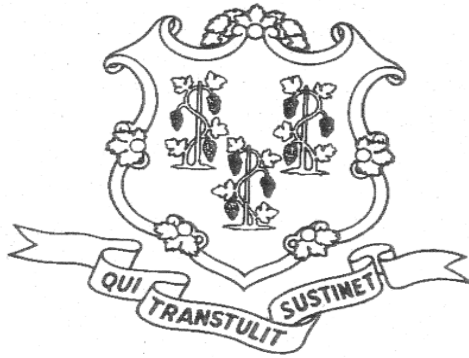


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2018

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 checked="" type="checkbox"/> SLTC (CCNH)                      (RHNS)	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH 2416	RHNS	SLTC	Medicare Provider 07-5198
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Medicaid Provider Numbers:	CCNH CT 000020164	RHNS	SLTC 520165
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**For Department Use Only**

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

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### General Information

Name of Facility (as licensed) 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2018	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, 2017 and ending September 30, 2018, 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)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility 23 Fair Streete Operations LLC		Period Covered:	From 10/1/2017	To 9/30/2018
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	SLTC
1. Dietary wages paid	\$			
2. Laundry wages paid	\$	1,718	1,443	275
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$	3,085,978	2,562,471	523,506
5. All other wages paid	\$	506,525	426,683	79,842
6. <b>Total Wages Paid</b>	<b>\$</b>	<b>3,594,221</b>	<b>2,990,598</b>	<b>603,623</b>
7. Total salaries paid	\$	245,744	199,989	45,755
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	<b>\$</b>	<b>3,839,965</b>	<b>3,190,586</b>	<b>649,378</b>

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 9/30/2018	Page 2	of 37
Name of Facility (as shown on license) 23 Fair Streete Operations LLC		Address (No. & Street, City, State, Zip) 23 Fair Street , Bristol, CT 06010		
License Numbers:	CCNH 2416	RHNS	SLTC	Medicare Provider No. 07-5198
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> SLTC				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No      If "Yes," explain fully.				
<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.:		



## General Information and Questionnaire Corporate Owners

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2018	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation 23 Fair Streete Operations LLC	Business Address 101 East State Street, Kennett Square, PA 19348	State(s) in Which Incorporated PA		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
N/A				
Names of Stockholders Owning at Least 10% of Shares				
N/A				





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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2018	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	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	384,207	384,207
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	63%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	552,446	552,446
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	15,228	15,228
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	85%	Medical Director /NP	Pg 13/B8, Pg 10/A12	24,000	24,000
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	91%	Outside Agency	Pg 13/B11 pg 10-12, 15	276,807	276,807
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>	40%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E2	1,064,266	1,064,266
Genesis Healthcare	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	179,997	179,997
Genesis Healthcare	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Capital Interest	Page 17, page 26-12A	38,824	38,824
		<input type="radio"/>	<input type="radio"/>					

\* Use additional sheets if necessary.

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2018	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 9/30/2018		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 type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?								<input type="radio"/> Yes <input 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 9/30/2018	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period?				
<input checked="" type="radio"/> Yes <input type="radio"/> No		If "No," explain.		
<b>Independent Accounting Firm</b>				
Name of Accounting Firm 1 KPMG Peat Marwick 2 3 4		Address (No. & Street, City, State, Zip Code) 1600 Market Street, Philadelphia, PA 19103		
Services Provided by This Firm ( <i>describe fully</i> )				
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.				
<input type="radio"/> Yes <input checked="" type="radio"/> No				
<b>Legal Services Information</b>				
Name of Legal Firm or Independent Attorney 1 Marshal Arthur B Cyr and Marshal Richard Palladino 2 Treasure oState of CT 3 4 5			Telephone Number	
Address ( <i>No. &amp; Street, City, State, Zip Code</i> ) 1 17 Riverside Ave PO Box 302 Bristol, CT 06011-0302 2 240 Stafford Ave Bristol, CT 06010-4682 3 4 5				
Services Provided by This Firm ( <i>describe fully</i> )				
1	State Marshall fees		\$	118
2	Probate Court fees for the Conservator		\$	472
3			\$	
4			\$	
5			\$	
			Charge for Services Provided	
			\$	590
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No            Legal Fees pg. 15 1-e				

### Schedule of Resident Statistics

Name of Facility 23 Fair Streete Operations LLC		License No. 2416			Report for Year Ended 9/30/2018				Page 8	of 37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total SLTC	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	SLTC	Total	CCNH	RHNS	SLTC	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	120	104		16	120	104		16	120	104		16	
B. On last day of THIS report period	120	104		16	120	104		16	120	104		16	
2. Number of Residents													
A. As of midnight of PREVIOUS report period	83	69		14	83	69		14	81	71		10	
B. As of midnight of THIS report period	79	68		11	81	71		10	79	68		11	
3. Total Number of Days Care Provided During Period													
A. Medicare	2,351	2,010		341	1,778	1,486		292	573	524		49	
B. Medicaid (Conn.)	22,324	18,545		3,779	16,844	14,023		2,821	5,480	4,522		958	
C. Medicaid (other states)													
D. Private Pay	853	682		171	703	556		147	150	126		24	
E. State SSI for RCH													
F. Other (Specify)	4,235	3,870		365	3,053	2,777		276	1,182	1,093		89	
G. Total Care Days During Period (3A thru F)	29,763	25,107		4,656	22,378	18,842		3,536	7,385	6,265		1,120	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	18	18			18	18							
B. Other Bed Reserve Days	127	127			75	75			52	52			
5. <b>Total Resident Days (3G + 4A + 4B)</b>	29,908	25,252		4,656	22,471	18,935		3,536	7,437	6,317		1,120	

