State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2019

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 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2142C			07-5404

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	2142C		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2019	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Maefair Health Care Center [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, 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
		2/17/2020		2/17/2020
Printed Name (Administrator) Rita Lynch			Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	State of CT	Date 2/17/2020	Signed (Notary Public)	Comm. Expires 8/1/2020
Address of Notary Public 38 Linda Dr. Plainville CT 06062				

(Notary Seal)

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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 10/1/2018	To 9/30/2019
Address of Facility 21 Maefair Court Trumbull, CT 06611				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900		Date 2/13/2020	

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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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-459-5152	9/30/2019	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))

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

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ◉ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Rita Lynch	1514

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

Name	License No.:
Not Applicable	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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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	reasurer/Secreta	
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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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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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	%**				
Maefair Landlord, LLC	135 South Rd, Farmington, CT	○	⊙		lease of facility	Pg 22, Ln 9 and 10b, p	1,336,508	1,336,508
Athena Health Care 401k	135 South Rd, Farmington, CT 06032	⊙	○	>98%	Participates in Common 401k Plan			
Athena Health Care Systems	135 South Road, Farmington, CT 06032	⊙	○	<50%	see attached			
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	⊙	○	>50%	Pharmacy Services	Pg 20, 5a2	351,826	351,826
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

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

Maefair Health Care
RELATED PARTIES QUESTIONNAIRE
PAGE 4

Report for FYE 9/30/2019

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	135 South Rd Farmington, CT 06032	X		<50%	Management Fees	Pg 17	$646,714	$266,912
					Promotion	Pg 16, M3	$342	$342
					Postage	Pg 16, M7	$280	$280
					Data/Payroll Processing	Pg 16, M13	$4,004	$4,004
					Software Fees	Pg 16, M13	$380	$380
					Cyber Security insurance	Pg 27, 14a	$1,625	$1,625
					Painters	Pg 22, 6a	$22,195	$22,195
					Employee relations	Pg 16, L3	$3,064	$3,064
					Health Insurance	Pg 15, 1a5	$1,142,641	$1,142,641
					Employee physicals	Pg 16, M13	$387	$387
					Nursing Fill in and consulting	Pg 13, L 11a2	$3,982	$3,982
Athena Health Care Assoc 401K Plan	135 South Rd Farmington, CT 06032				Facility participates in group 401k plan			
Athena Captive LLC	135 South Rd Farmington, CT 06032		x		Workers Comp Captive	pg. 15 a1	$471,351	$471,351
Misc Facilities	Various Address	X		>98%	Interfacility Loan Payable	Pg. 34 Ln 3		

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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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 (*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

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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
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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	O	⊙	Postal Equipment	11/22/13	Annual renewal	1,207	302
LEAF Capital Funding, LLC PO Box 979127, Miami, FL 33197-9127	O	⊙	Copier System	02/25/16	48 months	15,314	15,314
	O	⊙					
	O	⊙					
	O	⊙					
	O	⊙					
	O	⊙					
	O	⊙					
	O	⊙					
	O	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? O Yes ⊙ No **Total** *** 15,616

* 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
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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual O Cash O Modified Cash

Is the accounting basis for this period the same as for the previous period? ⊙ Yes O 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	2018 Audit, Yearend financials & tax returns	$ 12,900
2	Preparation of Medicare Cost report	$ 2,700
3	Line of Credit audit fees - Disallowed	$ 3,253
4		$
		Charge for Services Provided $ 18,853

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes O 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/Conservator fee/Senior Planning Services	203-452-5068
3 Midcap Financial Services	301-860-7600
4 Jackson Lewis P.C.	
5	

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 7255 Woodmont Ave, Bethesda, MD
4 1133 Westchester Ave, West Harrison, NY
5

Services Provided by This Firm (*describe fully*)

1	Collections:Disallowed	$ 17
2	Conservator:Disallow	$ 1,478
3	Line of Credit Services: Disallow	$ 218
4	Employee Matters: Disallow	$ 67
5		$
		Charge for Services Provided $ 1,780

