

State of Connecticut



Annual Report of Long-Term Care Facility
Cost Year 2024

Name of Facility (as licensed) 23 Fair Street Operations LLC	
Address (No. & Street, City, State, Zip Code) 23 Fair Street , Bristol, CT 06010	
Type of Facility Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input checked="" type="checkbox"/> Other	
Report for Year Beginning 10/1/2023	Report for Year Ending 9/30/2024

License Numbers:	CCNH / RHNS 2416	(Specify)	Other Vent Unit	Medicare Provider 07-5198
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Medicaid Provider Numbers:	CCNH / RHNS CT 000020164	(Specify)	Other
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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
23 Fair Street Operations LLC	2416	9/30/2024	1	37

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 Street Operations LLC [facility name], for the cost report period beginning October 1, 2023 and ending September 30, 2024, 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 Street Operations LLC		Period Covered:	From 10/1/2023	To 9/30/2024
Address of Facility 23 Fair Street , Bristol, CT 06010				
Report Prepared By Rick Fink		Phone Number 410-494-7657	Date 12/28/2024	
Item	Total	CCNH / RHNS	(Specify)	Other
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$	4,057,843	2,800,444	1,257,399
5. All other wages paid	\$	792,471	562,655	229,817
6. Total Wages Paid	\$	4,850,314	3,363,099	1,487,215
7. Total salaries paid	\$	376,740	267,485	109,255
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	5,227,054	3,630,584	1,596,470

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 9/30/2024	Page 2	of 37
Name of Facility (as shown on license) 23 Fair Street Operations LLC		Address (No. & Street, City, State, Zip) 23 Fair Street , Bristol, CT 06010		
License Numbers:	CCNH / RHNS 2416	(Specify)	Other Vent Unit	Medicare Provider No. 07-5198
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input checked="" type="checkbox"/> Other				
Type of Ownership (Check appropriate box) <input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" 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.:		

[illegible]

General Information and Questionnaire
Corporate Owners

Name of Facility 23 Fair Street Operations LLC	License No. 2416	Report for Year Ended 9/30/2024	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Names of Stockholders Owning at Least 10% of Shares				
See the attached				

Owner(s) of Facility

General Information and Questionnaire Related Parties*

Name of Facility 23 Fair Street Operations LLC	License No. 2416	Report for Year Ended 9/30/2024	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		<input type="radio"/>	<input checked="" type="radio"/>		Home Office	Pg 16/m12	661,244	661,244
Powerback Rehabilitation		<input checked="" type="radio"/>	<input type="radio"/>	70%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	818,872	818,872
AlignMed Partners		<input checked="" type="radio"/>	<input type="radio"/>	84%	Medical Director /NP	Pg 13/B8, Pg 10/A12	59,090	59,090
Career Staffing Carstaff_C		<input checked="" type="radio"/>	<input type="radio"/>	45%	Nursing Agency/ Temporary Services	Pg 13/B11 pg 10-12, 1	2,459	2,459
Powerback Respiratory		<input checked="" type="radio"/>	<input type="radio"/>	40%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	1,892,859	1,892,859
Genesis Healthcare Ins Program		<input type="radio"/>	<input checked="" type="radio"/>		Insurance	Pg 27/14	172,342	172,342
		<input type="radio"/>	<input checked="" type="radio"/>					
		<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 Street Operations LLC	License No. 2416	Report for Year Ended 9/30/2024	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item	Method of Allocation			
Dietary	Number of meals served to residents			
Laundry	Number of pounds processed			
Housekeeping	Number of square feet serviced			
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants			
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (<i>See listing page 13</i>)			
Maintenance and operation of plant	Square feet			
Property costs (depreciation)	Square feet			
Employee health and welfare	Gross salaries			
Management services	Appropriate cost center involved			
All other General Administrative expenses	Total of Direct and Allocated Costs			
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <div style="display: flex; justify-content: center; align-items: center; gap: 20px;"> <input checked="" type="radio"/> Yes <input type="radio"/> No </div> <div style="display: flex; justify-content: flex-end;"> If "No," explain fully why such allocation was not made. </div>				
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data. The Related Party reporting is consistent with prior years and has be subjected to audit.				
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.) <div style="display: flex; justify-content: center; align-items: center; gap: 20px;"> <input checked="" type="radio"/> Yes <input type="radio"/> No </div> <div style="display: flex; justify-content: flex-end;"> If "No," explain fully why such allocation was not made. </div>				
N/A				

General Information and Questionnaire
Other Lines of Business

Name of Facility 23 Fair Street Operations LLC	License No. 2416	Report for Year Ended 9/30/2024	Page 6	of 37		
<table border="1"> <tr> <td>Square footage of entire facility.</td> <td>40,014</td> </tr> </table>					Square footage of entire facility.	40,014
Square footage of entire facility.	40,014					
Outpatient Therapy						
Does the Facility provide outpatient therapy services?		No				
<i>If yes, please complete the following:</i>						
	Square footage of therapy space.					
Meals on Wheels						
Does the facility provide Meals on Wheels?		No				
<i>If yes, please complete the following:</i>						
	Square footage of kitchen					
	Number of meals served per week					
No	Are meals included in meals served on page 18 of the Annual Report?					
No	Are direct costs included in the Annual Report?					
	<i>If yes, please state where costs are reported.</i>					
No	Are drivers for the program included in the facility's payroll?					
	<i>If yes, please complete the following:</i>					
	Amount Reported					
	Annual Report page and line					
	Please state the salary amounts of specific cooks and/or dietary aides					
	Please state where the cooks and/or dietary aides are reported in the Annual Report					
Apartments, Independent Living, Assisted Living						
Does the facility have apartments, independent living, and/or assisted living?		No				
<i>If yes, please complete the following:</i>						
	Square footage of apartments					
	Square footage of independent living					
	Square footage of assisted living					
	Please identify the services provided:					

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
23 Fair Street Operati	2416	9/30/2024	7	37

Child Day Care

Does the Facility provide Child Day Care?

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care?

