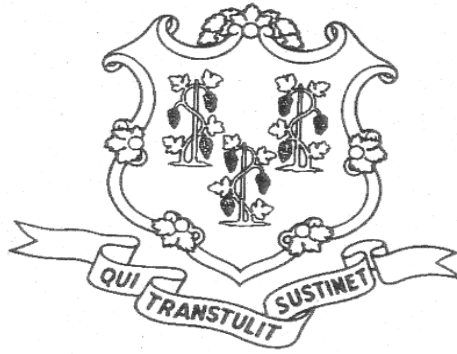


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

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 <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH 2142C	RHNS	(Specify)	Medicare Provider 07-5404
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Medicaid Provider Numbers:	CCNH 2142C	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2018	Page 1	of 37
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Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Maefair Health Care Center [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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) Terri Golec			Printed Name (Owner) Lawrence Santilli		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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State of Connecticut
Department of Social Services
 55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Maefair Health Care Center	Period Covered:	From 10/1/2017	To 9/30/2018	
Address of Facility 21 Maefair Court Trumbull, CT 06611				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900	Date 4/10/2019		
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.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-459-5152		Report for Year Ended 9/30/2018	Page 2	of 37
Name of Facility (as shown on license) Maefair Health Care Center		Address (No. & Street, City, State, Zip) 21 Maefair Court Trumbull, CT 06611		
License Numbers:	CCNH 2142C	RHNS	(Specify)	Medicare Provider No. 07-5404
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Terri Golec		Nursing Home Administrator's License No.:	000979	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		
Not Applicable				

General Information and Questionnaire
Corporate Owners

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2018	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address		State(s) in Which Incorporated	
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	
Michael E. Mosier	21 Maefair Court, Trumbull, CT 06611	Treasurer/Secretary		
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	

**General Information and Questionnaire
Related Parties***

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2018	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? Yes No If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Athena Health Care 401k	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		401k Plan			
Laurel Ridge Health Care Center	642 Danbury Road Ridgefield, CT 06877	<input checked="" type="radio"/>	<input type="radio"/>	>98%	Bank Fees	Pg 16m13	7,090	7,090
Athena Health Care Systems	135 South Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	<50%	see attached			
Maefair Landlord, LLC	135 South Rd, Farmington, CT	<input type="radio"/>	<input checked="" type="radio"/>		lease of facility	Pg 22, Ln 9 and 10b, p	1,340,654	1,340,654
Miscellaneous Facilities	various	<input checked="" type="radio"/>	<input type="radio"/>	>98%	Interfacility Loans	Pg 33, A2		
Procure LTC	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Pharmacy Services		331,727	331,727
Northbridge Health Center	2875 Main Street, Bridgeport, CT 06606	<input checked="" type="radio"/>	<input type="radio"/>	>98%	Legal Fees		450	450
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2018	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (<i>See listing page 13</i>)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required? Yes No If "No," explain fully why such allocation was not made.

Not Applicable

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.

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 Maefair Health Care Center		License No. 2142C		Report for Year Ended 9/30/2018			Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	<input type="radio"/>	<input checked="" type="radio"/>	Postal Equipment	11/22/13	Annual renewal	1,099	1,099	
Hewlett Packard Financial Services, PO Box 402582, Atlanta, GA	<input type="radio"/>	<input checked="" type="radio"/>	PCC Equipment	07/18/13	60 months	7,125	7,125	
LEAF Capital Funding, LLC PO Box 979127, Miami, FL 33197-9127	<input type="radio"/>	<input checked="" type="radio"/>	Copier System	02/25/16	48 months	15,314	15,314	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes	<input checked="" type="radio"/> No
Total ***							23,538	

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
 ** Attach copies of newly acquired leases.
 *** Amount should agree to Page 22, Line 6e.

