State of Connecticut

15-8

Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed) 22 South Street Operations LLC, d/b/a Fox Hill center	
Address (No. & Street, City, State, Zip Code) 1253 Hartford Turnpike, Rockville, CT 06066	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2370			07-5183

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	000008029		

For Department Use Only

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	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 IMPRISIONMENT 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 22 South Street Operations LLC, d/b/a Fox Hill center [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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
				11/13/2015
Printed Name (Administrator) Person,Ginny Marie			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare	
Subscribed and Sworn to before me:	State of PA	Date 11/13/15	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
OLUSEGUN A. OMOLAJA, Notary Public
Upper Darby Twp., Delaware County
My Commission Expires May 28, 2017

Table of Contents

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	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 IMPRISIONMENT 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 22 South Street Operations LLC, d/b/a Fox Hill center [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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) Person,Ginny Marie			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1A Rev. 6/95

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility 22 South Street Operations LLC, d/b/a Fox Hill center	Period Covered:		From 10/1/2014	To 9/30/2015
Address of Facility 1253 Hartford Turnpike, Rockville, CT 06066				
Report Prepared By Thomas Farnan	Phone Number 978-247-5029		Date 12/21/2015	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$	451,808	451,808		
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$	4,150,834	4,150,834		
5. All other wages paid	$	579,733	579,733		
6. ***Total Wages Paid***	$	5,182,376	5,182,376		
7. Total salaries paid	$	261,944	261,944		
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	5,444,320	5,444,320		

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 10/2005

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-875-0771	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
22 South Street Operations LLC, d/b/a Fox Hill center	1253 Hartford Turnpike, Rockville, CT 06066

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2370			07-5183

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ◉ LLC ○ Partnership ○ Profit Corp. ○ Non-Profit Corp. ○ Government ○ 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? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Person,Ginny Marie	CT-1882

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox H	2370	9/30/2015	3A	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
22 South Street Operations LLC, d/b/a Fox Hill center	101 East State Street, Kennett Square, PA 19348	PA

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			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill ce	2370	9/30/2015	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	4	37

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 Health Ventures	101 East State Street, Kennett Square, PA 19348	⊙	○		Home Office	Pg 16/m12	512,527	512,527
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	⊙	○	63%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	1,069,484	1,069,484
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	⊙	○	55%	Staffing Pool	Pg 10/A12	7,168	7,168
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	⊙	○	85%	Case Management	Pg 13/B8, Pg 10/A12	61,200	61,200
Career Staffing	101 East State Street, Kennett Square, PA 19348	⊙	○		Staffing Pool	Pg 13/B11 a,b,c	8,650	8,650
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	⊙	○	43%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	111,730	111,730
Liberty Health (Insurance)	101 East State Street, Kennett Square, PA 19348	⊙	○		Insurance	Pg 27/14	164,333	164,333
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Capital Interest	Page 17, page 26-12A	49,635	49,635
		○	○					

* Use additional sheets if necessary.

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill	2370	9/30/2015	5	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 *(See listing page 13)*
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 9/2002

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	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
						Total ***	

Is a Mileage Log Book Maintained for All Leased Vehicles ? O Yes O No

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d	2370	9/30/2015	7	37

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	Address (No. & Street, City, State, Zip Code)
1 KPMG Peat Marwick	1600 Market Street, Philadelphia, PA 19103
2	
3	
4	

Services Provided by This Firm (*describe fully*)

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

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

○ Yes ⊙ No

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Bloom & Witkin	617-456-0500
2 Ellington Probate Court	860-872-0519
3 Wiggin And Dana LLP	
4	
5	

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

1 175 Federal Street Boston, MA 02110
2 14 Park Place, Vernon CT 06066-0268
3 130 Union St P.O. Box 388 Rockville, CT 06066
4
5

Services Provided by This Firm (*describe fully*)