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
⊙ Yes O No Pg 15, Line 1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	130	130			130	130			132	132		
B. As of midnight of THIS report period	131	131			132	132			131	131		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,599	5,599			4,375	4,375			1,224	1,224		
B. Medicaid (Conn.)	39,204	39,204			29,277	29,277			9,927	9,927		
C. Medicaid (other states)												
D. Private Pay	1,628	1,628			1,051	1,051			577	577		
E. State SSI for RCH												
F. Other (Specify) Managed Care	337	337			300	300			37	37		
G. Total Care Days During Period (3A thru F)	46,768	46,768			35,003	35,003			11,765	11,765		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	501	501			388	388			113	113		
B. Other Bed Reserve Days	13	13			13	13						
5. ***Total Resident Days*** **(3G + 4A + 4B)**	47,282	47,282			35,404	35,404			11,878	11,878		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? O Yes ⊙ No
If "YES", provide the following information:

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

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	8	109		5		9		
Per Diem Rate								
a. One bed rm.	592.36	254.71		606.00		434.30		
b. Two bed rms.	592.36	254.71		594.00		434.30		
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,708	3,708		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,737	1,737		
2. Restorative Treatments				
C. Other	12,940	12,940		
D. ***Total Physical Therapy Treatments***	18,385	18,385		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	695	695		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	400	400		
2. Restorative Treatments				
C. Other	1,526	1,526		
D. ***Total Speech Therapy Treatments***	2,621	2,621		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,255	3,255		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	940	940		
2. Restorative Treatments				
C. Other	13,712	13,712		
D. ***Total Occupational Therapy Treatments***	17,907	17,907		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2019	10	37

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

Item	Total Cost and Hours					
	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	132,697	2,091				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	295,643	12,443				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	62,971	2,041				
c. Dietary Workers	487,050	29,729				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	281,865	20,749				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	65,024	2,112				
b. Other Maintenance Workers	44,491	2,055				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	119,640	7,956				
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	206,214	3,910				
b. RN						
1. Direct Care	425,840	10,367				
2. Administrative**	411,958	13,143				
c. LPN						
1. Direct Care	1,523,654	51,195				
2. Administrative**						
d. Aides and Attendants	1,902,136	113,970				
e. Physical Therapists	396,643	9,951				
f. Speech Therapists	70,902	1,885				
g. Occupational Therapists	260,584	6,026				
h. Recreation Workers	206,680	11,129				
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	269,689	8,128				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	7,163,681	308,880				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

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

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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
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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.

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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	9/30/2019	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 10/1/18-11/23/18	23,175			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	320	A2	Unknown		
Theresa LeBel 11/24/18-1/20/19	23,148			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	370	A2	Laurel Ridge Health Care 642 Danbury Road Ridgefield, CT	118	7,889
Rita Lynch 1/21/19-9/30/19	86,374			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	1,401	A2	Unknown		
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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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	37,233	887				
2. Dentist	8,132	47				
3. Pharmacist	12,711	96				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,300	266				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	1,957					
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	4,894	14				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	3,484	56				
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	104,711	1,366				

* 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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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	9/30/2019	14	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	○	⊙	
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	○	⊙	
Quest Diagnostics, 3404 Collection CTR Dt, Chicago IL, 60693	Lab Services	○	⊙	
Yale New Haven Hospital, 1450 Chapel St, New Haven, CT 06511	Physician Services	○	⊙	
Masstex Imaging LLC, 3 Electronics Ave Suite 201, Danvers MA, 01923-1099	Speech Therapy Services	○	⊙	
Yale Medical Group, 789 Howard Ave #2, New Haven, CT 06519	Physician Services	○	⊙	
Urological Associates, 51-53 Kenosia Ave, Danbury, CT 06810	Physician Services	○	⊙	
Dr. Christopher Luthie, 3690 Main Street, Bridgeport, CT	Medical Director	○	⊙	
Laura Svenson, P.O Box 213 Gerogetown, CT 06829-0213	Dietician	○	⊙	
ProHealth, P.O. Box 150472, Hartford, CT 06115	Physician Services	○	⊙	
Orthopaedic Specialty Group, 305 Black Rock Turnpike, Fairfield, CT 06825	Orthopaedic Services	○	⊙	
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	○	⊙	
Procare LTC, 111 Executive Blvd, Farmingdale NY 11735	Pharmacist	⊙	○	Common Owners: Minority Interest
Southern CT Vascular Center, LLC, P.O. Box 40, Windsor CT 06095	Physician Services	○	⊙	
Connecticut Image Guided Surgery, P.O. Box 416139, Boston, MA 02241	Physician Services	○	⊙	
SDX Dysphagia Experts, 21 Waterville Rd, Avon,	Speech Therapy Services	○	⊙	