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

Name of Facility 23 Fair Streete Operations LLC			License No. 2416			Report for Year Ended 9/30/2018			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	SLTC	Lost			Gained			CCNH	RHNS	SLTC	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	SLTC		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH		CCNH	SLTC	CCNH	RHNS	SLTC	R.C.H.	ICF-IID				
No. of Residents	5		50	11	13								
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	617.47		292.17		611.59								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments					TOTAL	CCNH	RHNS	SLTC					
A. Medicare - Part B					2,463	1,905		558					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments					827	318		509					
C. Other					9,476	6,706		2,770					
<b>D. Total Physical Therapy Treatments</b>					<b>12,766</b>	<b>8,929</b>		<b>3,837</b>					
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B					368	223		145					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments					219	30		189					
C. Other					792	364		428					
<b>D. Total Speech Therapy Treatments</b>					<b>1,379</b>	<b>617</b>		<b>762</b>					
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B					1,612	1,087		525					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments					501	206		295					
C. Other					7,343	5,285		2,058					
<b>D. Total Occupational Therapy Treatments</b>					<b>9,456</b>	<b>6,578</b>		<b>2,878</b>					



Schedule of Other Salaries and Wages (Page 10)

Position		CCNH		RHNS		SLTC	
		\$	Hours	\$	Hours	\$	Hours
Ward Clerks	0	\$ 33,416.83	1,687			\$ 6,365.11	321
Coordinator-Staffing Centers	0	\$ 29,958.52	1,775			\$ 5,706.38	338
Central Supply	0	\$ 22,016.00	1,076			\$ 4,193.52	205
Medical Records	0	\$ 21,605.01	895			\$ 4,115.24	170
	0	\$ -	-			\$ -	-
	0	\$ -	-			\$ -	-
	0	\$ -	-			\$ -	-
	0	\$ -	-			\$ -	-
	0	\$ -	-			\$ -	-
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	0	\$ -	-			\$ -	-
	0	\$ -	-			\$ -	-
	0	\$ -	-			\$ -	-
<b>Total</b>		\$ 106,996.36	\$ 5,432.73	\$ -	-	\$ 20,380.26	\$ 1,034.80
		0	0			0	0

Schedule of Other Fees (Page 13)

Service		CCNH		RHNS		SLTC	
		\$	Hours	\$	Hours	\$	Hours
1020620010	Consulting Fees	696.83	n/a			-	-
3155620020	Purchased Services	4,406.52	n/a			-	-
3010620020	Purchased Services	60.00	n/a			-	n/a
	-	-	n/a			677,520.95	n/a
	-	-	n/a			-	-
	-	-	n/a			-	-
	-	-	n/a			-	-
<b>Total</b>		\$ 5,163.35	-	\$ -	-	\$ 677,520.95	-
		0					



**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	9/30/2018			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	SLTC							
<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	9/30/2018			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	SLTC							
<b>Section III - Administrators***</b>										
Lathrop, Christopher George 8/4/2018-current	13,220		2,518		Management of Center	326	2			
Yong Crandall 10/1/2017- 8/3/2018	91,394		17,408		Management of Center	1,817	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.

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of		
23 Fair Streete Operations LLC	2416	9/30/2018	13	37		
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	SLTC	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	50,690	347				
3. Pharmacist	7,277	149				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	381,322	5,224			15,835	217
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	4,000	21			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	55,253	708			8,775	113
b. Other						
10. Occupational Therapist						
a. Resident Care	92,726	1,270			2,986	41
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	240,464	4,008				
2. Administrative***						
b. LPN						
1. Direct Care	37,569	874				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	5,163				677,521	
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>874,464</b>	<b>12,600</b>			<b>725,118</b>	<b>520</b>

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

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

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

### Report of Expenditures

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

Name of Facility 23 Fair Streete Operations LLC		License No. 2416	Report for Year Ended 9/30/2018	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
		<input checked="" type="radio"/>	<input type="radio"/>		
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
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		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
23 Fair Streete Operations LLC	2416	9/30/2018	15	37
Item	Total	CCNH	RHNS	SLTC
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 151,348	125,619		25,729
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 70,516	58,528		11,988
4. Social Security (F.I.C.A.)	\$ 279,334	231,847		47,487
5. Health Insurance	\$ 382,408	317,399		65,009
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*	\$ 257,169	216,022		41,147
d. Accounting and Auditing	\$			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 590	496		94
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 13,323	11,191		2,132
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 25,798	21,670		4,128
2. Cellular Phones	\$ 2,658	2,233		425
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	\$ 1,474	1,238		236
3. Resident Day User Fee	\$ 566,521	475,820		90,701
<b>Subtotal</b>	\$ 1,751,139	1,462,063		289,076