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

Schedule of Resident Statistics

Name of Facility 23 Fair Street Operations LLC				License No. 2416				Report for Year Ended 9/30/2024				Page 8	of 37
	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total	Other	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
						Total	CCNH / RHNS	(Specify)	Other	Total	CCNH / RHNS	(Specify)	Other
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	95	65			30	95	65		30				
B. On last day of THIS report period	95	65			30					95	65		30
2. Number of Residents													
A. As of midnight of PREVIOUS report period	86	60			26	86	60		26				
B. As of midnight of THIS report period	90	63			27					90	63		27
3. Total Number of Days Care Provided During Period													
A. Medicare	14,431	13,792			639	10,369	9,982		387	4,062	3,810		252
B. Medicaid (Conn.)	7,029	842			6,187	5,467	704		4,763	1,562	138		1,424
C. Medicaid (other states)													
D. Private Pay	1,823	1,685			138	1,488	1,442		46	335	243		92
E. State SSI for RCH													
F. Other (Specify)	7,451	5,713			1,738	5,564	4,271		1,293	1,887	1,442		445
G. Total Care Days During Period (3A thru F)	30,734	22,032			8,702	22,888	16,399		6,489	7,846	5,633		2,213
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days													
B. Other Bed Reserve Days	323	159			164	242	132		110	81	27		54
5. Total Resident Days (3G + 4A + 4B)	31,057	22,191			8,866	23,130	16,531		6,599	7,927	5,660		2,267

Schedule of Resident Statistics (Cont'd)

Name of Facility 23 Fair Street Operations LLC				License No. 2416		Report for Year Ended 9/30/2024				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)	Other	Lost			Gained			CCNH / RHNS	(Specify)	Other	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.				
Change in Resident Days		CCNH / RHNS	(Specify)	Other
1st change				
2nd change				
3rd change				
4th change				

6. Number of Residents and Rates on September 30 of Cost Year								
Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	Other	R.C.H.	ICF-MR
No. of Residents	7	56		27				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	816.26	#####		500.74				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments				TOTAL	CCNH / RHNS	(Specify)	Outpatient	Other
A. Medicare - Part B				1,848	1,848			
B. Medicaid (Exclusive of Part B)								
1. Maintenance Treatments								
2. Restorative Treatments				1,929	1,929			
C. Other				13,290	13,290			
D. Total Physical Therapy Treatments				17,067	17,067			

8. Total Number of Speech Therapy Treatments								
A. Medicare - Part B				157	157			
B. Medicaid (Exclusive of Part B)								
1. Maintenance Treatments								
2. Restorative Treatments				910	910			
C. Other				1,185	1,185			
D. Total Speech Therapy Treatments				2,252	2,252			

9. Total Number of Occupational Therapy Treatments								
A. Medicare - Part B				2,272	2,272			
B. Medicaid (Exclusive of Part B)								
1. Maintenance Treatments								
2. Restorative Treatments				1,585	1,585			
C. Other				11,054	11,054			
D. Total Occupational Therapy Treatments				14,911	14,911			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility 23 Fair Street Operations LLC	License No. 2416	Report for Year Ended 9/30/2024	Page 10	of 37					
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No									
	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	Other	Adjustment	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)	103,980	(32,543)	1,477				42,471	(13,292)	603
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	196,935		6,827				80,438		2,788
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	65,318		1,555				26,679		635
b. Other Maintenance Workers	31,446		1,428				12,844		583
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	163,506		2,908				66,784		1,188
b. RN									
1. Direct Care	758,279		15,229				87,186		1,771
2. Administrative**	69,223		1,493				28,274		610
c. LPN									
1. Direct Care	856,380		23,301				551,185		15,168
2. Administrative**									
d. Aides and Attendants	1,048,393		68,638				562,910		24,840
e. Physical Therapists									
f. Speech Therapists									
g. Occupational Therapists									
h. Recreation Workers	86,398		3,329				35,289		1,360
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	182,558		4,733				74,566		1,933
n. Marketing									
o. Other (Specify) See Attached Schedule	68,170		2,440				27,844		997
A-13. Total Salary Expenditures	3,630,584	(32,543)	133,357				1,596,470	(13,292)	52,476

* 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 in the Adjustment column.

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

Name of Facility 23 Fair Street Operations LLC				License No. 2416		Report for Year Ended 9/30/2024			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)	Other							
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 Street Operations LLC				2416		9/30/2024			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)	Other							
Section III - Administrators***										
Shahen, Janet	146,450				Management of Center	2,080	2			
Section IV - Assistant Administrators										
					Management of Center		2			

*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 9/30/2024			Page 13	of 37	
	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	Other	Adjustment	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	74,255	(66,653)	509						
3. Pharmacist	12,679		259				5,179		106
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	294,348	(294,348)	4,032				58,802		806
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	37,190		100				21,900		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	63,730	(63,730)	817				59,595		764
b. Other									
10. Occupational Therapist									
a. Resident Care	262,292	(262,292)	3,593				70,450		965
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care									
2. Administrative***									
b. LPN									
1. Direct Care									
2. Administrative***									
c. Aides	2,459		68						
d. Other									
12. Other (Specify) See Attached Schedule	41,275	(8,112)					1,369,095		
B-13 Total Fees Paid in Lieu of Salaries	788,228	(695,135)	9,378				1,585,021		2,740

* 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 in the Adjustment column.

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

Report of Expenditures
Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis*

Name of Facility 23 Fair Street Operations LLC		License No. 2416		Report for Year Ended 9/30/2024	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Career Staffing	Nursing Agency	<input type="radio"/>	<input checked="" type="radio"/>	Common Ownership		
Powerback Rehabilitation	Physical, Occupational, and Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>	Common Ownership		
AlignMed Partners	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>	Common Ownership		
Genesis Eldercare Staffing Services	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>	Common Ownership		
Powerback Respiratory	Respiratory and Oxygen Supplies	<input type="radio"/>	<input checked="" type="radio"/>	Common Ownership		
		<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"/>			
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		<input type="radio"/>	<input checked="" type="radio"/>			
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		<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"/>			

