

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2019

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 Chronic and Convalescent                      Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH)                      (RHNS)	
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 2416	RHNS	(Specify)	Medicare Provider 07-5198
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Medicaid Provider Numbers:	CCNH CT 000020164	RHNS	ICF-IID
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**For Department Use Only**

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

**General Information**

Name of Facility (as licensed) 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2019	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 October 1, 2018 and ending September 30, 2019, 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) Lathrop, Christopher George			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)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility 23 Fair Streete Operations LLC		Period Covered:	From 10/1/2018	To 9/30/2019
Address of Facility 23 Fair Street , Bristol, CT 06010				
Report Prepared By Thomas Farnan		Phone Number 978-247-5029	Date 12/21/2018	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$	3,310,613	2,764,530	546,083
5. All other wages paid	\$	543,101	455,109	87,992
6. <b>Total Wages Paid</b>	\$	3,853,714	3,219,638	634,075
7. Total salaries paid	\$	265,168	221,310	43,858
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$	4,118,882	3,440,949	677,933

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 9/30/2019	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	(Specify)	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 type="checkbox"/> (Specify)				
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.				
<b>Administrator</b>				
Name of Administrator Lathrop, Christopher George		Nursing Home Administrator's License No.:	1988	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		









**VILLAGE GREEN OF BRISTOL**  
**REHABILITATION AND HEALTH CENTER**

23 Fair Street  
Forestville, CT 06010

**23 Fair Street Operations LLC (Operator)**

EIN: 38-3974821  
101 East State Street  
Kennett Square, PA 19348

*Ownership*

Summit Care, LLC (100%)

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**Summit Care, LLC**

EIN: 95-3656297  
101 East State Street  
Kennett Square, PA 19348

*Ownership*

Summit Care Parent, LLC (100%)

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**Summit Care Parent, LLC**

EIN: 38-3901040  
101 East State Street  
Kennett Square, PA 19348

*Ownership*

Skilled Healthcare, LLC (100%)

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**Skilled Healthcare, LLC**

EIN: 20-0084014  
101 East State Street  
Kennett Square, PA 19348

*Ownership*

Genesis HealthCare LLC (100%)

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-  
-  
**Genesis HealthCare LLC**

EIN: 27-3237296  
101 East State Street  
Kennett Square, PA 19348

*Ownership*



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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2019	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 Healthcare Corp	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	425,172	425,172
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	66%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	525,961	525,961
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input type="radio"/>	<input checked="" type="radio"/>	50%	Staffing Pool	Pg 10/A12, p15-1	(65)	(65)
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	87%	Medical Director /NP	Pg 13/B8, Pg 10/A12	23,750	23,750
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	84%	Outside Agency	Pg 13/B11 pg 10-12, 15	133,027	133,027
Respiratory Health Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	50%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E2	1,340,652	1,340,652
Genesis Healthcare Corp	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	163,283	163,283
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		
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.

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

**General Information and Questionnaire**  
**Basis for Allocation of Costs**

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2019	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 9/30/2019		Page of 6   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 checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?								<input type="radio"/> Yes <input checked="" type="radio"/> No
<b>Total ***</b>								

\* 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 9/30/2019	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 2 3 4 5	Telephone Number
---	------------------

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

### Schedule of Resident Statistics

Name of Facility 23 Fair Streete Operations LLC		License No. 2416			Report for Year Ended 9/30/2019				Page 8	of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	120	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	79	68		11	79	68		11	89	75		14
B. As of midnight of THIS report period	89	73		16	89	75		14	89	73		16
3. Total Number of Days Care Provided During Period												
A. Medicare	2,420	1,842		578	1,742	1,164		578	678	678		
B. Medicaid (Conn.)	23,188	19,228		3,960	17,253	14,519		2,734	5,935	4,709		1,226
C. Medicaid (other states)												
D. Private Pay	431	400		31	224	193		31	207	207		
E. State SSI for RCH												
F. Other (Specify)	5,140	4,834		306	3,974	3,725		249	1,166	1,109		57
G. Total Care Days During Period (3A thru F)	31,179	26,304		4,875	23,193	19,601		3,592	7,986	6,703		1,283
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	6	6							6	6		
B. Other Bed Reserve Days	131	131			70	70			61	61		
5. <b>Total Resident Days (3G + 4A + 4B)</b>	31,316	26,441		4,875	23,263	19,671		3,592	8,053	6,770		1,283