1	Real Estate Tax Abatement-reduced the assessment values of Real Estate Tax	$
2	Probate Court Fee	$
3	Probate Court Regarding Uncollectable Accounts	$
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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	8	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	150	150			150	150			150	150		
B. On last day of THIS report period	150	150			150	150			150	150		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	116	116			116	116			114	114		
B. As of midnight of THIS report period	119	119			114	114			119	119		
3. Total Number of Days Care Provided During Period												
A. Medicare	7,384	7,384			5,372	5,372			2,012	2,012		
B. Medicaid (Conn.)	28,849	28,849			21,795	21,795			7,054	7,054		
C. Medicaid (other states)												
D. Private Pay	4,544	4,544			3,220	3,220			1,324	1,324		
E. State SSI for RCH												
F. Other (Specify)	2,283	2,283			1,816	1,816			467	467		
G. Total Care Days During Period (3A thru F)	43,060	43,060			32,203	32,203			10,857	10,857		
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	5	5			4	4			1	1		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	43,065	43,065			32,207	32,207			10,858	10,858		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox H	2370	9/30/2015	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ◉ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID
No. of Residents	21	74		24				
Per Diem Rate								
a. One bed rm.				375.00				
b. Two bed rms.	495.32	190.56		368.01				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	4,630	4,630		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	894	894		
C. Other	21,173	21,173		
D. ***Total Physical Therapy Treatments***	26,697	26,697		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	391	391		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	49	49		
C. Other	1,724	1,724		
D. ***Total Speech Therapy Treatments***	2,164	2,164		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,628	3,628		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	683	683		
C. Other	20,843	20,843		
D. ***Total Occupational Therapy Treatments***	25,154	25,154		

State of Connecticut
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
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

Item	Total Cost and Hours					
	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)	109,284	2,126				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	212,985	9,440				
5. Dietary Service						
a. Head Dietitian	44,995	1,266				
b. Food Service Supervisor	47,421	1,967				
c. Dietary Workers	359,392	25,374				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	49,429	1,934				
b. Other Maintenance Workers	26,218	1,611				
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	152,660	3,322				
b. RN						
1. Direct Care	1,098,701	30,068				
2. Administrative**	183,870	4,921				
c. LPN						
1. Direct Care	1,163,282	37,371				
2. Administrative**						
d. Aides and Attendants	1,638,598	101,461				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	146,024	7,456				
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	145,077	5,688				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	66,383	3,621				
A-13. Total Salary Expenditures	5,444,320	237,627				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
*** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

Position		CCNH $	CCNH Hours	RHNS $	RHNS Hours	(Specify) $	(Specify) Hours
Ward Clerks	0	9235	453			0	0
Central Supply	0	33407	1639			0	0
Medical Records	0	21715	1439			0	0
Coordinator-Staffing Centers	0	2025	90			0	0
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
0	0	0	0				
Total		66383	3621	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

Service		CCNH $	CCNH Hours	RHNS $	RHNS Hours	(Specify) $	(Specify) Hours
1020620010	Consulting Fees	148.85	n/a			-	
1020620010	Consulting Fees	409.70	n/a				
3010620020	Purchased Services	520.00	n/a				
3015620020	Purchased Services	12,916.46	n/a				
3155620020	Purchased Services	(60.85)	n/a				
3155620020	Purchased Services	64,020.55	n/a				
1020620010	Consulting Fees	220.88	n/a				
0	0	-	-				
0							
0							
0							
Total		78176	0	$ -	-	$ -	-

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-11 Rev. 10/2005

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
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	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* **										
Person,Ginny Marie	109,284				Management of Center	2,126	2			
Section IV - Assistant Administrators										

*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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill cent	2370	9/30/2015	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	1,018	28				
2. Dentist	15,120	104				
3. Pharmacist	11,106	227				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	965,855	13,231				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	73,492	389				
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	36,028	462				
b. Other						
10. Occupational Therapist						
a. Resident Care	115,506	1,582				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	646	11				
2. Administrative***						
b. LPN						
1. Direct Care	8,217	194				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	78,176					
B-13 Total Fees Paid in Lieu of Salaries	1,305,164	16,226				

