-h	Laboratory	\$ 11,957	11,957		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 23,472	23,472		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 48,863	48,863		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 1,713,986	1,624,816		89,170

*** 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.

23 Fair Streete Operations LLC
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	SLTC
20	5-j	Consolidated Billing	\$ 12	\$ -	\$ -
20	5-j	Respiratory Supplies	\$ 17,483	\$ -	\$ -
20	5-j	Respiratory Rental	\$ 3,506	\$ -	\$ -
20	5-i	Cable TV	\$ 27,861	allow \$3600	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
Total Other Ancillary Costs			\$ 48,863	\$ -	\$ -
			\$ -		

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	SLTC
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	SLTC
0	0-Jan		0 -	-	-
0	0-Jan		0 -	-	-
0	0-Jan		0 -	-	-
0	0-Jan		0 -	-	-
0	0-Jan		0 -	-	-
0	0-Jan		0 -	-	-
0	0-Jan		0 -	-	-
0	0-Jan		0 -	-	-
0	0-Jan		0 -	-	-
Total Other Property Adjustments			\$ -	\$ -	\$ -
			\$ -		

Page Ref	Line Ref	Description	CCNH	RHNS	SLTC
27	14 c1	General liability Insurance Adjust	\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
Total Other Adjustments			\$ -	\$ -	\$ -
			\$ -		

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	SLTC
Total Unallowable Building Interest			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
23 Fair Streete Operations LLC	2416	9/30/2016			30	37
Item	Total	CCNH	RHNS	SLTC		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 7,504,749	7,504,749				
b. Medicaid Room and Board Contractual Allowance **	\$ (2,860,211)	(2,860,211)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents(<i>all inclusive</i>)	\$ 834,550	834,550				
b. Medicare Room and Board Contractual Allowance **	\$ (224,215)	(224,215)				
4. a. Private-Pay Residents and Other	\$ 1,214,661	1,214,661				
b. Private-Pay Room and Board Contractual Allowance **	\$ (282,255)	(282,255)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 105,125	105,125				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (28,243)	(28,243)				
c. Prescription Drugs - Non-Medicare	\$ 98,085	80,204				17,881
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (24,210)	(19,797)				(4,413)
2. a. Medical Supplies - Medicare	\$ 50	50				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (14)	(14)				
c. Medical Supplies - Non-Medicare	\$ 98	80				18
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (37)	(30)				(7)
3. a. Physical Therapy - Medicare	\$ 446,608	446,608				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (119,988)	(119,988)				
c. Physical Therapy - Non-Medicare	\$ 243,363	198,998				44,365
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (74,373)	(60,815)				(13,558)
4. a. Speech Therapy - Medicare	\$ 98,980	98,980				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (26,593)	(26,593)				
c. Speech Therapy - Non-Medicare	\$ 86,644	70,849				15,795
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (29,592)	(24,197)				(5,395)
5. a. Occupational Therapy - Medicare	\$ 551,445	551,445				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (148,154)	(148,154)				
c. Occupational Therapy - Non-Medicare	\$ 291,161	238,082				53,079
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (91,858)	(75,112)				(16,746)
6. a. Other (<i>Specify</i>) - Medicare	\$ 73,761	60,315				13,447
b. Other (<i>Specify</i>) - Non-Medicare	\$ 610,333	499,069				111,264
III. Total Resident Revenue (Section I. thru Section II.)	\$ 8,249,870	8,034,141				215,729
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 31	31				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 170	170				
V. Total Other Revenue (1 thru 8)	\$ 201	201				
VI. Total All Revenue (III + V)	\$ 8,250,071	8,034,342				215,729

* 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.

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
23 Fair Streete Operations LLC	2416	9/30/2016	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	(1,416)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,281,131
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(16,706)
4. Inventories			\$	4,221
5. Prepaid Expenses			\$	39,523
a. Prepaid Expenses	0			
b. Prepaid Property Tax	33,372			
c. Prepaid Escrow Real Estate				
d. Prepaid Personal Property Tax	6,152			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

A-9. Total Current Assets (Lines A1 thru 8)			\$	1,306,753
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	43,821		
	Accum. Depreciation	522		
	Net		\$	43,299
3. Buildings	*Historical Cost	107,746		
	Accum. Depreciation	1,356		
	Net		\$	106,390
4. Leasehold Improvements	*Historical Cost			
	Accum. Depreciation			
	Net		\$	
5. Non-Movable Equipment	*Historical Cost	4,370		
	Accum. Depreciation	182		
	Net		\$	4,188
6. Movable Equipment	*Historical Cost	688,227		
	Accum. Depreciation	187,192		
	Net		\$	501,035
7. Motor Vehicles	*Historical Cost			
	Accum. Depreciation			
	Net		\$	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
PPE CIP				

B-10. Total Fixed Assets (Lines B1 thru 9)			\$	654,912

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
23 Fair Streete Operations LLC	2416	9/30/2016	32	37
Account			Amount	
Total Brought Forward:			\$ 1,961,665	
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			\$	
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	
			\$	
3. Buildings			\$	
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	
			\$	
4. Non-Movable Equipment			\$	
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	
			\$	
5. Movable Equipment			\$	
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	
			\$	
6. Motor Vehicles			\$	
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	
			\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			\$	
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	
			\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	
O L/T A Suspense			(2,659,512)	
I/C Due to/Due From Owned			(2,659,512)	
I/C Due to/Due From Multicare				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ (2,659,512)	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ (697,847)	

* 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 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2016	Page 33	of 37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	384,029
2. Notes Payable (<i>itemize</i>)			\$	

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>)			\$	87,493
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	84
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable (<i>Current Portion</i>)			\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$	
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities (<i>itemize</i>)			\$	260,222
A/R Credit Gross Up Liability		101,694	Accr Exp Other	
Accr Exp Water and Sewer		3,664	Deferred Revenue 935	
Accr Exp Gas		5,802	Accrued Provider/Bed T: 142,873	
Accr Exp Electricity		5,254	Accr Sales and Use Tax	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	731,828

* 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 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2016	Page 34	of 37
Account				Amount
Total Brought Forward:				731,828
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
LT Debt-Financing Obligation				

B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$
C. Total All Liabilities (Lines A-13 + B-5)				\$ 731,828

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

Name of Facility	License No.	Report for Year Ended	Page	of
23 Fair Streete Operations LLC	2416	9/30/2016	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(22,435)
6. Gain or Loss for Period	12/1/2015	thru 9/30/2016	\$	(1,407,242)
7. Total Net Worth			\$	(1,429,677)
C. Total Reserves and Net Worth			\$	(1,429,677)
D. Total Liabilities, Reserves, and Net Worth			\$	(697,849)

H. Changes in Total Net Worth

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2016	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2015			\$	(173,210)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	8,250,070
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	9,506,537
D. Net Income or Deficit			\$	(1,256,467)
E. Balance			\$	(1,429,677)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period		09/30/16	\$	(1,429,677)

I. Preparer's/Reviewer's Certification

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2016	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 checked="" type="checkbox"/> SLTC		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
Thomas Farnan Title -Sr. Director of Reimbursement				
Address Address			Phone Number	
200 Brickstone Square, Andover, MA 01810			978-247-5029	