* 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	9/30/2019	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	471,351	471,351		
2. Disability Insurance	$				
3. Unemployment Insurance	$	77,497	77,497		
4. Social Security (F.I.C.A.)	$	502,248	502,248		
5. Health Insurance	$	996,391	996,391		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	40,942	40,942		
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*	$	93,983	93,983		
d. Accounting and Auditing	$	18,853	18,853		
e. Legal (*Services should be fully described on Page 7)*	$	1,780	1,780		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	70,189	70,189		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	68,625	68,625		
2. Cellular Phones	$	305	305		
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	$	880,683	880,683		
Subtotal	$	3,222,847	3,222,847		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
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	9/30/2019	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,222,847	3,222,847		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	7,130	7,130		
3. Gifts to Staff and Residents	$	17,328	17,328		
4. Employee Travel	$	7,412	7,412		
5. Education Expenses Related to Seminars and Conventions	$	6,506	6,506		
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*)	$	3,000	3,000		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	13,437	13,437		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	(54)	(54)		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$	4,518	4,518		
7. Postage	$	6,233	6,233		
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	5,658	5,658		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	220	220		
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**	$	440,140	440,140		
13. Other (*Specify*)	$	95,278	95,278		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	3,829,653	3,829,653		

* 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	$ 13,437		
Total Other Advertising	$ 13,437	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 5,403		
ALTCFM	$ 255		
Total Dues	$ 5,658	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	$ 15,795		
Payroll Processing Fees	$ 20,479		
Employee Physicals	$ 10,092		
Other Professional Fees	$ 2,774		
Data Processing	$ 33,058		
Licenses	$ 1,380		
Citation 2019-01-LTC-007	$ 11,700		
Total Other Administrative and General	$ 95,278	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2019	Page 17 | of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc 135 South Rd Farmington, CT 06032	614,442	Contract Attached to a prior year	See Below
Allocation of the above	Admin/Gen: 405,532; Indirect: 98,311; Direct 110,599	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 Rd 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.**

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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	9/30/2019	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	305,548	305,548		
2. Non-Food Supplies	$	37,568	37,568		
3. Other (*Specify*)_____ Dishes = $1,037	$	1,037	1,037		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____ Management Services	$	98,311	98,311		
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	442,464	442,464		

2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals:	Total no. of meals served per day:*	384	384		

G.	Is cost of employee meals included in 2D?	⊙ Yes	○ No	
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	⊙ Yes	○ No	If yes, specify cost. $1,160
K.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⊙ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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CSP-19 Rev. 9/2018

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 9/30/2019		Page 19 of 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. $	17,460	17,460		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)* — $				
c. Other (*Specify*) Supplies = $3,354 — $	3,354	3,354		
3D. ***Total Laundry Expenditures*** (3a + b + c) — $	20,814	20,814		

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

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

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

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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	9/30/2019	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	67,477	67,477		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	67,477	67,477		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Procare		$	296,422	296,422		
b. Medicine Cabinet Drugs		$	28,795	28,795		
c. Medical and Therapeutic Supplies		$	252,510	252,510		
d. Ambulance/Limousine***		$	(160)	(160)		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	39,355	39,355		
f. X-rays and Related Radiological Procedures***		$	9,439	9,439		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	27,578	27,578		
i. Recreation		$	19,870	19,870		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	229,932	229,932		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	903,741	903,741		

* 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)
Management Fee Direct	$ 110,599		
Cable TV Fees	$ 54,474		
Oxygen Concentrator Rentals	$ 7,046		
Medical Equip Rentals-Medicaid	$ 44,305		
Physical Therapy Supplies	$ 13,508		
Total Other Resident Care	$ 229,932	$ -	$ -

