

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) 23 Fair Streete Operations LLC	
Address (No. & Street, City, State, Zip Code) 23 Fair Street , Bristol, CT 06010	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

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 9/30/2021	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, 2020 and ending September 30, 2021, 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) Shahen,Janet			Printed Name (Owner) Diane Morris - VP Reimbursement	
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 10/1/2020	To 9/30/2021
Address of Facility 23 Fair Street , Bristol, CT 06010					
Report Prepared By Rick Fink	Phone Number 410-494-7657		Date 12/21/2020		
Item	Total	CCNH	RHNS	(Specify)	
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$	3,516,677	2,623,749	892,928	
5. All other wages paid	\$	579,543	441,914	137,629	
<b>6. Total Wages Paid</b>	<b>\$</b>	<b>4,096,220</b>	<b>3,065,663</b>	<b>1,030,557</b>	
7. Total salaries paid	\$	312,050	237,158	74,892	
<b>8. Total Wages and Salaries Paid (As per page 10 of Report)</b>	<b>\$</b>	<b>4,408,270</b>	<b>3,302,821</b>	<b>1,105,449</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 9/30/2021	Page 2
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 <input checked="" type="checkbox"/> 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 Shahen,Janet		Nursing Home Administrator's License No.:	001551
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name		License No.:	

## **General Information and Questionnaire Partners/Members**

State of Connecticut

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

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**General Information and Questionnaire  
Corporate Owners**

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021	Page of 3A   37
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
23 Fair Streete Operations LLC	101 East State Street, Kennett Square, PA 19348	DE

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
See Attached			

Names of Stockholders Owning at Least 10% of Shares			
See Attached			

# **General Information and Questionnaire**

## **Individual Proprietorship**

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

## General Information and Questionnaire

### Related Parties\*

Name of Facility 23 Fair Streete Operations LLC		License No. 2416			Report for Year Ended 9/30/2021			Page 4	of 37
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input checked="" type="radio"/> Yes <input type="radio"/> 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 Administrative Services LLC	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	558,240	558,240	
Genesis Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	594,030	594,030	
Genesis Staffing Services	101 East State Street, Kennett Square, PA 19348	<input type="radio"/>	<input checked="" type="radio"/>		Staffing Pool	Pg 10/A12, p15-1			
Genesis Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Medical Director /NP	Pg 13/B8, Pg 10/A12	45,000	45,000	
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Outside Agency	Pg 13/B11 pg 10-12, 1			
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>		Respiratory Therapy	Pg 13/B12, Pg 20/C5E	1,590,267	1,590,267	
Genesis Healthcare Ins Program	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	202,309	202,309	
		<input type="radio"/>	<input checked="" type="radio"/>						
		<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 9/30/2021	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist ( <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?       Yes       No      If "No," explain fully why such allocation was not made.

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

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

Yes       No      If "No," explain fully why such allocation was not made.

# **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.

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

○ No

Total \*\*\*

\* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

\*\* Attach copies of newly acquired leases.

\*\*\* Amount should agree to Page 22, Line 6e.

# **General Information and Questionnaire**

## **Accounting Basis**

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021	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
---	---

Services Provided by This Firm (*describe fully*)

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

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

Yes       No      Included in Management Fee pg. 16 m-12

## Legal Services Information

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

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

**Services Provided by This Firm (*describe fully*)**

1	\$
2	\$
3	\$
4	\$
5	\$

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

Are These Charges Reflected in the Expenditure Portion of This Report? 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 9/30/2021				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				16	120	104		16				
A. On last day of PREVIOUS report period	120	104										
B. On last day of THIS report period	120	90		30					120	90		30
2. Number of Residents												
A. As of midnight of PREVIOUS report period	78	64		14	78	64		14				
B. As of midnight of THIS report period	80	56		24					80	56		24
3. Total Number of Days Care Provided During Period												
A. Medicare	2,059	1,847		212	1,601	1,448		153	458	399		59
B. Medicaid (Conn.)	20,430	15,119		5,311	15,563	11,743		3,820	4,867	3,376		1,491
C. Medicaid (other states)												
D. Private Pay	589	547		42	272	272			317	275		42
E. State SSI for RCH												
F. Other (Specify)	4,985	3,905		1,080	3,633	3,017		616	1,352	888		464
G. Total Care Days During Period (3A thru F)	28,063	21,418		6,645	21,069	16,480		4,589	6,994	4,938		2,056
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	5	5							5	5		
B. Other Bed Reserve Days	107	107			70	70			37	37		
5. <b>Total Resident Days (3G + 4A + 4B)</b>	<b>28,175</b>	<b>21,530</b>		<b>6,645</b>	<b>21,139</b>	<b>16,550</b>		<b>4,589</b>	<b>7,036</b>	<b>4,980</b>		<b>2,056</b>

## Schedule of Resident Statistics (Cont'd)

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?  Yes  No

If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change	
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)		
				(1)	(2)	(3)	(1)	(2)	(3)					
3/15/2021	X		X	14					14				Converted 14 NF beds to 14 Vent	

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.

