

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 Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing 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

Data Required for Real Wage Adjustment			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
6. Total Wages Paid	\$	4,096,220	3,065,663	1,030,557
7. Total salaries paid	\$	312,050	237,158	74,892
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	4,408,270	3,302,821	1,105,449

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

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021	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 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, 14		
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.

Name of Facility 23 Fair Streete Operations LLC			License No. 2416		Report for Year Ended 9/30/2021		Page 6	of 37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed		
	Yes	No							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes	<input checked="" type="radio"/> No	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
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Services Provided by This Firm (*describe fully*)

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

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Included in Management Fee pg. 16 m-12

Legal Services Information

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

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

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No 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												
A. On last day of PREVIOUS report period	120	104		16	120	104		16				
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. Total Resident Days (3G + 4A + 4B)	28,175	21,530		6,645	21,139	16,550		4,589	7,036	4,980		2,056

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		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	
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.													
Change in Resident Days								CCNH	RHNS	(Specify)			
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	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		
D. Total Physical Therapy Treatments								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		
D. Total Speech Therapy Treatments								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		
D. Total Occupational Therapy Treatments								9,761	7,109		2,652		

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
23 Fair Streete Operations LLC	2416	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***						
4. Other (Specify)						
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
A-13. Total Salary Expenditures	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 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	9/30/2021				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
23 Fair Streete Operations LLC				2416	9/30/2021			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)							
Section III - Administrators***										
Shahen,Janet 10/1/2020-present	106,327		33,577		Management of Center	2,168	2			
Section IV - Assistant Administrators										
					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	9/30/2021	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	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-13 Total Fees Paid in Lieu of Salaries	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.

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	9/30/2021	15	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 (<i>Specify</i>) 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 (<i>Services should be fully described on Page 7</i>)	\$ 96	73		23
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
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 (<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	\$ 285	217		68
3. Resident Day User Fee	\$ 528,869	393,647		135,222
Subtotal	\$ 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)

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	9/30/2021		16	37
Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		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
C-14 Total Administrative & General Expenditures	\$	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	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
Total Other Travel and Entertainment	\$ 6,344	\$ -	\$ 2,003

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
Total Other Advertising	\$ -	\$ -	\$ -

Schedule of Dues

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

Schedule of Contributions

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

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
1020660990 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
	\$ -	\$ -	\$ -
Total Other Administrative and General	\$ 18,362	\$ -	\$ 5,798

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
23 Fair Streete Operations LLC		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 (<i>Specify</i>) _____	\$	675	513		162
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)					
c. Other (<i>Specify</i>) _____	\$	466,551	354,579		111,972
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 615,725	467,952		147,773
2E. Dietary Questionnaire					
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		License No.	Report for Year Ended		Page	of
23 Fair Streete Operations LLC		2416	9/30/2021		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>) (<i>Complete Schedule C-2 att. Page 21</i>)		\$	187,448	142,460		44,988
c. Other (<i>Specify</i>)		\$				
3D. Total Laundry Expenditures (3a + b + c)		\$	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		License No.	Report for Year Ended		Page	of
23 Fair Streete Operations LLC		2416	9/30/2021		20	37
Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt.	\$	16,162	12,507		3,655
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.	\$	145,480	112,582		32,898
C. Other (<i>Specify</i>)		\$				
4D. Total Housekeeping Expenditures (4a + b + c)		\$	161,642	125,089		36,553
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 (Specify)**** See Attached Schedule		\$	551,145	86,287		464,858
5M. Total Resident Care Expenditures (5a - 5j)		\$	1,174,595	579,204		595,392

* 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	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
Total Other Resident Care	\$ 86,287	\$ -	\$ 464,858

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 9/30/2021				Page of 21 37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Laundry Purchased Services	142,460		44,988	19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	112,582		32,898	20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Dietary Purchased Services	354,579		111,972	18	2b
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
23 Fair Streete Operations LLC	2416	9/30/2021			22	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. Total Maint. & Operating Expense (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. Total Depreciation Costs (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. Total Amortization Costs (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. Total Property Expenses (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.