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

Name of Facility 23 Fair Streete Operations LLC			License No. 2416			Report for Year Ended 9/30/2019			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <span style="float: right;"><input type="radio"/> Yes <input checked="" type="radio"/> No</span>													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid			Self-Pay			Other State Assisted				
	CCNH	RHNS	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR			
No. of Residents	8	50	16	15									
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	644.33	254.67		640.71									
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									2,861	2,303		558	
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									1,571	1,062		509	
C. Other									8,901	6,131		2,770	
<b>D. Total Physical Therapy Treatments</b>									13,333	9,496		3,837	
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									235	145		90	
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									308	189		119	
C. Other									774	428		346	
<b>D. Total Speech Therapy Treatments</b>									1,317	762		555	
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									1,434	909		525	
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									1,151	856		295	
C. Other									7,068	5,010		2,058	
<b>D. Total Occupational Therapy Treatments</b>									9,653	6,775		2,878	



### Report of Expenditures - Salaries & Wages

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2019	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	94,652	1,747			18,029	333
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	179,378	7,396			34,167	1,409
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	58,445	1,795			13,030	400
b. Other Maintenance Workers	25,695	1,798			5,729	401
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	126,658	2,704			25,829	550
b. RN						
1. Direct Care	328,280	8,496		RN	81,170	2,435
2. Administrative**	85,329	2,094		NUMD		
c. LPN						
1. Direct Care	1,104,551	35,669		LPN	203,769	7,040
2. Administrative**				NLN1		
d. Aides and Attendants	1,158,236	66,265		PCA	244,357	14,752
e. Physical Therapists				ACN1		
f. Speech Therapists				CNA		
g. Occupational Therapists						
h. Recreation Workers	76,382	3,903			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	115,209	3,602			21,944	686
n. Marketing						
o. Other (Specify)						
See Attached Schedule	88,134	4,216			16,787	803
<b>A-13. Total Salary Expenditures</b>	<b>3,440,949</b>	<b>139,685</b>			<b>677,933</b>	<b>29,435</b>

\* 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	9/30/2019			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
23 Fair Streete Operations LLC				2416	9/30/2019			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Lathrop, Christopher George 8/4/2018-current	94,652		18,029		Management of Center	2,080	2			
<b>Section IV - Assistant Administrators</b>										
					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	9/30/2019	13	37		
<b>Total Cost and Hours</b>						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian						
2. Dentist	36,264	248				
3. Pharmacist	10,868	222				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	386,592	5,296			15,344	210
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	3,750	20			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	38,059	488			3,781	48
b. Other						
10. Occupational Therapist						
a. Resident Care	83,748	1,147			2,640	36
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	130,642	2,177				
2. Administrative***						
b. LPN						
1. Direct Care	13,267	309				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	30,767				871,558	
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>733,957</b>	<b>9,907</b>			<b>913,322</b>	<b>445</b>

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

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

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



**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	9/30/2019		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 183,988	154,550			29,438
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 70,479	59,202			11,277
4. Social Security (F.I.C.A.)	\$ 300,772	252,648			48,124
5. Health Insurance	\$ 412,316	346,345			65,971
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*	\$ 206,639	173,577			33,062
d. Accounting and Auditing	\$				
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$				
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 13,271	11,148			2,123
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 21,620	18,161			3,459
2. Cellular Phones	\$ 3,628	3,048			580
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	\$ 1,234	1,037			197
3. Resident Day User Fee	\$ 586,563	496,240			90,323
<b>Subtotal</b>	\$ 1,800,510	1,515,956			284,554