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	8	39	17	9			7	
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	730.27	318.44		521.41				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL		CCNH	RHNS	(Specify)
	A. Medicare - Part B				
		2,085	1,254		831
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments		1,380	568		812
C. Other		10,406	8,872		1,534
<b>D. Total Physical Therapy Treatments</b>		13,871	10,694		3,177
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B		402	46		356
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments		500	122		378
C. Other		2,017	1,439		578
<b>D. Total Speech Therapy Treatments</b>		2,919	1,607		1,312
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B		1,526	892		634
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments		1,226	497		729
C. Other		7,009	5,720		1,289
<b>D. Total Occupational Therapy Treatments</b>		9,761	7,109		2,652

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of		
		9/30/2021		10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No							
Total Cost and Hours							
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours		
A. Salaries and Wages*							
1. Operators/Owners (Complete also Sec. I of Schedule A1)							
2. Administrator(s) (Complete also Sec. III of Schedule A1)	106,327	1,648			33,577 520		
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)							
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	190,973	7,682			60,307 2,426		
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	55,660	1,655			16,265 484		
b. Other Maintenance Workers	25,888	1,658			7,565 484		
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	130,831	2,411			41,315 761		
b. RN							
1. Direct Care	484,779	10,846	RN		155,609 4,150		
2. Administrative**	67,787	1,567	NUMD		21,407 495		
c. LPN							
1. Direct Care	995,583	29,987	LPN		312,100 9,618		
2. Administrative**			NLN1				
d. Aides and Attendants	984,577	48,640	PCA		375,069 19,417		
e. Physical Therapists			ACN1				
f. Speech Therapists			CNA				
g. Occupational Therapists							
h. Recreation Workers	65,377	3,247			20,645 1,026		
i. Physicians							
1. Medical Director							
2. Utilization Review							
3. Resident Care***							
j. Dentists							
k. Pharmacists							
l. Podiatrists							
m. Social Workers/Case Management	104,016	3,129			32,847 988		
n. Marketing							
o. Other (Specify) See Attached Schedule	91,022	3,939			28,744 1,244		
<i>A-13. Total Salary Expenditures</i>	3,302,821	116,409			1,105,449 41,614		

\* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

\*\* Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and

Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

**Schedule of Other Salaries and Wages (Page 10)**

**Schedule of Other Fees (Page 13)**

State of Connecticut

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

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

Name of Facility 23 Fair Streete Operations LLC			License No. 2416		Report for Year Ended 9/30/2021			Page 11	of 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.

State of Connecticut

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

CSP-12 Rev. 10/2005

**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		9/30/2021			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>										
Shahen,Janet 10/1/2020-present	106,327		33,577		Management of Center	2,168	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 23 Fair Street Operations LLC	License No. 2416	Report for Year Ended 9/30/2021		Page 13	of 37
Total Cost and Hours					
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	52,714	361			
3. Pharmacist	8,314	170			2,625 54
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	358,603	4,912			47,778 654
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	25,000	100			20,000 100
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	42,096	540			30,764 394
b. Other					
10. Occupational Therapist					
a. Resident Care	69,454	951			27,844 381
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	2,957	49			
2. Administrative***					
b. LPN					
1. Direct Care	26,693	621			
2. Administrative***					
c. Aides	59,293	2,427			
d. Other					
12. Other (Specify)					
See Attached Schedule	48,252				1,081,251
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	693,374	10,131			1,210,264 1,584

\* 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\***

\* Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021	Page 15	of 37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 173,301	129,976		43,325
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 68,828	51,621		17,207
4. Social Security (F.I.C.A.)	\$ 323,831	242,873		80,958
5. Health Insurance	\$ 258,744	194,058		64,686
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$			
9. Other (Specify) See Attached Schedule	\$ 492	492		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 161,943	123,077		38,866
d. Accounting and Auditing	\$			
e. Legal (Services should be fully described on Page 7)	\$ 96	73		23
f. Insurance on Lives of Owners and Operators (Specify)*	\$			
g. Office Supplies	\$ 14,433	10,969		3,464
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 19,387	14,734		4,653
2. Cellular Phones	\$ 2,948	2,240		708
i. Appraisal (Specify purpose and attach copy)*	\$			
j. Corporation Business Taxes (franchise tax)	\$			
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$			
2. Other (Specify) See Attached Schedule	\$ 285	217		68
3. Resident Day User Fee	\$ 528,869	393,647		135,222
<b>Subtotal</b>	\$ 1,553,156	1,163,976		389,180