General Information and Questionnaire
Accounting Basis

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2018	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual Cash Modified Cash

Is the accounting basis for this period the same as for the previous period? Yes No If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	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 Midcap Financial Services, LLC	7255 Woodmont ave, Bethesda, MD
4	

Services Provided by This Firm (*describe fully*)

1 2017 Audit, Yearend financials & tax returns	\$ 9,800
2 Preparation of Medicare Cost report	\$ 2,700
3 Line of Credit audit fees - Disallowed	\$ 3,474
4	\$
	Charge for Services Provided
	\$ 15,974

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

- Yes No Pg 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Goldman, Gruder & Woods	203-899-8900
2 Trumbull Probate/Conservator fee/Senior Planning Services	203-452-5068
3 Murtha Cullina	860-240-6000
4 Shipman & Goodwin	860-251-5000
5 Midcap Financial Services	301-860-7600

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

- 1 200 Connecticut Ave. Norwalk, CT
 2 (5866 Main Street, Trumbull, CT) (100 Blvd of the Americas, Lakewood NJ, 08701)
 3 185 Asylum Street, Hartford, CT
 4 One Constitution Plaza, Hartford, CT
 5 7255 Woodmont Ave, Bethesda, MD

Services Provided by This Firm (*describe fully*)

1 Collections:Disallowed	\$ 22,248
2 Conservator:Disallow	\$ 1,057
3 Annual Filing Fee with Secretary of State: Allowed	\$ 92
4 Employee Matters/Professional Services: Disallow	\$ 5,602
5 Line of Credit Services: Disallow	\$ 1,712
	Charge for Services Provided
	\$ 30,711

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

Schedule of Resident Statistics

Name of Facility Maefair Health Care Center			License No. 2142C		Report for Year Ended 9/30/2018				Page 8	of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	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	132	132			132	132			130	130		
B. As of midnight of THIS report period	133	133			130	130			133	133		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,750	5,750			4,590	4,590			1,160	1,160		
B. Medicaid (Conn.)	39,906	39,906			29,309	29,309			10,597	10,597		
C. Medicaid (other states)												
D. Private Pay	1,103	1,103			974	974			129	129		
E. State SSI for RCH												
F. Other (Specify) Managed Care	568	568			450	450			118	118		
G. Total Care Days During Period (3A thru F)	47,327	47,327			35,323	35,323			12,004	12,004		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	672	672			493	493			179	179		
B. Other Bed Reserve Days	5	5			5	5						
5. Total Resident Days (3G + 4A + 4B)	48,004	48,004			35,821	35,821			12,183	12,183		

Annual Report of Long-Term Care Facility

CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facility Maefair Health Care Center			License No. 2142C			Report for Year Ended 9/30/2018			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid			Self-Pay			Other State Assisted				
	CCNH	RHNS	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR			
No. of Residents	6		118			1			8				
Per Diem Rate													
a. One bed rm.	576.84		244.77			546.00			453.49				
b. Two bed rms.	576.84		244.77			534.00			453.49				
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments													
A. Medicare - Part B									TOTAL	CCNH	RHNS	(Specify)	
B. Medicaid (Exclusive of Part B)									8,638	8,638			
1. Maintenance Treatments									1,403	1,403			
2. Restorative Treatments													
C. Other									12,393	12,393			
D. Total Physical Therapy Treatments									22,434	22,434			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									1,330	1,330			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									214	214			
2. Restorative Treatments													
C. Other									1,494	1,494			
D. Total Speech Therapy Treatments									3,038	3,038			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									4,870	4,870			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments									1,128	1,128			
2. Restorative Treatments													
C. Other									10,343	10,343			
D. Total Occupational Therapy Treatments									16,341	16,341			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2018	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	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)	132,222	2,143				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	296,606	12,769				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	63,212	2,137				
c. Dietary Workers	470,614	30,970				
6. Housekeeping Service						
a. Head Housekeeper	1,757	78				
b. Other Housekeeping Workers	217,999	18,170				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	71,071	2,588				
b. Other Maintenance Workers	38,839	1,950				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	128,246	9,674				
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	193,955	4,129				
b. RN						
1. Direct Care	462,628	12,088				
2. Administrative**	467,183	16,385				
c. LPN						
1. Direct Care	1,494,673	55,004				
2. Administrative**						
d. Aides and Attendants	1,756,710	122,721				
e. Physical Therapists	471,942	14,275				
f. Speech Therapists	69,973	1,918				
g. Occupational Therapists	300,989	7,413				
h. Recreation Workers	191,255	11,011				
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	241,495	8,125				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	7,071,369	333,548				