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CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2019	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
Procare LTC	Suite 121, Farmingdale NY 11735	⊙	○	Common Owners: Minority Interest	Pharmacy	373,029			20	5a2
CWPM	PO Box 415, Plainville, CT 06062	○	⊙		Rubbish Removal	33,975			22	6f
ADP	Philadelphia, PA 19170-0351	○	⊙		Payroll Processing	18,389			16	m13
Thyssen Krupp Elevator	P.O. Box 933007 Atlanta, GA 31193-3007	○	⊙		Elevator Service	24,335			22	6a
Outdoor Lawn Service	P.O. Box 320144 Fairfield, CT 06825	○	⊙		landscaping/snow removal	36,167			22	6f
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

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

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2019			Page 22 of 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	138,170	138,170		
b. Heat	$	53,517	53,517		
c. Light & Power	$	136,709	136,709		
d. Water	$	67,485	67,485		
e. Equipment Lease (*Provide detail on page 6*)	$	15,616	15,616		
f. Other (*itemize*)	$	95,445	95,445		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	506,942	506,942		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	3,618	3,618		
b. Building & Building Improvements	$	45,073	45,073		
c. Non-Movable Equipment	$	6,495	6,495		
d. Movable Equipment	$	41,409	41,409		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	96,595	96,595		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	4,390	4,390		
c. Leasehold Improvements	$	27,185	27,185		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	31,575	31,575		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	1,063,535	1,063,535		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	204,587	204,587		
c. Personal property taxes	$	20,792	20,792		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,417,084	1,417,084		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	$ 17,024		
Rubbish Removal	$ 36,574		
Snow Removal	$ 19,143		
Supplies	$ 22,704		
Total Other Repairs and Maintenance	$ 95,445	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2019	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	49,876	S/L	Various	3,618	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								3,618
B. **Building and Building Improvements**								
1. Acquired prior to this report period	1,298,324		1,298,324	1,045,786	S/L	Various	45,073	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
B-4. Subtotal								45,073
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	444,838		444,838	427,072	SL	Various	6,495	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
C-4. Subtotal								6,495

	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	2018	1,814,137		1,814,137	1,648,756	S/L	Various	29,140	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2019	241,934		241,934		S/L	Various	12,268	
D-3. Subtotal												41,408
E. ***Total Depreciation***												96,594

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/31/2018	Ice Machine	$ 4,947	10	$ 248	
10/31/2018	Refridgerator (2)	$ 1,168	10	$ 58	
12/31/2018	Generator Battery	3416	5	342	
2/28/2019	Café Trays	1670	10	84	
3/31/2019	Café Trays	886	10	44	
6/30/2019	Bed Conrol Box	1409	10	70	
7/31/2019	Tables & Chairs	71597	10	3580	
7/31/2019	Dresser & Cabinets	139124	10	6956	
7/31/2019	Patient Room Lighting	16445	10	822	
9/30/2019	HPC Foodservice	1272	10	64	
Total additions for Movable Equipment		$ 241,934		$ 12,268	*
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:					
2/28/2019	Heating Motor/ Boiler Repair	$ 2,820	10	$ 141	
2/28/2019	PA System	$ 1,380	10	$ 69	
5/31/2019	Hot Water Pump	$ 5,842	10	$ 292	
8/31/2019	Replaced Wood Door	$ 1,669	15	$ 56	
8/31/2019	Walk-in Freezer	$ 2,100	15	$ 70	
8/31/2019	Condensate on RTU	$ 3,270	10	$ 164	
9/30/2019	Replaced Fire Alarm System	$ 37,965	10	$ 1,898	
Total additions for Leasehold Improvement		$ 55,046		$ 2,689	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

***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	9/30/2019	24	37

Item	Date of Acquisition Month	Date of Acquisition Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1. Finance Fees	2	18	36 months	13,170	2,927	SL		4,390	
2.									
3.									
B-4. Subtotal									4,390
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2018	Various	801,373	445,710	SL	Variou	24,496	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2019	Various	55,046		SL	Variou	2,689	
C-4. Subtotal									27,185
D. ***Total Amortization***									31,575

* 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.