\* 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**

Attachment Page 15

## **Schedule of Other Employee Benefits**

## Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
1020640110 Sales Tax	\$ 217	\$ -	\$ 68
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 217</b>	<b>\$ -</b>	<b>\$ 68</b>

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<b><i>Subtotals Brought Forward:</i></b>		1,553,156	1,163,976		389,180
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$				
5. Education Expenses Related to Seminars and Conventions	\$				
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$				
7. Other ( <i>Specify</i> ) See Attached Schedule	\$	8,347	6,344		2,003
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	\$				
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	\$	2,202	1,674		528
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	9,829	7,470		2,359
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$	862	862		
11. Services Provided by Contract ( <i>Specify and Complete     Schedule C-2, Page 21 for each firm or individual</i> )	\$	3,115	2,367		748
12. Administrative Management Services**	\$	752,666	572,026		180,640
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	24,160	18,362		5,798
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$	2,354,337	1,773,081		581,257

\* 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)
1020630020 Advertising	\$ 2,945	\$ -	\$ 930
1020630330 Marketing Expense	\$ 1,872	\$ -	\$ 591
1020630331 Marketing Exp- Corporate Spend	\$ 1,527	\$ -	\$ 482
3165630330 Marketing Expense	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total Other Travel and Entertainment</b>	<b>\$ 6,344</b>	<b>\$ -</b>	<b>\$ 2,003</b>

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total Other Advertising</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
1020630310 Licenses and Certification fee	\$ 7,470	\$ -	\$ 2,359
Chamber of Commerce	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total Dues</b>	<b>\$ 7,470</b>	<b>\$ -</b>	<b>\$ 2,359</b>

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
1020630135 Political Contributions	\$ 862	\$ -	\$ -
1020630130 Contribution	\$ -	\$ -	\$ -
<b>Total Contributions</b>	<b>\$ 862</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
1020630060 Bank Service Charges	\$ 2,628	\$ -	\$ 830
1020630120 Collection Fees	\$ 215	\$ -	\$ 68
1020630140 Education Expense	\$ -	\$ -	\$ -
1020630180 Employee Physicals	\$ (4,404)	\$ -	\$ (1,391)
1020630200 Employee Relations	\$ 4,230	\$ -	\$ 1,336
1020630380 Printing	\$ 706	\$ -	\$ 223
3080630441 Foreign Recruitment Cost	\$ -	\$ -	\$ -
1020630610 Training Expense	\$ 60	\$ -	\$ 19
1020630640 Uniforms	\$ -	\$ -	\$ -
1020640090 Miscellaneous	\$ 373	\$ -	\$ 118
1020660080 Rental Expense	\$ 2,022	\$ -	\$ 638
1020660090 Accrued Expense Estimation	\$ 5,061	\$ -	\$ 1,598
1020720070 State Tax Annual Report Filing	\$ 61	\$ -	\$ 19
5095720090 Landlord Operating Taxes	\$ -	\$ -	\$ -
1020640080 Fines & Penalties	\$ 7,410	\$ -	\$ 2,340
	\$ -	\$ -	\$ -
<b>Total Other Administrative and General</b>	<b>\$ 18,362</b>	<b>\$ -</b>	<b>\$ 5,798</b>

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021	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 Administrative Services LLC, 101 East St., Kennett Square, PA 19348	558,240	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12

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

**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
	2416	9/30/2021		18	37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$ 126,639	96,246			30,393
2. Non-Food Supplies	\$ 21,860	16,614			5,246
3. Other (Specify) _____	\$ 675	513			162
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 466,551	354,579			111,972
c. Other (Specify) _____	\$				
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 615,725</b>	<b>467,952</b>			<b>147,773</b>
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 9/30/2021		Page 19   37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	4,423	3,361	1,062
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. \$			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$	187,448	142,460	44,988
c. Other (Specify)	\$			
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	191,871	145,821	46,050
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 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 16,162	12,507		3,655
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 145,480	112,582		32,898
C. Other ( <i>Specify</i> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>161,642</b>	<b>125,089</b>		<b>36,553</b>
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	235,718	235,718		
b. Medicine Cabinet Drugs	\$	16,119	16,119		
c. Medical and Therapeutic Supplies	\$	217,143	165,029		52,114
d. Ambulance/Limousine***	\$	3,279	3,279		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	77,532	8,262		69,270
f. X-rays and Related Radiological Procedures***	\$	7,397	7,397		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	25,805	25,805		
i. Recreation	\$	40,457	31,308		9,149
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other ( <i>Specify</i> )**** See Attached Schedule	\$	551,145	86,287		464,858
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>1,174,595</b>	<b>579,204</b>		<b>595,392</b>