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

(Carry Subtotals forward to next page)

**\*\*\* DO NOT Include Holiday Parties / Awards / Gifts to Staff**

23 Fair Streete Operations LLC  
9/30/2018

Attachment Page 15

**Schedule of Other Employee Benefits**

Description		CCNH	RHNS	SLTC
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
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-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
-	-	-	-	
<b>Total</b>		\$ -	\$ -	\$ -

-----  
**Schedule of Other Taxes**

Description		CCNH	RHNS	SLTC
1020640110	Sales Tax	\$ 1,238	\$ -	\$ 236
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
<b>Total</b>		\$ 1,238	\$ -	\$ 236

0 0

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

Name of Facility	License No.	Report for Year Ended	Page	of	
23 Fair Streete Operations LLC	2416	9/30/2018	16	37	
Item		Total	CCNH	RHNS	SLTC
<b>Subtotals Brought Forward:</b>		1,751,139	1,462,063		289,076
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	255	214		41
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	1,636	1,374		262
5. Education Expenses Related to Seminars and Conventions	\$	275	231		44
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> )	\$	25	21		4
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )***	\$	15,020	12,617		2,403
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	\$	1,524	1,280		244
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> )	\$	10,416	8,750		1,667
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	800	672		128
9. Subscriptions	\$	531	446		85
10. Contributions***	\$	1,580	1,580		
See Attached Schedule					
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$	4,130	3,469		661
12. Administrative Management Services**	\$	402,001	337,681		64,320
13. Other ( <i>Specify</i> )	\$	23,341	19,607		3,735
See Attached Schedule					
<b>C-14 Total Administrative &amp; General Expenditures</b>	<b>\$</b>	<b>2,212,674</b>	<b>1,850,005</b>		<b>362,670</b>

\* 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.





0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
<b>Total Dues</b>		\$ 8,750	\$ -	\$ 1,667
		\$ -	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	SLTC
1020630135 Political Contributions	1,580.34	-	-
<b>Total Contributions</b>	\$ 1,580	\$ -	\$ -
	\$ -		

Schedule of Other Administrative and General

Description	CCNH	RHNS	SLTC
1020630060 Bank Service Charges	\$ 2,903.36	\$ -	\$ 553.02
1020630120 Collection Fees	\$ 8,510.97	\$ -	\$ 1,621.14
1020630140 Education Expense	\$ 4.37	\$ -	\$ 0.83
1020630180 Employee Physicals	\$ 4,120.11	\$ -	\$ 784.78
1020630200 Employee Relations	\$ 493.90	\$ -	\$ 94.08
1020630380 Printing	\$ 91.01	\$ -	\$ 17.33
3080630441 Foreign Recruitment Cost	\$ -	\$ -	\$ -
1020630610 Training Expense	\$ 580.71	\$ -	\$ 110.61
1020630640 Uniforms	\$ -	\$ -	\$ -
1020640090 Miscellaneous	\$ (2.22)	\$ -	\$ (0.42)
1020660080 Rental Expense	\$ 3,025.65	\$ -	\$ 576.32
1020660990 Accrued Expense Estimation	\$ (137.90)	\$ -	\$ (26.27)
1020720070 State Tax Annual Report Filing	\$ 16.80	\$ -	\$ 3.20
5095720090 Landlord Operating Taxes	\$ -	\$ -	\$ -
-	-	-	-
-	-	-	-
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-	-	-	-
-	-	-	-
<b>Total Other Administrative and General</b>	\$ 19,607	\$ -	\$ 3,735
	0	0	0

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2018	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 Healthcare , 101 East St., Kennett Square, PA 19348	384,207	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Healthcare , 101 East St., Kennett Square, PA 19348	38,824	Capital Interest	pg 26 12-A-1

**\* In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.**

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

Name of Facility		License No.	Report for Year Ended		Page	of
23 Fair Streete Operations LLC		2416	9/30/2018		18	37
Item		Total	CCNH	RHNS	SLTC	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 156,474	131,438			25,036
2.	Non-Food Supplies	\$ 21,803	18,315			3,488
3.	Other (Specify) _____ Contra Meal Exp T& E/Education Expense	\$ (327)	(275)			(52)
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$ 457,954	384,681			73,273
c. Other (Specify) _____		\$				
<b>2D. Total Dietary Expenditures (2a + b + c)</b>		\$ 635,904	534,159			101,745
2F. Dietary Questionnaire		Total	CCNH	RHNS	SLTC	
G. Resident Meals: Total no. of meals served per day:*						
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No						
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.						
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify cost.						
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.						
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify cost.						
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.						
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)						

\* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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

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

Name of Facility 23 Fair Streete Operations LLC		License No. 2416	Report for Year Ended 9/30/2018	Page 19	of 37
Item		Total	CCNH	RHNS	SLTC
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	6,267	5,264		1,003
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. \$	554	465		89
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	183,842	154,427		29,415
c. Other (Specify)	\$				
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	<b>\$</b>	<b>190,663</b>	<b>160,156</b>		<b>30,507</b>
<b>3F. Laundry Questionnaire</b>					
G. Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

\* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4. All allocations should add to total recorded in 3E.  
 \*\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.  
 \*\*\* Pounds of Laundry only required for multi-level facilities.

