State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2020

Name of Facility (as licensed) 22 South Street Operations LLC, d/b/a Fox Hill center		
Address (No. & Street, City, State, Zip Code) 1253 Hartford Turnpike, Rockville, CT 06066		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2045			07-5183

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	000008029		

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
22 South Street Operations LLC, d/b/a Fox Hill center	2045	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 22 South Street Operations LLC, d/b/a Fox Hill center [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) Jonah Kraus			Printed Name (Owner) Lashuan Bethea-VP-Legislative Affairs-Genesis Healthcare	
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 22 South Street Operations LLC, d/b/a Fox Hill center	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 1253 Hartford Turnpike, Rockville, CT 06066				
Report Prepared By Thomas Farnan	Phone Number 978-247-5029		Date 12/28/2020	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$	4,001,494	4,001,494		
5. All other wages paid	$	532,967	532,967		
6. ***Total Wages Paid***	$	4,534,461	4,534,461		
7. Total salaries paid	$	342,255	342,255		
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	4,876,716	4,876,716		

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
	860-875-0771	9/30/2020	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
22 South Street Operations LLC, d/b/a Fox Hill center	1253 Hartford Turnpike, Rockville, CT 06066

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2045			07-5183

Type of Facility (Check appropriate box(es))

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

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.:	
Jonah Kraus		CT 001864

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2045	9/30/2020	3	37

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox H	2045	9/30/2020	3A	37

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
22 South Street Operations LLC, d/b/a Fox Hill center	101 East State Street, Kennett Square, PA 19348	PA

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
See Attached			
Names of Stockholders Owning at Least 10% of Shares			
See Attached			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill cer	2045	9/30/2020	3B	37

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

Owner(s) of Facility

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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	%**				
Genesis Healthcare Administrative LLC	101 East State Street, Kennett Square, PA 19348	⊙	○		Home Office	Pg 16/m12	472,049	472,049
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	⊙	○	64%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	533,467	533,467
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	○	⊙	37%	Staffing Pool	Pg 10/A12, p15-1		
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	⊙	○	85%	Medical Director /NP	Pg 13/B8, Pg 10/A12	22,352	22,352
Career Staffing	101 East State Street, Kennett Square, PA 19348	⊙	○	66%	Outside Agency	Pg 13/B11 pg 10-12, 1		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	⊙	○	50%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	62,024	62,024
Liberty Health (Insurance)	101 East State Street, Kennett Square, PA 19348	⊙	○		Insurance	Pg 27/14	236,220	236,220
Genesis Healthcare	101 East State Street, Kennett Square, PA 19348	⊙	○		Capital Interest	Page 17, page 26-12A		
		○	⊙					

* 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.

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		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/	2045	9/30/2020	7	37

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 KPMG Peat Marwick	1600 Market Street, Philadelphia, PA 19103
2	
3	
4	

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 Included in Management Fee pg. 16 m-12

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1	
2	
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	$
2	$
3	$
4	$
5	$
	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

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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 (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	150	150			150	150						
B. On last day of THIS report period	150	150							150	150		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	109	109			109	109						
B. As of midnight of THIS report period	110	110							110	110		
3. Total Number of Days Care Provided During Period												
A. Medicare	3,209	3,209			2,590	2,590			619	619		
B. Medicaid (Conn.)	27,527	27,527			21,327	21,327			6,200	6,200		
C. Medicaid (other states)												
D. Private Pay	2,393	2,393			1,998	1,998			395	395		
E. State SSI for RCH												
F. Other (Specify)	2,400	2,400			1,843	1,843			557	557		
G. Total Care Days During Period (3A thru F)	35,529	35,529			27,758	27,758			7,771	7,771		
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)**	35,529	35,529			27,758	27,758			7,771	7,771		