\* 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)
	0	\$ -	\$ -	\$ -
	0	\$ -	\$ -	\$ -
	0	\$ -	\$ -	\$ -
	0	\$ -	\$ -	\$ -
	0	\$ -	\$ -	\$ -
	0	\$ -	\$ -	\$ -
	0	\$ -	\$ -	\$ -
<b>Total</b>		\$ -	\$ -	\$ -

**Schedule of Other Taxes**

Description		CCNH	RHNS	(Specify)
Sales Tax		1036.56	0	197.44
	0	0	0	0
	0	\$ -	\$ -	\$ -
	0	\$ -	\$ -	\$ -
<b>Total</b>		\$ 1,037	\$ -	\$ 197



**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	9/30/2019		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>	1,800,510	1,515,956		284,554	
i. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 471	396		75	
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 2,090	1,756		334	
5. Education Expenses Related to Seminars and Conventions	\$ 265	223		42	
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> )*** See Attached Schedule	\$ 5,385	4,524		862	
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	\$ 2,424	2,036		388	
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 9,671	8,124		1,547	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 275	231		44	
9. Subscriptions	\$ 523	439		84	
10. Contributions*** See Attached Schedule	\$ 974	974			
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$ 6,079	5,106		973	
12. Administrative Management Services**	\$ 423,666	355,879		67,787	
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 34,765	29,202		5,562	
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 2,287,099	1,924,846		362,252	

\* 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	\$ -	\$ -	\$ -
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

## Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising	1,349.49	-	257.05
Marketing Expense	1,241.06	-	236.39
Marketing Exp- Corporate Spend	1,933.20	-	368.23
Marketing Expense	-	-	-
<b>Total Other Advertising</b>	\$ 4,524	\$ -	\$ 862

## Schedule of Dues

Description	CCNH	RHNS	(Specify)
Licenses and Certification fee	8,355.00	-	1,591.00
Chamber of Commerce	-231	0	-44
0	0	0	0
0	0	0	0
0	0	0	0
<b>Total Dues</b>	\$ 8,124	\$ -	\$ 1,547

## Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Political Contributions	\$ 899	\$ -	\$ -
Contribution	\$ 75	\$ -	\$ -
\$ -	\$ -	\$ -	\$ -
<b>Total Contributions</b>	\$ 974	\$ -	\$ -

## Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Service Charges	4435.26	0	844.81
Collection Fees	9339.82	0	1779.01
Education Expense	3.94	0	0.75
Employee Physicals	10302.6	0	1962.4
Employee Relations	2230.73	0	424.9
Printing	86.95	0	16.56
Foreign Recruitment Cost	0	0	0
Training Expense	385.12	0	73.36
Uniforms	0	0	0
Miscellaneous	30.7	0	5.85
Rental Expense	2369.04	0	451.25
Accrued Expense Estimation	-15.34	0	-2.92
State Tax Annual Report Filing	33.6	0	6.4
Landlord Operating Taxes	0	0	0
0	0	0	0
<b>Total Other Administrative and General</b>	\$ 29,202	\$ -	\$ 5,562

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2019	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	425,172	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348			

**\* 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	9/30/2019		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 138,810	116,600			22,210
2.	Non-Food Supplies	\$ 22,945	19,274			3,671
3.	Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$ 466,645	391,982			74,663
c. Other (Specify) _____		\$				
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>		\$ 628,400	527,856			100,544
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)	
F.	Resident Meals: Total no. of meals served per day:*					
G.	Is cost of employee meals included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			
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 meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.	
K.	Is any revenue collected 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)					
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.	
N.	Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

**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 9/30/2019	Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	4,631	3,890	741
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.			
		Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.			
		Amt. \$			
4. Repair and/or purchase of linens.***		Lbs.			
		Amt. \$	2,067	1,736	331
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	195,700	164,388	31,312
c. Other (Specify)		\$			
<b>3D. Total Laundry Expenditures (3a + b + c)</b>		\$	<b>202,398</b>	<b>170,014</b>	<b>32,384</b>
3E. Laundry Questionnaire					
F.	Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