\* 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)
3060610160 Incontinency	\$ 33,453	\$ -	\$ -
3060610160 Incontinency	\$ 5,728	\$ -	\$ -
3060610161 Incontinency - Rebates	\$ (6,885)	\$ -	\$ -
3080630030 Advertising-Help Wanted	\$ 2,863	\$ -	\$ -
3080630030 Advertising-Help Wanted	\$ 9,753	\$ -	\$ -
1020630100 Case Management	\$ -	\$ -	\$ -
3080630140 Education Expense	\$ 41	\$ -	\$ -
3080630140 Education Expense	\$ 89	\$ -	\$ -
3080630200 Employee Relations	\$ -	\$ -	\$ -
3080630200 Employee Relations	\$ 417	\$ -	\$ -
3120630530 Supplies	\$ (284)	\$ -	\$ -
3120630530 Supplies	\$ 593	\$ -	\$ -
3155630530 Supplies	\$ 5,229	\$ -	\$ -
3155630530 Supplies	\$ 966	\$ -	\$ -
3155630530 Supplies	\$ 6,373	\$ -	\$ 43,718
3120630535 Office Supplies	\$ 154	\$ -	\$ -
3120630535 Office Supplies	\$ 172	\$ -	\$ -
3165630535 Office Supplies	\$ 110	\$ -	\$ -
3170630535 Office Supplies	\$ 23	\$ -	\$ -
3080630610 Training Expense	\$ 10,550	\$ -	\$ -
3225630630 Tuition Reimbursement	\$ (2,435)	\$ -	\$ -
3120660080 Rental Expense	\$ 380	\$ -	\$ -
3155660080 Rental Expense	\$ 9,381	\$ -	\$ -
3155660080 Rental Expense	\$ 6,650	\$ -	\$ 421,140
3010610300 Consolidated Billing	\$ 2,968	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total Other Resident Care</b>	<b>\$ 86,287</b>	<b>\$ -</b>	<b>\$ 464,858</b>

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

\* 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 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	129,637	100,321			29,316
b. Heat	\$	26,836	20,767			6,069
c. Light & Power	\$	120,872	93,539			27,333
d. Water	\$	15,781	12,212			3,569
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$					
f. Other <i>(itemize)</i>	\$					
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$	293,126	226,839			66,287
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$	4,137	3,201			936
b. Building & Building Improvements	\$	25,858	20,011			5,847
c. Non-Movable Equipment	\$	437	338			99
d. Movable Equipment	\$	41,946	32,461			9,485
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$	72,378	56,011			16,367
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	548,100	424,155			123,945
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	116,779	90,371			26,408
c. Personal property taxes	\$					
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$	737,257	570,537			166,720

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

**Schedule of Other Repairs and Maintenance**

Description	CCNH	RHNS	(Specify)
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total Other Repairs and Maintenance</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

## Depreciation Schedule

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
11/30/2020	Settlement of Revera Capex 2020	\$ (7,812)	15 09	\$ (413)
11/30/2020	Settlement of Revera Capex 2020	\$ (28,464)	05 07	\$ (4,248)
<b>Total additions for Land Improvement</b>		\$ (36,275)		\$ (4,662) *
<b>Deletions:</b>				
			-	
<b>Total deletions for Land Improvement</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>				
10/31/2020	New Bulk Oxygen Tank System	\$ 19,000	20 00	\$ 871
10/31/2020	New Fire Door & Associated Hardware	\$ 8,001	20 00	\$ 367
11/30/2020	Settlement of Revera CAPEX 2020	\$ (72,838)	15 10	\$ (3,834)
2/28/2021	Replaced Exhaust Fan in Kitchen w/ new	\$ 3,189	20 00	\$ 93
2/28/2021	New Interior Door - 50% Deposit	\$ 887	20 00	\$ 26
9/30/2021	Load Bank/ Rental Panel & Wiring to Gen	\$ 27,136	20 00	\$ -
11/30/2020	Settlement of Revera Capex 2020	\$ (14,513)	06 00	\$ (2,016)
<b>Total additions for Building Improvement</b>		\$ (29,138)		\$ (4,493) *
<b>Deletions:</b>				
10/1/2020	Sept 2020 Accruals	\$ (19,000)		
<b>Total deletions for Building Improvement</b>		\$ (19,000)		\$ - **