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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	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	8	70		10				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	605.54	206.55		476.43				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	2,470	2,470		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	298	298		
C. Other	12,002	12,002		
D. ***Total Physical Therapy Treatments***	14,770	14,770		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	290	290		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	107	107		
2. Restorative Treatments				
C. Other	943	943		
D. ***Total Speech Therapy Treatments***	1,340	1,340		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,137	2,137		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	386	386		
C. Other	11,915	11,915		
D. ***Total Occupational Therapy Treatments***	14,438	14,438		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2045	9/30/2020	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	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)	147,657	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	232,293	9,957				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers						
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	63,408	2,203				
b. Other Maintenance Workers	3,010	190				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
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	194,598	3,033				
b. RN						
1. Direct Care	983,700	22,349				
2. Administrative**	145,212	3,403				
c. LPN						
1. Direct Care	1,237,513	34,497				
2. Administrative**						
d. Aides and Attendants	1,526,422	73,707				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	97,781	4,324				
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	136,475	4,280				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	108,647	4,795				
A-13. Total Salary Expenditures	4,876,716	164,819				

* 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		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Ward Clerks	$ 18,625	$ 826	$ -	$ -	$ -	$ -
Central Supply	$ 27,972	$ 1,210	$ -	$ -	$ -	$ -
Medical Records	$ 18,839	$ 1,054	$ -	$ -	$ -	$ -
Coordinator-Staffing Centers	$ 43,211	$ 1,705	$ -	$ -	$ -	$ -
Total	$ 108,647	4,795	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Consulting Fees	$ 4,563	n/a	$ -	$ -	$ -	$ -
Purchased Services	$ 200	n/a	$ -	$ -	$ -	$ -
Purchased Services	$ 3,960	n/a	$ -	$ -	$ -	$ -
Purchased Services	$ 61,324	n/a	$ -	$ -	$ -	$ -
0	$ -	n/a	$ -	$ -	$ -	$ -
0	$ -	n/a	$ -	$ -	$ -	$ -
Total	$ 70,046	-	$ -	-	$ -	-

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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
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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	(Specify)							
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.

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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
22 South Street Operations LLC, d/b/a Fox Hill center	2045	9/30/2020	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Jonah Kraus	11,058				Management of Center	200	2			
Vitko-Aniolek,Stephanie Margaret 10/1/2019-8/22/20	136,599				Management of Center	1,880	2			
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
22 South Street Operations LLC, d/b/a Fox Hill cent	2045	9/30/2020	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	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						
2. Dentist	11,888	81				
3. Pharmacist	11,449	234				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	480,351	6,580				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	64,098	339				
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	22,982	295				
b. Other						
10. Occupational Therapist						
a. Resident Care	75,279	1,031				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	67,317	1,123				
2. Administrative***						
b. LPN						
1. Direct Care	19,568	462				
2. Administrative***						
c. Aides	46,554	1,906				
d. Other						
12. Other (Specify)						
See Attached Schedule	70,046					
B-13 Total Fees Paid in Lieu of Salaries	869,532	12,051				

* 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
22 South Street Operations LLC, d/b/a Fox Hill center	2045	9/30/2020	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
		○	⊙	
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	⊙	○	Common Ownership
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	⊙	○	Common Ownership
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	⊙	○	Common Ownership
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	⊙	○	Common Ownership
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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		○	⊙	
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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
22 South Street Operations LLC, d/b/a Fox Hill c	2045	9/30/2020	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	237,754	237,754		
2. Disability Insurance	$				
3. Unemployment Insurance	$	48,746	48,746		
4. Social Security (F.I.C.A.)	$	359,896	359,896		
5. Health Insurance	$	353,374	353,374		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	5,146	5,146		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	113,090	113,090		
d. Accounting and Auditing	$				
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	17,036	17,036		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	18,915	18,915		
2. Cellular Phones	$	2,133	2,133		
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*)	$	325	325		
See Attached Schedule					
3. Resident Day User Fee	$	628,394	628,394		
Subtotal	$	1,784,810	1,784,810		

* 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	(Specify)
Benefit Allocations	$ 393	$ -	$ -
Union Health & Welfare	$ 4,744	$ -	$ -
Benefit Allocations	$ 10	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
Total	$ 5,146	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Sales Tax	$ 325	$ -	$ -
Sales Tax	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
Total	$ 325	$ -	$ -