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended					Page	of
23 Fair Street Operations LLC	2416	9/30/2024					15	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment	
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 98,503	123,086	(55,119)			55,299	(24,763)	
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 39,346	27,149				12,197		
4. Social Security (F.I.C.A.)	\$ 387,239	267,195				120,044		
5. Health Insurance	\$ 153,861	106,164				47,697		
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$							
8. Uniform Allowance	\$							
9. Other (<i>Specify</i>) See Attached Schedule	\$							
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$							
c. Bad Debts*	\$	221,607	(221,607)			90,515	(90,515)	
d. Accounting and Auditing	\$							
e. Legal (<i>Services should be fully described on Page 15b</i>)	\$ 37,749	26,802				10,947		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$							
g. Office Supplies	\$ 13,412	9,523				3,890		
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$ 19,447	13,807				5,640		
2. Cellular Phones	\$ 1,770	1,256				513		
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	\$ 920	635				285		
3. Resident Day User Fee	\$ 557,391	371,028				186,363		
Subtotal	\$ 1,309,638	1,168,251	(276,725)			533,391	(115,279)	

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

Schedule of Other Employee Benefits

69% 31%

[illegible]

1020520020	10205200; Union Hea	5.57
3080520020	30055200; Union Hea	327.34
3210520020	30805200; Union Hea	151.77
3215520020	32155200; Union Hea	5662.56
3225520020	32255200; Union Hea	12980.05
5035520020	50355200; Union Hea	466.59
3005520020		
1020520060		

correct - -

Schedule of Other Taxes

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Sales Tax	\$ 635				\$ 285	
Sales Tax	\$ -				\$ -	
Total	\$ 635	\$ -	\$ -	\$ -	\$ 285	\$ -

1020640110

correct **920** \$ -

General Information and Questionnaire
Accounting Basis

Name of Facility 23 Fair Street Operations LLC	License No. 2416	Report for Year Ended 9/30/2024	Page 15b	of 37	
The records of this facility for the period covered by this report were maintained on the following basis: <input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash					
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain.					
Independent Accounting Firm					
Name of Accounting Firm 1 Grant Thornton 2 3 4		Address (No. & Street, City, State, Zip Code) 1600 Market Street, Philadelphia, PA 19103			
Services Provided by This Firm (<i>describe fully</i>)					
1 Year end financial audit		\$			
2		\$			
3		\$			
4		\$			
			Charge for Services Provided		
			\$		
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. <input checked="" type="radio"/> Yes <input type="radio"/> No					
Legal Services Information					
Name of Legal Firm or Independent Attorney 1 Goldman Gruder & Woods LLC 2 Stotler Hayes Group LLC 3 4 5			Telephone Number		
Address (<i>No. & Street, City, State, Zip Code</i>) 1 200 Connecticut Ave Norwalk, CT 06854 2 297 Willbrook Blvd Pawleys Island, SC 29585 3 4 5					
Services Provided by This Firm (<i>describe fully</i>)					
1 Legal fees for the probate court, guardianship, Medicaid application etc...		\$			18,561
2 Legal fees for the probate court, guardianship, Medicaid application etc...		\$			19,188
3		\$			
4		\$			
5		\$			
			Charge for Services Provided		
			\$ 37,749		
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. <input checked="" type="radio"/> Yes <input type="radio"/> No					

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

Name of Facility	License No.	Report for Year Ended					Page	of
23 Fair Street Operations LLC	2416	9/30/2024					16	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment	
Subtotals Brought Forward:	1,309,638	1,168,251	(276,725)			533,391	(115,279)	
1. Travel and Entertainment								
1. Resident Travel and Entertainment \$								
2. Holiday Parties for Staff \$	2,484	1,763				720		
3. Gifts to Staff and Residents \$								
4. Employee Travel \$	286	203				83		
5. Education Expenses Related to Seminars and Conventions \$	567	403				164		
6. Automobile Expense (<i>not purchase or depreciation</i>) \$								
7. Other (<i>Specify</i>) \$								
See Attached Schedule								
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (<i>all such expenses</i>) \$	264	187				77		
2. Advertising Telephone Directory (<i>all such expenses</i>)*** \$								
3. Advertising Other (<i>Specify</i>)*** \$		6,516	(6,516)			2,661	(2,661)	
See Attached Schedule								
4. Fund-Raising*** \$								
5. Medical Records \$	1,308	929				379		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)*** \$								
7. Postage \$	2,226	1,581				646		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) \$	7,022	4,985				2,036		
See Attached Schedule								
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$								
9. Subscriptions \$	44,969	31,928				13,041		
10. Contributions*** \$								
See Attached Schedule								
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>) \$	13,254	9,410				3,844		
12. Administrative Management Services** \$	661,244	398,045	71,438			162,582	29,179	
13. Other (<i>Specify</i>) \$	64,574	56,702	(10,855)			23,160	(4,434)	
See Attached Schedule								
C-14 Total Administrative & General Expenditures \$	2,107,834	1,680,902	(222,657)			742,784	(93,195)	

* 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 in the Adjustment column.

Schedule of Other Travel and Entertainment

71% 29%

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
	\$ -					
	\$ -					
	\$ -					
	\$ -					
	\$ -					
	\$ -					
	\$ -					
Total Other Travel and Entertainment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

correct

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Advertising	\$ 1,104	\$ (1,104)			\$ 451	\$ (451)
Marketing Expense	\$ 331	\$ (331)			\$ 135	\$ (135)
Marketing Exp- Corporate Spend	\$ 5,081	\$ (5,081)			\$ 2,075	\$ (2,075)
Marketing Exp- Corporate Spend	\$ -	\$ -			\$ -	\$ -
Marketing Expense	\$ -	\$ -			\$ -	\$ -
Marketing Expense	\$ -	\$ -			\$ -	\$ -
Total Other Advertising	\$ 6,516	\$ (6,516)	\$ -	\$ -	\$ 2,661	\$ (2,661)

1020630020
1020630330
1020630331
3165630330
3080630330
3005630330
correct 9,177 -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Licenses & Certifications	\$ 4,985				\$ 2,036	
Dues to Chamber of Commerce	\$ -				\$ -	
Total Dues	\$ 4,985	\$ -	\$ -	\$ -	\$ 2,036	\$ -

1020630310

correct 7,022 -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Contributions	\$ -	\$ -			\$ -	\$ -
Political Contributions	\$ -				\$ -	
Total Contributions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