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

Name of Facility		License No.	Report for Year Ended		Page	of
23 Fair Streete Operations LLC		2416	9/30/2018		20	37
Item			Total	CCNH	RHNS	SLTC
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt.	\$ 21,408	17,505		3,903
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.	\$ 136,590	111,690		24,900
c.	Other ( <i>Specify</i> ) T&E-Mileage/Parking/Tolls		\$			
4D.	<b>Total Housekeeping Expenditures</b> (4a + b + c)		\$ 157,998	129,195		28,803
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy		\$			
	2. Purchased from		\$ 236,820	236,820		
b.	Medicine Cabinet Drugs		\$ 24,784	24,784		
c.	Medical and Therapeutic Supplies		\$ 135,323	113,671		21,652
d.	Ambulance/Limousine***		\$ 770	770		
e.	Oxygen					
	1. For Emergency Use		\$			
	2. Other***		\$ 56,890	24,614		32,276
f.	X-rays and Related Radiological Procedures***		\$ 9,081	9,081		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )		\$			
h.	Laboratory***		\$ 12,677	12,677		
i.	Recreation		\$ 40,075	32,769		7,306
j.	Direct Management Services*		\$			
k.	Indirect Management Services*		\$			
l.	Other ( <i>Specify</i> )**** See Attached Schedule		\$ 418,635	63,429		355,205
5M.	<b>Total Resident Care Expenditures</b> (5a - 5j)		\$ 935,055	518,616		416,439

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

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

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

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

**Schedule of Other Resident Care**

Description	CCNH	RHNS	SLTC
3060610160	Incontinency	39,707	-
3080630030	Advertising-Help War	344	-
3080630080	Books, Dues & Subsc	-	-
3080630140	Education Expense	7,299	-
3155630530	Supplies	9,318	128,981
3120630530	Supplies	692	-
3165630530	Supplies	38	-
3165630535	Office Supplies	180	-
3120630535	Office Supplies	250	-
3155660080	Rental Expense	12,337	226,225
3120660080	Rental Expense	-	-
3010610300	Consolidated Billing	804	-
3080630310	Licenses & Certificati	-	-
3080630550	T&E-Lodging/Transp	-	-
3080630610	Training Expense	-	-
3165630550	T&E-Lodging/Transp	798	-
3080640090	Miscellaneous	(2,865)	-
3060610161	Incontinency - Rebate	(5,471)	-
	-	-	-
	-	-	-
	-	-	-
	-	-	-
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<b>Total Other Resident Care</b>		<b>63429</b>	<b>0</b>
		<b>0</b>	<b>0</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 9/30/2018			Page of 21   37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	SLTC	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Laundry Purchased Services	183,842			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	136,590			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Dietary Purchased Services	456,124			18	2b
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

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

### C. Expenditures Other Than Salaries (cont'd) - Maintenance and Property

Name of Facility	License No.	Report for Year Ended			Page	of
23 Fair Streete Operations LLC	2416	9/30/2018			22	37
Item		Total	CCNH	RHNS	SLTC	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	167,638	137,078			30,560
b. Heat	\$	35,932	29,382			6,550
c. Light & Power	\$	125,381	102,524			22,857
d. Water	\$	14,761	12,070			2,691
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>343,712</b>	<b>281,054</b>			<b>62,658</b>
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$	8,799	7,195			1,604
b. Building & Building Improvements	\$	14,468	11,830			2,638
c. Non-Movable Equipment	\$	437	357			80
d. Movable Equipment	\$	242,961	198,669			44,292
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$</b>	<b>266,665</b>	<b>218,051</b>			<b>48,614</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	\$	551,718	451,140			100,578
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	142,828	116,790			26,038
c. Personal property taxes	\$					
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$</b>	<b>961,211</b>	<b>785,981</b>			<b>175,230</b>

\* 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**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>SLTC</b>
<b>Total Other Repairs and Maintenance</b>	\$ -	\$ -	\$ -

.....

### Depreciation Schedule

Name of Facility 23 Fair Streete Operations LLC				License No. 2416			Report for Year Ended 9/30/2018			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	9,409	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				222,231			8,417			12,580			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)				84,243		84,243				1,888			
B-4. Subtotal											14,468		
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period				4,370		4,370	619	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. Motor Vehicles (attach schedule)									S/L	Various			
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)													
d.													
2. Movable Equipment													
a. Acquired prior to this report period						744,404		744,404	425,481	S/L	Various	239,367	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						48,649		48,649				3,594	
D-3. Subtotal													242,961
<b>E. Total Depreciation</b>													266,665