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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
22 South Street Operations LLC, d/b/a Fox Hill center	2045	9/30/2020	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,784,810	1,784,810		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	199	199		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	7,844	7,844		
5. Education Expenses Related to Seminars and Conventions	$	415	415		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	7,875	7,875		
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	$	3,462	3,462		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	11,248	11,248		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	500	500		
9. Subscriptions	$	544	544		
10. Contributions***	$	2,239	2,239		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	13,487	13,487		
12. Administrative Management Services**	$	403,626	403,626		
13. Other (*Specify*)	$	47,765	47,765		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,284,015	2,284,015		

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

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

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

Schedule of Other Travel and Entertainment

Description		CCNH	RHNS	(Specify)
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
Total Other Travel and Entertainment		$ -	$ -	$ -

Schedule of Other Advertising

Description		CCNH	RHNS	(Specify)
Advertising		$ 2,098	$ -	$ -
Marketing Expense		$ 1,632	$ -	$ -
Marketing Exp- Corporate Spend		$ 4,145	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
Total Other Advertising		$ 7,875	$ -	$ -

Schedule of Dues

Description		CCNH	RHNS	(Specify)
Licenses & Certifications		$ 11,748	$ -	$ -
Dues to Chamber of Commerce		$ (500)	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
Total Dues		$ 11,248	$ -	$ -

Schedule of Contributions

Description		CCNH	RHNS	(Specify)
Contributions		$ -	$ -	$ -
Political Contributions		$ 2,239	$ -	$ -
	0	$ -	$ -	$ -
Total Contributions		$ 2,239	$ -	$ -

Schedule of Other Administrative and General

Description		CCNH	RHNS	(Specify)
Bank Service Charges		$ 5,125	$ -	$ -
Collection Fees		$ 24,366	self-disallowed	$ -
Education Expense		$ 8	$ -	$ -
Employee Physicals		$ 13,559	$ -	$ -
Employee Relations		$ 1,219	$ -	$ -
Printing		$ 292	$ -	$ -
Training Expense		$ 175	$ -	$ -
Fines & Penalties		$ -	self-disallowed	$ -
Miscellaneous		$ 20	$ -	$ -
Rental Expense		$ 2,115	$ -	$ -
Accrued Expense Estimation		$ (81)	self-disallowed	$ -
Landlord Operating Taxes		$ -	$ -	$ -
State Tax Annual Report Filing		$ 20	$ -	$ -
Recruiting Fees		$ -	$ -	$ -
Non-recurring Charges		$ -	$ -	$ -
Uniforms		$ 947	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
	0	$ -	$ -	$ -
Total Other Administrative and General		$ 47,765	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
22 South Street Operations LLC, d/b/a Fo	2045	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 #
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	472,049	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12

*** 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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CSP-18 Rev. 9/2018

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

Name of Facility	License No.	Report for Year Ended	Page of
22 South Street Operations LLC, d/b/a Fox Hill center	2045	9/30/2020	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	176,871	176,871		
2. Non-Food Supplies	$	26,483	26,483		
3. Other (*Specify*)_____	$	2,539	2,539		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	618,552	618,552		
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	824,445	824,445		

		Total	CCNH	RHNS	(Specify)
2E.	Dietary Questionnaire				
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.
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
22 South Street Operations LLC, d/b/a Fox Hill center	2045	9/30/2020	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	5,066	5,066		
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. $	4,768	4,768		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	154,663	154,663		
c. Other (*Specify*)	$				
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	164,496	164,496		

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
22 South Street Operations LLC, d/b/a Fox Hill	2045	9/30/2020	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	15,553	15,553		
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	280,300	280,300		
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	295,853	295,853		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	161,246	161,246		
b. Medicine Cabinet Drugs		$	6,942	6,942		
c. Medical and Therapeutic Supplies		$	128,430	128,430		
d. Ambulance/Limousine***		$	2,863	2,863		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	8,374	8,374		
f. X-rays and Related Radiological Procedures***		$	13,628	13,628		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	21,864	21,864		
i. Recreation		$	46,280	46,280		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	61,744	61,744		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	451,370	451,370		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Incontinency	$ 39,302	$ -	$ -
Advertising-Help Wanted	$ (8,684)	$ -	$ -
Advertising-Help Wanted	$ 2,463	$ -	$ -
Books, Dues & Subscriptions	$ 62	$ -	$ -
Education Expense	$ 590	$ -	$ -
Supplies	$ 512	$ -	$ -
Supplies	$ 17,472	$ -	$ -
Supplies	$ -	$ -	$ -
Office Supplies	$ 39	$ -	$ -
Office Supplies	$ -	$ -	$ -
Office Supplies	$ -	$ -	$ -
Training Expense	$ -	$ -	$ -
Rental Expense	$ 785	$ -	$ -
Rental Expense	$ 4,368	$ -	$ -
Consolidated Billing	$ 8,471	$ -	$ -
Tuition Reimbursement	$ -	$ -	$ -
Tuition Reimbursement	$ -	$ -	$ -
Tuition Reimbursement	$ -	$ -	$ -
Miscellaneous	$ (3,636)	$ -	$ -
Licenses & Certifications	$ -	$ -	$ -
Supplies	$ -	$ -	$ -
0	$ -	$ -	$ -
0	$ -	$ -	$ -
Total Other Resident Care	$ 61,744	$ -	$ -