1020630130
1020630135

correct - -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
Bank Service Charges	\$ 2,596				\$ 1,060	
Collection Fees	\$ 1,184	\$ (1,184)			\$ 484	\$ (484)
Employee Physicals	\$ 6,024				\$ 2,460	
Employee Relations	\$ 5,217				\$ 2,131	
Printing	\$ 61				\$ 25	
Training Expense	\$ 80				\$ 33	
Uniforms	\$ 20,504				\$ 8,375	
Equipment Non-Capitalized	\$ 30				\$ 12	
Fines & Penalties	\$ 9,670	\$ (9,670)			\$ 3,950	\$ (3,950)
Miscellaneous	\$ 2,897				\$ 1,183	
Rental Expense	\$ 1,378				\$ 563	
Repairs & Maintenance	\$ 5,206				\$ 2,126	
Accrued Expense Estimation	\$ -				\$ -	
State Tax Annual Report Filing	\$ 57				\$ 23	
Recruiting Fees	\$ 1,797				\$ 734	
	\$ -				\$ -	
	\$ -				\$ -	
	\$ -				\$ -	
	\$ -				\$ -	
	\$ -				\$ -	
	\$ -				\$ -	
	\$ -				\$ -	
	\$ -				\$ -	
	\$ -				\$ -	
	\$ -				\$ -	
Total Other Administrative and General	\$ 56,702	\$ (10,855)	\$ -	\$ -	\$ 23,160	\$ (4,434)

102063006 Bank Servc 1020630060 Bank Service Charges 3,656.10 C01M13
102063012 Collection F 1020630120 Collection Fees 1,594.00 C01M13
102063018 Employee P 1020630120 Collection Fees 74.14 C01M13
102063020 Employee R 1020630180 Employee Physicals 8,484.30 C01M13
102063038 Printing 1020630200 Employee Relations 6,291.42 C01M13
102063061 Training Ex 1020630200 Employee Relations 963.81 C01M13
102063064 Uniforms 1020630200 Employee Relations 93.00 C01M13
102064006 Equipment 1020630380 Printing 85.34 C01M13
102064008 Fines & Per 1020630610 Training Expense 113.00 C01M13
102064009 Miscellaneous 1020630640 Uniforms 28,879.41 C01M13
102066008 Rental Exp 1020640060 Equipment Non-Capitalized 42.78 C01M13
102066010 Repairs & h 1020640080 Fines & Penalties 13,620.00 C01M13
102066099 Accrued Ex 1020640090 Miscellaneous 4,082.70 C01M13
102072007 State Tax A 1020640090 Miscellaneous (1.82) C01M13
308063044 Recruiting F 1020660080 Rental Expense 1,484.06 C01M13
1020660080 Rental Expense 456.17 C01M13
1020660100 Repairs & Maintenance 5,900.46 C01M13
1020660100 Repairs & Maintenance 1,344.86 C01M13
1020660100 Repairs & Maintenance 87.01 C01M13
1020660990 Accrued Expense Estimation 0.00 C01M13
1020720070 State Tax Annual Report Filing 80.00 C01M13
3080630440 Recruiting Fees 2,531.51 C01M13

correct 79,862 -

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility 23 Fair Street Operations LLC	License No. 2416	Report for Year Ended 9/30/2024	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	661,244	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 23 Fair Street Operations LLC		License No. 2416	Report for Year Ended 9/30/2024			Page 18	of 37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
2. Dietary							
a. In-House Preparation & Service							
1. Raw Food	\$ 187,688	133,259				54,430	
2. Non-Food Supplies	\$ 33,169	23,550				9,619	
3. Other (Specify) _____ Contra Meal Expense	\$						
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 613,663	435,701				177,962	
c. Other (Specify) _____ Books, Dues & Subscriptions Miscellaneous	\$ (3,186)	(2,262)				(924)	
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 831,335	590,248				241,087	
2E. Dietary Questionnaire	Total	CCNH / RHNS	(Specify)		Other		
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 Street Operations LLC		License No. 2416	Report for Year Ended 9/30/2024				Page 19	of 37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
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. \$	4,203	2,984			1,219	
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 (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	261,307	185,528			75,779	
c. Other (Specify)		\$	7,048	5,004			2,044	
Miscellaneous								
3D. Total Laundry Expenditures (3a + b + c)		\$	272,558	193,516			79,042	
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 Street Operations LLC		License No. 2416	Report for Year Ended 9/30/2024				Page 20	of 37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
4. Housekeeping	Sq. Ft. Serviced by Personnel							
a. In-House Care	Amt.	\$ 10,965	7,785				3,180	
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)								
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.	\$ 259,199	184,031				75,168	
C. Other (<i>Specify</i>) Miscellaneous		\$ (3,863)	(2,742)				(1,120)	
4D. Total Housekeeping Expenditures (4a + b + c)		\$ 266,301	189,074				77,227	
5. Resident Care (Supplies)**								
a. Prescription Drugs***								
1. Own Pharmacy	\$							
2. Purchased from Prescription Drugs	\$		285,991	(285,991)				
b. Medicine Cabinet Drugs	\$	28,028	56,030	(28,002)				
c. Medical and Therapeutic Supplies	\$	228,859	162,490				66,369	
d. Ambulance/Limousine***	\$							
e. Oxygen								
1. For Emergency Use	\$							
2. Other***	\$	87,717	(16,072)	16,072			87,717	
f. X-rays and Related Radiological Procedures***	\$		22,068	(22,068)				
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$							
h. Laboratory***	\$		32,176	(32,176)				
i. Recreation	\$	5,762	4,091				1,671	
j. Direct Management Services*	\$							
k. Indirect Management Services*	\$							
l. Cable TV	\$	7,200	43,323	(36,123)				
m. Other (Specify)**** See Attached Schedule	\$	590,188	68,079	(20,918)			545,807	(2,780)
n. Physical Therapy Expense	\$							
o. Speech Therapy Expense	\$							
5P. Total Resident Care Expenditures (5a - 5o)		\$ 947,753	658,176	(409,207)			701,564	(2,780)

* 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 in the Adjustment column.