23 Fair Streete Operations LLC  
 9/30/2018

**Schedule of Land Improvements Acquired during this report period**

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

\*Ties to Page 23, Line A3  
 \*\*Ties to Page 23, Line A2

**Schedule of Building Improvements Acquired during this report period**

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
10/31/2017	Magic Force Swing Door Operating	3,071.45	20.00	140.77
1/31/2018	90 min fire rated steel doors and hardware	10,212.21	20.00	340.41
3/31/2018	Deposit for 28 isolated grounded outlets	12,708.83	20.00	317.72
4/30/2018	O2 and vacuum lines	18,985.00	20.00	395.52
4/30/2018	90 minute fire rated door hinges lock	4,687.43	20.00	97.65
5/31/2018	(28) Grounded Outlets	12,708.83	20.00	211.81
5/31/2018	Build Soffet	11,957.99	20.00	199.30
5/31/2018	Add Resp Rooms	7,500.00	20.00	125.00
6/30/2018	New Birch Fire Door	2,410.95	10.00	60.27

<b>Total additions for Building Improvements</b>		\$ 84,243		\$ 1,888 *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

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**Schedule of Non-Movable Equipment Acquired during this report period**

<b>Acquisition Date</b>	<b>Description of Item</b>	<b>Cost</b>	<b>Useful Life</b>	<b>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**

<b>Acquisition Date</b>	<b>Description of Item</b>	<b>Cost</b>	<b>Useful Life</b>	<b>Depreciation</b>
<b>Additions:</b>				
2/28/2018	DermaFloat Alternating Pressure Air	2,103.27	3.00	408.97
2/28/2018	Meridian Countertop Ice Machine	6,453.32	10.00	376.44
2/28/2018	Amana Digismart 15,000 BTU PTA	757.19	7.00	63.10
3/31/2018	3 Invacare Perfecto2 V 5-Liter Oxyg	1,461.19	7.00	104.37
3/31/2018	2 DermaFloat Alternating Pressure A	4,283.81	3.00	713.97

4/30/2018	2 Invacare Perfecto2 V 5-Liter Oxyg	974.12	7.00	57.98
4/30/2018	2 Invacare Platinum 10 Oxygen Con	2,287.55	7.00	136.16
4/30/2018	UniMac 60 lb. Cap, Hardmount Was	11,303.23	7.00	672.81
4/30/2018	UniMac installation	1,951.87	7.00	116.18
5/31/2018	Vacum Pump	12,378.07	5.00	825.20
6/30/2018	(8) TV w/ Tilt Mount	2,826.44	7.00	100.94
7/31/2018	Direct Choice Bariatric Reclining Sh	539.17	5.00	17.97
9/30/2018	September 2018 DSSI Accrual	1,329.38		-
<b>Total additions for Movable Equipment</b>		<b>\$ 48,649</b>		<b>\$ 3,594 *</b>
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		<b>\$ -</b>		<b>\$ - **</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>\$ -</b>		<b>\$ - *</b>
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		<b>\$ -</b>		<b>\$ - **</b>

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**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 9/30/2018			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 9/30/2018	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					
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	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					
<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	Building and Equipment	12/01/15	20	451,140	
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	9/30/2018			26	37
Item		Total	CCNH	RHNS	SLTC		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$ 38,825	31,747		7,078		
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)		\$ 38,825	31,747		7,078		

(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		9/30/2018		27	37
Item				Total	CCNH	RHNS	SLTC
Subtotals Brought Forward:				38,825	31,747		7,078
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> \$				38,825	31,747		7,078
14. Insurance							
a. Insurance on Property (buildings only) \$				8,922	7,296		1,626
b. Insurance on Automobiles \$							
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)			\$	171,075	139,888		31,187
2. Fire and Extended Coverage			\$				
3. Other (Specify)			\$				
14d. <b>Total Insurance Expenditures (14a + b + c)</b> \$				179,997	147,184		32,813
15. <b>Total All Expenditures (A-13 thru C-14)</b> \$				11,095,585	8,503,146		2,592,439

### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
23 Fair Streete Operations LLC				2416	9/30/2018	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	SLTC
<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	\$ 34,192	28,722		5,471
<b>Page 13 - Professional Fees</b>							
5.	13	8-c	Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 529,360	529,360		
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 257,169	216,022		41,147
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 *	\$ 15,020	12,617		2,403
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 1,580	1,580		
21.			Unallowable Management Fees	\$ 17,794	14,947		2,847
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 134,484	112,967		21,518
<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)				\$ 989,600	916,215		73,385

\* All except "Help Wanted".

(Carry Subtotal forward to next page )

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

**Schedule of Other Salaries Adjustment**

Page Ref	Line Ref	Description	CCNH	RHNS	SLTC
10	2	Administrator's salary disallowed	28,721.63	-	5,470.79
10	a12o		0	-	-
10	a12o		0	-	-
0	0		0	-	-
0	0		0	-	-
0	0		0	-	-
<b>Total Other Salaries Adjustment</b>			28,721.63	-	5,470.79

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	SLTC
13	5	Rehabilitation Services	3120620020	381,321.74	-
13	5	Rehabilitation Services	3195620020	-	-
13	9	Speech Therapist	3170620020	55,252.59	-
13	10	Occupational Therapist	3105620020	92,726.06	-
13	12	Other	3010620020	60.00	-
13	12	Other	3015620020	-	-
13	12	Respiratory Purchased Services	3155620020	-	-
				-	-
				-	-
				-	-
				-	-
				-	-
				-	-
<b>Total Other Fees Adjustments</b>			529,360.39	-	-