**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	9/30/2019		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	19,173	15,678		3,495
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. \$	143,635	117,450		26,185
C. Other ( <i>Specify</i> )			\$			
<b>4D. Total Housekeeping Expenditures (4a + b + c)</b>			\$ 162,808	133,128		29,680
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	210,731	210,731		
b.	Medicine Cabinet Drugs	\$	9,658	9,658		
c.	Medical and Therapeutic Supplies	\$	126,043	105,876		20,167
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	71,497	21,420		50,077
f.	X-rays and Related Radiological Procedures***	\$	10,057	10,057		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h.	Laboratory***	\$	13,931	13,931		
i.	Recreation	\$	39,538	32,330		7,208
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	512,112	59,675		452,437
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>			\$ 993,567	463,678		529,889

\* 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	\$ 46,253	\$ -	\$ -
Incontinency - Rebates	\$ (636)	\$ -	\$ -
Incontinency - Rebates	\$ (6,911)	\$ -	\$ -
Advertising-Help Wanted	\$ 501	\$ -	\$ -
Advertising-Help Wanted	\$ 44	\$ -	\$ -
Advertising-Help Wanted	\$ 412	\$ -	\$ -
Education Expense	\$ 246	\$ -	\$ -
Education Expense	\$ 317	\$ -	\$ -
Supplies	\$ 480	\$ -	\$ -
Supplies	\$ 8,290	\$ -	\$ -
Supplies	\$ 4,369	\$ -	\$ 101,361
Supplies	\$ 123	\$ -	\$ -
Office Supplies	\$ 59	\$ -	\$ -
Training Expense	\$ 16,500	\$ -	\$ -
Tuition Reimbursement	\$ (7,840)	\$ -	\$ -
Miscellaneous	\$ (13,468)	\$ -	\$ -
Miscellaneous	\$ (3,319)	\$ -	\$ -
Rental Expense	\$ 505	\$ -	\$ -
Rental Expense	\$ 9,709	\$ -	\$ -
Rental Expense	\$ 4,041	\$ -	\$ 351,076
	0	\$ -	\$ -
	0	\$ -	\$ -
	0	\$ -	\$ -
<b>Total Other Resident Care</b>	<b>\$ 59,675</b>	<b>\$ -</b>	<b>\$ 452,437</b>

**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 9/30/2019			Page of 21   37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Laundry Purchased Services	164,388		31,312	19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	117,450		26,185	20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Dietary Purchased Services	391,982		74,663	18	2b
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

\* 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	9/30/2019			22	37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	149,188	121,991			27,197
b. Heat	\$	23,232	18,997			4,235
c. Light & Power	\$	117,845	96,362			21,483
d. Water	\$	26,261	21,474			4,787
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$					
f. Other <i>(itemize)</i>	\$					
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$</b>	<b>316,526</b>	<b>258,824</b>			<b>57,702</b>
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$	8,799	7,195			1,604
b. Building & Building Improvements	\$	19,060	15,585			3,475
c. Non-Movable Equipment	\$	437	357			80
d. Movable Equipment	\$	70,105	57,325			12,780
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$</b>	<b>98,401</b>	<b>80,462</b>			<b>17,939</b>
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$</b>					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	548,100	448,181			99,919
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	151,498	123,880			27,618
c. Personal property taxes	\$					
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$</b>	<b>797,999</b>	<b>652,523</b>			<b>145,476</b>