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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 9/30/2019	14,222,404			
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	9/30/2019	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*) $	32,210	32,210		
Vender Interest = $10,397; Line of Credit Interest = $21,8				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	32,210	32,210		
14. Insurance				
a. Insurance on Property (buildings only) $	77,188	77,188		
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)*** $	77,188	77,188		
15. ***Total All Expenditures (A-13 thru C-14)*** $	14,565,965	14,565,965		

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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	9/30/2019	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	$	260,584	260,584		
4.			Other - See attached Schedule	$	4,608	4,608		
Page 13 - Professional Fees								
5.	13	B8c	Resident Care Physicians **	$	1,957	1,957		
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.	15	1a9	Discriminatory Benefits	$				
9.	15	1c	Bad Debts	$	93,983	93,983		
10.	15	1d	Accounting	$	1,780	1,780		
10a.			Legal	$	3,253	3,253		
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	$	17,328	17,328		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	$	1,750	1,750		
16.	16	l5	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 *	$	13,437	13,437		
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$				
21.	16	m12	Unallowable Management Fees	$	250,670	250,670		
22.	30	IV7	Barber and Beauty	$	8,091	8,091		
23.			Other - See attached Schedule	$	27,495	27,495		
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.	19	3d	Laundry services to employees, guests and others who are not residents	$				
Page 20 - Housekeeping Expenditures								
26.	20	4d	Housekeeping services to employees, guests and others who are not residents	$				
			Subtotal (Items 1 - 26)	$	686,096	686,096		

* 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	$ 4,608		
Total Other Salaries Adjustment			$ 4,608	$ -	$ -

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	$ 15,795		
16	M13	Citation 2019-01-LTC 007	$ 11,700		
Total Other A&G Adjustments			$ 27,495	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page
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Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	686,096	686,096		
Page 20 - Resident Care Supplies***							
27.	20	5a1&	Prescription Drugs $	296,422	296,422		
28.	20	5d	Ambulance/Limousine $	(160)	(160)		
29.	20	5f	X-rays, etc $	9,439	9,439		
30.	20	5h	Laboratory $	27,578	27,578		
31.	20	5c	Medical Supplies $	35,082	35,082		
32.	20	5e2	Oxygen (non emergency) $	39,355	39,355		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	69,111	69,111		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $	5,713	5,713		
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 $	50,874	50,874		
43.			Interest Income on Account Rec. $	14	14		
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $	68,364	68,364		
46.			Management Fees Indirect $	60,768	60,768		
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)***		$	1,348,656	1,348,656		

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

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental	$ 44,320		
20	5a2	Ebox	$ 24,791		
Total Other Ancillary Costs			$ 69,111	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excess Movable Equipment Depreciation	$ 5,713		
Total Excess Movable Equipment Depreciation			$ 5,713	$ -	$ -

---

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		Radio & Television Revenue	$ 50,874		Pg 20, Line 5j

Total Other Adjustments			$ 50,874	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	2142C	9/30/2019	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	23,376,534	23,376,534		
b. Medicaid Room and Board Contractual Allowance **	$	(13,445,942)	(13,445,942)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,240,308	2,240,308		
b. Medicare Room and Board Contractual Allowance **	$	122,040	122,040		
4. a. Private-Pay Residents and Other	$	2,375,360	2,375,360		
b. Private-Pay Room and Board Contractual Allowance **	$	(439,054)	(439,054)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	198,837	198,837		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(198,837)	(198,837)		
c. Prescription Drugs - Non-Medicare	$	224,842	224,842		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(224,842)	(224,842)		
2. a. Medical Supplies - Medicare	$	21,682	21,682		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	612,133	612,133		
b. Physical Therapy - Medicare Contractual Allowance **	$	(517,512)	(517,512)		
c. Physical Therapy - Non-Medicare	$	299,250	299,250		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(299,250)	(299,250)		
4. a. Speech Therapy - Medicare	$	179,255	179,255		
b. Speech Therapy - Medicare Contractual Allowance **	$	(145,115)	(145,115)		
c. Speech Therapy - Non-Medicare	$	109,525	109,525		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(109,525)	(109,525)		
5. a. Occupational Therapy - Medicare	$	630,505	630,505		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(548,534)	(548,534)		
c. Occupational Therapy - Non-Medicare	$	305,170	305,170		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(305,170)	(305,170)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	20,939	20,939		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	14,482,599	14,482,599		
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)*	$	14	14		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	8,091	8,091		
8. Other (*Specify*)	$	127,838	127,838		
V. Total Other Revenue (1 thru 8)	$	135,943	135,943		
VI. Total All Revenue (III +V)	$	14,618,542	14,618,542		