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

Schedule of Other Resident Care

71% 29%

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	RCH	Adjustment
Incontinency	\$ 35,298				\$ 14,417	
Incontinency - Rebates	\$ (5,999)				\$ (2,450)	
Advertising-Help Wanted	\$ 4,603				\$ 1,880	
Books, Dues & Subscriptions	\$ 134				\$ 55	
Education Expense	\$ 6,937				\$ 2,833	
Education Expense	\$ -				\$ -	
Supplies	\$ 326				\$ 133	
Supplies	\$ 10,118	\$ (10,118)			\$ 84,855	
Supplies	\$ 238				\$ 97	
Office Supplies	\$ 52				\$ 21	
Office Supplies	\$ 96				\$ 39	
Office Supplies	\$ -				\$ -	
Training Expense	\$ 1,065				\$ 435	
Training Expense	\$ -				\$ -	
Rental Expense	\$ 3,994	\$ (3,994)			\$ 438,909	
Consolidated Billing	\$ 6,806	\$ (6,806)			\$ 2,780	\$ (2,780)
Tuition Reimbursement	\$ 4,083				\$ 1,668	
Tuition Reimbursement	\$ 178				\$ 73	
Tuition Reimbursement	\$ (75)				\$ (31)	
Case Management	\$ 31				\$ 13	
Meetings & Seminars	\$ 18				\$ 7	
Tuition Reimbursement	\$ 178				\$ 73	
	\$ -				\$ -	
	\$ -				\$ -	
	\$ -				\$ -	
Total Other Resident Care	\$ 68,079	\$ (20,918)	\$ -	\$ -	\$ 545,807	\$ (2,780)

0 3060610160	3060610160		Labor	Rental	Supply
0 3060610161	3060610161	Oct-23	121,966	42,276	8,735
3080630030	3080630030	Nov-23	119,951	39,616	7,088
3080630080		Dec-23	113,607	36,746	8,128
3080630140	3080630140	Jan-24	115,648	37,141	8,111
3080630200		Feb-24	121,303	38,726	5,554
3120630530	3120630530	Mar-24	111,722	39,531	4,017
3155630530	3155630530	Apr-24	105,794	35,899	5,589
3170630530	3170630530	May-24	116,441	30,564	7,206
3090630535	3090630535	Jun-24	118,105	33,213	7,405
3120630535	3120630535	Jul-24	100,919	35,597	7,412
3165630535		Aug-24	109,863	36,183	8,175
0 3080630610	3080630610	Sep-24	113,776	33,420	7,434
3120660080			#####	438,909.10	84,854.98
3155660080	3155660080				
3010610300	3010610300				
3080630630	3080630630				
3210630630	3210630630				
3225630630	3225630630				
1020630100					
3165630340					
3215630630					

correct 613,886.24 -

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

Name of Facility 23 Fair Street Operations LLC				License No. 2416	Report for Year Ended 9/30/2024				Page 21	of 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)	Other	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Laundry Purchased Services	261,307			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	259,199			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Dietary Purchased Services	613,663			18	2b
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<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 23 Fair Street Operations LLC		License No. 2416	Report for Year Ended 9/30/2024				Page 22	of 37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$	180,850	128,403				52,446	
b. Heat	\$	25,887	18,380				7,507	
c. Light & Power	\$	139,051	98,726				40,325	
d. Water	\$	19,301	13,704				5,597	
e. Equipment Lease (Provide detail on page 22b)	\$							
f. Other (itemize)	\$							
See Attached Schedule								
6g. Total Maint. & Operating Expense (6a - 6f)		\$ 365,089	259,213				105,876	
7. Depreciation (complete schedule page 23*)								
a. Land Improvements	\$	3,205	2,275				929	
b. Building & Building Improvements	\$	35,052	24,887				10,165	
c. Non-Movable Equipment	\$	732	520				212	
d. Movable Equipment	\$	36,586	25,976				10,610	
*7e. Total Depreciation Costs (7a + b + c + d)		\$ 75,574	53,658				21,917	
8. Amortization (Complete att. Schedule Page 24*)								
a. Organization Expense	\$							
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$							
d. Other (Specify)	\$							
*8e. Total Amortization Costs (8a + b + c + d)		\$						
9. Rental payments on leased real property less real estate taxes included in item 10b		\$ 564,504	400,798				163,706	
10. Property Taxes								
a. Real estate taxes paid by owner	\$							
b. Real estate taxes paid by lessor	\$	101,883	72,337				29,546	
c. Personal property taxes	\$							
11. Total Property Expenses (7e + 8e + 9 + 10)		\$ 741,962	526,793				215,169	

* 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	Adjustment	(Specify)	Adjustment	Other	Adjustment
Total Other Repairs and Maintenance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

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 Street Operations LLC			License No. 2416		Report for Year Ended 9/30/2024		Page 22b	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"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?								<input checked="" type="radio"/> Yes <input type="radio"/> No
<div style="display: flex; justify-content: space-between;"> * 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. </div>								Total ***

Depreciation Schedule

Name of Facility 23 Fair Street Operations LLC					License No. 2416			Report for Year Ended 9/30/2024			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					58,954		58,954	46,353	S/L	Various	3,205		
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal												3,205	
B. Building and Building Improvements													
1. Acquired prior to this report period					538,420		538,420	155,558	S/L	Various	33,809		
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)					27,110						1,243		
B-4. Subtotal												35,052	
C. Non-Movable Equipment													
1. Acquired prior to this report period					4,370		4,370		S/L	Various	437		
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)					7,081						295		
C-4. Subtotal												732	
	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
	Yes	No	Month	Year									
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period													
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative													
d. Standard Resident													
e. Specialized Resident													
Total Acquired during this report period													
D-3. Subtotal												36,586	
E. Total Depreciation												75,574	

Schedule of Land Improvements Acquired during this report period

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

*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:				
10/31/2023	6-Hallway Fire Doors Pymt # 2	\$ 27,110	20 00	\$ 1,243
Total additions for Building Improvements		\$ 27,110		\$ 1,243 *
Deletions:				
Total deletions for Building Improvements		\$ -		\$ - **