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

\*\*Ties to Page 23, Line B2

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

				ttachment Pages 23 24
<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>				
11/30/2020	3 - Welch Allyn 4400 Spot Monitors & 3 -	\$ 6,946.25	07 00	\$ 744.24
11/30/2020	2 - PTACs w/ 15000 BTU	\$ 1,284.67	07 00	\$ 137.65
1/31/2021	Record Sales & Use Tax per tax departm	\$ 32.00	07 00	\$ 3.05
2/28/2021	2 - Avalo Emergency Carts	\$ 5,684.89	07 00	\$ 473.74
12/31/2020	2 - Accent Tables, 24 - Dining Armchairs,	\$ 10,219.59	10 00	\$ 766.47
12/31/2020	Maxwell Thomas Odessa Round End Tab	\$ 300.87	10 00	\$ 22.57
12/31/2020	30 - UltraCare XT UCXT Adjustable Heigh	\$ 45,930.17	10 00	\$ 3,444.77
12/31/2020	6 - Nexus Table Bases for 42" Tops	\$ 973.40	10 00	\$ 73.01
1/31/2021	Maxwell Thomas Lubbock Loveseat w/ R	\$ 1,463.75	10 00	\$ 97.59
1/31/2021	Maxwell Thomas Zakynthos Accent Table	\$ 180.07	10 00	\$ 12.01
1/31/2021	Maxi Rest Bariatric Bed, Bari Wheelchair,	\$ 4,505.73	10 00	\$ 300.39
2/28/2021	10 - Maxwell Thomas Kennewick Lounge	\$ 13,020.20	10 00	\$ 759.51
6/30/2021	2 - Wheelchairs	\$ 731.96	10 00	\$ 18.30
6/30/2021	Meditation Accent Table	\$ 121.24	10 00	\$ 3.03
6/30/2021	30 - Overbed Tables w/ U Base	\$ 2,190.17	10 00	\$ 54.76
8/31/2021	Simplicity Heavy Duty Dual Stage Snow B	\$ 4,290.98	05 00	\$ 71.52
12/31/2020	58 - Panacea Custom Foam Mattresses	\$ 12,471.49	03 00	\$ 3,117.87
1/31/2021	Panacea Original Foam Bariatric Mattress	\$ 466.25	03 00	\$ 103.61
12/31/2020	8 - Mobile Pedestal File Cabinets, various	\$ 2,656.46	10 00	\$ 199.24
12/31/2020	10 - Logan Office Chairs	\$ 1,695.80	10 00	\$ 127.19
12/31/2020	4 - New Data drops for AP's	\$ 503.00	07 00	\$ 53.90
10/31/2020	Genesis 76ix72i Stationary Safety Partition	\$ 324.37	05 00	\$ 48.65
9/30/2021	September 2021 DSSI Accrual	\$ 278.59		
<b>Total additions for Movable Equipment</b>		\$ 116,272		\$ 10,633 *
<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 Improvemen</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvemen</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility 23 Fair Streete Operations LLC			License No. 2416		Report for Year Ended 9/30/2021			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.									
<b>A-4. Subtotal</b>									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
<b>B-4. Subtotal</b>									
<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)									
<b>C-4. Subtotal</b>									
<b>D. Total Amortization</b>									

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

- Minimum of 5 years or 60 months.
- Life of mortgage; OR
- Remaining Life of Lease; OR
- 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 9/30/2021	Page 25	of 37
--	---------------------	------------------------------------	------------	----------

#### 11. Property Questionnaire

##### Part A

Is the property either owned by the Facility  
or leased from a Related Party?\*

Yes

No

If "Yes," complete Part B.  
If "No," complete Part C.

\*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	120			
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				

##### Part B - Owner and Related Parties

1st Mortgage 2nd Mortgage 3rd Mortgage 4th Mortgage

1. Financing
  - a. Type of Financing (e.g., fixed, variable)
  - b. Date Mortgage Obtained
  - c. Interest Rate for the Cost Year
  - d. Term of Mortgage (number of years)
  - e. Amount of Principal Borrowed
  - f. Principal balance outstanding as of \_\_\_\_\_

##### Complete if Mortgage was Refinanced

##### During Current Cost Year

- g. Type of Financing (e.g., fixed, variable)
- h. Date of Refinancing
- i. New Interest Rate
- j. Term of Mortgage (number of years)
- k. Amount of Principal Borrowed
- l. Principal Outstanding on Note Paid-Off

##### Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021			Page 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					
<b>12 B7. Total Building Interest Expense (A1 - A4 + B5)</b>	<b>\$</b>				

(Carry Subtotals forward to next page )

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021			Page 27	of 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)		\$ 16,044	12,416			3,628
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$ 186,264	144,143			42,121
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$				
14d. <b>Total Insurance Expenditures (14a + b + c)</b>		\$ 202,308	156,559			45,749
15. <b>Total All Expenditures (A-13 thru C-14)</b>		\$ 12,042,769	8,041,276			4,001,493

## **D. Adjustments to Statement of Expenditures**

Name of Facility 23 Fair Streete Operations LLC			License No. 2416	Report for Year Ended 9/30/2021		Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b><i>Page 10 - Salaries and Wages</i></b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 49,255	37,434		11,821
<b><i>Page 13 - Professional Fees</i></b>							
5.	13	8-c	Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 501,097	501,097		
<b><i>Pages 15 &amp; 16 - Administrative and General</i></b>							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 161,943	123,077		38,866
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 *	\$ 8,347	6,344		2,003
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 862	862		
21.			Unallowable Management Fees	\$ 194,426	147,763		46,662
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 17,492	13,294		4,198
<b><i>Page 18 - Dietary Expenditures</i></b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b><i>Page 19 - Laundry Expenditures</i></b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b><i>Page 20 - Housekeeping Expenditures</i></b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 933,421	829,870			103,551

\* 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	\$ 37,434	\$ -	\$ 11,821
<b>Total Other Salaries Adjustment</b>			\$ 37,434	\$ -	\$ 11,821

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	\$ 358,603	\$ -	\$ -
13	5	Rehabilitation Services	\$ -	\$ -	\$ -
13	9	Speech Therapist	\$ 42,096	\$ -	\$ -
13	10	Occupational Therapist	\$ 69,454	\$ -	\$ -
13	12	Other	\$ -	\$ -	\$ -
13	12	Other	\$ -	\$ -	\$ -
13	12	Other-Labor	\$ 30,945	\$ -	\$ -
<b>Total Other Fees Adjustments</b>			\$ 501,097	\$ -	\$ -

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Page Ref	Line Ref		0	CCNH	RHNS
16	m-8a	1020630310	\$ 608	\$ -	\$ 192
16	m-13	1020630120	\$ 215	\$ -	\$ 68
16	m-13	1020660990	\$ 5,061	\$ -	\$ 1,598
16	m-13	7010800030	\$ -	\$ -	\$ -
16	m-13	1020640080	\$ 7,410	\$ -	\$ 2,340
0	0-Jan		0	\$ -	\$ -
0	0		0	\$ -	\$ -
0	0		0	\$ -	\$ -
<b>Total Other A&amp;G Adjustments</b>			\$ 13,294	\$ -	\$ 4,198

State of Connecticut

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

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

Name of Facility 23 Fair Streete Operations LLC			License No. 2416	Report for Year Ended 9/30/2021		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 933,421	829,870		103,551
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5-a-2	Prescription Drugs	\$ 235,718	235,718		
28.	20	5-d	Ambulance/Limousine	\$ 3,279	3,279		
29.	20	5-f	X-rays, etc	\$ 7,397	7,397		
30.	20	5-h	Laboratory	\$ 25,805	25,805		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 8,262	8,262		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 31,566	31,566		
<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	\$ 35,515	27,484		8,031
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 156,534	121,136		35,398
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>				\$ 1,437,497	1,290,517		146,980

\*\*\* 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	\$ 2,968	\$ -	\$ -
20	5-1	Respiratory Supplies	\$ 12,568	\$ -	\$ -
20	5-1	Respiratory Rental	\$ 16,030	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
<b>Total Other Ancillary Costs</b>			<b>\$ 31,566</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Excess Movable Equipment Depreciation**