* *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)
30	Medicaid - Retro SNF	$ 13,825		
30	Medicare - Retro	$ 7,114		
Total Other Resident Revenue		$ 20,939	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
pg 31, L A	Interest on A/R	NA	$ 14		
Total Interest Income			$ 14	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
15, 1c	Bad Debt Recoveries	$ 127,838		
Total Other Revenue		$ 127,838	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
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Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 14,390
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,501,889
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 20,715
5. Prepaid Expenses				$ 399,825
a. Prepaid Insurance		387,658		
b. Ppd exp-health insurance & maintenance repairs		6,747		
c. Ppd exp-fmla license		2,867		
d. See Schedule		2,553		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 125,655
Due from Related Parties		125,655		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,062,474
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	63,905		$ 10,411
	Accum. Depreciation	53,494	Net	
3. Buildings	*Historical Cost	1,299,096		$ 207,465
	Accum. Depreciation	1,091,631	Net	
4. Leasehold Improvements	*Historical Cost	856,419		$ 383,524
	Accum. Depreciation	472,895	Net	
5. Non-Movable Equipment	*Historical Cost	444,830		$ 11,273
	Accum. Depreciation	433,557	Net	
6. Movable Equipment	*Historical Cost	2,039,889		$ 349,723
	Accum. Depreciation	1,690,166	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (2,822)
Equipment Carryforward adjustments		16,183		
See Schedule		(19,005)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 959,574

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	5d	Ppd Exp - LEAF	$ 2,553
Total Prepaid Expenses			$ 2,553

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	
31	B9	Depr Adjustment due to conversion/ Project Development	$ (19,005)
Total Other Other Fixed Assets (Itemize)			$ (19,005)