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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
22 South Street Operations LLC, d/b/a Fox Hill center	2045	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	(Specify)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Laundry Purchased Services	154,663			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Housekeeping Purchased Services	280,300			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Dietary Purchased Services	614,916			18	2b
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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
22 South Street Operations LLC, d/b/a Fox Hi	2045	9/30/2020	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	172,526	172,526		
b. Heat	$	75,831	75,831		
c. Light & Power	$	77,428	77,428		
d. Water	$	44,871	44,871		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	370,655	370,655		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	16,851	16,851		
c. Non-Movable Equipment	$	517	517		
d. Movable Equipment	$	9,310	9,310		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	26,678	26,678		
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	$	191,725	191,725		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	95,263	95,263		
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	313,666	313,666		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Total Other Repairs and Maintenance	$ -	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2045	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					S/L	Various		
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	527		527					
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	5,381		5,381	60	S/L	Various	718	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	62,482		62,482				16,134	
B-4. Subtotal								16,851
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)	15,505		15,505				517	
C-4. Subtotal								517

	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.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					23,132		23,132	556	S/L	Various	3,022	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					81,903		81,903				6,287	
D-3. Subtotal												9,310
E. ***Total Depreciation***												26,678

Schedule of Land Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
9/30/2020	September 2020 Accruals -150028	$ 527	3	$ -	
1/0/1900	1/0/1900	$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
Total additions for Land Improvement		$ 527		$ -	*
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:					
1/31/2020	New Door 90 minute rated Hollow metal d	$ 1,228	20	$ 41	
1/31/2018	LED Lighting Upgrade for Center - Finan	$ 60,347	10	$ 16,093	
9/30/2020	Sept 2020 Accrual - Saucier 0010022051	$ 906	20	$ -	
1/0/1900	0	$ -	-	$ -	
1/0/1900	0	$ -	-	$ -	
1/0/1900	0	$ -	-	$ -	
1/0/1900	0	$ -	-	$ -	
1/0/1900	0	$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
		$ -	-	$ -	
Total additions for Building Improvemen		$ 62,482		$ 16,134	*
Deletions:					
1/0/1900	0	$ -	$ -		
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:				
5/31/2020	First Installment for replacement of North	$ 15,505	$ 10	$ 517
1/0/1900	1/0/1900	$ -	$ -	$ -