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

### **Schedule of Other - Indirect Adjustments**

Attachment Page 29

### **Schedule of Other - Miscellaneous Administrative Adjustments**

### **Schedule of Other - Direct Adjustments**

### **Schedule of Unallowable Building Interest**

**F. Statement of Revenue**

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021			Page 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> )	\$ (9,443,542)	(5,099,513)			(4,344,029)
b. Medicaid Room and Board Contractual Allowance **	\$ 4,291,809	2,317,577			1,974,232
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ (902,660)	(514,516)			(388,144)
b. Medicare Room and Board Contractual Allowance **	\$ 80,871	46,096			34,775
4. a. Private-Pay Residents and Other	\$ (2,531,268)	(1,873,138)			(658,130)
b. Private-Pay Room and Board Contractual Allowance **	\$ 690,818	511,205			179,613
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ (88,635)	(50,522)			(38,113)
b. Prescription Drugs - Medicare Contractual Allowance **	\$ 7,941	4,526			3,415
c. Prescription Drugs - Non-Medicare	\$ (161,930)	(125,312)			(36,618)
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ 47,040	36,403			10,637
2. a. Medical Supplies - Medicare	\$ (8)	(5)			(3)
b. Medical Supplies - Medicare Contractual Allowance **	\$ 1	1			
c. Medical Supplies - Non-Medicare	\$ (23)	(18)			(5)
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ 8	6			2
3. a. Physical Therapy - Medicare	\$ (267,988)	(152,753)			(115,235)
b. Physical Therapy - Medicare Contractual Allowance **	\$ 24,010	13,686			10,324
c. Physical Therapy - Non-Medicare	\$ (343,149)	(265,551)			(77,598)
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ 107,964	83,549			24,415
4. a. Speech Therapy - Medicare	\$ (125,919)	(71,774)			(54,145)
b. Speech Therapy - Medicare Contractual Allowance **	\$ 11,281	6,430			4,851
c. Speech Therapy - Non-Medicare	\$ (208,821)	(161,599)			(47,222)
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ 70,833	54,815			16,018
5. a. Occupational Therapy - Medicare	\$ (224,892)	(128,188)			(96,704)
b. Occupational Therapy - Medicare Contractual Allowance **	\$ 20,149	11,485			8,664
c. Occupational Therapy - Non-Medicare	\$ (283,484)	(219,378)			(64,106)
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ 91,034	70,448			20,586
6. a. Other ( <i>Specify</i> ) - Medicare	\$ (165,560)	(94,369)			(71,191)
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (1,532,184)	(873,345)			(658,839)
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ (10,836,305)	(6,473,755)			(4,362,550)
<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> )	\$ (1,268)	(1,268)			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 137,809	137,809			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 136,540	136,540			
<b>VI. Total All Revenue</b> (III +V)	\$ (10,699,765)	(6,337,214)			(4,362,550)

\* 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	CCN1	RHNS	(Specify)
II-6-a	Medicare-X-Ray	\$ (917)	\$ -	\$ (924)
II-6-a	Medicare-Laboratory	\$ (4,687)	\$ -	\$ (3,536)
II-6-a	Medicare-Respiratory Therapy & Supplies	\$ (67,670)	\$ -	\$ (51,049)
II-6-a	Medicare-Nursing Treatment Supplies	\$ -	\$ -	\$ -
II-6-a	Medicare-Audiology	\$ -	\$ -	\$ -
II-6-a	Medicare-Incontinency	\$ -	\$ -	\$ -
II-6-a	Medicare-Oxygen & Supplies	\$ -	\$ -	\$ -
II-6-a	Medicare-Physician Visit	\$ -	\$ -	\$ -
II-6-a	Medicare-Ambulance	\$ -	\$ -	\$ -
II-6-a	Medicare-Flu Shot	\$ (3,556)	\$ -	\$ (2,682)
II-6-a	Medicare-Capitation Contracts	\$ -	\$ -	\$ -
II-6-a	Medicare-Radiology Service	\$ -	\$ -	\$ -
II-6-a	Medicare-Outpatient Therapy Program	\$ (26,827)	\$ -	\$ (20,238)
II-6-a	Medicare	\$ -	\$ -	\$ -
II-6-a	Contractuals-Medicare-X-Ray	\$ 82	\$ -	\$ 62
II-6-a	Contractuals-Medicare-Laboratory	\$ 420	\$ -	\$ 317
II-6-a	Contractuals-Medicare-Respiratory Therapy & Supplies	\$ 6,063	\$ -	\$ 4,574
II-6-a	Contractuals-Medicare-Nursing Treatment Supplies	\$ -	\$ -	\$ -
II-6-a	Contractuals-Medicare-Audiology	\$ -	\$ -	\$ -
II-6-a	Contractuals-Medicare-Incontinency	\$ -	\$ -	\$ -
II-6-a	Contractuals-Medicare-Oxygen & Supplies	\$ -	\$ -	\$ -
II-6-a	Contractuals-Medicare Physician Visit	\$ -	\$ -	\$ -
II-6-a	Contractuals-Medicare-Ambulance	\$ -	\$ -	\$ -
II-6-a	Contractuals-Medicare-Flu Shot	\$ 316	\$ -	\$ 240
II-6-a	Contractuals-Medicare-Capitation Contracts	\$ -	\$ -	\$ -
II-6-a	Contractuals-Medicare Radiology Service	\$ -	\$ -	\$ -
II-6-a	Contractuals-Medicare-Outpatient Therapy Program	\$ 2,403	\$ -	\$ 1,813
II-6-a	Contractuals-Medicare	\$ -	\$ -	\$ -
<b>Total Other Resident Revenue - Medicare</b>		<b>\$ (94,369)</b>	<b>\$ -</b>	<b>\$ (71,191)</b>