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	SLTC	
16	m-8a	1020630310	Chamber of Commerc	672.00	-	128.00
16	m-13	1020630120	Collection Fees	8,510.97	-	1,621.14
16	m-13	1020660990	Estimated Accrual	(137.90)	-	(26.27)
16	m-13	7010800030	Non-recurring charges	-	-	-
16	m-13	1020640080	Penalty	-	-	-
0	0		0	-	-	-
15	1a3		0	-	-	-
15	1a4		0	-	-	-
15	1-a-1	adj workers comp	0	103,921.83	-	19,794.63
0	0		0	-	-	-
<b>Total Other A&amp;G Adjustments</b>			112,966.90	-	21,517.50	

**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	9/30/2018	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	SLTC
Subtotals Brought Forward				\$ 989,600	916,215		73,385
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5-a-2	Prescription Drugs	\$ 236,820	236,820		
28.	20	5-d	Ambulance/Limousine	\$ 770	770		
29.	20	5-f	X-rays, etc	\$ 9,081	9,081		
30.	20	5-h	Laboratory	\$ 12,677	12,677		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 24,614	24,614		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 22,458	22,458		
<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	\$ 33,448	27,351		6,098
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 151,693	124,039		27,654
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>				\$ 1,481,162	1,374,025		107,137

\*\*\* Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

23 Fair Streete Operations LLC  
9/30/2018

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	SLTC
20.00	5-1	Consolidated Billing	803.59	-	-
20.00	5-1	Respiratory Supplies	9,317.53	-	-
20.00	5-1	Respiratory Rental	12,336.55	-	-
-	0-Jan	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
<b>Total Other Ancillary Costs</b>			<b>\$ 22,458</b>	<b>\$ -</b>	<b>\$ -</b>
			<b>\$ -</b>		

**Schedule of Excess Movable Equipment Depreciation**

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

**Schedule of Other Property Adjustments**

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

Page Ref	Line Ref	Description	CCNH	RHNS	SLTC
27	14 c1	General liability Insurance Adjust	124,039	-	27,653.60
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
<b>Total Other - Miscellaneous Administrative</b>			124,039	\$ -	\$ 27,654
			<u>\$ 124,039</u>		<u>\$ 27,654</u>

Schedule of Unallowable Building Interest

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

Schedule of Other - Miscellaneous - Other Indirect

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-i	Cable TV	27,351	allow \$3600	6,098
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
<b>Total Other - Miscellaneous - Other Indirect</b>			\$ 27,351	\$ -	\$ 6,098



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## F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
23 Fair Streete Operations LLC	2416	9/30/2018			30	37
Item	Total	CCNH	RHNS	SLTC		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 9,270,519	5,469,606		3,800,913		
b. Medicaid Room and Board Contractual Allowance **	\$ (3,511,836)	(2,071,983)		(1,439,853)		
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 994,487	994,487				
b. Medicare Room and Board Contractual Allowance **	\$ (219,948)	(219,948)				
4. a. Private-Pay Residents and Other	\$ 2,158,939	323,841		1,835,098		
b. Private-Pay Room and Board Contractual Allowance **	\$ (666,397)	(99,960)		(566,437)		
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 91,282	91,282				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (20,189)	(20,189)				
c. Prescription Drugs - Non-Medicare	\$ 144,785	118,391		26,394		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (45,535)	(37,234)		(8,301)		
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$ 88	72		16		
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (29)	(24)		(5)		
3. a. Physical Therapy - Medicare	\$ 419,777	419,777				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (92,841)	(92,841)				
c. Physical Therapy - Non-Medicare	\$ 272,017	222,428		49,589		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (87,520)	(71,565)		(15,955)		
4. a. Speech Therapy - Medicare	\$ 96,665	96,665				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (21,379)	(21,379)				
c. Speech Therapy - Non-Medicare	\$ 94,016	76,877		17,139		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (31,022)	(25,367)		(5,655)		
5. a. Occupational Therapy - Medicare	\$ 339,741	339,741				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (75,140)	(75,140)				
c. Occupational Therapy - Non-Medicare	\$ 205,764	168,253		37,511		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (65,383)	(53,464)		(11,919)		
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 122,549	100,209		22,341		
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 892,483	729,784		162,700		
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 10,265,894	6,362,318		3,903,575		
<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> )	\$ 48	48				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 2,431	2,431				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 2,479	2,479				
<b>VI. Total All Revenue</b> (III +V)	\$ 10,268,373	6,364,797		3,903,575		