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

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

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

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

Name of Facility				License No.	Report for Year Ended				Page	of
Maefair Health Care Center				2142C	9/30/2018				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	9/30/2018			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 10/1/17-9/30/18	132,222			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,143	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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Maefair Health Care Center	2142C	9/30/2018	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	34,755	828				
2. Dentist	5,360	47				
3. Pharmacist	14,483	126				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	32,700	116				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	11,176					
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	2,896	8				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	4,977	80				
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	106,347	1,204				

* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

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

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

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

Name of Facility Maefair Health Care Center		License No. 2142C	Report for Year Ended 9/30/2018	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Dr Wayne Levin, 66 Deepdene Road, Trumbull, CT 06611	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Athena Health Care, 135 South Road, Farmington, CT 06032	MDS Fill in	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners	
Healthdrive Eye Care Group, 888 Worcester Street, Wellesley, MA 02482	Eye Care	<input type="radio"/>	<input checked="" type="radio"/>		
Swallowing Diagnostics, 21 Waterville, Rd, Avon, CT	Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>		
CT Dental, 240 Pomeroy Ave, Suite 205, Meriden, CT 06450	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
Quest Diagnostics, 3404 Collection CTR Dt, Chicago IL, 60693	Lab Services	<input type="radio"/>	<input checked="" type="radio"/>		
Yale New Haven Hospital, 1450 Chapel St, New Haven, CT 06511	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Masstex Imaging LLC, 3 Electronics Ave Suite 201, Danvers MA, 01923-1099	Speech Therapy services	<input type="radio"/>	<input checked="" type="radio"/>		
Yale Medical Group, 789 Howard Ave #2, New Haven, CT 06519	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Urological Associates, 51-53 Kenosia Ave, Danbury, CT 06810	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Christopher Luthie, 3690 Main Street, Bridgeport, CT	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Laura Svenson, P.O Box 213 Gerogetown, CT 06829-0213	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
ProHealth, P.O. Box 150472, Hartford, CT 06115	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Orthopaedic Specialty Group, 305 Black Rock Turnpike, Fairfield, CT 06825	Orthopaedic Services	<input type="radio"/>	<input checked="" type="radio"/>		
St. Vincent's Medical Center, 2800 Main St, Bridgeport, CT 06606	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Bridgeport Hospital, 267 Grant St, Bridgeport, CT 06610	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Connecticut Handivan, Inc, 208 Quinnipac Ave, North Haven, CT 06473	Transportation Service	<input type="radio"/>	<input checked="" type="radio"/>		
Northeast Medical Group, Inc, 20 York St, New Haven, CT 06510	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Procare LTC, 111 Executive Blvd, Farmingdale NY 11735	Pharmacist	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners: Minority Interest	
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

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
Maefair Health Care Center	2142C	9/30/2018	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 524,697	524,697		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 76,370	76,370		
4. Social Security (F.I.C.A.)	\$ 482,485	482,485		
5. Health Insurance	\$ 1,089,384	1,089,384		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 37,968	37,968		
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 138,094	138,094		
d. Accounting and Auditing	\$ 15,974	15,974		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 30,711	30,711		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 65,279	65,279		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 61,382	61,382		
2. Cellular Phones	\$ 183	183		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$ 4,651	4,651		
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 888,179	888,179		
Subtotal	\$ 3,415,357	3,415,357		

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
Maefair Health Care Center	2142C	9/30/2018		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	3,415,357	3,415,357			
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 8,961	8,961			
3. Gifts to Staff and Residents	\$ 11,374	11,374			
4. Employee Travel	\$ 2,631	2,631			
5. Education Expenses Related to Seminars and Conventions	\$ 11,334	11,334			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 1,958	1,958			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 11,541	11,541			
4. Fund-Raising***	\$				
5. Medical Records	\$ (215)	(215)			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$ 8,337	8,337			
7. Postage	\$ 6,736	6,736			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 9,451	9,451			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 560	560			
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$ 436,797	436,797			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 93,904	93,904			
C-14 Total Administrative & General Expenditures	\$ 4,018,726	4,018,726			