\* 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 9/30/2019			Page 23	of 37		
Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
<b>A. Land Improvements</b>											
1. Acquired prior to this report period	95,229		95,229	18,208	S/L	Various	8,799				
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)											
A-4. Subtotal								8,799			
<b>B. Building and Building Improvements</b>											
1. Acquired prior to this report period	306,473		306,473	22,885	S/L	Various	16,979				
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	80,002						2,081				
B-4. Subtotal								19,060			
<b>C. Non-Movable Equipment</b>											
1. Acquired prior to this report period	4,370		4,370	1,056	S/L	Various	437				
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)											
C-4. Subtotal								437			
	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							
<b>D. Movable Equipment</b>											
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											
b. Disposals (attach schedule)											
c. Acquired during this report period (attach schedule)											
D-3. Subtotal											
<b>E. Total Depreciation</b>											



<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

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Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
10/1/2018	September 2018 DSSI Accrual	\$ (1,329.38)	0	\$ -
10/31/2018	2 PTAC units	\$ 1,329.38	07 00	\$ 174.08
11/30/2018	Blader Scanner & Rolling Stand	\$ 7,709.27	07 00	\$ 917.78
11/30/2018	2 PTAC resistance heat units	\$ 1,501.64	07 00	\$ 178.77
2/28/2019	4 Continu.us 32" LTC LED HDTV 200x200 VESA	\$ 1,229.32	07 00	\$ 102.45
3/31/2019	7 Lifts of various types	\$ 26,957.31	07 00	\$ 1,925.52
5/31/2019	Counter Hydrocollator w/ 4 heat packs	\$ 321.16	07 00	\$ 15.29
7/31/2019	5 Continu.us 32" LTC LED HDTVs	\$ 1,536.65	07 00	\$ 36.59
1/31/2019	Tilt in Space Shower Chair	\$ 441.34	10 00	\$ 29.43
1/31/2019	Maxi Rest Bariatric Bed, 3 function expandable end panels	\$ 3,316.52	10 00	\$ 221.11
1/31/2019	Panacea 6300 Bariatric Bed,3 function, 750lbs	\$ 3,386.72	10 00	\$ 225.78
1/31/2019	Challenger Range 60", 10 burners,	\$ 5,171.80	10 00	\$ 344.79
1/31/2019	3-1/2 quart Food Processor 1-1/2HP SS Bowl	\$ 1,581.78	10 00	\$ 105.45
1/31/2019	2 Tracer IV Heavy Duty Wheelchairs 450lbs cap	\$ 719.96	10 00	\$ 48.00
3/31/2019	Install Program for new Oven	\$ 1,474.00	10 00	\$ 73.70
3/31/2019	1 Gallon Stainless Steel 3 Speed Blender	\$ 1,198.69	10 00	\$ 59.93
5/31/2019	10 Overbed Tables Hayward Cherry Hbase	\$ 1,275.99	10 00	\$ 42.53
5/31/2019	Maxwell Thomas Overbed Tables Hayward Cherry Hbase	\$ 127.60	10 00	\$ 4.25
7/31/2019	AeroServ 4 Electric Hot Food Unit	\$ 3,448.26	10 00	\$ 57.47
8/31/2019	Labor for installing Aeroserv steam table	\$ 1,637.49	10 00	\$ 13.65
8/31/2019	Smart-Therm Induction Base Heater for 208V/240V	\$ 5,879.40	10 00	\$ 49.00
8/31/2019	14 Gauge 304 Stainless Steel Work Table	\$ 371.98	10 00	\$ 3.10
11/30/2018	9 Promatt Plus Mattress Systems	\$ 19,158.19	03 00	\$ 5,321.71
1/31/2019	Bulk Slet Barimatt Mattresses 48x80	\$ 391.20	03 00	\$ 86.93
2/28/2019	Mattress Gen Bulk SLCT Barimatt 48x80	\$ 391.20	03 00	\$ 76.07
5/31/2019	Cherry Finished Cyrus Workstation	\$ 138.63	10 00	\$ 4.62
6/30/2019	15 Logan Office Chairs	\$ 2,528.62	10 00	\$ 63.22
8/31/2019	12 Logan Office Chairs	\$ 2,049.53	10 00	\$ 17.08
2/28/2019	50 foot drop installed for postage meters	\$ 417.50	07 00	\$ 34.79
5/31/2019	Ran 2 Cat5 cables to connect Adtrans in basement	\$ 2,392.88	07 00	\$ 113.95
<b>Total additions for Movable Equipment</b>		\$ 96,755		\$ 10,347 *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Leasehold Improvement</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3