\* 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	SLTC
II-6-a	Medicare	X-Ray	2,287.44	-	509,967,843
II-6-a	Medicare	Laboratory	5,009.70	-	1116.873711
II-6-a	Medicare	Respiratory Therapy & Supplie	82,987.75	-	18501.48845
II-6-a	Medicare	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare	Audiology	-	-	0
II-6-a	Medicare	Incontinency	-	-	0
II-6-a	Medicare	Oxygen & Supplies	-	-	0
II-6-a	Medicare	Physician Visit	-	-	0
II-6-a	Medicare	Ambulance	-	-	0
II-6-a	Medicare	Flu Shot	2,417.12	-	538.8788
II-6-a	Medicare	Capitation Contracts	-	-	0
II-6-a	Medicare	Radiology Service	-	-	0
II-6-a	Medicare	Outpatient Therapy Program	35,963.26	-	8017.7363
II-6-a	Medicare		0	-	0
II-6-a	Contractuals-Medicare	X-Ray	(505.91)	-	-112.7883867
II-6-a	Contractuals-Medicare	Laboratory	(1,107.98)	-	-247.016328
II-6-a	Contractuals-Medicare	Respiratory Therapy & Supplie	(18,354.21)	-	-4091.930623
II-6-a	Contractuals-Medicare	Nursing Treatment Supplies	-	-	0
II-6-a	Contractuals-Medicare	Audiology	-	-	0
II-6-a	Contractuals-Medicare	Incontinency	-	-	0
II-6-a	Contractuals-Medicare	Oxygen & Supplies	-	-	0
II-6-a	Contractuals-Medicare	Physician Visit	-	-	0
II-6-a	Contractuals-Medicare	Ambulance	-	-	0
II-6-a	Contractuals-Medicare	Flu Shot	(534.59)	-	-119.1825549
II-6-a	Contractuals-Medicare	Capitation Contracts	-	-	0
II-6-a	Contractuals-Medicare	Radiology Service	-	-	0
II-6-a	Contractuals-Medicare	Outpatient Therapy Program	(7,953.91)	-	-1773.263853
II-6-a	Contractuals-Medicare		0	-	0
<b>Total Other Resident Revenue - Medicare</b>			<b>\$ 100,209</b>	<b>\$ -</b>	<b>\$ 22,341</b>
			\$ -	\$ -	\$ -

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

**Related Exp**

Page Ref	Description		CCNH	RHNS	SLTC
II-6-b	Medicaid	X-Ray	-	-	-
II-6-b	Medicaid	Laboratory	-	-	-
II-6-b	Medicaid	Respiratory Therapy & Supplie	675,053.22	-	150,497.99
II-6-b	Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Medicaid	Audiology	-	-	-
II-6-b	Medicaid	Incontinency	-	-	-
II-6-b	Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Medicaid	Physician Visit	-	-	-
II-6-b	Medicaid	Ambulance	-	-	-
II-6-b	Medicaid	Flu Shot	-	-	-
II-6-b	Medicaid	Capitation Contracts	-	-	-
II-6-b	Medicaid	Radiology Service	-	-	-
II-6-b	Medicaid	Outpatient Therapy Program	226,520.89	-	50,501.11
II-6-b	Medicaid		0	-	-
II-6-b	Contractuals-Medicaid	X-Ray	-	-	-
II-6-b	Contractuals-Medicaid	Laboratory	-	-	-
II-6-b	Contractuals-Medicaid	Respiratory Therapy & Supplie	(255,722.08)	-	(57,011.29)
II-6-b	Contractuals-Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Contractuals-Medicaid	Audiology	-	-	-
II-6-b	Contractuals-Medicaid	Incontinency	-	-	-
II-6-b	Contractuals-Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Contractuals-Medicaid	Physician Visit	-	-	-
II-6-b	Contractuals-Medicaid	Ambulance	-	-	-
II-6-b	Contractuals-Medicaid	Flu Shot	-	-	-

II-6-b	Contractuals-Medicaid	Capitation Contracts	-	-	-
II-6-b	Contractuals-Medicaid	Radiology Service	-	-	-
II-6-b	Contractuals-Medicaid	Outpatient Therapy Program	(85,810.11)	-	(19,130.71)
II-6-b	Contractuals-Medicaid	Daycare	-	-	-
II-6-b	Private,insurance, other	X-Ray	3,747.63	-	835.50
II-6-b	Private,insurance, other	Laboratory	4,748.51	-	1,058.65
II-6-b	Private,insurance, other	Respiratory Therapy & Supplie	175,852.37	-	39,204.95
II-6-b	Private,insurance, other	Nursing Treatment Supplies	-	-	-
II-6-b	Private,insurance, other	Audiology	-	-	-
II-6-b	Private,insurance, other	Incontinency	-	-	-
II-6-b	Private,insurance, other	Oxygen & Supplies	-	-	-
II-6-b	Private,insurance, other	Physician Visit	-	-	-
II-6-b	Private,insurance, other	Ambulance	-	-	-
II-6-b	Private,insurance, other	Flu Shot	-	-	-
II-6-b	Private,insurance, other	Capitation Contracts	-	-	-
II-6-b	Private,insurance, other	Radiology Service	-	-	-
II-6-b	Private,insurance, other	Outpatient Therapy Program	61,180.31	-	13,639.69
II-6-b	Private,insurance, other	Daycare	-	-	-
II-6-b	Contractuals-Non-Medicaid	X-Ray	(1,156.77)	-	(257.89)
II-6-b	Contractuals-Non-Medicaid	Laboratory	(1,465.72)	-	(326.77)
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplie	(54,280.13)	-	(12,101.34)
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Contractuals-Non-Medicaid	Audiology	-	-	-
II-6-b	Contractuals-Non-Medicaid	Incontinency	-	-	-
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Contractuals-Non-Medicaid	Physician Visit	-	-	-
II-6-b	Contractuals-Non-Medicaid	Ambulance	-	-	-
II-6-b	Contractuals-Non-Medicaid	Flu Shot	-	-	-
II-6-b	Contractuals-Non-Medicaid	Capitation Contracts	-	-	-
II-6-b	Contractuals-Non-Medicaid	Radiology Service	-	-	-
II-6-b	Contractuals-Non-Medicaid	Outpatient Therapy Program	(18,884.45)	-	(4,210.14)
II-6-b	Contractuals-Non-Medicaid	Daycare	-	-	-
0	0	0	-	-	-
0	0	0	-	-	-
<b>Total Other Resident Revenue</b>			\$ 729,784	\$ -	\$ 162,700
			\$ -	\$ -	\$ -