* 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)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 11,541		
Total Other Advertising	\$ 11,541	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 9,196		
ALTCFM	\$ 255		
Total Dues	\$ 9,451	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	\$ 19,353		
Payroll Processing Fees	\$ 27,369		
Employee Physicals	\$ 18,976		
	\$ -		
Data Processing	\$ 24,908		
Licenses	\$ 2,638		
Citation 2018-41 GSS 19a-527	\$ 660		
Total Other Administrative and General	\$ 93,904	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	2142C	9/30/2018	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	609,377	Contract Attached to a Prior Year	See Below
Allocation of the above	402,189	Admin/Gen 66%	Pg 16, Line 12
Allocation of the above	97,500	Indirect 16%	Pg 20, Line 5k
Allocation of the above	109,688	Direct 18%	Pg 20, Line 5j
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	34,608	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.**

C. Expenditures Other Than Salaries (cont'd) - Dietary Basis for Allocation of Costs (See Note on Page 5)

Name of Facility Maefair Health Care Center		License No. 2142C	Report for Year Ended 9/30/2018	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$	300,162	300,162		
2. Non-Food Supplies	\$	36,737	36,737		
3. Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)					
c. Other (Specify) _____					
		\$ 97,500	97,500		
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 434,399	434,399		
2F. Dietary Questionnaire					
G. Resident Meals: Total no. of meals served per day:*		389	389		
H. Is cost of employee meals included in 2E? <input checked="" type="radio"/> Yes <input type="radio"/> No					
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify cost. \$1,160					
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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.

C. Expenditures Other Than Salaries (cont'd) - Laundry Basis for Allocation of Costs
(See Note on Page 5)

Name of Facility Maefair Health Care Center		License No. 2142C	Report for Year Ended 9/30/2018		Page 19	of 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. \$				
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. \$	17,123	17,123		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Other (Specify)		\$	6,632	6,632		
3D. Total Laundry Expenditures (3a + b + c)		\$	23,755	23,755		
3F. Laundry Questionnaire						
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				

* 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.

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

**C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care
 Basis for Allocation of Costs (See Note on Page 5)**

Name of Facility		License No.	Report for Year Ended		Page	of
Maefair Health Care Center		2142C	9/30/2018		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	56,269	56,269		
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$				
C.	Other (<i>Specify</i>)	\$				
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	56,269	56,269		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from Procure	\$	299,843	299,843		
b.	Medicine Cabinet Drugs	\$	17,329	17,329		
c.	Medical and Therapeutic Supplies	\$	250,729	250,729		
d.	Ambulance/Limousine***	\$	457	457		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	28,384	28,384		
f.	X-rays and Related Radiological Procedures***	\$	18,096	18,096		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	11,174	11,174		
i.	Recreation	\$	23,027	23,027		
j.	Direct Management Services*	\$	78,197	78,197		
k.	Indirect Management Services*	\$	69,509	69,509		
l.	Other (Specify)**** See Attached Schedule	\$	112,409	112,409		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	909,154	909,154		

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Cable TV Fees	\$ 53,070		
	\$ -		
Medical Equip Rentals-Medicaid	\$ 19,486		
Physical Therapy Supplies	\$ 22,146		
Medical Equip Rentals-Other	\$ 17,707		
Total Other Resident Care	\$ 112,409	\$ -	\$ -