**Annual Report of Long-Term Care Facility**

CSP-24 Rev. 10/2006

**Amortization Schedule\***

Name of Facility 23 Fair Streete Operations LLC			License No. 2416		Report for Year Ended 9/30/2019			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									

\* 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 9/30/2019	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
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		n/a		
2. Date Structure Completed				
3. If <b>NOT</b> 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				
<b>Part B - Owner and Related Parties</b>		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				
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
Well Tower /Healthcare REIT, Inc	04/01/11	12/01/15	20	448,181
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	9/30/2019	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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)	\$			

*(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		9/30/2019		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. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$			
14. Insurance							
a. Insurance on Property (buildings only)				\$ 11,006	9,000		2,006
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$ 152,277	124,517		27,760
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$ 163,283	133,517		29,766
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$ 11,318,241	8,439,292		2,878,949

### D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
23 Fair Streete Operations LLC			2416	9/30/2019	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 20,125	16,905		3,220
<b>Page 13 - Professional Fees</b>							
5.	13	8-c	Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 508,399	508,399		
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 206,639	173,577		33,062
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 *	\$ 5,385	4,524		862
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 974	974		
21.			Unallowable Management Fees	\$ (1,506)	(1,266)		(241)
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 63,842	53,627		10,215
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 803,858	756,740		47,118

\* 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	\$ 16,905	\$ -	\$ 3,220
10	a12o		0 \$ -	\$ -	\$ -
10	a12o		0 \$ -	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
<b>Total Other Salaries Adjustment</b>			\$ 16,905	\$ -	\$ 3,220

## Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	13	Rehabilitation Services	\$ 386,592	\$ -	\$ -
13	5	Rehabilitation Services	\$ -	\$ -	\$ -
13	9	Speech Therapist	\$ 38,059	\$ -	\$ -
13	10	Occupational Therapist	\$ 83,748	\$ -	\$ -
13	12	Other	\$ -	\$ -	\$ -
13	12	Other	\$ -	\$ -	\$ -
13	12	Respiratory Purchased Servies	\$ -	\$ -	\$ -
<b>Total Other Fees Adjustments</b>			\$ 508,399	\$ -	\$ -

## Schedule of Other A&amp;G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-8a	Chamber of Commerce	\$ 672.00	\$ -	\$ 128.00
16	m-13	Collection Fees	\$ 9,339.82	\$ -	\$ 1,779.01
16	m-13	Estimated Accrual	\$ (15.34)	\$ -	\$ (2.92)
16	m-13	Non-recurring charges	\$ -	\$ -	\$ -
16	m-13	Penalty	\$ -	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
			0 \$ -	\$ -	\$ -
15	1a4		0 \$ -	\$ -	\$ -
15	1-a-1	adj workers comp	\$ 43,630.82	\$ -	\$ 8,310.63
<b>Total Other A&amp;G Adjustments</b>			\$ 53,627	\$ -	\$ 10,215

**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	9/30/2019	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 803,858	756,740		47,118
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5-a-2	Prescription Drugs	\$ 210,731	210,731		
28.	20	5-d	Ambulance/Limousine	\$			
29.	20	5-f	X-rays, etc	\$ 10,057	10,057		
30.	20	5-h	Laboratory	\$ 13,931	13,931		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 21,420	21,420		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 478,846	478,846		
<b>Page 22 - Maintenance and Property</b>							
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	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$ 32,615	26,669		5,946
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 75,201	61,492		13,709
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 1,646,659	1,579,887		66,773