Depreciation Schedule

Name of Facility 23 Fair Streete Operations LLC		License No. 2416			Report for Year Ended 9/30/2021			Page 23	of 37				
Property Item		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals				
A. Land Improvements													
1. Acquired prior to this report period		95,229		95,229	35,806	S/L	Various	8,799					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)		(36,275)		(36,275)				(4,662)					
A-4. Subtotal									4,137				
B. Building and Building Improvements													
1. Acquired prior to this report period		438,793		438,793	70,652	S/L	Various	30,351					
2. Disposals (attach schedule)		(19,000)		(19,000)									
3. Acquired during this report period (attach schedule)		(29,138)		(29,138)				(4,493)					
B-4. Subtotal									25,858				
C. Non-Movable Equipment													
1. Acquired prior to this report period		4,370		4,370	1,930	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									
		Yes	No	Month	Year	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
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a. Motor Vehicles (attach schedule)									S/L	Various			
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)													
d.													
2. Movable Equipment													
a. Acquired prior to this report period						910,813		910,813	770,434	S/L	Various	31,312	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						116,272		116,272				10,633	
D-3. Subtotal													41,946
E. Total Depreciation													72,378

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
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)
Total additions for Land Improvement		\$ (36,275)		\$ (4,662) *
Deletions:				
			-	
Total deletions for Land Improvement		\$ -		\$ - **

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
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)
Total additions for Building Improvement		\$ (29,138)		\$ (4,493) *
Deletions:				
10/1/2020	Sept 2020 Accruals	\$ (19,000)		
Total deletions for Building Improvement		\$ (19,000)		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Non-Movable Equipment		\$ -		\$ - *
Deletions:				

Total deletions for Non-Movable Equipmen		\$	-	\$ -

Attachment Pages 23 24

**

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility 23 Fair Streete Operations LLC			License No. 2416		Report for Year Ended 9/30/2021			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							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*			<input type="radio"/> Yes <input checked="" type="radio"/> No		
<small>*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.</small>			If "Yes," complete Part B. If "No," complete Part C.		
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		License No.	Report for Year Ended			Page	of
23 Fair Streete Operations LLC		2416	9/30/2021			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$					

(Carry Subtotals forward to next page)

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	9/30/2021	27	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment	\$			
A. Item	Rate	Amount		
Lender				
Address of Lender				
2. Other (Specify)	\$			
A. Item	Rate	Amount		
Lender				
Address of Lender				
B. Item	Rate	Amount		
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)	\$			
12. D. Other Interest Expense (Specify)	\$			
13. Total All Interest Expense (12B7 + 12C3 + 12D)	\$			
14. Insurance				
a. Insurance on Property (buildings only)	\$	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. Total Insurance Expenditures (14a + b + c)	\$	202,308	156,559	45,749
15. Total All Expenditures (A-13 thru C-14)	\$	12,042,769	8,041,276	4,001,493

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
23 Fair Streete Operations LLC			2416	9/30/2021	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 49,255	37,434		11,821
Page 13 - Professional Fees							
5.	13	8-c	Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 501,097	501,097		
Pages 15 & 16 - Administrative and General							
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
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 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
Total Other Salaries Adjustment			\$ 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	\$ -	\$ -
Total Other Fees Adjustments			\$ 501,097	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Page Ref	Line Ref		0 CCNH	RHNS	SLTC-Vent
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		\$ -	\$ -	\$ -
Total Other A&G Adjustments			\$ 13,294	\$ -	\$ 4,198

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	9/30/2021	29	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
Page 20 - Resident Care Supplies***							
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		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			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	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 1,437,497	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 \$ -	\$ -	\$ -
Total Other Ancillary Costs			\$ 31,566	\$ -	\$ -

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 \$ -	\$ -	\$ -
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-i	Cable TV	\$ 27,484	allow \$3600	\$ 8,031
Total Other Adjustments			\$ 27,484	\$ -	\$ 8,031