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

Name of Facility Maefair Health Care Center			License No. 2142C		Report for Year Ended 9/30/2018			Page of 21 37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Procure LTC	Suite 121, Farmingdale NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners: Minority Interest	Pharmacy	331,727			20	5a2
CWPM	PO Box 415, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal	28,589			22	6f
ADP	Philadelphia, PA 19170-0351	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing	22,828			16	m13
Thyssen Krupp Elevator	P.O. Box 933007 Atlanta, GA 31193-3007	<input type="radio"/>	<input checked="" type="radio"/>		Elevator Service	17,934			22	6a
JDS Construction Services LLC	229 Alberta St, Fairfield CT 06825	<input type="radio"/>	<input checked="" type="radio"/>		landscaping/snow removal	58,888			22	6f
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Maefair Health Care Center	2142C	9/30/2018			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 152,116	152,116				
b. Heat	\$ 53,573	53,573				
c. Light & Power	\$ 130,500	130,500				
d. Water	\$ 74,664	74,664				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 23,538	23,538				
f. Other (<i>itemize</i>)	\$ 124,020	124,020				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 558,411	558,411				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 4,593	4,593				
b. Building & Building Improvements	\$ 61,545	61,545				
c. Non-Movable Equipment	\$ 10,682	10,682				
d. Movable Equipment	\$ 36,346	36,346				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 113,166	113,166				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 2,927	2,927				
c. Leasehold Improvements	\$ 23,658	23,658				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 26,585	26,585				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,065,091	1,065,091				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 200,011	200,011				
c. Personal property taxes	\$ 30,520	30,520				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,435,373	1,435,373				

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

Depreciation Schedule

Name of Facility Maefair Health Care Center			License No. 2142C			Report for Year Ended 9/30/2018			Page 23	of 37			
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
A. Land Improvements													
1. Acquired prior to this report period			63,904		63,904	45,283	S/L	Various	4,593				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal										4,593			
B. Building and Building Improvements													
1. Acquired prior to this report period			1,298,324		1,298,324	984,241	S/L	Various	61,545				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)							S/L	Various					
B-4. Subtotal										61,545			
C. Non-Movable Equipment													
1. Acquired prior to this report period			444,838		444,838	416,390	SL	Various	10,682				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal										10,682			
		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	2017	1,773,750		1,773,750	1,612,410	S/L	Various	33,318	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)				9	2018	40,386		40,386		S/L	Various	3,028	
D-3. Subtotal													36,346
E. Total Depreciation													113,166

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Various	See attached			
		\$ 40,386	Various	\$ 3,028
Total additions for Movable Equipmen		\$ 40,386		\$ 3,028 *
Deletions:				
Total deletions for Movable Equipmen		\$ -		\$ - **

*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:				
Various	See attached			\$ -
		\$ 21,089	Various	\$ 955
Total additions for Leasehold Improvemen		\$ 21,089		\$ 955 *
Deletions:				
Total deletions for Leasehold Improvemen		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

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Amortization Schedule*

Name of Facility Maefair Health Care Center			License No. 2142C		Report for Year Ended 9/30/2018			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1. Bed Purchase License	9	1997	15 yrs	567,916	371,387	SL	6.67%		
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Finance Fees	2	18	36 months	13,170		SL		2,927	
2.									
3.									
B-4. Subtotal									2,927
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	9	2017	Various	212,368	50,665	SL	variou	22,703	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2018	various	21,089		SL	variou	955	
C-4. Subtotal									23,658
D. Total Amortization									26,585

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2018	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> 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
1. Financing				4th Mortgage
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		14,537,621		
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
Maefair Health Care Center		2142C	9/30/2018			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$					

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Maefair Health Care Center		2142C		9/30/2018		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)				\$	32,670	32,670	
Vender Interest = \$6,431; Line of Credit Interest = \$23,123;							
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	32,670	32,670	
14. Insurance							
a. Insurance on Property (buildings only)				\$	78,848	78,848	
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)				\$	78,848	78,848	
15. Total All Expenditures (A-13 thru C-14)				\$	14,725,321	14,725,321	