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Genesis Eldercare Hospitality Services, 101 East State Street, Kennett Square, PA 19348	Dietary Services	⊙	○	Common Ownership
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	⊙	○	Common Ownership
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	⊙	○	Common Ownership
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	⊙	○	Common Ownership
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	⊙	○	Common Ownership
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill ce	2370	9/30/2015	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	182,805	182,805		
2. Disability Insurance	$				
3. Unemployment Insurance	$	112,672	112,672		
4. Social Security (F.I.C.A.)	$	393,846	393,846		
5. Health Insurance	$	615,924	615,924		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$				
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	68,888	68,888		
d. Accounting and Auditing	$				
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	48,961	48,961		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	19,188	19,188		
2. Cellular Phones	$	86	86		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*) See Attached Schedule	$	460	460		
3. Resident Day User Fee	$	716,236	716,236		
Subtotal	$	2,159,066	2,159,066		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description		CCNH	RHNS	(Specify)
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
Total		$ -	$ -	$ -

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	460.00	0	0
1020640110	Sales Tax	-	0	0
0	0	0	0	0
0	0	-		
Total		$ 460	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,159,066	2,159,066		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	700	700		
5. Education Expenses Related to Seminars and Conventions	$	80	80		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	10,685	10,685		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	7,518	7,518		
4. Fund-Raising***	$				
5. Medical Records	$	251	251		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	3,702	3,702		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	9,601	9,601		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	425	425		
9. Subscriptions	$	1,145	1,145		
10. Contributions*** See Attached Schedule	$	2,474	2,474		
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual*)	$	4,711	4,711		
12. Administrative Management Services**	$	511,340	511,340		
13. Other (*Specify*) See Attached Schedule	$	31,104	31,104		
C-14 Total Administrative & General Expenditures	$	2,742,803	2,742,803		

* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

Description		CCNH	RHNS	(Specify)
				0
				0
				0
				0
				0
				0
Total Other Travel and Entertainment		$ -	$ -	$ -

Schedule of Other Advertising

Description		CCNH	RHNS	(Specify)
1020630020	Advertising	609.5	0	0
1020630020	Advertising	384.88	0	0
1020630020	Advertising	1015.57	0	0
1020630330	Marketing Expense	3957.1	0	0
1020630330	Marketing Expense	25.57	0	0
1020630330	Marketing Expense	138.66	0	0
3165630330	Marketing Expense	-739	0	0
1020630331	Marketing Exp- Corp	585.06	0	0
1020630331	Marketing Exp- Corp	1540.72	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
Total Other Advertising		$ 7,518	$ -	$ -

Schedule of Dues

Description		CCNH	RHNS	(Specify)
1020630310	Connecticut Associati	8,235.61	0	0
1020630310	North Central District	175.00	0	0
1020630310	State of Connecticut	1,190.00	0	0
1020630310	0	-	0	0
1020630310	0	-	0	0
1020630310	0	-	0	0
1020630310	0	-	0	0
0	0	0	0	0
Schedule of Other Administrative and Genera	0	0	0	0
Total Dues		$ 9,601	$ -	$ -

Schedule of Contributions

Description		CCNH	RHNS	(Specify)
1020630130	Contributions	412.5	0	0
1020630135	Political Contribution	2061.35	0	0
0	0	0	0	0
Total Contributions		$ 2,474	$ -	$ -

Schedule of Other Administrative and General

Description		CCNH	RHNS	(Specify)
1020630060	Bank Service Charges	5,733.54	0	0
1020630120	Collection Fees	22.97	self-disallowed	0
1020630120	Collection Fees	66.38	self-disallowed	0
1020630140	Education Expense	78.94	0	0
1020630140	Education Expense	38.89	0	0
1020630180	Employee Physicals	10,629.35	0	0
1020630200	Employee Relations	5,798.26	0	0
1020630200	Employee Relations	212.10	0	0
1020630380	Printing	31.76	0	0
1020630380	Printing	20.56	0	0
1020630380	Printing	161.36	0	0
1020630610	Training Expense	1,208.99	0	0
1020630610	Training Expense	84.03	0	0
1020630610	Training Expense	652.20	0	0
1020630640	Uniforms	613.60	0	0
1020640090	Miscellaneous	(2.96)	0	0
1020660080	Rental Expense	4,004.29	0	0
1020660990	Accrued Expense Esti	517.53	self-disallowed	0
5095720020	Cap Stk/Franchise Ta	175.08	0	0
1020630200	Employee Relations	50	0	0
1020630120	Collection Fees	1007.5	self-disallowed	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
Total Other Administrative and General		$ 31,104	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility 22 South Street Operations LLC, d/b/a Fo	License No. 2370	Report for Year Ended 9/30/2015	Page 17 | of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	512,527	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	49,635	Capital Interest	pg 26 12-A-1