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

### Related Exp

### Interest Income

## Account

#### Schedule of Other Revenues

**G. Balance Sheet**

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	3,470
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,615,274
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(83,621)
4. Inventories			\$	24,210
5. Prepaid Expenses			\$	#VALUE!
a. _____				
b. _____				
c. Prepaid Escrow Real Estate				
d. See Schedule		#VALUE!		
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)			\$	#VALUE!
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	58,954	\$	19,011
	Accum. Depreciation	39,943	Net	
3. Buildings	*Historical Cost	390,656	\$	294,146
	Accum. Depreciation	96,510	Net	
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
5. Non-Movable Equipment	*Historical Cost	4,370	\$	2,003
	Accum. Depreciation	2,367	Net	
6. Movable Equipment	*Historical Cost	1,027,085	\$	214,705
	Accum. Depreciation	812,380	Net	
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)			\$	529,865

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

(Carry Total forward to next page)

**Schedule of Prepaid Expenses Page 31 Line A5**

Page Ref	Line Ref	Description	
31	A5	Prepaid Expenses	145010
31	A5	Prepaid Prop Taxes	145040
31	A5	Prepaid Personal Property Tax	145310
<b>Total Prepaid Expenses</b>			#VALUE!

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

**Schedule of Other Fixed Assets (Itemize) Page 31 Line B9c**

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

**Schedule of Other Assets Page 32 Line D7**

**Schedule of Notes Payable (Itemize) Page 33 Line A2**

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

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

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

## G. Balance Sheet (cont'd)

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021	Page 32	of 37
Account		Amount		
Total Brought Forward:			\$	#VALUE!
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements	*Historical Cost Accum. Depreciation	Net	\$	
3. Buildings	*Historical Cost Accum. Depreciation	Net	\$	
4. Non-Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
5. Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
6. Motor Vehicles	*Historical Cost Accum. Depreciation	Net	\$	
7. Minor Equipment-Not Depreciable			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense	*Historical Cost Accum. Depreciation	Net	\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )			\$	#VALUE!
O L/T A Suspense	(8,179,974)			
I/C Due to/Due From Owned	(0)			
See Schedule	#VALUE!			
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	#VALUE!
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	#VALUE!

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

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021	Page 33	of 37					
Account				Amount					
<b>Liabilities</b>									
A. Current Liabilities									
1. Trade Accounts Payable				\$ 492,050					
2. Notes Payable ( <i>itemize</i> )				\$					
See Schedule									
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$					
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding: 2px;">Name of Lender</th> <th style="text-align: left; padding: 2px;">Purpose</th> <th style="text-align: left; padding: 2px;">Amount</th> <th style="text-align: left; padding: 2px;">Date Due</th> <th style="text-align: left; padding: 2px;"></th> </tr> </thead> </table>					Name of Lender	Purpose	Amount	Date Due	
Name of Lender	Purpose	Amount	Date Due						
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$ 200,829					
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$					
6. Accrued Payroll Taxes Payable				\$					
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> )				\$ #VALUE!					
See Schedule				#VALUE!					
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)				\$ #VALUE!					

\* 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 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			#VALUE!	
<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)			\$	#VALUE!

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021	Page 35	of 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			\$	(6,327,332)
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ (1,343,002)
7. Total Net Worth			\$	(7,670,334)
<b>C. Total Reserves and Net Worth</b>			\$	(7,670,334)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	#VALUE!

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
23 Fair Streete Operations LLC	2416	9/30/2021	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ (6,327,331)
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 10,699,766
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 12,042,769
D. Net Income or Deficit				\$ (1,343,003)
E. Balance				\$ (7,670,334)
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 (No., City, State, Zip )	Title	Amount		
2. Other Withdrawings ( <i>Specify</i> )				\$
Purpose	Amount			
3. Total Deductions				\$
H. <b>Balance at End of Period</b>	09/30/21			\$ (7,670,334)

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021	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)		

### Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Rick Fink		
Address		Phone Number
200 Brickstone Square, Andover, MA 01810		410-494-7657
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Rick Fink		410-494-7657
Contact Email Address		
Rick.Fink@genesishcc.com		