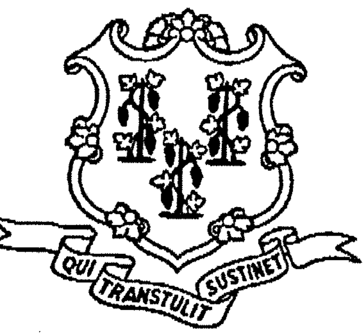
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Maefair Health Care Center	
Address (No. & Street, City, State, Zip Code) 21 Maefair Court Trumbull, CT 06611	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2142C			07-5404

Medicaid Provider Numbers:	CCNH	RHNS	ICF-MR
	2142C		

For Department Use Only

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

December 11, 2013

Mr. Michael E. Mosier
Chief Financial Officer
Athena Health Care Systems
135 South Road
Farmington, CT 06032

Subject: Alternative Annual Report Approval

Dear Mr. Mosier:

This letter is a follow-up to your verbal approval regarding your request for alternative annual report utilization. We have reviewed your request for approval of the Athena Health Care Systems version of the 2013 Annual Report for the State of Connecticut. Based on our review, your version of the annual report has been approved.

It is not necessary to request approval on an annual basis. This approval will remain in effect until modifications have been made to the Annual Report by the Department of Social Services. The provider community will be notified should such changes occur. At that time, you will be required to submit a new request for approval based on the modified annual report.

Should you have any questions, please feel free to contact me at (860) 687-0790.

Sincerely,

Brittany L. Hester, Administrative Assistant

CC: Claudette B. Pickens, CPA
CC: Chris Lavigne

7 Waterside Crossing, Ste 202 | Windsor, CT 06095
PH 860.687.0790 | PH 855.716.9377 | FX 860.687.0810
www.mslc.com

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2017**	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 **Maefair Health Care Center** [facility name] for the cost report period beginning **October 01, 2016** and ending **September 30, 2017**, 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 penalities 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
Terri Golec				
Printed Name (Administrator) **Terri Golec**			Printed Name (Owner) **Lawrence Santilli**	
Subscribed and Sworn to before me:	State of CT	Date 2-9-18	Signed (Notary Public) Tina Leopold	Comm. Expires 6/30/21
Address of Notary Public			505 Penfield Hill Rd Portland, CT 06480	

(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 **Maefair Health Care Center**		Period Covered:		From **10/1/2016**	To **9/30/2017**
Address of Facility **21 Maefair Court Trumbull, CT 06611**					
Report Prepared By **Athena Health Care Associates, Inc**		Phone Number **(860) 751-3900**		Date **2/9/2018**	
Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid............	$				
2. Laundry wages paid............	$				
3. Housekeeping wages paid............	$				
4. Nursing wages paid............	$				
5. All other wages paid............	$				
6. ***Total Wages Paid***	$				
7. Total salaries paid............	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$				

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.

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CSP-2 Rev. 10/2005

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-459-5152	**09/30/17**	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Maefair Health Care Center	**21 Maefair Court Trumbull, CT 06611**

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2142C			**07-5404**

Type of Facility (Check appropriate box(es))

- [x] Chronic and Convalescent Nursing Home only (CCNH)
- [ ] Rest Home with Nursing Supervision only (RHNS)
- [ ] (Specify)

Type of Ownership (Check appropriate box)

- [ ] PROPRIETORSHIP
- [ ] LLC
- [ ] PARTNERSHIP
- [x] 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 [x] No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Terri Golec	**000979**

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

Name	License No.:
Not Applicable	

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CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2017**	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
Not Applicable			

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CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2017	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
Maefair Health Care Center, Inc	**21 Maefair Court, Trumbull, CT 06611**	**CT**

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G. Santilli	**21 Maefair Court, Trumbull, CT 06611**	**President**	**880.1015**
Debra M Soucey	**21 Maefair Court, Trumbull, CT 06611**	**Secretary**	
Michael E. Mosier	**21 Maefair Court, Trumbull, CT 06611**	**Treasurer**	
Names of Stockholders Owning at Least 10% of Shares			
Other than noted above:			
Conservators for Lawrence E. Santilli	**21 Maefair Court, Trumbull, CT 06611**		**119.8985**

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CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2017**	3B	37

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

Owner(s) of Facility
Not Applicable

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2017	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	%**				
Shady Knoll Health Care Center	41 Skokorat Street Seymour, CT 06483	☑	☐	>98%	Interest allocation exchange	Page 27, 12D	$2,032	$2,032
Laurel Ridge Health Care Center	642 Danbury Road Ridgefield, CT 06877	☑	☐	>98%	Bank Fees	Pg 16m13	$8,750	$8,750
Athena Health Care Systems	135 South Road, Farmington, CT 06032	☑	☐	>98%	see attached			
Maefair Landlord, LLC	135 South Rd, Farmington, CT	☐	☑		lease of facility	Pg 22, Ln 9 and 10b, pg 27, Ln 14a	$1,339,876	$1,339,876
Miscellaneous Facilities	various	☑	☐	>98%	Interfacility Loans	Pg 33, A2		
		☐	☐					
		☐	☐					
		☐	☐					
		☐	☐					

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.

Maefair Health Care
RELATED PARTIES
PAGE 4

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No	%**				
Athena Health Care Systems	135 South Road Farmington, CT 06032	X		>50%	Management, Legal, Marketing, Bank Fees, A/R, MIS, mortgage fees, Insurance, Lobbying, Health Insurance Bank Charges, LOC Interest, payroll processing fees Computer conversion, data processing employee relations maintenance & repairs Nursing consulting	Pg 15, 1e & 1g, 1a5 Pg 16, m3, m13, Pg 17 Pg 27, 12D & 14a, Pg 16, L2 Pg 16, m13 pg 23 D2c, pg 16 m13 pg 16 L3 pg 22, 6a pg 13, B5 & B11	$733,123	$291,937
Athena Health Care Systems 401(k) plan	135 South Road Farmington, CT 06032	X		>50%	Facility Participates in a multi-facility 401 (k) plan			
Athena Captive LLC	135 South Road Farmington, CT 06032		X		Workers Comp Captive	Pg 15, L1a	$559,786	$559,786
Athena Health Care Insuranece	135 South Road		X		Health Insurance	Pg 15, 1a5	$1,528,049	$1,528,049

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2017**	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.

Not Applicable

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

Not Applicable

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.