D. Adjustments to Statement of Expenditures

Name of Facility Macfair Health Care Center				License No. 2142C	Report for Year Ended 9/30/2018	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.	10	A12g	Occupational Therapy	\$ 300,989	300,989		
4.			Other - See attached Schedule	\$ 3,413	3,413		
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **	\$ 11,176	11,176		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.	15	1a9	Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 138,094	138,094		
10.	15	1d	Accounting	\$ 3,474	3,474		
10a.			Legal	\$ 30,619	30,619		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	13	Gifts, flowers and coffee shops	\$ 11,374	11,374		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$ 6,224	6,224		
16.	16	15	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&k	Unallowable Advertising *	\$ 11,541	11,541		
19.	15	1j&k	Income Tax / Corporate Business Tax	\$ 4,651	4,651		
20.			Fund Raising / Contributions	\$			
21.	16	m12	Unallowable Management Fees	\$ 286,723	286,723		
22.	30	IV7	Barber and Beauty	\$ 13,423	13,423		
23.			Other - See attached Schedule	\$ 20,013	20,013		
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents	\$ 1,160	1,160		
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)				\$ 842,874	842,874		

* 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	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	\$ 19,353		
16	M13	Citation 2018-41 GSS 19a-527	\$ 660		
Total Other A&G Adjustments			\$ 20,013	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Maefair Health Care Center			2142C	9/30/2018	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 842,874	842,874		
Page 20 - Resident Care Supplies***							
27.	20	5a1&	Prescription Drugs	\$ 299,843	299,843		
28.	20	5d	Ambulance/Limousine	\$ 457	457		
29.	20	5f	X-rays, etc	\$ 18,096	18,096		
30.	20	5h	Laboratory	\$ 11,174	11,174		
31.	20	5c	Medical Supplies	\$ 29,136	29,136		
32.	20	5e2	Oxygen (non emergency)	\$ 28,384	28,384		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 82,398	82,398		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 4,524	4,524		
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$ 48	48		
44.			Other - Miscellaneous Administrative	\$			
45.	20	5k	Management Fees Direct	\$ 78,197	78,197		
46.	20	5k	Management Fees Indirect	\$ 69,509	69,509		
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 1,464,640	1,464,640		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental	\$ 17,707		
20	5a2	Ebox	\$ 15,221		
20	5j	Radio and Television	\$ 49,470		
0	0		0 \$ -		
0	0		0 \$ -		
0	0		0 \$ -		
0	0		0 \$ -		
0	0		0 \$ -		
Total Other Ancillary Costs			\$ 82,398	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excess Movable Equipment Depreciation	\$ 4,524		
Total Excess Movable Equipment Depreciation			\$ 4,524	\$ -	\$ -

Schedule of Other Property Adjustments

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

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Maefair Health Care Center	2142C	9/30/2018		30	37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 22,680,240	22,680,240			
b. Medicaid Room and Board Contractual Allowance **	\$ (12,748,597)	(12,748,597)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,907,778	1,907,778			
b. Medicare Room and Board Contractual Allowance **	\$ 330,572	330,572			
4. a. Private-Pay Residents and Other	\$ 2,383,960	2,383,960			
b. Private-Pay Room and Board Contractual Allowance **	\$ (525,990)	(525,990)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 216,826	216,826			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (216,826)	(216,826)			
c. Prescription Drugs - Non-Medicare	\$ 201,642	201,642			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (201,642)	(201,642)			
2. a. Medical Supplies - Medicare	\$ 15,736	15,736			
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 729,069	729,069			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (587,988)	(587,988)			
c. Physical Therapy - Non-Medicare	\$ 373,100	373,100			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (373,100)	(373,100)			
4. a. Speech Therapy - Medicare	\$ 165,280	165,280			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (129,999)	(129,999)			
c. Speech Therapy - Non-Medicare	\$ 167,810	167,810			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (167,810)	(167,810)			
5. a. Occupational Therapy - Medicare	\$ 660,220	660,220			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (542,512)	(542,512)			
c. Occupational Therapy - Non-Medicare	\$ 343,750	343,750			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (343,750)	(343,750)			
6. a. Other (<i>Specify</i>) - Medicare	\$				
b. Other (<i>Specify</i>) - Non-Medicare	\$ (11,975)	(11,975)			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 14,325,794	14,325,794			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 48	48			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$ 13,423	13,423			
8. Other (<i>Specify</i>)	\$ 38,448	38,448			
V. Total Other Revenue (1 thru 8)	\$ 51,919	51,919			
VI. Total All Revenue (III +V)	\$ 14,377,713	14,377,713			