*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:				
4/30/2024	Sewage Ejector Pump Pymt # 1	\$ 7,081	10 00	\$ 295
Total additions for Non-Movable Equipment		\$ 7,081		\$ 295 *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
9/30/2024	Implementation of Recruiting Manageme	Administrative	\$ 87	07 00	\$ -
9/30/2024	Implementation of Recruiting Manageme	Administrative	\$ 87	07 00	\$ -
9/30/2024	Implementation of Recruiting Manageme	Administrative	\$ 87	07 00	\$ -
9/30/2024	Subscription Fees Recruiting Manageme	Administrative	\$ 87	07 00	\$ -
9/30/2024	Implementation of UKG System	Administrative	\$ 698	07 00	\$ -
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipment			\$ 1,046		\$ - *
Deletions:					
Total deletions for Movable Equipment			\$ -		\$ - **

*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
Additions:				
Total additions for Leasehold Improvement		\$ -		\$ - *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

150050 016688

150075 016747

150085	016463
150085	016677
150117	016436

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility 23 Fair Street Operations LLC			License No. 2416		Report for Year Ended 9/30/2024			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 Street Operations LLC	License No. 2416	Report for Year Ended 9/30/2024	Page 25	of 37
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11. Property Questionnaire

Part A

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

☒ Yes ☐ No

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

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

Description	Total				
1. Date Land Purchased	n/a				
2. Date Structure Completed	n/a				
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	95				
6. Square Footage					
7. Acquisition Cost					
a. Land	n/a				
b. Building	n/a				

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
MidCap RE Loan	Building and Equipment	12/01/15	20	564,504
Address: One Seagate Suite 1500, Toledo, OH 43603-1475				

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

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

Name of Facility 23 Fair Street Operations LLC		License No. 2416	Report for Year Ended 9/30/2024				Page 26	of 37
Item			Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other Adjustment
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 23 Fair Street Operations LLC			License No. 2416		Report for Year Ended 9/30/2024			Page 27	of 37		
Item					Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	Other	Adjustment
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)					\$ 48,586	34,496				14,090	
b. Insurance on Automobiles											
c. Insurance other than Property (as specified above)											
1. Umbrella (Blanket Coverage)					\$ 50,973	87,867	(51,676)			35,889	(21,107)
2. Fire and Extended Coverage											
3. Other (Specify)											
14d. Total Insurance Expenditures (14a + b + c)					\$ 99,558	122,363	(51,676)			49,979	(21,107)
15. Total All Expenditures (A-13 thru C-14)					\$ 12,491,723	8,639,096	(1,411,219)			5,394,219	(130,374)

F. Statement of Revenue

Name of Facility 23 Fair Street Operations LLC		License No. 2416		Report for Year Ended 9/30/2024		Page 30	of 37
Item		Total	CCNH / RHNS	(Specify)	Other		
I. Resident Room, Board & Routine Care Revenue							
1. a. Medicaid Residents (<i>CT only</i>)	\$	10,120,952	5,566,524		4,554,428		
b. Medicaid Room and Board Contractual Allowance **	\$	(4,815,466)	(2,648,506)		(2,166,960)		
2. a. Medicaid (<i>All other states</i>)	\$						
b. Other States Room and Board Contractual Allowance **	\$						
3. a. Medicare Residents (<i>all inclusive</i>)	\$	1,215,459	704,966		510,493		
b. Medicare Room and Board Contractual Allowance **	\$	(121,540)	(70,493)		(51,047)		
4. a. Private-Pay Residents and Other	\$	4,487,139	3,320,483		1,166,656		
b. Private-Pay Room and Board Contractual Allowance **	\$	(1,452,903)	(1,075,148)		(377,755)		
II. Other Resident Revenue							
1. a. Prescription Drugs - Medicare	\$	67,690	39,260		28,430		
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(6,769)	(3,926)		(2,843)		
c. Prescription Drugs - Non-Medicare	\$	220,284	156,402		63,882		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(74,131)	(52,633)		(21,498)		
2. a. Medical Supplies - Medicare	\$	20	12		8		
b. Medical Supplies - Medicare Contractual Allowance **	\$	(2)	(1)		(1)		
c. Medical Supplies - Non-Medicare	\$	139	99		40		
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$	(57)	(41)		(17)		
3. a. Physical Therapy - Medicare	\$	284,451	164,981		119,469		
b. Physical Therapy - Medicare Contractual Allowance **	\$	(28,444)	(16,497)		(11,946)		
c. Physical Therapy - Non-Medicare	\$	620,249	440,377		179,872		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$	(217,043)	(154,101)		(62,943)		
4. a. Speech Therapy - Medicare	\$	93,299	54,114		39,186		
b. Speech Therapy - Medicare Contractual Allowance **	\$	(9,329)	(5,411)		(3,918)		
c. Speech Therapy - Non-Medicare	\$	225,920	160,403		65,517		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	(79,914)	(56,739)		(23,175)		
5. a. Occupational Therapy - Medicare	\$	319,422	185,265		134,157		
b. Occupational Therapy - Medicare Contractual Allowance **	\$	(31,941)	(18,526)		(13,415)		
c. Occupational Therapy - Non-Medicare	\$	554,344	393,585		160,760		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(195,604)	(138,879)		(56,725)		
6. a. Other (<i>Specify</i>) - Medicare	\$	288,041	167,064		120,977		
b. Other (<i>Specify</i>) - Non-Medicare	\$	1,972,550	1,192,516		780,034		
III. Total Resident Revenue (Section I. thru Section II.)		\$	13,436,817	8,305,149		5,131,668	
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>)	\$	1,946	1,946				
6. Private Duty Nurses' Fees	\$						
7. Barber, Coffee, Beauty and Gift shops	\$						
8. Other (<i>Specify</i>)	\$						
V. Total Other Revenue (1 thru 8)		\$	1,946	1,946			
VI. Total All Revenue (III + V)		\$	13,438,763	8,307,095		5,131,668	