Not Applicable:No Non-Nursing Home Cost Centers

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
Maefair Health Care Center	2142C	9/30/2017	6 of 37

Name and Address of Lessor	Related * to Owners, Operators, Officers: Yes	Related * to Owners, Operators, Officers: No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	☐	☑	Postal Equipment	11/22/13	Annual renewal	$1,099	$1,099
Hewlett Packard Financial Services, PO Box 402582, Atlanta, GA	☐	☑	PCC Equipment	07/18/13	60 months	$7,125	$6,531
LEAF Capital Funding, LLC PO Box 979127, Miami, FL 33197-9127	☐	☑	Copier System	02/25/16	48 months	$15,314	$15,314
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
						Total ***	$22,944

Is a Mileage Log Book Maintained for All Leased Vehicles ? **Not Applicable - No Vehicles** ☐ Yes ☐ 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.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2017	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	**Dworkin, Hilman, LaMorte & Sterczala**	**Four Corporate Dr, Shelton, CT**
2	**Marcum LLP**	**555 Long Wharf Drive, New Haven, CT**
3		
4		

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	2017 Audit, Yearend financials & tax returns	$ 9,500
2	Preparation of Medicare Cost report	$ 2,700
3		$ -
4		$ -
	Charge for Services Provided	$12,200

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

☑ Yes ☐ No **Pg 15, Line1d**

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	**Goldman, Gruder & Woods**	**203-899-8900**
2	**Trumbull Probate**	**203-452-5068**
3	**Murtha Cullina**	**860-240-6000**
4	**Shipman & Goodwin**	**860-251-5000**
5	**Schiff Hardin, LLP**	

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

1 **200 Connecticut Ave. Norwalk, CT**
2 **5866 Main Street, Trumbull, CT**
3 **185 Asylum Street, Hartford, CT**
4 **One Constitution Plaza, Hartford, CT**
5

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	Collections:Disallowed	$ 9,176
2	Conservator:Disallow	$ 600
3	Audit Letter/Annual filing: Allow ($333), Professional Services: Disallow ($563)	$ 896
4	Employee Matters: Disallow	$ 10,401
5	Professional Services: Disallow	$ 450
	Charge for Services Provided	$21,523

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

☑ Yes ☐ No **Pg 15, Line 1e**

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**09/30/17**	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.........	134	134			134	134			134	134		
B. On last day of THIS report period................	134	134			134	134			134	134		
2. Number of Residents												
A. As of midnight of PREVIOUS report period.....	131	131			134	134			131	131		
B. As of midnight of THIS report period............	130	130			132	132			130	130		
3. Total Number of Days Care Provided During Period												
A. Medicare...	6,570	6,570			4,874	4,874			1,696	1,696		
B. Medicaid (Conn.)..................................	36,880	36,880			27,406	27,406			9,474	9,474		
C. Medicaid (other states)...........................												
D. Private Pay...	2,530	2,530			2,089	2,089			441	441		
E. State SSI for RCH................................												
F. Other (Specify) Managed Care	1,019	1,019			739	739			280	280		
G. Total Care Days During Period (3A thru F)......	46,999	46,999			35,108	35,108			11,891	11,891		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days....................	700	700			434	434			266	266		
B. Other Bed Reserve Days........................	12	12			11	11			1	1		
5. *Total Resident Days* (3G + 4A + 4B).........	47,711	47,711			35,553	35,553			12,158	12,158		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2017**	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
			(Specify)	Lost			Gained						
	CCNH (1)	RHNS (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-MR
No. of Residents	11	103		6		10		
Per Diem Rate								
a. One bed rm.	542.91	244.87		546.00		410.93		
b. Two bed rms.	542.91	244.87		534.00		410.93		
c. Three or more bed rms.								

Item	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,991	3,991		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,659	1,659		
2. Restorative Treatments				
C. Other	12,312	12,312		
D. ***Total Physical Therapy Treatments***	17,962	17,962		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	498	498		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	170	170		
2. Restorative Treatments				
C. Other	1,291	1,291		
D. ***Total Speech Therapy Treatments***	1,959	1,959		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,949	2,949		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,394	1,394		
2. Restorative Treatments				
C. Other	9,649	9,649		
D. ***Total Occupational Therapy Treatments***	13,992	13,992		

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
Maefair Health Care Center	**2142C**	**9/30/2017**	10	37

Are time records maintained by all individuals receiving compensation? ☑ Yes ☐ No

Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
	Total Cost and 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)	131,250	2,065				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	305,014	12,790				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	60,154	1,971				
c. Dietary Workers	457,741	29,606				
6. Housekeeping Service						
a. Head Housekeeper	50,162	2,154				
b. Other Housekeeping Workers	223,850	18,422				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	55,438	2,170				
b. Other Maintenance Workers	44,710	2,176				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	127,869	9,243				
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	219,429	4,576				
b. RN						
1. Direct Care	497,080	11,973				
2. Administrative**	403,896	14,288				
c. LPN						
1. Direct Care	1,532,792	52,827				
2. Administrative**						
d. Aides and Attendants	1,716,257	112,901				
e. Physical Therapists	596,337	17,307				
f. Speech Therapists	70,531	1,874				
g. Occupational Therapists	366,278	9,020				
h. Recreation Workers	207,418	10,462				
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	207,296	7,049				
n. Marketing						
o. Other (Specify)						
A-13. Total Salary Expenditures	7,273,502	322,874				

* 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.

Maefair Health Care Center
9/30/2017

Schedule of Other Salaries and Wages (Page 10)

Position	$ CCNH	Hours CCNH	$ RHNS	Hours RHNS	$ (Specify)	Hours (Specify)
Total	$ -	-	$ -	-	$ -	-

Schedule of Physician: Other Fees (Page 13)

Service	$ CCNH	Hours CCNH	$ RHNS	Hours RHNS	$ (Specify)	Hours (Specify)
Medical Staff	$ 1,350	9				
Total	$ 1,350	9	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

Service	$ CCNH	Hours CCNH	$ RHNS	Hours RHNS	$ (Specify)	Hours (Specify)
Total	$ -	-	$ -	-	$ -	-

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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
Maefair Health Care Center	**2142C**	**9/30/2017**	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										
Not Applicable										
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).										
Not Applicable										

* 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
Maefair Health Care Center	**2142C**	**9/30/2017**	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* **										
Terri Golec 10/1/16-9/30/17	131,250			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,066	A2			
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.

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CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page 13 of 37
Maefair Health Care Center	2142C	9/30/2017	13 of 37

Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
	Total Cost and 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	35,472	767				
2. Dentist	10,050	59				
3. Pharmacist	11,591	126				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker	5,000					
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	30,000	64				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**	8,002	4				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
See Attached Schedule	1,350	9				
9. Speech Therapist						
a. Resident Care	8,560	29				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	4,853					
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	114,878	1,058				

* 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.