\*\*\* 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.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-1	Consolidated Billing	\$ -	\$ -	\$ -
20	5-1	Respiratory Supplies	\$ 114,020	\$ -	\$ -
20	5-1	Respiratory Rental	\$ 364,826	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
<b>Total Other Ancillary Costs</b>			\$ 478,846	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ -

error

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-i	Cable TV	26668.93389		5945.636111
0	0		0	0	0
0	0		0	0	0
0	0		0	0	0

<b>Total Other Adjustments</b>			\$ 26,669	\$ -	\$ 5,946

-----

**Schedule of Other - Miscellaneous Administrative Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 c1	General liability Insurance Adjust	\$ 61,492	0	\$ 13,709
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
<b>Total Other Adjustments</b>			\$ 61,492	\$ -	\$ 13,709

-----



Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0		\$ -	0	\$ -
0	0		\$ -	0	\$ -
0	0		\$ -	0	\$ -
0	0		\$ -	0	\$ -
0	0		\$ -	0	\$ -
0	0		\$ -	0	\$ -
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

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

## F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
23 Fair Streete Operations LLC	2416	9/30/2019			30	37
Item	Total	CCNH	RHNS	(Specify)		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ (9,860,192)	(6,409,125)		(3,451,067)		
b. Medicaid Room and Board Contractual Allowance **	\$ 5,086,373	3,306,142		1,780,231		
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ (1,014,866)	(324,757)		(690,109)		
b. Medicare Room and Board Contractual Allowance **	\$ 251,316	80,421		170,895		
4. a. Private-Pay Residents and Other	\$ (2,313,819)	(624,731)		(1,689,088)		
b. Private-Pay Room and Board Contractual Allowance **	\$ 746,011	201,423		544,588		
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ (87,860)	(28,115)		(59,745)		
b. Prescription Drugs - Medicare Contractual Allowance **	\$ 21,757	6,962		14,795		
c. Prescription Drugs - Non-Medicare	\$ (132,345)	(108,219)		(24,126)		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ 45,651	37,329		8,322		
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$ (61)	(50)		(11)		
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ 23	19		4		
3. a. Physical Therapy - Medicare	\$ (390,972)	(125,111)		(265,861)		
b. Physical Therapy - Medicare Contractual Allowance **	\$ 96,818	30,982		65,836		
c. Physical Therapy - Non-Medicare	\$ (319,626)	(261,358)		(58,268)		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ 118,135	96,599		21,536		
4. a. Speech Therapy - Medicare	\$ (93,958)	(30,067)		(63,891)		
b. Speech Therapy - Medicare Contractual Allowance **	\$ 23,268	7,446		15,822		
c. Speech Therapy - Non-Medicare	\$ (86,985)	(71,128)		(15,857)		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ 37,558	30,711		6,847		
5. a. Occupational Therapy - Medicare	\$ (308,986)	(98,876)		(210,110)		
b. Occupational Therapy - Medicare Contractual Allowance **	\$ 76,516	24,485		52,031		
c. Occupational Therapy - Non-Medicare	\$ (243,790)	(199,347)		(44,443)		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ 90,821	74,264		16,557		
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (267,967)	(85,749)		(182,218)		
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (1,287,029)	(411,849)		(875,180)		
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ (9,814,209)	(4,881,700)		(4,932,509)		
<b>IV. Other Revenue*</b>						
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> )	\$ (100)	(100)				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ (1,976)	(1,976)				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ (2,076)	(2,076)				
<b>VI. Total All Revenue</b> (III +V)	\$ (9,816,285)	(4,883,776)		(4,932,509)		

\* 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	9/30/2019	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	5,470
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,174,782
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	84
4. Inventories			\$	25,296
5. Prepaid Expenses			\$	69,626
a. _____				
b. _____				
c. _____				
d. See Schedule		69,626		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	1,275,258
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	95,229		
	Accum. Depreciation	27,007		
	Net		\$	68,222
3. Buildings	*Historical Cost	386,475		
	Accum. Depreciation	41,946		
	Net		\$	344,529
4. Leasehold Improvements	*Historical Cost			
	Accum. Depreciation			
	Net		\$	
5. Non-Movable Equipment	*Historical Cost	4,370		
	Accum. Depreciation	1,493		
	Net		\$	2,877
6. Movable Equipment	*Historical Cost	889,807		
	Accum. Depreciation	738,547		
	Net		\$	151,260
7. Motor Vehicles	*Historical Cost			
	Accum. Depreciation			
	Net		\$	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
PPE CIP				
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	566,888