### Interest Income

#### Account

Page Ref	Account	Balance	CCNH	RHNS	SLTC
IV-5	Interest on Overdue Accts	Interest	\$48.30	0	0
-	-	-	-	-	-
-	-	-	-	-	-
<b>Total Interest Income</b>			\$ 48	\$ -	\$ -
			\$ -	\$ -	\$ -

### Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	SLTC
IV-8	Bon Venture Services LLC	0 \$ 1,000	\$ -	\$ -
IV-8	Lab fee refund	0 \$ 1,431	\$ -	\$ -
IV-8	-	-	-	-
IV-8	-	-	-	-
IV-8	-	-	-	-
IV-8	-	-	-	-
IV-8	-	-	-	-
IV-8	-	-	-	-
IV-8	-	-	-	-
IV-8	-	-	-	-
<b>Total Other Revenue</b>		\$ 2,431	\$ -	\$ -
		\$ 0	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
23 Fair Streete Operations LLC	2416	9/30/2018	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	5,870
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,435,843
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(64,991)
4. Inventories			\$	28,386
5. Prepaid Expenses			\$	47,159
a. Prepaid Expenses				
b. Prepaid Property Tax	44,564			
c. Prepaid Escrow Real Estate				
d. Prepaid Personal Property Tax	2,595			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
_____				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	1,452,267
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	95,229		
	Accum. Depreciation	18,208		
	Net		\$	77,021
3. Buildings	*Historical Cost	306,473		
	Accum. Depreciation	22,885		
	Net		\$	283,588
4. Leasehold Improvements	*Historical Cost			
	Accum. Depreciation			
	Net		\$	
5. Non-Movable Equipment	*Historical Cost	4,370		
	Accum. Depreciation	1,056		
	Net		\$	3,314
6. Movable Equipment	*Historical Cost	793,053		
	Accum. Depreciation	668,442		
	Net		\$	124,611
7. Motor Vehicles	*Historical Cost			
	Accum. Depreciation			
	Net		\$	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
PPE CIP				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	488,534

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

(Carry Total forward to next page )

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

Name of Facility	License No.	Report for Year Ended	Page	of
23 Fair Streete Operations LLC	2416	9/30/2018	32	37
<b>Account</b>			<b>Amount</b>	
Total Brought Forward:			\$	1,940,801
<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> )			\$	(5,044,030)
O L/T A Suspense				
I/C Due to/Due From Owned			(5,044,030)	
I/C Due to/Due From Multicare				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	(5,044,030)
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	(3,103,229)

\* 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	9/30/2018	33	37
Account			Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable			\$	399,324
2. Notes Payable ( <i>itemize</i> )			\$	
_____				
_____				
_____				
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )			\$	
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )			\$	63,115
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$	
6. Accrued Payroll Taxes Payable			\$	153
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> )			\$	516,584
A/R Credit Gross Up Liability	297,077	Accr Exp Other	71,533	
Accr Exp Water and Sewer	1,901	Deferred Revenue	2,396	
Accr Exp Gas	1,164	Accrued Provider/Bed T:	135,873	
Accr Exp Electricity	6,003	Accr Sales and Use Tax	637	
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>			<b>\$</b>	<b>979,176</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 9/30/2018		Page 34	of 37
Account				Amount	
Total Brought Forward:				979,176	
<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					
_____					
_____					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 979,176	

**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	9/30/2018	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			\$	(3,255,194)
6. Gain or Loss for Period	10/1/2017	thru 9/30/2018	\$	(827,211)
7. Total Net Worth			\$	(4,082,405)
<b>C. Total Reserves and Net Worth</b>			\$	(4,082,405)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	(3,103,229)



### H. Changes in Total Net Worth

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2018	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2017			\$	(3,302,788)
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	10,268,371
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	11,047,988
D. Net Income or Deficit			\$	(779,617)
E. Balance			\$	(4,082,405)
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>			\$	(4,082,405)
				09/30/18

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2018	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> SLTC		
<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 Title -Sr. Director of Reimbursement				
Address Address			Phone Number	
200 Brickstone Square, Andover, MA 01810			978-247-5029	