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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
Maefair Health Care Center	2142C	9/30/2017	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers: Yes	Related** to Owners, Operators, Officers: No	Explanation of Relationship
Dr Wayne Levin, 66 Deepdene Road, Trumbull, CT 06611	Medical Director	☐	☑	
Athena Health Care, 135 South Road, Farmington, CT 06032	MDS Fill in	☑	☐	Common Owners
Healthdrive Eye Care Group, 888 Worcester Street, Wellesley, MA 02482	Eye Care	☐	☑	
Swallowing Diagnostics, 21 Waterville, Rd, Avon, CT	Therapy Services	☐	☑	
CT Dental, 240 Pomeroy Ave, Suite 205, Meriden, CT 06450	Dentist	☐	☑	
Dr. Iran Gomez, 3690 Main Street, Bridgeport, CT 06606	Medical Staff	☐	☑	
Dr. John Flores MD, 15 Corporate Drive, Trumbull, CT 06611	medical staff	☐	☑	
Omnicare/Value Health Care,525 Knotter Drive, Cheshire, CT	Pharmacy Consultants	☐	☑	
Access Therapies, PO Box 823461, Philadelphia, PA 19182-3461	Therapy Services	☐	☑	
Dr. Milla Stellman, 3715 Main Street, Bridgeport, CT 06606	Medical Staff	☐	☑	
Dr. Christopher Luthie, 3690 Main Street, Bridgeport, CT	Medical Staff	☐	☑	
Laura Svenson, P.O.Box 213, Georgetown, CT 06829	Dietician	☐	☑	
Senior Planning SVC, 100 Boulevard of the Americas, Lakewood NJ 08701	Medicaid Application assistance	☐	☑	
Vista Behavioral Health, LLC, 152 Simsbury Road, Building 9, 2nd floor, Avon, CT 06001	Behavioral Consulting	☐	☑	
St. Vincent's Medical Center, 2800 Main St, Bridgeport, CT 06606	Physician Services	☐	☑	
Bridgeport Hospital, 267 Grant St, Bridgeport, CT 06610	Physician Services	☐	☑	
Connecticut Handivan, Inc, 208 Quinnipac Ave, North Haven, CT 06473	Transportation Service	☐	☑	
Northeast Medical Group, Inc, 20 York St, New Haven, CT 06510	Physician Services	☐	☑	
Orthopaedic Specialty Group, 305 Black Rock Turnpike, Fairfield, CT 06825	Orthopaedic Services	☐	☑	
ProHealth, P.O. Box 150472, Hartford, CT 06115	Physician Services	☐	☑	
Urological Associates, 51-53 Kenosia Ave, Danbury, CT 06810	Physician Services	☐	☑	
Yale Medical Group, 789 Howard Ave #2, New Haven, CT 06519	Physician Services	☐	☑	

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

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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
Maefair Health Care Center	**2142C**	**9/30/2017**	14A	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Yale New Haven Hospital, 1450 Chapel St, New Haven, CT 06511	Physician Services	☐	☑	
Dr. Cimino, 52 Beach Road, ste 207, Fairfield, CT 06824	Physician Services	☐	☑	
		☐	☐	
		☐	☐	
		☐	☐	
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* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2017**	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation...............	$	559,786	559,786		
2. Disability Insurance......................	$				
3. Unemployment Insurance.................	$	94,586	94,586		
4. Social Security (F.I.C.A.).................	$	538,212	538,212		
5. Health Insurance..........................	$	1,445,750	1,445,750		
6. Life Insurance (employees only) (not-owners and not-operators)..........	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)..........	$	37,124	37,124		
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*.......................................	$	79,476	79,476		
d. Accounting and Auditing......................	$	12,200	12,200		
e. Legal (*Services should be fully described on Page 7)*	$	21,523	21,523		
f. Insurance on Lives of Owners and Operators (*Specify*)*......................	$				
g. Office Supplies................................	$	70,581	70,581		
h. Telephone and Cellular Phones..................					
1. Telephone & Pagers........................	$	48,425	48,425		
2. Cellular Phones.	$	379	379		
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	$				
3. Resident Day User Fee	$	864,784	864,784		
Subtotal	$	3,772,826	3,772,826		

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

(Carry Subtotals forward to next page)

Maefair Health Care Center
9/30/2017

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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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
Maefair Health Care Center		**2142C**	**9/30/2017**		16	37
Item		Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:		3,772,826	3,772,826			
l. Travel and Entertainment						
1. Resident Travel and Entertainment..........................	$					
2. Holiday Parties for Staff...............................	$	8,000	8,000			
3. Gifts to Staff and Residents................................	$	15,424	15,424			
4. Employee Travel..	$	2,420	2,420			
5. Education Expenses Related to Seminars and Conventions	$	7,944	7,944			
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*)..........	$	7,469	7,469			
2. Advertising Telephone Directory (*all such expenses*)***	$	598	598			
3. Advertising Other (*Specify*)***............................... See Attached Schedule	$	18,211	18,211			
4. Fund-Raising***..	$					
5. Medical Records...	$	(7)	(7)			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***.........	$	10,117	10,117			
7. Postage...	$	9,132	9,132			
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	8,201	8,201			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$					
9. Subscriptions...	$	1,000	1,000			
10. Contributions*** See Attached Schedule	$					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$					
12. Administrative Management Services**................	$	453,870	453,870			
13. Other (*Specify*) See Attached Schedule	$	95,995	95,995			
C-14 Total Administrative & General Expenditures	$	4,411,200	4,411,200			

* 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.

Maefair Health Care Center
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Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	$ 18,211		
Total Other Advertising	$ 18,211	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 7,946		
ALTCFM	$ 255		
Total Dues	$ 8,201	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	$ 14,033		
Payroll Processing Fees	$ 23,404		
Employee Physicals	$ 18,580		
Data Processing	$ 38,857		
Licenses	$ 570		
Energy Audit	$ 551		
Total Other Administrative and General	$ 95,995	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	**2142C**	**9/30/2017**	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 #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	$633,796	Contract Attached to a Prior Year	See Below
Allocation of the above	$418,305 $101,407 $114,084	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 18, Line 2C Pg 20, Line 5J
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	$35,565	Admin/Gen - Other Exp	Pg 16, Line 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.**

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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
Maefair Health Care Center	**2142C**	**9/30/2017**	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food...........................	$	294,637	294,637		
2. Non-Food Supplies.....................	$	35,024	35,024		
3. Other (*Specify*)________________	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**....................	$	101,407	101,407		
d. Other (*Specify*)________________	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	431,068	431,068		
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*		386	386		

	Question	Yes	No	
H.	Is cost of employee meals included in 2E?	☑ Yes	☐ No	
I.	Did you receive revenue from employees?	☐ Yes	☑ No	If yes, specify amount.
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. = $899
L.	Is any revenue collected from these people?	☐ Yes	☑ No	If yes, specify amount.
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 amount.
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.

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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
Maefair Health Care Center	2142C	9/30/2017	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
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. $	16,281	16,281		
b. Purchased Services *(by contract other than through Management Services)* *(Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**......................	$				
d. Other *(Specify)* **Supplies = $9,119**	$	9,119	9,119		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	25,400	25,400		

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 amount.
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 amount.
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.

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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
Maefair Health Care Center	2142C	9/30/2017	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	41,343	41,343		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*..................................		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)....		$	41,343	41,343		
5. Resident Care (Supplies)** a. Prescription Drugs***						
1. Own Pharmacy....................................		$				
2. Purchased from **Omnicare**		$	560,468	560,468		
b. Medicine Cabinet Drugs................................		$	2,657	2,657		
c. Medical and Therapeutic Supplies.......................		$	243,788	243,788		
d. Ambulance/Limousine***..............................		$	467	467		
e. Oxygen						
1. For Emergency Use..................................		$				
2. Other***..		$	37,369	37,369		
f. X-rays and Related Radiological Procedures***..		$	15,504	15,504		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***..		$	21,946	21,946		
i. Recreation..		$	22,078	22,078		
j. Other (Specify)**** See Attached Schedule		$	282,892	282,892		
5K. ***Total Resident Care Expenditures*** (5a - 5j).............		$	1,187,169	1,187,169		

* 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.