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)			$ -

Maefair Moveable Equipment Carryforward Schedule

Cost Year		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 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	TV's 2018 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	$13,624	$ 218,209
	Term	$ 5	$ 8	$ 10	$ 15	$ 20	$ 15	$ 5	$ 10	$ 10	$ 5	$ 5	$ 5	$ 5	$ 5	$ 5	$ 5	
1995	Deprec	$ 1,697	$ 84	$ 4,727	$ 279	$ 53												
1995	Book Value	$ 15,271	$ 1,252	$ 89,812	$ 8,096	$ 2,072												$ 6,840
1996	Deprec	$ 3,394	$ 167	$ 9,454	$ 558	$ 106												$ 116,503
1996	Book Value	$ 11,877	$ 1,085	$ 80,358	$ 7,538	$ 1,966												$ 13,679
1997	Deprec	$ 3,394	$ 167	$ 9,454	$ 558	$ 106	$ 1,216											$ 102,824
1997	Book Value	$ 8,483	$ 918	$ 70,904	$ 6,980	$ 1,860	$ 17,016											$ 14,895
1998	Deprec	$ 3,394	$ 167	$ 9,454	$ 558	$ 106	$ 1,216											$ 108,161
1998	Book Value	$ 5,089	$ 751	$ 61,450	$ 6,422	$ 1,754	$ 15,800											$ 14,895
1999	Deprec	$ 3,394	$ 167	$ 9,454	$ 558	$ 106	$ 1,216											$ 91,266
1999	Book Value	$ 1,695	$ 584	$ 51,996	$ 5,864	$ 1,648	$ 14,584											$ 14,895
2000	Deprec	$ 1,695	$ 167	$ 9,454	$ 558	$ 106	$ 1,216											$ 76,371
2000	Book Value	$ -	$ 417	$ 42,542	$ 5,306	$ 1,542	$ 13,368											$ 13,196
2001	Deprec		$ 167	$ 9,454	$ 558	$ 106	$ 1,216											$ 63,175
2001	Book Value		$ 250	$ 33,088	$ 4,748	$ 1,436	$ 12,152											$ 11,501
2002	Deprec		$ 167	$ 9,454	$ 558	$ 106	$ 1,216											$ 51,674
2002	Book Value		$ 83	$ 23,634	$ 4,190	$ 1,330	$ 10,936											$ 11,501
2003	Deprec		$ 83	$ 9,454	$ 558	$ 106	$ 1,216											$ 40,173
2003	Book Value		$ -	$ 14,180	$ 3,632	$ 1,224	$ 9,720											$ 11,417
2004	Deprec			$ 9,454	$ 558	$ 106	$ 1,216											$ 28,756
2004	Book Value			$ 4,726	$ 3,074	$ 1,118	$ 8,504											$ 11,334
2005	Deprec			$ 4,726	$ 558	$ 106	$ 1,216											$ 17,422
2005	Book Value			$ -	$ 2,516	$ 1,012	$ 7,288											$ 6,606
2006	Deprec				$ 558	$ 106	$ 1,216											$ 10,816
2006	Book Value				$ 1,958	$ 906	$ 6,072											$ 1,880
2007	Deprec				$ 558	$ 106	$ 1,216	$ 148	$ 4,414									$ 8,936
2007	Book Value				$ 1,400	$ 800	$ 4,856	$ 587	$ 39,716									$ 6,442
2008	Deprec				$ 558	$ 106	$ 1,216	$ 148	$ 4,414	$ 112								$ 47,359
2008	Book Value				$ 842	$ 694	$ 3,640	$ 439	$ 35,302	$ 2,109								$ 6,554
2009	Deprec				$ 558	$ 106	$ 1,216	$ 148	$ 4,414	$ 223	$ 15							$ 43,026
2009	Book Value				$ 284	$ 588	$ 2,424	$ 291	$ 30,888	$ 1,886	$ 136							$ 6,680
2010	Deprec				$ 284	$ 106	$ 1,216	$ 148	$ 4,414	$ 223	$ 31	$ 12						$ 36,497
2010	Book Value				$ -	$ 482	$ 1,208	$ 143	$ 26,474	$ 1,663	$ 105	$ 107						$ 6,434
2011	Deprec					$ 106	$ 1,208	$ 143	$ 4,414	$ 223	$ 31	$ 25						$ 30,182
2011	Book Value					$ 376	$ -	$ -	$ 22,060	$ 1,440	$ 74	$ 82						$ 6,150
2012	Deprec					$ 106			$ 4,414	$ 223	$ 31	$ 25						$ 24,032
2012	Book Value					$ 270			$ 17,646	$ 1,217	$ 43	$ 57						$ 4,799
2013	Deprec					$ 106			$ 4,414	$ 223	$ 31	$ 25	$ 72					$ 19,233
2013	Book Value					$ 164			$ 13,232	$ 994	$ 12	$ 32	$ 645					$ 4,871
2014	Deprec					$ 106			$ 4,414	$ 223	$ 12	$ 25	$ 143	$ -				$ 15,078
2014	Book Value					$ 58			$ 8,818	$ 771	$ -	$ 7	$ 502	$ -				$ 4,923
2015	Deprec					$ 58			$ 4,414	$ 223		$ 7	$ 143	$ 72				$ 10,155
2015	Book Value					$ -			$ 4,404	$ 548		$ -	$ 359	$ 647				$ 4,917
2016	Deprec								$ 4,404	$ 223			$ 143	$ 144	$ 267			$ 5,957
2016	Book Value								$ -	$ 325			$ 216	$ 503	$ 2,407			$ 5,181
2017	Deprec									$ 223			$ 143	$ 144	$ 535	$ 1,155		$ 3,450
2017	Book Value									$ 102			$ 73	$ 359	$ 1,872	$ 10,391		$ 2,200
2018	Deprec									$ 102			$ 73	$ 144	$ 535	$2,309	1,362	$ 12,796
2018	Book Value									$ -			$ -	$ 215	$ 1,337	$8,082	12,262	$ 4,524
2019														$ 144	$ 535	$2,309	2,725	$ 21,898
2019														$ 71	$ 802	$5,773	9,537	$ 5,713
2020														$ 71	$ 535	$2,309	2,725	$ 16,183
2020														$ -	$ 267	$3,464	6,812	$ 5,640
2021															$ 267	$2,309	2,725	$ 10,543
2021															$ 0	$1,155	4,088	$ 5,301
2022																$1,155	2,725	$ 5,243
2022																$0	1,363	$ 3,880
20023																	1,363	$ 1,363
2023																	0	$ 1,363
																		$ (0)