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	a5d	Prepaid Expenses	\$ -
31	a5d	Prepaid Property Tax	\$ 66,809
31	a5d	Prepaid Escrow Real Estate	\$ -
31	a5d	Prepaid Personal Property Tax	\$ 2,818
<b>Total Prepaid Expenses</b>			<b>\$ 69,626</b>

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

Page Ref	Line Ref	Description	
31	a8d		0 \$ -
31	a8d		0 \$ -
31	a8d		0 \$ -
31	a8d		0
<b>Total Other Current Assets (Itemize)</b>			<b>\$ -</b>

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

Page Ref	Line Ref	Description	
<b>Total Other Fixed Assets (Itemize)</b>			<b>\$ -</b>

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	7	ROU Bldg Asset-Oper Lease	\$ 0
32	7	AccumAmort-ROU Bldg OprLease	\$ -
<b>Total Other Assets</b>			<b>\$ 0</b>

Schedule of Notes Payable (Itemize) Page 33 Line A2

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

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

Page Ref	Line Ref	Description	
33	a12d	Accr Exp Other	\$ -
33	a12d	Accr Exp Water and Sewer	\$ 4,397
33	a12d	Accr Exp Gas	\$ 1,158
33	a12d	Accr Exp Electricity	\$ 10,465
33	a12d	Deferred Revenue	\$ 10,329
33	a12d	A/R Credit Gross Up Liability	\$ 519,700
33	a12d	Accrued Provider/Bed Tax	\$ 152,080
33	a12d	Accr Sales and Use Tax - FY18	\$ 65
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ 698,193</b>

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ -</b>

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

Name of Facility	License No.	Report for Year Ended	Page	of
23 Fair Streete Operations LLC	2416	9/30/2019	32	37
<b>Account</b>			<b>Amount</b>	
Total Brought Forward:			\$	1,842,146
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
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			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	
<b>D. Investment and Other Assets</b>				
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> )			\$	(6,123,451)
	O L/T A Suspense	(6,123,451)		
	See Schedule	0		
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	(6,123,451)
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	(4,281,305)

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
23 Fair Streete Operations LLC	2416	9/30/2019	33	37
Account			Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable			\$	497,198
2. Notes Payable ( <i>itemize</i> )			\$	
_____				
_____				
See Schedule				
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )			\$	
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )			\$	107,706
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$	
6. Accrued Payroll Taxes Payable			\$	(37)
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> )			\$	698,193
_____				
_____				
_____				
See Schedule				698,193
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>			<b>\$</b>	<b>1,303,060</b>

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

*(Carry Total forward to next page)*

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2019		Page 34	of 37
Account				Amount	
Total Brought Forward:				1,303,060	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> )					
				\$	
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
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					
_____					
See Schedule					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 1,303,060	



**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	9/30/2019	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(4,082,405)
6. Gain or Loss for Period	10/1/2018	thru 9/30/2019	\$	(1,501,958)
7. Total Net Worth			\$	(5,584,363)
<b>C. Total Reserves and Net Worth</b>			\$	(5,584,363)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	(4,281,303)

### H. Changes in Total Net Worth

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2019	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2018			\$	(4,101,655)
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	9,816,284
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	11,298,992
D. Net Income or Deficit			\$	(1,482,708)
E. Balance			\$	(5,584,363)
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
2. Other ( <i>itemize</i> )				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )			\$	
Name and Address ( <i>No., City, State, Zip</i> )		Title	Amount	
2. Other Withdrawings ( <i>Specify</i> )			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	(5,584,363)
				09/30/19

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2019	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Thomas Farnan				
Address 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				