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 9/2002

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
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	208,762	208,762		
2. Non-Food Supplies	$	22,560	22,560		
3. Other (*Specify*) _____	$	(7,800)	(7,800)		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	3,379	3,379		
c. Management Services**	$				
d. Other (*Specify*) _____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	226,901	226,901		

		Total	CCNH	RHNS	(Specify)
2F.	Dietary Questionnaire				
G.	Resident Meals: Total no. of meals served per day:*				

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 9/2002

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
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	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. $	5,389	5,389		
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. $	18,318	18,318		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	150,086	150,086		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	173,793	173,793		

3F. Laundry Questionnaire			
G. Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
H. Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K. Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3E.

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

*** Pounds of Laundry only required for multi-level facilities.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 9/2002

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
22 South Street Operations LLC, d/b/a Fox Hill	2370	9/30/2015	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	24,534	24,534		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	222,900	222,900		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	247,434	247,434		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	387,452	387,452		
b. Medicine Cabinet Drugs		$	29,386	29,386		
c. Medical and Therapeutic Supplies		$	135,426	135,426		
d. Ambulance/Limousine***		$	7,321	7,321		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	22,234	22,234		
f. X-rays and Related Radiological Procedures***		$	12,506	12,506		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	28,836	28,836		
i. Recreation		$	51,661	51,661		
j. Other (Specify)**** See Attached Schedule		$	95,045	95,045		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	769,866	769,866		

* 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.

22 South Street Operations LLC, d/b/a Fox Hill center
9/30/2015

Schedule of Other Resident Care

Description		CCNH	RHNS	(Specify)
3060610160	Incontinency	43730.05	0	0
3060610161	Incontinency - Rebates	-2901.03	0	0
3080630030	Advertising-Help Wan	784.51	0	0
3080630140	Education Expense	807.38	0	0
3080630140	Education Expense	155.71	0	0
3080630140	Education Expense	604.36	0	0
3080630310	Licenses & Certificatio	177	0	0
3120630530	Supplies	2520.21	0	0
3155630530	Supplies	11205.86	0	0
3155630530	Supplies	12668.28	0	0
3090630535	Office Supplies	4116.18	0	0
3120630535	Office Supplies	70.19	0	0
3080630550	T&E-Lodging/Transpo	185.15	0	0
3120660080	Rental Expense	2622	0	0
3120660080	Rental Expense	1682.52	0	0
3155660080	Rental Expense	17.09	0	0
3155660080	Rental Expense	13035.7	0	0
3010610300	Consolidated Billing	3563.8	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
			0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
Total Other Resident Care		$ 95,045	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	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	⊙	○	Vendor Contracted	Laundry Purchased Services	150,086			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	⊙	○	Vendor Contracted	Housekeeping Purchased Services	222,900			20	4b
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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).

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
22 South Street Operations LLC, d/b/a Fox Hi	2370	9/30/2015	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	168,802	168,802		
b. Heat	$	130,588	130,588		
c. Light & Power	$	135,939	135,939		
d. Water	$	51,702	51,702		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	487,032	487,032		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	475	475		
b. Building & Building Improvements	$	349,749	349,749		
c. Non-Movable Equipment	$	28,505	28,505		
d. Movable Equipment	$	59,851	59,851		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	438,581	438,581		
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	$	717,614	717,614		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	63,025	63,025		
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,219,220	1,219,220		

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	23	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	4,754		4,754	293	S/L	Various	475	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								475
B. **Building and Building Improvements**								
1. Acquired prior to this report period	6,393,398		6,393,398	923,542	S/L	Various	347,892	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	40,105		40,105				1,857	
B-4. Subtotal								349,749
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	150,018		150,018	79,613	S/L	Various	28,409	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	4,804		4,804				96	
C-4. Subtotal								28,505

	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					367,928		367,928	199,801	S/L	Various	57,724	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					44,871		44,871				2,127	
D-3. Subtotal												59,851
E. *Total Depreciation*												438,580