1/0/1900	1/0/1900	$ -	$ -	$ -	
1/0/1900	1/0/1900	$ -	$ -	$ -	
1/0/1900	1/0/1900	$ -	$ -	$ -	
1/0/1900	1/0/1900	$ -	$ -	$ -	
Total additions for Non-Movable Equipmen		$ 15,505		$ 517	*
Deletions:					
1/0/1900	1/0/1900	$ -	$ -		
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:					
10/31/2019	Re Route Duck Work behind New Gas Dr	$ 2,640	$ 7	$ 346	
11/30/2019	3 UniMac Washers	$ 7,248	$ 7	$ 863	
11/30/2019	Wrap Nellcor SpO2 Durasensor for vital s	$ 548	$ 7	$ 65	
12/31/2019	3 Spots Vital Signs Monitors w/NIBP	$ 5,463	$ 7	$ 585	
12/31/2019	3 Mobile Stands for vital signs monitors	$ 910	$ 7	$ 97	
12/31/2019	Attendant rolling stand for bladder scann	$ 308	$ 7	$ 33	
12/31/2019	Attendant Prodigy Bladder Scanner	$ 8,088	$ 7	$ 867	
4/30/2020	3 - Unimac Washing Machines, 2 55-60lb	$ 28,990	$ 7	$ 1,726	
8/31/2020	New 75lb. Gas Dryer & Install	$ 6,146	$ 7	$ 73	
9/30/2020	12 - Continu.us 28" LTC LED HDTVs	$ 2,764	$ 7	$ -	
2/29/2020	Food Processor 7 Liter 3 Hp Variable Sp	$ 3,362	$ 10	$ 196	
3/31/2020	Three Section Refrigerator & install / rem	$ 6,514	$ 10	$ 326	
8/31/2020	Chest Freezer 10.6 Cu. Ft.	$ 766	$ 10	$ 6	
9/30/2020	20 - Overbed Tables w/ H Chrome H Bas	$ 1,531	$ 10	$ -	
3/31/2020	30 - Panacea Custom Foam Mattresses	$ 6,625	$ 3	$ 1,104	
		$ -	$ -	$ -	
		$ -	$ -	$ -	
Total additions for Movable Equipmen		$ 81,903		$ 6,287	*
Deletions:					
1/0/1900	1/0/1900	$ -	$ -		
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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CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2045	9/30/2020	24	37

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

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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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
22 South Street Operations LLC, d/b/a	2045	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	n/a
2. Date Structure Completed	n/a
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	150
6. Square Footage	
7. Acquisition Cost	
a. Land	n/a
b. Building	n/a

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
Next HC-JV	Facility Lease	2/1/2019 -1/31/	15 years	191,725
587 Fifth Avenue New York, NY 10017				

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
22 South Street Operations LLC, d/b/a	2045	9/30/2020	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage	$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	$				
2. 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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CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
22 South Street Operations LLC, d	2045	9/30/2020	27 | 37

Item			Total	CCNH	RHNS	(Specify)
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)		$	20,423	20,423		
b. Insurance on Automobiles		$				
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*)		$	215,797	215,797		
2. Fire and Extended Coverage		$				
3. Other (*Specify*)		$				
14d. ***Total Insurance Expenditures (14a + b + c)***		$	236,220	236,220		
15. ***Total All Expenditures (A-13 thru C-14)***		$	10,686,969	10,686,969		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
22 South Street Operations LLC, d/b/a Fox Hill center	2045	9/30/2020	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $	38,326	38,326		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians ** $				
6.		B-10	Occupational Therapy $				
7.			Other - See attached Schedule $	644,095	644,095		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1-c	Bad Debts $	113,090	113,090		
10.			Accounting $				
10a.			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 * $	7,875	7,875		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $	2,239	2,239		
21.			Unallowable Management Fees $	(68,423)	(68,423)		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	123,218	123,218		
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) $	860,422	860,422		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	2	Administrator's salary disallowed	$ 38,326	$ -	$ -
0	0	0	$ -	$ -	$ -
0	0	0	$ -	$ -	$ -
0	0	0	$ -	$ -	$ -
0	0	0	$ -	$ -	$ -
0	0	0	$ -	$ -	$ -
0	0	0	$ -	$ -	$ -
Total Other Salaries Adjustment			$ 38,326	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	$ 88,927	$ -	$ -
13	5	Rehabilitation Services	$ 391,424	$ -	$ -
13	9	Speech Therapist	$ 22,982	$ -	$ -
13	10	Occupational Therapist	$ 75,279	$ -	$ -
13	12	Other	$ 200	$ -	$ -
13	12	Other	$ 3,960	$ -	$ -
13	12	Respiratory Purchased Servies	$ 61,324	$ -	$ -
Total Other Fees Adjustments			$ 644,095	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	$ 24,366	$ -	$ -
16	m-13	Estimated Accrual	$ (81)	$ -	$ -
16	m-13	Non-recurring Charges	$ -	$ -	$ -
16	m-13	Dues to Chamber of Commerce	$ 500	$ -	$ -
16	m-13	Penalty	$ -	$ -	$ -
16	m-12	0	$ -	$ -	$ -
15	1-a-1	adj workers comp	$ 98,433	$ -	$ -
Total Other A&G Adjustments			$ 123,218	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
22 South Street Operations LLC, d/b/a Fox Hill center	2045	9/30/2020	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	860,422	860,422		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs $	161,246	161,246		
28.	20	5-d	Ambulance/Limousine $	2,863	2,863		
29.	20	5-f	X-rays, etc $	13,628	13,628		
30.	20	5-h	Laboratory $	21,864	21,864		
31.			Medical Supplies $				
32.	20	5-e-2	Oxygen (non emergency) $	8,374	8,374		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	30,311	30,311		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $	(52,214)	(52,214)		
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.			Other - Indirect $	37,368	37,368		
43.			Interest Income on Account Rec. $				
44.			Other - Miscellaneous Administrative $	141,290	141,290		
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)*** $	1,225,151	1,225,151		