Maefair Health Care Center
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Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Management Fee Direct	$ 114,084		
Cable TV Fees	$ 35,980		
Oxygen Concentrator Rentals	$ 3,209		
Medical Equip Rentals-Medicaid	$ 56,798		
Physical Therapy Supplies	$ 41,614		
Medical Equip Rentals-Other	$ 31,207		
Total Other Resident Care	$ 282,892	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2017	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
Omnicare	Columbus, OH 43271-5268	☐	☑		Pharmacy	571,607			20	5a2
CWPM	PO Box 415, Plainville, CT 06062	☐	☑		Rubbish Removal	31,188			22	6f
ADP	Philadelphia, PA 19170-0351	☐	☑		Payroll Processing	23,010			16	m13
Fairfield County Groundskeeping LLC	P.O.Box 320774, Fairfield, CT 06825	☐	☑		landscaping/snow removal	29,506			22	6f
JDS Construction Services LLC		☐	☑		groundskeeping	10,140			22	6f
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
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		☐	☐							

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

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

Name of Facility	License No.	Report for Year Ended			Page of
Maefair Health Care Center	**2142C**	**9/30/2017**			22 | 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance.................... $		126,988	126,988		
b. Heat.................... $		50,818	50,818		
c. Light & Power.................... $		148,293	148,293		
d. Water.................... $		79,257	79,257		
e. Equipment Lease (*Provide detail on page 6*)........ $		22,944	22,944		
f. Other (*itemize*).................... $		134,944	134,944		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)............ $		563,244	563,244		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements.................... $		5,100	5,100		
b. Building & Building Improvements.................... $		81,554	81,554		
c. Non-Movable Equipment.................... $		15,139	15,139		
d. Movable Equipment.................... $		57,992	57,992		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)................ $		159,785	159,785		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense.................... $					
b. Mortgage Expense.................... $					
c. Leasehold Improvements.................... $		22,033	22,033		
d. Other (*Specify*).................... $					
*8e. ***Total Amortization Costs*** (8a + b + c + d)................ $		22,033	22,033		
9. Rental payments on leased real property less real estate taxes included in item 10b.................... $		1,060,283	1,060,283		
10. Property Taxes					
a. Real estate taxes paid by owner.................... $					
b. Real estate taxes paid by lessor.................... $		195,979	195,979		
c. Personal property taxes.................... $		10,636	10,636		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)............ $		1,448,716	1,448,716		

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

Maefair Health Care Center
9/30/2017

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	$ 20,399		
Rubbish Removal	$ 32,136		
Snow Removal	$ 19,247		
Supplies	$ 63,162		
Total Other Repairs and Maintenance	$ 134,944	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2017**	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	63,904		63,904	40,183	S/L	Various	5,100	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
A-4. Subtotal								5,100
B. **Building and Building Improvements**								
1. Acquired prior to this report period	1,298,324		1,298,324	902,687	S/L	Various	81,554	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
B-4. Subtotal								81,554
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	444,838		444,838	401,251	SL	Various	15,139	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
C-4. Subtotal								15,139

	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			9	2016	1,761,655		1,761,655	1,554,418	S/L	Various	56,782	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2017	12,095		12,095		S/L	Various	1,210	
D-3. Subtotal												57,992
E. ***Total Depreciation***												159,785

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:					
Total additions for Building Improvements		$ -		$ -	*
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:					
Total additions for Non-Movable Equipment		$ -		$ -	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

*Ties to Page 23, Line C3
**Ties to Page 23, Line C2

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Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Nov-16	computer equipment	$ 549	5	$ 55
Sep-17	33 long term care tvs	$ 11,546	5	$ 1,155
Total additions for Movable Equipment		$ 12,095		$ 1,210 *
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:					
Dec-16	5 ton roof top unit	$ 9,864	10	$ 493	
May-17	Tstar Alum Gld	$ 3,507	15	$ 117	
May-17	fire alarm system	$ 1,808	15	$ 60	
Total additions for Leasehold Improvements		$ 15,179		$ 670	*
Deletions:					
Total deletions for Leasehold Improvements		$ -		$ -	**

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2017**	24	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. **Finance Fees**									
3. **Finance Fees**									
B-4. Subtotal.....................................									
C. **Leasehold Improvements and Other** (Specify)									
1. Acquired prior to this report period	9	2016	Various	765,105	400,019	SL	Var	21,363	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2017	Various	15,179		SL	Var	670	
C-4. Subtotal.....................................									22,033
D. ***Total Amortization***									22,033

* 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.

Amortization Schedule - Detail of Leasehold Improvements & Other

Name of Facility **Maefair Health Care Center**			License No. **2142C**		Report for Year Ended **9/30/2017**			Page 24A	of 37
C. **Leasehold Improvements** (Specify)									
1. Acquired prior to this report period	9	2016	Various	197,189	28,632	SL	variou	21,363	
2. Disposals (attach schedule)									
3. Acquired during this report period	9	2017	various	15,179		SL	variou	670	
C-4. Subtotal.....................................									22,033
C. **Other** (Specify)									
1. Bed Purchase License	9	1997	15 yrs	567,916	371,387	SL	6.67%		
2.									
C-4. Subtotal.....................................									
Total Acquired prior to this report period	9	2016	Various	765,105	400,019	SL	Var	21,363	
Total Disposals									
Total Acquired during this report period	9	2017	Various	15,179		SL	Var	670	

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

Name of Facility	License No.	Report for Year Ended	Page	of
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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	4/1/1993
2. Date Structure Completed	4/1/1994
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	4/1/1994
5. Total Licensed Bed Capacity	134
6. Square Footage	
7. Acquisition Cost	
a. Land	1,260,000
b. Building	7,823,776

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	03/29/12			
c. Interest Rate for the Cost Year	3.22%			
d. Term of Mortgage (number of years)	35			
e. Amount of Principal Borrowed	16,336,000			
f. Principal balance outstanding as of 9/30/2017	14,842,862			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
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Item		Total	CCNH	RHNS	(Specify)
12. Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage..................................	$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage............................	$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage..............................	$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage............................	$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount........................	$				
2. Loan Origination Date........................					
3. Interest Rate %................................					
4. Term..					
5. CHEFA Interest Expense.......................					
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)	$				

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	**2142C**	**9/30/2017**	27 | 37

Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment 1. Automotive Equipment..................... $						
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (*Specify*)............................. $						
A. Item	Rate	Amount -				
Lender						
Address of Lender						
B. Item	Rate	Amount -				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)........................... $						
12. D. Other Interest Expense (*Specify*)............... $			45,711	45,711		
Vender Interest = $3,811; Line of Credit Interest = $32,117; Key Bank Loan Interest & Fees = $9,783						
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)......$			45,711	45,711		
14. Insurance a. Insurance on Property (buildings only)....... $			85,498	85,498		
b. Insurance on Automobiles..................... $						
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*)............. $						
2. Fire and Extended Coverage............... $						
3. Other (*Specify*)............................. $						
14d. ***Total Insurance Expenditures*** (14a + b + c)... $			85,498	85,498		
15. ***Total All Expenditures (A-13 thru C-14)***......... $			15,627,729	15,627,729		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	2142C	9/30/2017	28 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages								
1.			Outpatient Service Costs.................	$				
2.			Salaries not related to Resident Care....	$				
3.	10	A12g	Occupational Therapy....................	$	366,278	366,278		
4.	Var	Var	Other - See attached Schedule...........	$	3,413	3,413		
Page 13 - Professional Fees								
5.	13	B8c	Resident Care Physicians **.............	$	8,002	8,002		
6.			Occupational Therapy...................	$				
7.			Other - See attached Schedule...........	$				
Pages 15 & 16 - Administrative and General								
8.	15	1a9	Discriminatory Benefits..................	$				
9.	15	1c	Bad Debts...............................	$	79,476	79,476		
10.	15	1d&e	Accounting & Legal......................	$	21,190	21,190		
11.	30	IV3	Telephone................................	$				
12.			Cellular Telephone........................	$				
13.			Life insurance premiums on the life of Owners, Partners, Operators..........	$				
14.	16	l3	Gifts, flowers and coffee shops...........	$	15,424	15,424		
15.	16	l5	Education expenditures to colleges or universities for tuition and related costs for owners and employees................	$	1,750	1,750		
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	m2&3	Unallowable Advertising *...............	$	18,809	18,809		
19.			Income Tax / Corporate Business Tax...	$				
20.			Fund Raising / Contributions.............	$				
21.	16	m12	Unallowable Management Fees...........	$	291,183	291,183		
	18	2c		$	70,590	70,590		
	20	5j		$	79,414	79,414		
22.	30	IV7	Barber and Beauty.........................	$	15,102	15,102		
23.	Var	Var	Other - See attached Schedule............	$	14,033	14,033		
Page 18 - Dietary Expenditures								
24.	18	2a1	Meals to employees, guests and others who are not residents......................	$	3,410	3,410		
Page 19 - Laundry Expenditures								
25.	19	3d	Laundry services to employees, guests and others who are not residents..........	$				
Page 20 - Housekeeping Expenditures								
26.	20	4d	Housekeeping services to employees and others who are not residents..........	$				
			Subtotal (Items 1 - 26)	$	988,074	988,074		

* 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.

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Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A12M	Marketing Salaries & Benefits	3,413		
Total Other Salaries Adjustment			$ 3,413	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Charges	14,033		
Total Other A&G Adjustments			$ 14,033	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	988,074	988,074		
Page 20 - Resident Care Supplies*								
27.	20	5a1&2	Prescription Drugs......................	$	560,468	560,468		
28.	20	5d	Ambulance/Limousine.................	$	467	467		
29.	20	5f	X-rays, etc.............................	$	15,504	15,504		
30.	20	5h	Laboratory.............................	$	21,946	21,946		
31.	20	5c	Medical Supplies........................	$	40,242	40,242		
32.	20	5e2	Oxygen (non emergency)...............	$	37,369	37,369		
33.			Occupational Therapy..................	$				
34.	Var	Var	Other - See Attached Schedule........	$	31,207	31,207		
Page 22 - Maintenance and Property								
35.	Var	Var	Excess Movable Equipment Depreciation See Attached Schedule....................	$	2,200	2,200		
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.	20	5j	Radio and Television Revenue..........	$	34,183	34,183		
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.	30	IV5	Interest Income on Accounts Rec........	$	739	739		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule.........................	$				
Not For Profit Providers Only								
50.	Var	Var	Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule....................	$				
51.			***Total Amount of Decrease (Items 1 - 50)***	$	1,732,399	1,732,399		

*** 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.

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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental	31,207		
Total Other Ancillary Costs			$ 31,207	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excess Movable Equipment Depreciation	2,200		
Total Excess Movable Equipment Depreciation			2,200		

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)
Total Other Adjustments			$ -	$ -	$ -

Maefair Moveable Equipment Carryforward Schedule

Cost Year		Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount		Amount	Amount	Totals
		Excess Over CON Adj #1	Excess Over CON Adj #2	Excess Over CON Adj #3	Excess Over CON Adj #4	Excess Over CON Adj #5	Bed Addition Adj	Heritage Furn 2007 Profit	Heritage Furn 2007 Profit	Heritage Furn 2008 Profit	Heritage Furn 2009 Profit	Heritage Furn 2010 Profit	TV's 2013 Cost Report		TV's 2016 Cost Report	TV's 2017 Cost Report	
	Cost	16,968	1,336	94,539	8,375	2,125	18,232	735	44,130	2,220	151	119	716	719	$2,674	$11,546	204,585
	Term	5	8	10	15	20	15	5	10	10	5	5	5	5	5	5	
1995	Deprec	1,697	84	4,727	279	53											6,840
1995	Book Value	15,271	1,252	89,812	8,096	2,072											116,503
1996	Deprec	3,394	167	9,454	558	106											13,679
1996	Book Value	11,877	1,085	80,358	7,538	1,966											102,824
1997	Deprec	3,394	167	9,454	558	106	1,216										14,895
1997	Book Value	8,483	918	70,904	6,980	1,860	17,016										106,161
1998	Deprec	3,394	167	9,454	558	106	1,216										14,895
1998	Book Value	5,089	751	61,450	6,422	1,754	15,800										91,266
1999	Deprec	3,394	167	9,454	558	106	1,216										14,895
1999	Book Value	1,695	584	51,996	5,864	1,648	14,584										76,371
2000	Deprec	1,695	167	9,454	558	106	1,216										13,196
2000	Book Value	-	417	42,542	5,306	1,542	13,368										63,175
2001	Deprec		167	9,454	558	106	1,216										11,501
2001	Book Value		250	33,088	4,748	1,436	12,152										51,674
2002	Deprec		167	9,454	558	106	1,216										11,501
2002	Book Value		83	23,634	4,190	1,330	10,936										40,173
2003	Deprec		83	9,454	558	106	1,216										11,417
2003	Book Value		-	14,180	3,632	1,224	9,720										28,756
2004	Deprec			9,454	558	106	1,216										11,334
2004	Book Value			4,726	3,074	1,118	8,504										17,422
2005	Deprec			4,726	558	106	1,216										6,606
2005	Book Value			-	2,516	1,012	7,288										10,816
2006	Deprec				558	106	1,216										1,880
2006	Book Value				1,958	906	6,072										8,936
2007	Deprec				558	106	1,216	148	4,414								6,442
2007	Book Value				1,400	800	4,856	587	39,716								47,359
2008	Deprec				558	106	1,216	148	4,414	112							6,554
2008	Book Value				842	694	3,640	439	35,302	2,109							43,026
2009	Deprec				558	106	1,216	148	4,414	223	15						6,680
2009	Book Value				284	588	2,424	291	30,888	1,886	136						36,497
2010	Deprec				284	106	1,216	148	4,414	223	31	12					6,434
2010	Book Value				-	482	1,208	143	26,474	1,663	105	107					30,182
2011	Deprec					106	1,208	143	4,414	223	31	25					6,150
2011	Book Value					376	-	-	22,060	1,440	74	82					24,032
2012	Deprec					106			4,414	223	31	25					4,799
2012	Book Value					270			17,646	1,217	43	57					19,233
2013	Deprec					106			4,414	223	31	25	72				4,871
2013	Book Value					164			13,232	994	12	32	645				15,078
2014	Deprec					106			4,414	223	12	25	143	-			4,923
2014	Book Value					58			8,818	771	-	7	502	-			10,155
2015	Deprec					58			4,414	223		7	143	72			4,917
2015	Book Value					-			4,404	548		-	359	647			5,957
2016	Deprec								4,404	223			143	144	267		5,181
2016	Book Value								-	325			216	503	2,407		3,450
2017	Deprec									223			143	144	535	1,155	2,200
2017	Book Value									102			73	359	1,872	10,391	12,796
2018	Deprec									102			73	144	535	$2,309	3,162
2018	Book Value									-			-	215	1,337	$8,082	9,634
2019														144	535	$2,309	2,988
2019														71	802	$5,773	6,646
2020														71	535	$2,309	2,915
2020														-	267	$3,464	3,731
															267	$2,309	2,576
															0	$1,155	1,155
																$1,155	1,155
																$0	(0)