* 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	Ancillary Allow:MC B	\$ (29)		
0	Medicaid-Retro SNF	\$ (59,404)		
0	Medicare: Retro	\$ 47,458		
Total Other Resident Revenue		\$ (11,975)	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
pg 31, L A	Interest on A/R	NA	\$ 48		
Total Interest Income			\$ 48	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
0	0	\$ -		
0	Misc Income	\$ 7,530		
0	Fee Income A&G	\$ (281)		
0	Fee Income Administrator	\$ (84)		
0	0	\$ -		
0	0	\$ -		
0	0	\$ -		
15, 1c	Bad Debt Recoveries	\$ 31,283		
Total Other Revenue		\$ 38,448	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2018	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	31,491
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,039,129
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	20,538
5. Prepaid Expenses			\$	420,649
a. _____				
b. _____				
c. _____				
d. See Schedule	420,649			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	455,655
Due from Related Parties	455,655			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,967,462
B. Fixed Assets				
1. Land				
2. Land Improvements	*Historical Cost	63,905	\$	14,030
	Accum. Depreciation	49,875		Net
3. Buildings	*Historical Cost	1,299,096	\$	252,538
	Accum. Depreciation	1,046,558		Net
4. Leasehold Improvements	*Historical Cost	233,457	\$	159,135
	Accum. Depreciation	74,322		Net
5. Non-Movable Equipment	*Historical Cost	444,830	\$	17,766
	Accum. Depreciation	427,064		Net
6. Movable Equipment	*Historical Cost	1,792,242	\$	143,485
	Accum. Depreciation	1,648,757		Net
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation			Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	1,841
See Schedule	1,841			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	588,795

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

(Carry Total forward to next page)

Cost Year	Amount	Amount	Amount	Amount	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 Addillon Adj	Herilage Furn 2007 Profit	Herilage Furn 2007 Profit	Herilage Furn 2008 Profit	Herilage Furn 2009 Profit	Herilage Furn 2010 Profit	TV's 2013 Cost Report	TV's 2016 Cost Report	TV's 2017 Cost Report	TV's 2018 Cost Report					
Cost Term	\$ 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	\$ 13,624	\$ 5	\$ 5	\$ 5	\$ 216,209
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
1995 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														\$ 14,695
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															\$ 11,117
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	\$ 1,683	\$ 105	\$ 107												\$ 30,162
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	\$ 223	\$ 216	\$ 503	\$ 2,407												\$ 3,450
2017 Deprec	\$ -	\$ -	\$ -	\$ 102	\$ 102	\$ 143	\$ 144	\$ 535	\$ 1,155											\$ 2,200
2017 Book Value	\$ -	\$ -	\$ -	\$ 102	\$ 102	\$ 73	\$ 359	\$ 1,872	\$ 10,391											\$ 12,796
2018 Deprec	\$ -	\$ -	\$ -	\$ 102	\$ 102	\$ 73	\$ 144	\$ 535	\$ 2,309											\$ 4,524
2018 Book Value	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,362										\$ -
2019										\$ 215	\$ 1,337	\$ 8,082	\$ 12,262							\$ -21,896
2019										\$ 144	\$ 535	\$ 2,309	\$ 2,725							\$ 5,713
2020										\$ 71	\$ 802	\$ 5,773	\$ 9,537							\$ 16,183
2020										\$ 71	\$ 535	\$ 2,309	\$ 2,725							\$ 5,640
2021										\$ -	\$ 267	\$ 3,464	\$ 6,812							\$ 10,543
2021										\$ -	\$ 267	\$ 2,309	\$ 2,725							\$ 5,301
2022										\$ 0	\$ 1,155	\$ 4,088	\$ 5,243							\$ 5,243
2022										\$ 1,155	\$ 2,725	\$ 3,880	\$ 3,880							\$ 3,880
2023										\$ 0	\$ 1,363	\$ 1,363	\$ 1,363							\$ 1,363
2023										\$ 0	\$ 1,363	\$ 1,363	\$ 1,363							\$ 1,363