*** 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	(Specify)
20	5-j	Consolidated Billing	$ 8,471	$ -	$ -
20	5-j	Respiratory Supplies	$ 17,472	$ -	$ -
20	5-j	Respiratory Rental	$ 4,368	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
Total Other Ancillary Costs			$ 30,311	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Page 22	7a	Land Imp	$ (4,033)	$ -	$ -
Page 22	7b	Bldg Imp	$ (22,399)	$ -	$ -
Page 22	7c	Non Movable Equip	$ (6,449)	$ -	$ -
Page 22	7d	Movable Equip	$ (19,333)	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
Total Excess Movable Equipment Depreciation			$ (52,214)	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-i	Cable TV - Allowable $3,600 Account#3005660130	$ 37,368	$ -	$ -
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 Adjustments			$ 37,368	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14c1	General liability Insurance Adjust	$ 141,290	$ -	$ -
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 Adjustments			$ 141,290	$ -	$ -

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Adjustments			$ -	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox	2045	9/30/2020	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	11,654,188	11,654,188		
b. Medicaid Room and Board Contractual Allowance **	$	(6,057,539)	(6,057,539)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,479,479	1,479,479		
b. Medicare Room and Board Contractual Allowance **	$	(216,978)	(216,978)		
4. a. Private-Pay Residents and Other	$	2,221,157	2,221,157		
b. Private-Pay Room and Board Contractual Allowance **	$	(600,314)	(600,314)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	78,791	78,791		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(11,555)	(11,555)		
c. Prescription Drugs - Non-Medicare	$	95,599	95,599		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(27,881)	(27,881)		
2. a. Medical Supplies - Medicare	$	84	84		
b. Medical Supplies - Medicare Contractual Allowance **	$	(12)	(12)		
c. Medical Supplies - Non-Medicare	$	168	168		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(74)	(74)		
3. a. Physical Therapy - Medicare	$	377,124	377,124		
b. Physical Therapy - Medicare Contractual Allowance **	$	(55,308)	(55,308)		
c. Physical Therapy - Non-Medicare	$	357,003	357,003		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(99,643)	(99,643)		
4. a. Speech Therapy - Medicare	$	80,407	80,407		
b. Speech Therapy - Medicare Contractual Allowance **	$	(11,792)	(11,792)		
c. Speech Therapy - Non-Medicare	$	68,407	68,407		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(20,989)	(20,989)		
5. a. Occupational Therapy - Medicare	$	401,100	401,100		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(58,825)	(58,825)		
c. Occupational Therapy - Non-Medicare	$	370,632	370,632		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(104,698)	(104,698)		
6. a. Other *(Specify)* - Medicare	$	54,155	54,155		
b. Other *(Specify)* - Non-Medicare	$	247,314	247,314		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	10,220,000	10,220,000		
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)*	$	596	596		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	5,365	5,365		
8. Other (*Specify*)	$	638,193	638,193		
V. Total Other Revenue (1 thru 8)	$	644,154	644,154		
VI. Total All Revenue (III +V)	$	10,864,153	10,864,153		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-a	Medicare	X-Ray	$ 6,788	$ -	$ -
II-6-a	Medicare	Laboratory	$ 15,936	$ -	$ -
II-6-a	Medicare	Respiratory Thera	$ 26,170	$ -	$ -