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Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
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Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	19,947,612	19,947,612		
b. Medicaid Room and Board Contractual Allowance **	$	(10,743,027)	(10,743,027)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents (*all inclusive*)	$	2,194,502	2,194,502		
b. Medicare Room and Board Contractual Allowance **	$	367,523	367,523		
4. a. Private-Pay Residents and Other	$	3,329,385	3,329,385		
b. Private-Pay Room and Board Contractual Allowance **	$	(530,526)	(530,526)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	350,622	350,622		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(350,622)	(350,622)		
c. Prescription Drugs - Non-Medicare	$	280,609	280,609		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(280,609)	(280,609)		
2. a. Medical Supplies - Medicare	$	26,842	26,842		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	903,266	903,266		
b. Physical Therapy - Medicare Contractual Allowance **	$	(719,552)	(719,552)		
c. Physical Therapy - Non-Medicare	$	494,550	494,550		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(494,550)	(494,550)		
4. a. Speech Therapy - Medicare	$	134,855	134,855		
b. Speech Therapy - Medicare Contractual Allowance **	$	(106,802)	(106,802)		
c. Speech Therapy - Non-Medicare	$	143,635	143,635		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(143,635)	(143,635)		
5. a. Occupational Therapy - Medicare	$	757,254	757,254		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(631,351)	(631,351)		
c. Occupational Therapy - Non-Medicare	$	425,200	425,200		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(425,200)	(425,200)		
6. a. Other (*Specify*) - Medicare	$				
b. Other (*Specify*) - Non-Medicare	$	(19,614)	(19,614)		
III *Total Resident Revenue* (Section I.thru Section II.)	$	14,910,367	14,910,367		
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 (*Specify*)	$	739	739		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	15,102	15,102		
8. Other (*Specify*)	$	32,808	32,808		
V. Total Other Revenue (1 thru 8)	$	48,649	48,649		
VI. Total All Revenue (III + V)	$	14,959,016	14,959,016		

* *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)
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Retroactives	$ (19,614)		
Total Other Resident Revenue		$ (19,614)	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
pg 31, L A2	Interest on A/R	NA	$ 739		
Total Interest Income			$ 739	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
15, 1c	Bad Debt Recoveries	$ 32,808		
Total Other Revenue		$ 32,808	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2017**	31	37

Account			Amount
Assets			
A. Current Assets			
1. Cash (*on hand and in banks*)			$ 245,532
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			$ 1,219,146
3. Other Accounts Receivable (Excluding Owners or Related Parties)			$
4 Inventories			$ 20,576
5. Prepaid Expenses			$ 264,916
a. Prepaid Insurance		252,382	
b. Ppd exp-health insurance & maintenance repairs		10,996	
c. Ppd exp-fmla license		1,263	
d. Ppd exp - Pitney Bowes		275	
6. Interest Receivable			$
7. Medicare Final Settlement Receivable			$
8. Other Current Assets (*itemize*)			$ 456,020
Due from Related Parties		456,020	
A-9. ***Total Current Assets*** (Lines A1 thru 8)			$ 2,206,190
B. Fixed Assets			
1. Land			$
2. Land Improvements	*Historical Cost	63,905	$ 18,622
	Accum. Depreciation	(45,283) Net	
3. Buildings	*Historical Cost	1,299,096	$ 314,083
	Accum. Depreciation	(985,013) Net	
4. Leasehold Improvements	*Historical Cost	212,368	$ 161,704
	Accum. Depreciation	(50,664) Net	
5. Non-Movable Equipment	*Historical Cost	444,830	$ 28,448
	Accum. Depreciation	(416,382) Net	
6. Movable Equipment	*Historical Cost	1,760,954	$ 148,543
	Accum. Depreciation	(1,612,411) Net	
7. Motor Vehicles	*Historical Cost		$
	Accum. Depreciation	Net	
8. Minor Equipment-Not Depreciable			$
9. Other Fixed Assets (*itemize*)			$ (7,259)
Equipment Carryforward adjustments		12,796	
Depr adjustment due to conversion		(20,055)	
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)			$ 664,141

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

(*Carry Total forward to next page*)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2017**	32	37

Account				Amount
			Total Brought Forward:	$ 2,870,331
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$ 1,260,000
2. Land Improvements	*Historical Cost......			
	Accum. Depreciation		Net........	$
3. Buildings	*Historical Cost......	7,823,776		
	Accum. Depreciation	(5,607,045)	Net........	$ 2,216,731
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)				$ 3,476,731
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*)				$ (8,734,040)
Name and Address	Amount	Loan Date		
Related Party Investment	(8,734,040)	3/29/2012		
7. Other Assets (*itemize*)				$ 232,602
IRS Deposits		33,573		
Unamortized Bed License		196,529		
Finance Fees		2,500		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (8,501,438)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ (2,154,376)

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2017**	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 1,520,094
2. Notes Payable (*itemize*)				$ 789,000
Key Bank Line of Credit		496,000		
Due to Related Parties		293,000		
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*)				$ 181,005
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 1,930
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*)				$ 503,316
Acc'd Operating Expenses		274,896		
Acc'd Expense - Sales Tax		535		
Provider Taxes Due		216,254		
Accd Health insurance		11,631		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,995,345

(Carry Total forward to next page)

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

** Interest Bearing - Do Not Include in Return on Equity Calculation.

Maefair Health Care
#2170 as of 9/30/17

Management Fee	$7,122.48
Health Insurance	$65,298.68
9/30 Payroll	$136,996.08
Payroll fees	$388.98
Office supplies	$880.14
data processing fee	$123.46
Management fee	$25,182.83
Health Insurance	$2,936.43
rubbish removal	($2,599.02)
gas invoice	$1,929.86
legal invoice	$146.31
legal invoice	$227.50
legal invoice	$97.50
lab invoice	$356.89
lab invoice	$3,625.00
water invoice	$1,298.85
water invoice	$1,287.30
Office supplies	$350.00
Office supplies	$200.00
Office supplies	$330.55
Office supplies	$318.96
data processing fee	$571.13
payroll fees	$2,043.57
oxygen invoice	$2,359.80
lab invoice	$2,077.34
bank fee	$4,992.92
nursing supplies	$4,828.67
water invoice	$11,524.22
	$274,896.43 9/30/2017