* 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

58%

42%

Page Ref	Description	CCNH / RHNS	(Specify)	Other
II-6-a	X-Ray	\$ 2,413		\$ 1,747
II-6-a	Laboratory	\$ 6,404		\$ 4,637
II-6-a	Respiratory Therapy & Supplies	\$ 135,198		\$ 97,902
II-6-a	Nursing Treatment Supplies	\$ -		\$ -
II-6-a	Audiology	\$ -		\$ -
II-6-a	Incontinency	\$ -		\$ -
II-6-a	Oxygen & Supplies	\$ -		\$ -
II-6-a	Physician Visit	\$ -		\$ -
II-6-a	Ambulance	\$ -		\$ -
II-6-a	Flu Shot	\$ 3,390		\$ 2,455
II-6-a	Capitation Contracts	\$ -		\$ -
II-6-a	Equipment Rental	\$ 38,221		\$ 27,677
II-6-a	X-Ray	\$ (241)		\$ (175)
II-6-a	Laboratory	\$ (640)		\$ (464)
II-6-a	Respiratory Therapy & Supplies	\$ (13,519)		\$ (9,790)
II-6-a	Nursing Treatment Supplies	\$ -		\$ -
II-6-a	Audiology	\$ -		\$ -
II-6-a	Incontinency	\$ -		\$ -
II-6-a	Oxygen & Supplies	\$ -		\$ -
II-6-a	Physician Visit	\$ -		\$ -
II-6-a	Ambulance	\$ -		\$ -
II-6-a	Flu Shot	\$ (339)		\$ (245)
II-6-a	Capitation Contracts	\$ -		\$ -
II-6-a	Equipment Rental	\$ (3,822)		\$ (2,768)
Total Other Resident Revenue - Medicare		\$ 167,064	\$ -	\$ 120,977

X-Ray	(4,160.00)	415.98
Laboratory	(11,041.59)	1,104.10
Respirator	(233,099.49)	23,308.76
Nursing Ti	-	-
Audiology	-	-
Incontinen	-	-
Oxygen &	-	-
Physician	-	-
Ambulance	-	-
Flu Shot	(5,845.00)	584.47
Capitation C	-	-
Radiotherapy	-	-
Equipment	(65,898.00)	6,589.46

Schedule of Other Non-Medicare Resident Revenue

Related Exp

55%

45%

74%

26%

Page Ref	Description	CCNH / RHNS	(Specify)	Other
II-6-b	X-Ray	\$ 8,616		\$ 2,966
II-6-b	Laboratory	\$ 17,892		\$ 6,431
II-6-b	Respiratory Therapy & Supplies	\$ 1,598,050		\$ 1,088,763
II-6-b	Nursing Treatment Supplies	\$ -		\$ -
II-6-b	Audiology	\$ -		\$ -
II-6-b	Incontinency	\$ -		\$ -
II-6-b	Oxygen & Supplies	\$ -		\$ -
II-6-b	Physician Visit	\$ -		\$ -
II-6-b	Ambulance	\$ -		\$ -
II-6-b	Flu Shot	\$ -		\$ -
II-6-b	Capitation Contracts	\$ -		\$ -
II-6-b	Equipment Rental	\$ 470,611		\$ 326,718
II-6-b	X-Ray	\$ (2,770)		\$ (944)
II-6-b	Laboratory	\$ (5,840)		\$ (2,121)
II-6-b	Respiratory Therapy & Supplies	\$ (689,120)		\$ (493,001)
II-6-b	Nursing Treatment Supplies	\$ -		\$ -
II-6-b	Audiology	\$ -		\$ -
II-6-b	Incontinency	\$ -		\$ -
II-6-b	Oxygen & Supplies	\$ -		\$ -
II-6-b	Physician Visit	\$ -		\$ -
II-6-b	Ambulance	\$ -		\$ -
II-6-b	Flu Shot	\$ -		\$ -
II-6-b	Capitation Contracts	\$ -		\$ -
II-6-b	Equipment Rental	\$ (204,921)		\$ (148,777)
		\$ -		\$ -
Total Other Resident Revenue		\$ 1,192,516	\$ -	\$ 780,034

	Medicaid		Others	
X-Ray	240.00	(114.19)	(11,821.52)	3,827.72
Laboratory	(565.71)	269.16	(23,757.34)	7,692.45
Respirator	(2,053,639.00)	977,104.59	(633,173.30)	205,016.89
Nursing Ti	-	-	-	-
Audiology	-	-	-	-
Incontinen	-	-	-	-
Oxygen &	-	-	-	-
Physician	-	-	-	-
Ambulance	-	-	-	-
Flu Shot	-	-	-	-
Capitation	-	-	-	-
Equipment	(628,485.00)	299,028.01	(168,843.36)	54,670.25

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	Other
IV-5	Interest On Overdue Accounts		\$ 1,946		
Total Interest Income			\$ 1,946	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	Other
IV-8	Interest Income	\$ -		
IV-8	Rental Income	\$ -		
IV-8	Telehealth Services	\$ -		
IV-8	Federal Stimulus	\$ -		
IV-8	State COVID support	\$ -		
IV-8	Misc Income	\$ -		
IV-8				
Total Other Revenue		\$ -	\$ -	\$ -

G. Balance Sheet

Name of Facility 23 Fair Street Operations LLC	License No. 2416	Report for Year Ended 9/30/2024	Page 31	of 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)			\$	2,186,672
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(18,823)
4 Inventories			\$	28,805
5. Prepaid Expenses			\$	55,518
a. _____				
b. _____				
c. _____				
d. See Schedule 55,518				
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)			\$	2,255,643
B. Fixed Assets				
1. Land			\$	
2. Land Improvements			\$	9,396
*Historical Cost 58,954				
Accum. Depreciation 49,557 Net				
3. Buildings			\$	374,920
*Historical Cost 565,530				
Accum. Depreciation 190,609 Net				
4. Leasehold Improvements			\$	
*Historical Cost _____				
Accum. Depreciation _____ Net				
5. Non-Movable Equipment			\$	7,478
*Historical Cost 11,451				
Accum. Depreciation 3,973 Net				
6. Movable Equipment			\$	128,589
*Historical Cost 1,059,619				
Accum. Depreciation 931,030 Net				
7. Motor Vehicles			\$	
*Historical Cost _____				
Accum. Depreciation _____ Net				
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	520,384

* 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 Prop Taxes	\$ 13,473
31	A5	Prepaid Escrow Real Estate	\$ -
31	A5	Prepaid Escrow Insurance	\$ -
31	A5	Prepaid Escrow Replace Reserve	\$ -
31	A5	Prepaid Personal Property Tax	\$ 42,045
31	A5	Prepaid Expenses	\$ -
Total Prepaid Expenses			\$ 55,518