II-6-a	Medicare	Nursing Treatmen	$ -	$ -	$ -
II-6-a	Medicare	Audiology	$ -	$ -	$ -
II-6-a	Medicare	Incontinency	$ -	$ -	$ -
II-6-a	Medicare	Oxygen & Supplie	$ -	$ -	$ -
II-6-a	Medicare	Physician Visit	$ -	$ -	$ -
II-6-a	Medicare	Ambulance	$ 5,190	$ -	$ -
II-6-a	Medicare	Flu Shot	$ 9,378	$ -	$ -
II-6-a	Medicare Contractual	X-Ray	$ (995)	$ -	$ -
II-6-a	Medicare Contractual	Laboratory	$ (2,337)	$ -	$ -
II-6-a	Medicare Contractual	Respiratory Thera	$ (3,838)	$ -	$ -
II-6-a	Medicare Contractual	Nursing Treatmen	$ -	$ -	$ -
II-6-a	Medicare Contractual	Audiology	$ -	$ -	$ -
II-6-a	Medicare Contractual	Incontinency	$ -	$ -	$ -
II-6-a	Medicare Contractual	Oxygen & Supplie	$ -	$ -	$ -
II-6-a	Medicare Contractual	Physician Visit	$ -	$ -	$ -
II-6-a	Medicare Contractual	Ambulance	$ (761)	$ -	$ -
II-6-a	Medicare Contractual	Flu Shot	$ (1,375)	$ -	$ -
	0	0	$ -	$ -	$ -
Total Other Resident Revenue - Medicare			$ 54,155	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	$ 780	$ -	$ -
II-6-b	Medicaid	Laboratory	$ 245	$ -	$ -
II-6-b	Medicaid	Respiratory Thera	$ 52,629	$ -	$ -
II-6-b	Medicaid	Nursing Treatmen	$ -	$ -	$ -
II-6-b	Medicaid	Audiology	$ -	$ -	$ -
II-6-b	Medicaid	Incontinency	$ -	$ -	$ -
II-6-b	Medicaid	Oxygen & Supplie	$ -	$ -	$ -
II-6-b	Medicaid	Physician Visit	$ -	$ -	$ -
II-6-b	Medicaid	Ambulance	$ -	$ -	$ -
II-6-b	Medicaid	Flu Shot	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid	X-Ray	$ (405)	$ -	$ -
II-6-b	Contractuals-Medicaid	Laboratory	$ (127)	$ -	$ -
II-6-b	Contractuals-Medicaid	Respiratory Thera	$ (27,355)	$ -	$ -
II-6-b	Contractuals-Medicaid	Nursing Treatmen	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid	Audiology	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid	Incontinency	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid	Oxygen & Supplie	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid	Physician Visit	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid	Ambulance	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid	Flu Shot	$ -	$ -	$ -
II-6-b	Non-Medicaid	X-Ray	$ 3,704	$ -	$ -
II-6-b	Non-Medicaid	Laboratory	$ 23,690	$ -	$ -
II-6-b	Non-Medicaid	Respiratory Thera	$ 31,484	$ -	$ -
II-6-b	Non-Medicaid	Nursing Treatmen	$ -	$ -	$ -
II-6-b	Non-Medicaid	Audiology	$ -	$ -	$ -
II-6-b	Non-Medicaid	Incontinency	$ -	$ -	$ -
II-6-b	Non-Medicaid	Oxygen & Supplie	$ -	$ -	$ -
II-6-b	Non-Medicaid	Physician Visit	$ -	$ -	$ -
II-6-b	Non-Medicaid	Ambulance	$ 4,905	$ -	$ -
II-6-b	Non-Medicaid	Flu Shot	$ -	$ -	$ -
II-6-b	Non-Medicaid	Capitation Contra	$ 239,820	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	X-Ray	$ (1,001)	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Laboratory	$ (6,403)	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Respiratory Thera	$ (8,509)	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Nursing Treatmen	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Audiology	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Incontinency	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplie	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Physician Visit	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Ambulance	$ (1,326)	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Flu Shot	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Capitation Contra	$ (64,816)	$ -	$ -
0	0	0	$ -	$ -	$ -
Total Other Resident Revenue			$ 247,314	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Accounts	0	$ 596	$ -	$ -
Total Interest Income			$ 596	$ -	$ -