22 South Street Operations LLC, d/b/a Fox Hill center
9/30/2015

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
1/0/1900	1/0/1900	0	0	0	
1/0/1900	1/0/1900	0	0	0	
		0	0	0	
		0	0	0	
		0	0	0	
		0	0	0	
Total additions for Land Improvements		0		0	*
Deletions:					
		0.00	0.00	0.00	
		0.00	0.00	0.00	
		0.00	0.00	0.00	
		0.00	0.00	0.00	
		0.00	0.00	0.00	
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:				
2/28/2015	Grease trap manhole install	7,200.00	20.00	210.00
3/31/2015	(2) 30 amp circuits and (2) L5-30 rec	1,200.00	20.00	30.00
9/30/2015	Wiring and wrap around LED fixtures	1,935.00	20.00	-
11/30/2014	7 exterior steel doors	27,579.18	15.00	1,532.18
2/28/2015	Exterior doors and frames	2,190.81	15.00	85.20

Total additions for Building Improvements		$ 40,105		$ 1,857	*
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:					
6/30/2015	1st install on kitchen A/C compressor	1,950.00	10.00	48.75	
7/31/2015	Compressor for kitchen A/C	1,950.00	10.00	32.50	
7/31/2015	Parts and labor for drainage work	903.98	10.00	15.07	
Total additions for Non-Movable Equipment		$ 4,804		$ 96	*
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	Cost	Useful Life	Depreciation
Additions:				
3/31/2015	Sales and Use Tax March 2015	457.00	7.00	32.64
6/30/2015	2 Attendant Vital Signs Monitors and	4,302.39	7.00	153.66
7/31/2015	Wired up 2 new washers in laundry ro	553.02	7.00	13.17
7/31/2015	2 bases for washers	638.10	7.00	15.19
9/30/2015	GE Zoneline PTAC Resistance He	1,280.08	7.00	-
9/30/2015	2 UniMac washers	26,078.00	7.00	-
12/31/2014	1.6 cu ft medical grade refrigerator	527.54	10.00	39.57

3/31/2015	Maxwell Thomas, Overbed Table,	457.45	10.00	22.87	
6/30/2015	Countertop Ice Nug Maker/Disp	3,188.35	10.00	79.71	
12/31/2014	20 MATTRESS,GENESIS VISCO	6,512.03	3.00	1,628.01	
2/28/2015	Two Way Radio,VHF,5 Watts,10 C	366.83	3.00	71.33	
4/30/2015	Infocus projector	509.86	3.00	70.81	
Total additions for Movable Equipment		$ 44,871		$ 2,127	*
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**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	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
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a	2370	9/30/2015	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ No

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	150
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
Healthcare REIT, Inc	Building and Equipment	04/01/11	20	717,614
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended			Page of
22 South Street Operations LLC, d/b/a	2370	9/30/2015			26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	49,635	49,635		
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)	$	49,635	49,635		

(Carry Subtotals forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/	2370	9/30/2015	27	37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	49,635	49,635		
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) $	49,635	49,635		
14. Insurance				
a. Insurance on Property (buildings only) $	7,543	7,543		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	156,790	156,790		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	164,333	164,333		
15. ***Total All Expenditures (A-13 thru C-14)*** $	12,830,500	12,830,500		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2002

D. Adjustments to Statement of Expenditures

Name of Facility 22 South Street Operations LLC, d/b/a Fox Hill center				License No. 2370	Report for Year Ended 9/30/2015		Page 28 of 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 $	23,188	23,188		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians ** $				
6.		B-10	Occupational Therapy $				
7.			Other - See attached Schedule $	1,194,785	1,194,785		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1-c	Bad Debts $	68,888	68,888		
10.			Accounting & 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 * $	7,518	7,518		
~~19.~~	~~—~~	~~—~~	~~Income Tax / Corporate Business Tax $~~				
20.			Fund Raising / Contributions $	2,474	2,474		
21.			Unallowable Management Fees $	560,975	560,975		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	2,039	2,039		
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) $	1,859,867	1,859,867		