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 c1	General liability Insurance Adjust	\$ 121,136	\$ -	\$ 35,398
Total Other Adjustments			\$ 121,136	\$ -	\$ 35,398

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
23 Fair Streete Operations LLC	2416	9/30/2021			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
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		
II. Other Resident Revenue						
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)		
III. Total Resident Revenue (Section I. thru Section II.)	\$ (10,836,305)	(6,473,755)		(4,362,550)		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ (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				
V. Total Other Revenue (1 thru 8)	\$ 136,540	136,540				
VI. Total All Revenue (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.

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
23 Fair Streete Operations LLC	2416	9/30/2021	31	37
Account			Amount	
Assets				
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				
A-9. Total Current Assets (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-10. Total Fixed Assets (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	#VALUE!
31	A5	Prepaid Prop Taxes	145040	#VALUE!
31	A5	Prepaid Personal Property Tax	145310	#VALUE!
Total Prepaid Expenses				#VALUE!

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

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

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

Page Ref	Line Ref	Description		
Total Other Fixed Assets (Itemize)				\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description		
32	D7	ROU Bldg Asset-Oper Lease	150510	#VALUE!
32	D7	AccumAmort-ROU Bldg OprLease	150511	#VALUE!
Total Other Assets				#VALUE!

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description		
Total Notes Payable				\$ -

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

Page Ref	Line Ref	Description		
33	A12	Accr Exp Other	210010	#VALUE!
33	A12	Accr Exp Water and Sewer	210090	#VALUE!
33	A12	Accr Exp Gas	210100	#VALUE!
33	A12	Accr Exp Electricity	210110	#VALUE!
33	A12	Accr Exp Suspense	210240	#VALUE!
33	A12	Accr Exp Nursing Purchased Ser	210310	#VALUE!
33	A12	Deferred Revenue	210340	#VALUE!
33	A12	A/R Credit Gross Up Liability	210345	#VALUE!
33	A12	Accrued Provider/Bed Tax	210350	#VALUE!
33	A12	Accr Gross Rec Tax-FY11	215311	#VALUE!
33	A12	Accr Gross Rec Tax-FY12	215312	#VALUE!
33	A12	Accr Gross Rec Tax-FY13	215313	#VALUE!
33	A12	Accr Gross Rec Tax-FY14	215314	#VALUE!
33	A12	Accr Gross Rec Tax-FY15	215315	#VALUE!
33	A12	Accr Gross Rec Tax-FY16	215316	#VALUE!
33	A12	Accr Gross Rec Tax-FY17	215317	#VALUE!
33	A12	Accr Gross Rec Tax-FY18	215318	#VALUE!
33	A12	Accr Sales and Use Tax - FY18	215418	#VALUE!
Total Other Current Liabilities (Itemize)				#VALUE!

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

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

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			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	#VALUE!
O L/T A Suspense		(8,179,974)		
I/C Due to/Due From Owned		(0)		
See Schedule		#VALUE!		
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	#VALUE!
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	#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		License No.	Report for Year Ended	Page	of
23 Fair Streete Operations LLC		2416	9/30/2021	33	37
Account				Amount	
Liabilities					
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>)				\$	
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!	
A-13. Total Current Liabilities (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!
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
LT Debt-Financing Obligation				

See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$
C. Total All Liabilities (Lines A-13 + B-5)				\$ #VALUE!

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	9/30/2021	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(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)
C. Total Reserves and Net Worth			\$	(7,670,334)
D. Total Liabilities, Reserves, and Net Worth			\$	#VALUE!

H. Changes in Total Net Worth

Name of Facility 23 Fair Streete Operations LLC	License No. 2416	Report for Year Ended 9/30/2021	Page 36	of 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 <i>(No., City, State, Zip)</i>	Title	Amount		
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose	Amount			
3. Total Deductions			\$	
H. Balance at End of Period			\$	(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				
<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				
Rick Fink				
Address 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				