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
Page 30 -IV	Rehab Screen	100250OTIB (Oth	$ 400	$ -	$ -
Page 30 -IV	Telehealth Facility Fee	100250OTB (Othe	$ 1,173	$ -	$ -
Page 30 -IV	Telehealth Facility Fee	100250OTD (Oth	$ 183	$ -	$ -
Page 30 -IV	Telehealth Facility Fee & Rehab Screen	100250OTIB (Oth	$ 1,859	$ -	$ -
Page 30 -IV	Federal Stimulus 1	0	$ 117,787	$ -	$ -
Page 30 -IV	Federal Stimulus 2	0	$ 90,777	$ -	$ -
Page 30 -IV	Federal Stimulus 3	0	$ 425,000	$ -	$ -
Page 30 -IV	REHAB CARE SETTLEMENT	0	$ 1,013	$ -	$ -
Total Other Revenue			$ 638,193	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a F	2045	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 5,886
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 928,933
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (241,170)
4 Inventories				$ 65,830
5. Prepaid Expenses				$ 29,269
a.				
b.				
c.				
d. See Schedule		29,269		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 788,747
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	527		$ 527
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	67,863		$ 50,952
	Accum. Depreciation	16,911	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	15,505		$ 14,988
	Accum. Depreciation	517	Net	
6. Movable Equipment	*Historical Cost	105,035		$ 95,169
	Accum. Depreciation	9,866	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 161,636

* 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	
30	A5	Prepaid Expenses	$ 6,701
30	A5	Prepaid Prop Taxes	$ 20,112
30	A5	Prepaid Escrow Real Estate	$ 2,456
30	A5	Prepaid Escrow Insurance	
30	A5	Prepaid Escrow Replace Reserve	
30	A5	Prepaid Personal Property Tax	
30	A5		
Total Prepaid Expenses			$ 29,269

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	
Total Other Other Fixed Assets (Itemize)			$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	ROU Bldg Asset-Oper Lease	
32	D7	AccumAmort-ROU Bldg OprLease	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description	
33	A12	Accr Exp Nursing Purchased Ser	$ 536,051
33	A12	Accr Exp Fuel Oil	$ 3,566
33	A12		
33	A12		
33	A12		
33	A12		
33	A12		
33	A12		
33	A12		
33	A12		
Total Other Current Liabilities (Itemize)			$ 539,617

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a F	2045	9/30/2020	32	37

Account				Amount
			Total Brought Forward:	$ 950,383
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*)				$ 365,137
I/C Due to/Due From Owned		365,137		
I/C Due to/Due From Multicare				
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 365,137
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 1,315,520

* 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
22 South Street Operations LLC, d/b/a Fox Hi	2045	9/30/2020	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 355,610
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*)	$ 207,410
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$ 323
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*)	$ 1,198,325

Accrued Provider/Bed Tax	137,660	Accr Exp Electricity	3,988
Accr Exp Other	21,488	Deferred Revenue	266,961
Accr Exp Water and Sewer	15,324	A/R Credit Gross Up Lia	212,789
Accr Exp Gas	498	See Schedule	539,617

A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 1,761,668

* 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
22 South Street Operations LLC, d/b/a Fox H	2045	9/30/2020	34	37

Account	Amount
Total Brought Forward:	1,761,668
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*)		$ 1,947
LT Debt-Financing Obligation		
Escheatable Funds	1,947	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 1,947
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 1,763,615

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

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a	2045	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	$ 2,096,903
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (2,722,179)
	6. Gain or Loss for Period 10/1/2019 thru 9/30/2020	$ 177,182
	7. Total Net Worth	$ (448,094)
C.	***Total Reserves and Net Worth***	$ (448,094)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 1,315,521

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a F	2045	9/30/2020	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2019			$ (625,281)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 10,864,154
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 10,686,967
D.	Net Income or Deficit			$ 177,187
E.	Balance			$ (448,094)
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		$ (448,094)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox	2045	9/30/2020	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Thomas Farnan

Addres Address	Phone Number
200 Brickstone Square, Andover, MA 01810	978-247-5029

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Thomas Farnan	978-247-5029

Contact Email Address
thomas.farnan@genesishcc.com