145040
145280
145290
145300
145310
145010

Schedule of Other Current Assets (Itemize) 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	Line D7	Elimination Intercompany	\$ -
32	Line D7	I/C Due to/Due From GHCLLC	\$ 65,202,576
32	Line D7	I/C Due to/Due From GHCLLC PR	\$ (48,098,581)
32	Line D7	I/C Due to/Due From GHCLLC A/P	\$ (20,940,177)
32	Line D7	I/C Due to/Due From GHCLLC EX	\$ (2,474)
32	Line D7	I/C Due to/Due From GHCLLC AR	\$ (5,923,774)
32	Line D7	I/C Due to/Due From GHCLLC IN	\$ (297,185)
32	Line D7	O L/T A Suspense	\$ -
32	Line D7	ROU Bldg Asset-Oper Lease	\$ -
32	Line D7	AccumAmort-ROU Bldg OprLease	\$ -
Total Other Assets			\$ (10,059,615)

Eliminatix 190010
I/C Due t 198000
I/C Due t 198010
I/C Due t 198020
I/C Due t 198030
I/C Due t 198040
I/C Due t 198050
O L/T A : 180050
ROU Bld 150510
AccumAu 150511

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	\$ 35,669
33	A12	Accr Exp Water and Sewer	\$ 5,153
33	A12	Accr Exp Gas	\$ 1,137
33	A12	Accr Exp Electricity	\$ 8,178
33	A12	Accr Exp Nursing Purchased Ser	\$ -
33	A12	Accr Exp Due to Prior Owner	\$ -
33	A12	Accr Exp Optum Pay Advance	\$ 2,600
33	A12	A/R Credit Gross Up Liability	\$ 176,575
33	A12	Accrued Provider/Bed Tax	\$ 151,665
33	A12	Accr Sales and Use Tax - FY18	\$ 0
33	A12	CP OprLease-Bldg Obligation	\$ -
33	A12	CP-Self Insurance WC Reserve	\$ 21,858
33	A12	CP-Self Insurance GLPL Reserve	\$ -
33	A12	Accr Exp Suspense	\$ -
Total Other Current Liabilities (Itemize)			\$ 402,835

Accr Exp 210010
Accr Exp 210090
Accr Exp 210100
Accr Exp 210110
Accr Exp 210310
Accr Exp 210330
Accr Exp 210430
A/R Crec 210345
Accrued 210350
Accr Sal 215418
CP OprL 227610
CP-Self I 220110
CP-Self I 220120
Accr Exp 210240

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

Page Ref	Line Ref	Description	
34	B4	LT OprLease-Bldg Obligation	\$ -
34	B4	LT WC Case Reserves	\$ 65,509
34	B4	LT GLPL Case Reserves	\$ -
34	B4	LT WC Insurance Recoveries	\$ 51,954
34	B4	LT GLPL Insurance Recoveries	\$ -
34	B4	LT WC Development	\$ 93,232
34	B4	LT GLPL Development	\$ -
34	B4	LT WC Discount	\$ (15,418)
34	B4	LT WC Gross-up to CP	\$ (21,858)
34	B4	LT GLPL Gross-up to CP	\$ -
34	B4-I	Escheatable Funds	\$ 9,896
Total Other Current Liabilities (Itemize)			\$ 183,314

LT OprL 276010
LT WC C 287110
LT GLPL 287120
LT WC li 287210
LT GLPL 287220
LT WC C 287310
LT GLPL 287320
LT WC C 287410
LT WC C 287510
LT GLPL 287520
Escheat 290060

G. Balance Sheet (cont'd)

Name of Facility 23 Fair Street Operations LLC	License No. 2416	Report for Year Ended 9/30/2024	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 2,776,026	
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>) _____ _____ See Schedule			\$ (10,059,615)	
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ (10,059,615)	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ (7,283,589)	

* 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 Street Operations LLC		License No. 2416		Report for Year Ended 9/30/2024		Page 33		of 37	
Account								Amount	
Liabilities									
A. Current Liabilities									
1. Trade Accounts Payable								\$	1,350,085
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>)								\$	188,899
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)								\$	
6. Accrued Payroll Taxes Payable								\$	1,452
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>)								\$	402,835

See Schedule									402,835
A-13. Total Current Liabilities (Lines A1 thru 12)								\$	1,943,271

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

G. Balance Sheet (cont'd)

Name of Facility 23 Fair Street Operations LLC		License No. 2416	Report for Year Ended 9/30/2024		Page 34	of 37	
Account					Amount		
Total Brought Forward:					1,943,271		
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>)					\$ 183,314		
See Schedule 183,314							
B-5. Total Long-Term Liabilities (Lines B1 thru 4)					\$ 183,314		
C. Total All Liabilities (Lines A-13 + B-5)					\$ 2,126,585		

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

Name of Facility 23 Fair Street Operations LLC	License No. 2416	Report for Year Ended 9/30/2024	Page 35	of 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			\$ (8,815,622)	
6. Gain or Loss for Period 10/1/2023 thru 9/30/2024			\$ (594,552)	
7. Total Net Worth			\$ (9,410,174)	
C. Total Reserves and Net Worth			\$ (9,410,174)	
D. Total Liabilities, Reserves, and Net Worth			\$ (7,283,589)	

H. Changes in Total Net Worth

Name of Facility 23 Fair Street Operations LLC	License No. 2416	Report for Year Ended 9/30/2024	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2023			\$	(10,357,214)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	13,438,763
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	12,491,723
D. Net Income or Deficit			\$	947,040
E. Balance			\$	(9,410,174)
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		09/30/24	\$	(9,410,174)

I. Preparer's/Reviewer's Certification

Name of Facility 23 Fair Street Operations LLC	License No. 2416	Report for Year Ended 9/30/2024	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> Home (CCNH) & RHNS Combined	<input type="checkbox"/> (Specify)	<input checked="" type="checkbox"/> Other		
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 in the Adjustments columns. 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	
1220 E Joppa Road Suite 318 Building B Towson MD 21286.			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				