(0)

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
Maefair Health Care Center	2142C	9/30/2018	32	37
Account			Amount	
Total Brought Forward:			\$	2,556,257
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 <u>7,823,776</u>	
Accum. Depreciation <u>5,607,045</u>			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)			\$	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 (<i>itemize</i>)			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$ (8,734,040)	
Name and Address		Amount	Loan Date	
Related Party Investment		(8,734,040)	3/29/12	
7. Other Assets (<i>itemize</i>)			\$ 206,772	
Unamortized Bed License			196,529	
LOC Midcap Fees			10,243	
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	(8,527,268)
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	(2,494,280)

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

Cost Report
Maefair
Accrued Expenses #2170
30-Sep-18

Quarterly mgmt fee adjmt	\$4,786.77
Health Insurance IBNR	\$65,298.68
Health Insurance IBNR	\$43,516.05
Dr Ngygen-Medical Director	(\$4,500.00)
Dr Lomibao-Medical Director	(\$3,500.00)
September Relay Health Care	\$170.27
Nursing Supplies	\$44.09
Nursing Supplies	\$3,837.29
Nursing Supplies	\$119.65
Nursing Supplies	\$100.62
Nursing Supplies	\$4,520.77
AHC Weston Void	(\$1,501.18)
Year end Audit Fee	\$9,800.00
Water bill	\$14,705.60
	<u><u>\$137,398.61</u></u>

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		Prepaid Insurance	\$ 408,960
		Ppf exp-health insurance	\$ 10,184
		Ppd exp-fmla license	\$ 912
		Ppd HP finance lease	\$ 593
		Total Prepaid Expenses	\$ 420,649

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

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

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

Page Ref	Line Ref	Description	
		Equipment carryforward adjustments	\$ 21,896
		Depr adjustment due to conversion	\$ (20,055)
		Total Other Other Fixed Assets (Itemize)	\$ 1,841

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Total Other Assets	\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
		Total Notes Payable	\$ -

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

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

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

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

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
Maefair Health Care Center		2142C	9/30/2018	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	1,738,695
2. Notes Payable (<i>itemize</i>)				\$	446,525
Midcap Line of Credit					277,515
Due to Related Parties					169,010
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	171,811
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	8,310
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	378,832
					Provider Taxes Due
					231,703
					Acc'd Health insurance
					9,425
Acc'd Operating Expenses					137,399
Acc'd Expense - Sales Tax					305
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	2,744,173

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2018	Page 34	of 37
Account			Amount	
Total Brought Forward:			2,744,173	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
Related Party		(554,164)		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ (554,164)
C. Total All Liabilities (Lines A-13 + B-5)				\$ 2,190,009

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	9/30/2018	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 (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	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			\$	(7,853,430)
6. Gain or Loss for Period	10/1/2017	thru 9/30/2018	\$	(309,590)
7. Total Net Worth			\$	(8,161,020)
C. Total Reserves and Net Worth			\$	(4,684,289)
D. Total Liabilities, Reserves, and Net Worth			\$	(2,494,280)

H. Changes in Total Net Worth

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2018	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2017			\$	(7,976,354)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	14,377,713
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	14,687,303
D. Net Income or Deficit			\$	(309,590)
E. Balance			\$	(8,285,944)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2017 AJE - Accrued Health Insurance	115,541			
2017 Nursing Supply Rebate	9,658			
Prior year Pitney Bowes Lease	(275)			
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	124,924
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>	Title	Amount		
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose	Amount			
3. Total Deductions			\$	
H. Balance at End of Period			\$	(8,161,020)

I. Preparer's/Reviewer's Certification

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2018	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
Athena Health Care Associates, Inc				
Address Address		Phone Number		
135 South Road Farmington, CT 06032		(860) 751-3900		