* 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	0	23188	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
Total Other Salaries Adjustment				$ 23,188	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	139007.1	0	0
13	5	Rehabilitation Services	3195620020	826847.53	0	0
13	9	Speech Therapist	3170620020	36028.02	0	0
13	10	Occupational Therapist	3105620020	115506.39	0	0
13	12	Other	3010620020	520	0	0
13	12	Other	3015620020	12916.46	0	0
13	12	Respiratory Purchased Servies	3155620020	63959.7	0	0
					0	0
					0	0
					0	0
					0	0
					0	0
Total Other Fees Adjustments				$ 1,194,785	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	1020630120	1096.85	0	0
16	m-13	Estimated Accrual	1020660990	517.53	0	0
16	m-13	Non-recurring Charges	7010800030	0	0	0
16	m-13	Dues to Chamber of Commerce	0	425	0	0
16	m-13	Penalty	1020640080	0	0	0
16	m-12	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
Total Other A&G Adjustments				$ 2,039	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 10/2006

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

Name of Facility	License No.	Report for Year Ended	Page of
22 South Street Operations LLC, d/b/a Fox Hill center	2370	9/30/2015	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	1,859,867	1,859,867		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs $	387,452	387,452		
28.	20	5-d	Ambulance/Limousine $	7,321	7,321		
29.	20	5-f	X-rays, etc $	12,506	12,506		
30.	20	5-h	Laboratory $	28,836	28,836		
31.			Medical Supplies $				
32.	20	5-e-2	Oxygen (non emergency) $	22,234	22,234		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	82,234	82,234		
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.			Research or Experimental Activities $				
43.			Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $	120,042	120,042		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			***Total Amount of Decrease (Items 1 - 50)*** $	2,520,492	2,520,492		

*** 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.

Attachment Page 29

22 South Street Operations LLC, d/b/a Fox Hill center
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	3563.8	3010610300	0
20	5-j	Respiratory Supplies	23874.14	3155630530	0
20	5-j	Respiratory Rental	13052.79	3155660080	0
20	5-i	Cable TV	41742.96	3005660130	allow $3600
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Other Ancillary Costs			$ 82,234	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14c1	General liability Insurance Adjust	120042.2895	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Other Adjustments			$ 120,042	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0-Jan	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Unallowable Building Interest			$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a F(	2370	9/30/2015	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	10,410,973	10,410,973		
b. Medicaid Room and Board Contractual Allowance **	$	(4,986,453)	(4,986,453)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,930,877	2,930,877		
b. Medicare Room and Board Contractual Allowance **	$	(874,758)	(874,758)		
4. a. Private-Pay Residents and Other	$	2,567,051	2,567,051		
b. Private-Pay Room and Board Contractual Allowance **	$	(472,929)	(472,929)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	312,807	312,807		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(93,361)	(93,361)		
c. Prescription Drugs - Non-Medicare	$	120,576	120,576		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(24,424)	(24,424)		
2. a. Medical Supplies - Medicare	$	38	38		
b. Medical Supplies - Medicare Contractual Allowance **	$	(11)	(11)		
c. Medical Supplies - Non-Medicare	$	205	205		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(55)	(55)		
3. a. Physical Therapy - Medicare	$	1,027,249	1,027,249		
b. Physical Therapy - Medicare Contractual Allowance **	$	(306,596)	(306,596)		
c. Physical Therapy - Non-Medicare	$	306,528	306,528		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(70,629)	(70,629)		
4. a. Speech Therapy - Medicare	$	167,260	167,260		
b. Speech Therapy - Medicare Contractual Allowance **	$	(49,921)	(49,921)		
c. Speech Therapy - Non-Medicare	$	49,425	49,425		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(10,715)	(10,715)		
5. a. Occupational Therapy - Medicare	$	1,045,135	1,045,135		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(311,934)	(311,934)		
c. Occupational Therapy - Non-Medicare	$	322,402	322,402		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(71,907)	(71,907)		
6. a. Other *(Specify)* - Medicare	$	79,973	79,973		
b. Other *(Specify)* - Non-Medicare	$	153,361	153,361		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	12,220,167	12,220,167		
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	$	3,984	3,984		
5. Interest Income *(Specify)*	$	458	458		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	17,628	17,628		
8. Other (*Specify*)	$	1,965	1,965		
*V. **Total Other Revenue*** (1 thru 8)	$	24,036	24,036		
*VI. **Total All Revenue*** (III +V)	$	12,244,203	12,244,203		