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	**2142C**	**9/30/2017**	34 of 37

Account	Amount
Total Brought Forward:	2,995,345
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

Account		Amount
4. Other Long-Term Liabilities (*itemize*)		$ (650,098)
Related Party	**(650,098)**	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ (650,098)
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 2,345,247

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2017**	35	37

Account		Amount
A. **Reserves**		
1. Reserve for value of leased land	$	1,260,000
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$	2,216,731
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	$	3,476,731
B. **Net Worth**		
1. Owner's Capital	$	
2. Capital Stock	$	2,000
3. Paid-in Surplus	$	
4. Treasury Stock	$	
5. Cumulated Earnings	$	(7,309,641)
6. Gain or Loss for Period 10/1/2016 thru 9/30/2017	$	(668,713)
7. Total Net Worth	$	(7,976,354)
C. ***Total Reserves and Net Worth***	$	(4,499,623)
D. ***Total Liabilities, Reserves, and Net Worth***	$	(2,154,376)

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2017**	36	37

Account			Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2016			$ (7,341,717)
B. Total Revenue (*From Statement of Revenue Page 30*) …………………………			$ 14,959,016
C. Total Expenditures (*From Statement of Expenditures Page 27*) ………………			$ 15,627,729
D. Net Income or Deficit………………………………………………………………			$ (668,713)
E. Balance…………………………………………………………………………			$ (8,010,430)
F. Additions			
1. Additional Capital Contributed (*itemize*)			
2016 AJE - Accrued Health Insurance	**23,070**		
2016 wage enhancement reversal	**10,000**		
Change in Swap	**1,948**		
Prior year expense adjustment	**(942)**		
2. Other (*itemize*)			
F-3. Total Additions………………………………………………………………			$ 34,076
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*** 09/30/17			$ (7,976,354)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2017**	37	37

Check appropriate category		
CCNH	RHNS	Other (*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 appplicable 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
[signature]	CFO	2/9/18

Printed Name of Preparer

Athena Health Care Associates, Inc

Address	Phone Number
135 South Road Farmington, CT 06032	(860) 751-3900

Cost report forms generated by Athena Health Care Associates, Inc as approved in letter dated 12/11/13.

Name of Facility	License No.	Report for Year Ended	Page
Maefair Health Care Center	2198-C/2198-C	9/30/2017	ERROR REPORT

INCOME/EXPENSE STATEMENT
ERROR CHECK LIST

RED CELLS INDICATE POSSIBLE ERROR

***** REVIEW THE FOLLOWING FOR POSSIBLE ERRORS *****
RECONCILIATION OF COST REPORT PAGES TO INTERFACE:
(NUMBERS FROM INTERFACE MUST EQUAL COST REPORT PAGES)

		TOTAL	CCNH	RHNS	OTHER: (Specify)
PG 1A PER INTERFACE	N/A				
PG 1A PER COST REPORT	N/A				
DIFFERENCE					
PG 10 PER INTERFACE		7,273,502	7,273,502		
PG 10 PER COST REPORT		7,273,502	7,273,502		
DIFFERENCE					
PG 1A PER COST REPORT	N/A				
PG 10 PER COST REPORT	N/A				
DIFFERENCE					
PG 13 PER INTERFACE		114,878	114,878		
PG 13 PER COST REPORT		114,878	114,878		
DIFFERENCE					
PG 15 & 16 PER INTERFACE		4,411,200	4,411,200		
PG 15 & 16 PER COST REPORT		4,411,200	4,411,200		
DIFFERENCE					
PG 18 PER INTERFACE		431,068	431,068		
PG 18 PER COST REPORT		431,068	431,068		
DIFFERENCE					
PG 19 PER INTERFACE		25,400	25,400		
PG 19 PER COST REPORT		25,400	25,400		
DIFFERENCE					
PG 20 PER INTERFACE		1,228,512	1,228,512		
PG 20 PER COST REPORT		1,228,512	1,228,512		
DIFFERENCE					
PG 22 PER INTERFACE		2,011,960	2,011,960		
PG 22 PER COST REPORT		2,011,960	2,011,960		
DIFFERENCE					
PG 26 & 27 PER INTERFACE		131,209	131,209		
PG 26 & 27 PER COST REPORT		131,209	131,209		
DIFFERENCE					
TOTAL EXPENSES PER INTERFACE		15,627,729	15,627,729		
TOTAL EXPENSES PER COST REPORT		15,627,729	15,627,729		
DIFFERENCE					
TOTAL REVENUES PER INTERFACE		14,959,016	14,959,016		
TOTAL REVENUES PER COST REPORT		14,959,016	14,959,016		
DIFFERENCE					
EQUIPMENT LEASES PER PAGE 6		22,944			
EQUIPMENT LEASES PER PAGE 22,LINE 6e		22,944			
DIFFERENCE					

Name of Facility	License No.	Report for Year Ended	Page
Maefair Health Care Center	2198-C/2198-C	9/30/2017	ERROR REPORT

BALANCE SHEET ERROR CHECK LIST
***** REVIEW THE FOLLOWING FOR POSSIBLE ERRORS *****
RECONCILIATION OF COST REPORT PAGES TO INTERFACE:
(NUMBERS FROM INTERFACE MUST EQUAL COST REPORT PAGES)
RED CELLS INDICATE POSSIBLE ERROR

	TOTAL
PG 31 CURRENT ASSETS PER INTERFACE	2,206,190
PG 31 CURRENT ASSETS PER COST REPORT	2,206,190
DIFFERENCE	
PG 31 FIXED ASSETS PER INTERFACE	664,141
PG 31 FIXED ASSETS PER COST REPORT	664,141
DIFFERENCE	
PG 32 LEASED ASSETS PER INTERFACE	3,476,731
PG 32 LEASED ASSETS PER COST REPORT	3,476,731
DIFFERENCE	
PG 32 OTHER ASSETS PER INTERFACE	(8,501,438)
PG 32 OTHER ASSETS PER COST REPORT	(8,501,438)
DIFFERENCE	
PG 32 TOTAL ASSETS PER INTERFACE	(2,154,376)
PG 32 TOTAL ASSETS PER COST REPORT	(2,154,376)
DIFFERENCE	
PG 33 CURRENT LIABS PER INTERFACE	2,995,345
PG 33 CURRENT LIABS PER COST REPORT	2,995,345
DIFFERENCE	
PG 34 LONG TERM LIABS PER INTERFACE	(650,098)
PG 34 LONG TERM LIABS PER COST REPORT	(650,098)
DIFFERENCE	
PG 34 TOTAL LIABS PER INTERFACE	2,345,247
PG 34 TOTAL LIABS PER COST REPORT	2,345,247
DIFFERENCE	
PG 35 RESERVES PER INTERFACE	3,476,731
PG 35 RESERVES PER COST REPORT	3,476,731
DIFFERENCE	
PG 35 NET WORTH PER INTERFACE	(7,976,354)
PG 35 NET WORTH PER COST REPORT	(7,976,354)
DIFFERENCE	
PG 35 TOTAL LIAB & WORTH PER INTERFACE	(2,154,376)
PG 35 TOTAL LIAB & WORTH PER COST REPORT	(2,154,376)
DIFFERENCE	
PG 32 TOTAL ASSETS PER COST REPORT	(2,154,376)
PG 35 TOTAL LIAB & WORTH PER COST REPORT	(2,154,376)
DIFFERENCE	
NET INCOME PER BALANCE SHEET	(668,713)
NET INCOME PER INCOME STATEMENT	(668,713)
DIFFERENCE	
PG 35 NET WORTH PER COST REPORT	(7,976,354)
TOTAL NET WORTH PER PG 36	(7,976,354)
DIFFERENCE	