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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	9/30/2019	32	37

Account				Amount
			Total Brought Forward:	$ 3,022,048
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	6,650,215	Net	$ 1,173,561
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)				$ 2,433,561
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)	3/29/12		
7. Other Assets (*itemize*)				$ 202,382
Deferred Finance Fees		5,853		
Unamortized Bed License		196,529		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (8,531,658)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ (3,076,049)

* 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	9/30/2019	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 2,000,692
	2. Notes Payable (*itemize*)				$ 370,780
	Midcap Line of Credit		201,770		
	Due to Related Parties		169,010		
	See Schedule				
	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*)				$ 204,408
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 10,002
	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*)				$ 296,602
	Security Deposits-Private Pay		223,946	Provider Taxes Due	
	Acc'd Int-Private Pay Security Depo:		5,571	Accd Health insurance	
	Acc'd Operating Expenses		61,482		
	Acc'd Expense - Sales Tax		5,603	See Schedule	
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,882,484

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

(Carry Total forward to next page)

Maefair
Accrued Expenses #2170
30-Sep-19

Date	Description	Amount
9/30/2016	Quarterly mgmt fee adjmt	$7,122.48
	Health Insurance	$43,244.29
9/30/2019	Telephone	$3,068.18
9/30/2019	Water	$238.24
9/30/2019	Labs	$3,735.44
9/30/2019	Bank Fees	($8,553.48)
9/30/2019	Food	($479.09)
9/30/2019	Health Insurance	($5,210.79)
9/30/2019	DHL	$10,100.00
9/30/2019	G. Rogers Void	($60.00)
9/30/2019	Pension	($4,308.96)
9/30/2019	Ambulance	$180.00
9/30/2019	Water	$12,406.10
		$61,482.41 9/30/2019

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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	9/30/2019	34	37

Account	Amount
Total Brought Forward:	2,882,484
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ (205,169)
Related Party	(241,205)	
Note Payable - McKesson	36,036	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ (205,169)
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 2,677,315

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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	9/30/2019	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		$ 1,173,561
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		$ 2,433,561
B. **Net Worth**		
1. Owner's Capital		$
2. Capital Stock		$ 2,000
3. Paid-in Surplus		$
4. Treasury Stock		$
5. Cumulated Earnings		$ (8,438,030)
6. Gain or Loss for Period	10/1/2018 thru 9/30/2019	$ 52,577
7. Total Net Worth		$ (8,383,453)
C. ***Total Reserves and Net Worth***		$ (5,949,892)
D. ***Total Liabilities, Reserves, and Net Worth***		$ (3,272,577)

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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	9/30/2019	36	37

Account			Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2018			$ (8,161,020)
B. Total Revenue (*From Statement of Revenue Page 30*)			$ 14,618,542
C. Total Expenditures (*From Statement of Expenditures Page 27*)			$ 14,565,965
D. Net Income or Deficit			$ 52,577
E. Balance			$ (8,108,443)
F. Additions			
1. Additional Capital Contributed (*itemize*)			
2018 AJE - health insurance	55,580		
Prior year Hewlett Packard exp adjmt	(590)		
	(330,000)		
2. Other (*itemize*)			
F-3. Total Additions			$ (275,010)
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*** 09/30/19			$ (8,383,453)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
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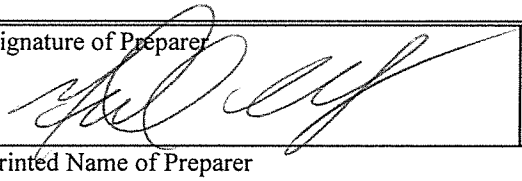
Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
	CFO	2/17/2020

Printed Name of Preparer	
Athena Health Care Associates, Inc	
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