* *Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.*

** *Facility should report all contractual allowances and/or payer discounts.*

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-a	Medicare	X-Ray	9,757.36	-	0
II-6-a	Medicare	Laboratory	19,714.00	-	0
II-6-a	Medicare	Respiratory Therapy & Supplie	73,637.77	-	0
II-6-a	Medicare	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare	Audiology	-	-	0
II-6-a	Medicare	Incontinency	-	-	0
II-6-a	Medicare	Oxygen & Supplies	6,982.20	-	0
II-6-a	Medicare	Physician Visit	-	-	0
II-6-a	Medicare	Ambulance	-	-	0
II-6-a	Medicare	Flu Shot	3,905.00	-	0
II-6-a	Medicare Contractual	X-Ray	(2,912.21)	-	0
II-6-a	Medicare Contractual	Laboratory	(5,883.90)	-	0
II-6-a	Medicare Contractual	Respiratory Therapy & Supplie	(21,978.15)	-	0
II-6-a	Medicare Contractual	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare Contractual	Audiology	-	-	0
II-6-a	Medicare Contractual	Incontinency	-	-	0
II-6-a	Medicare Contractual	Oxygen & Supplies	(2,083.93)	-	0
II-6-a	Medicare Contractual	Physician Visit	-	-	0
II-6-a	Medicare Contractual	Ambulance	-	-	0
II-6-a	Medicare Contractual	Flu Shot	(1,165.50)	-	0
Total Other Resident Revenue - Medicare			$ 79,973	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	800.81	-	0
II-6-b	Medicaid	Laboratory	900.20	-	0
II-6-b	Medicaid	Respiratory Therapy & Supplie	8,190.19	-	0
II-6-b	Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Medicaid	Audiology	-	-	0
II-6-b	Medicaid	Incontinency	-	-	0
II-6-b	Medicaid	Oxygen & Supplies	6,555.00	-	0
II-6-b	Medicaid	Physician Visit	-	-	0
II-6-b	Medicaid	Ambulance	-	-	0
II-6-b	Medicaid	Flu Shot	-	-	0
II-6-b	Contractuals-Medicaid	X-Ray	(383.56)	-	0
II-6-b	Contractuals-Medicaid	Laboratory	(431.16)	-	0
II-6-b	Contractuals-Medicaid	Respiratory Therapy & Supplie	(3,922.78)	-	0
II-6-b	Contractuals-Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Contractuals-Medicaid	Audiology	-	-	0
II-6-b	Contractuals-Medicaid	Incontinency	-	-	0
II-6-b	Contractuals-Medicaid	Oxygen & Supplies	(3,139.59)	-	0
II-6-b	Contractuals-Medicaid	Physician Visit	-	-	0
II-6-b	Contractuals-Medicaid	Ambulance	-	-	0
II-6-b	Contractuals-Medicaid	Flu Shot	-	-	0
II-6-b	Non-Medicaid	X-Ray	1,897.19	-	0

II-6-b	Non-Medicaid	Laboratory	4,243.65	-	0
II-6-b	Non-Medicaid	Respiratory Therapy & Supplie	23,629.51	-	0
II-6-b	Non-Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Non-Medicaid	Audiology	-	-	0
II-6-b	Non-Medicaid	Incontinency	-	-	0
II-6-b	Non-Medicaid	Oxygen & Supplies	3,186.30	-	0
II-6-b	Non-Medicaid	Physician Visit	-	-	0
II-6-b	Non-Medicaid	Ambulance	-	-	0
II-6-b	Non-Medicaid	Flu Shot	-	-	0
II-6-b	Non-Medicaid	Capitation Contracts	144,535.00	-	0
II-6-b	Contractuals-Non-Medicaid	X-Ray	(349.52)	-	0
II-6-b	Contractuals-Non-Medicaid	Laboratory	(781.81)	-	0
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplie	(4,353.28)	-	0
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Contractuals-Non-Medicaid	Audiology	-	-	0
II-6-b	Contractuals-Non-Medicaid	Incontinency	-	-	0
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplies	(587.01)	-	0
II-6-b	Contractuals-Non-Medicaid	Physician Visit	-	-	0
II-6-b	Contractuals-Non-Medicaid	Ambulance	-	-	0
II-6-b	Contractuals-Non-Medicaid	Capitation Contracts	(26,627.77)	-	0
Total Other Resident Revenue			$ 153,361	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Accou	0	458.46	-	-
0	0	0	-	-	-
0	0	0	-	-	-
Total Interest Income			$ 458	$ -	$ -