Name of Facility	License No.	Report for Year Ended	Page
Maefair Health Care Center	2198-C/2198-C	9/30/2017	ERROR REPORT

INFORMATIONAL PAGES
ERROR CHECK LIST

RED CELLS INDICATE POSSIBLE ERROR

*** REVIEW THE FOLLOWING FOR POSSIBLE ERRORS ***

RECONCILIATION OF COST REPORT PAGES TO INTERFACE INPUT:
(NUMBERS FROM INTERFACE MUST EQUAL COST REPORT PAGES)

	TOTAL	CCNH	RHNS	OTHER: (Specify)
PG 7 TOTAL LEGAL FEES DETAIL	21,523	NOT APPLICABLE		
PG 15, LINE 1e LEGAL FEES PER COST REPORT	21,523	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
PG 7 TOTAL ACCOUNTING FEES DETAIL	12,200	NOT APPLICABLE		
PG 15, LINE 1d ACCOUNTING FEES PER C/RPT	12,200	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
PG 11 OWNER'S SALARY PER COST REPORT	-			
PG 10 OWNER'S SALARY PER COST REPORT	-			
DIFFERENCE				
PG 12 ADMINISTRATOR'S SALARY PER C/RPT	131,250	131,250		
PG 10 ADMINISTRATOR'S SALARY PER C/RPT	131,250	131,250		
DIFFERENCE				
PG 12 ASST ADMIN'S SALARY PER COST REPORT	-			
PG 10 ASST ADMIN'S SALARY PER COST REPORT	-			
DIFFERENCE				
PT TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	17,962	NOT APPLICABLE		
HORIZONTAL TOTALS	17,962	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
ST TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	1,959	NOT APPLICABLE		
HORIZONTAL TOTALS	1,959	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
OT TREATMENTS CROSSFOOT CHECK:(PG 9)				
VERTICAL TOTALS	13,992	NOT APPLICABLE		
HORIZONTAL TOTALS	13,992	NOT APPLICABLE		
DIFFERENCE		NOT APPLICABLE		
NO. OF CERTIFIED BEDS RECONCILATION:				
NUMBER OF BEDS-BEG OF REPORT PERIOD(PG 8	134	134		
ADDITIONS/DELETIONS DURING PERIOD(PG 9)	-			
CALCULATED CERT. BEDS AT END OF PERIOD	134	134		
ACTUAL CERT. BEDS END OF PERIOD(PG 8)	134	134		
DIFFERENCE				

COMPARISON OF ACTUAL PATIENT DAYS TO MAXIMUM POSSIBLE PATIENT DAYS:

	TOTAL	CCNH	RHNS	OTHER
AVERAGE CERTIFIED BEDS	134.00000	134.00000		
MAXIMUM PATIENT DAYS	48,910	48,910		
ACTUAL PATIENT DAYS	47,711	47,711		
PERCENT OCCUPIED(NOT TO EXCEED 100%)	97.5486%	97.5486%		

Name of Facility	License No.	Report for Year Ended	Page
Maefair Health Care Center	2198-C/2198-C	9/30/2017	ERROR REPORT

DEPRECIATION TIE-IN
ERROR CHECK LIST

RED CELLS INDICATE POSSIBLE ERROR

***** REVIEW THE FOLLOWING FOR POSSIBLE ERRORS *****

RECONCILIATION OF COST REPORT BALANCE SHEET TO DEPRECIATION PAGES:
(BOOK VALUE NUMBERS FROM EACH COLUMN BELOW MUST EQUAL)

FIXED ASSET CATEGORY	BOOK VALUE PG 23 OR 24	BOOK VALUE PG 31 OR 32	Difference
LAND IMPROVEMENTS	18,621	18,622	(1)
BUILDING AND BUILDING IMPROVEMENTS	314,083	314,083	-
LEASEHOLD IMPROVEMENTS	161,703	161,704	(1)
NON-MOVEABLE EQUIPMENT	28,448	28,448	-
MOTOR VEHICLES	-	-	-
MOVEABLE EQUIPMNT(NET OF LEASED EQUIP)	161,340	148,543	12,797
LEASED MOVEABLE EQUIPMENT	-	-	-
ORGANIZATION/START-UP	-	-	-
OTHER-PG 24	196,529	N/A **	

FIXED ASSET CATEGORY	EXPENSE PG 23 OR 24	EXPENSE PG 22	Difference
LAND IMPROVEMENTS	5,100	5,100	-
BUILDING AND BUILDING IMPROVEMENTS	81,554	81,554	-
NON-MOVEABLE EQUIPMENT	15,139	15,139	-
MOVEABLE EQUIPMENT(NET OF LEASED EQUIP) & MOTOR VEHICLES	57,992	57,992	-
LEASED MOVEABLE EQUIPMENT	-	N/A *	
ORGANIZATION/START-UP	-	-	-
FINANCE FEES	-	-	-
LEASEHOLD IMPROVES	22,033	22,033	-
OTHER AMORTIZATION	-	-	-

* NOT APPLICABLE BECAUSE THERE IS NO CORRESPONDING LINE ON PAGE 22.
**NOT APPLICABLE BECAUSE THERE IS NO CORRESPONDING LINE ON PAGES 31 OR 32.

FIXED ASSET CATEGORY		PG 23a/24a	PG 23/24	Difference
COMPARE DETAIL ADDITIONS TO PAGES 23 & 24				
LAND IMPROVEMENTS	ADDITIONS	-	-	-
	DEPREC	-	-	-
BUILDING IMPROVEMENTS	ADDITIONS	-	-	-
	DEPREC	-	-	-
NON-MOVEABLE EQUIPMENT	ADDITIONS	-	-	-
	DEPREC	-	-	-
MOVE EQUIP(NET OF LEASED EQUIP&VEHICLES	ADDITIONS	12,095	12,095	-
	DEPREC	1,210	1,210	(1)
LEASEHOLD IMPROVES	ADDITIONS	15,179	15,179	-
	DEPREC	670	670	0