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
IV-8	donation	0	318.15	0	0
IV-8	Medical Record	0	1,647.00	0	0
Total Other Revenue			$ 1,965	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a	2370	9/30/2015	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 4,549
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,377,684
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 2,411
4 Inventories				$ 81,024
5. Prepaid Expenses				$ 16,101
a. Prepaid Expenses				
b. Prepaid Property Tax		12,273		
c. Prepaid Personal Property Tax				
d. Prepaid Personal Property Tax		3,828		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,481,770
B. Fixed Assets				
1. Land				$ 1,080,000
2. Land Improvements	*Historical Cost	4,754		$ 3,985
	Accum. Depreciation	769	Net	
3. Buildings	*Historical Cost	6,433,503		$ 5,160,212
	Accum. Depreciation	1,273,291	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	154,822		$ 46,703
	Accum. Depreciation	108,119	Net	
6. Movable Equipment	*Historical Cost	412,799		$ 153,147
	Accum. Depreciation	259,652	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 6,444,047

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a F	2370	9/30/2015	32	37

Account				Amount
			Total Brought Forward:	$ 7,925,817
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 (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 505,941
I/C Due to/Due From Owned		505,941		
I/C Due to/Due From Multicare				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 505,941
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 8,431,757

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox Hil	2370	9/30/2015	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 407,667
2. Notes Payable (*itemize*)					$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll(*Exclusive of Owners and/or Stockholders only*)					$ 217,221
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 527,553
Accrued Provider/Bed Tax	177,220	Accr Exp Electricity	6,352		
Accr Exp Other	3,635	Deferred Revenue	45,926		
Accr Exp Water and Sewer	23,672	Accr Exp Suspense	(1,665)		
Accr Exp Gas	721	A/R Credit Gross Up Lia	271,692		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 1,152,441

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox	2370	9/30/2015	34	37

Account	Amount
Total Brought Forward:	1,152,441
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 6,816,058
LT Debt-Financing Obligation	6,816,058	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 6,816,058
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 7,968,499

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a	2370	9/30/2015	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 *(equity)*		$
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		$ 2,096,903
4. Treasury Stock		$
5. Cumulated Earnings		$ (1,047,343)
6. Gain or Loss for Period	10/1/2014 thru 9/30/2015	$ (586,302)
7. Total Net Worth		$ 463,258
C. ***Total Reserves and Net Worth***		$ 463,258
D. ***Total Liabilities, Reserves, and Net Worth***		$ 8,431,757

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fo	2370	9/30/2015	36	37

Account		Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014	$ 1,049,557
B.	Total Revenue (*From Statement of Revenue Page 30*)	$ 12,244,202
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$ 12,830,501
D.	Net Income or Deficit	$ (586,299)
E.	Balance	$ 463,258
F.	Additions	
	1. Additional Capital Contributed (*itemize*)	
	2. Other (*itemize*)	
F-3.	Total Additions	$
G.	Deductions	
	1. Drawings of Owners/Operators/Partners (*Specify*)	$

Name and Address (*No., City, State, Zip*)	Title	Amount

	2. Other Withdrawings (*Specify*)	$

Purpose	Amount

	3. Total Deductions	$
H.	***Balance at End of Period*** 09/30/15	$ 463,258

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
22 South Street Operations LLC, d/b/a Fox	2370	9/30/2015	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Thomas Faman	Sr. Director of Reimbursement	12/28/2015

Printed Name of Preparer

Thomas Faman Title -Sr. Director of Reimbursement

Addres Address	Phone Number
200 Brickstone Square, Andover, MA 01810	978-247-5029