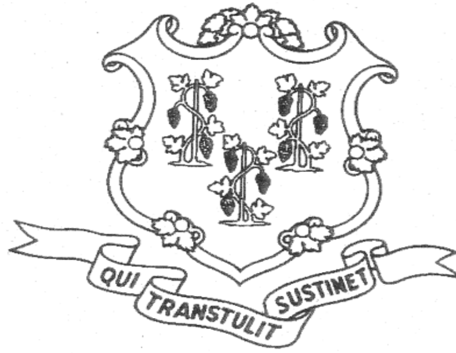
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2020

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 10/1/2019	Report for Year Ending 9/30/2020	

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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CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2020	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, 2019 and ending September 30, 2020, 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) Rita Lynch			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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Department of Social Services
55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page	of
			1A	37
Name of Facility Maefair Health Care Center	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 21 Maefair Court Trumbull, CT 06611				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900		Date 2/15/2021	

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	9/30/2020	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

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	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
Maefair Health Care Center	2142C	9/30/2020	3	37

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2020	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Maefair Health Care Center, Inc	21 Maefair Court, Trumbull, CT 06611	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G. Santilli	21 Maefair Court, Trumbull, CT 06611	President	880.1015
Michael E. Mosier	21 Maefair Court, Trumbull, CT 06611	reasurer/Secretar	
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
Maefair Health Care Center	2142C	9/30/2020	3B	37

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
Maefair Health Care Center	2142C	9/30/2020	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Maefair Landlord, LLC	135 South Rd, Farmington, CT	○	⊙		lease of facility	Pg 22, Ln 9 and 10b, pg	1,333,206	1,333,206
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	260,628	260,628
Laurel Ridge Health Care	135 South Rd, Farmington, CT 06032	○	⊙		Bank Charges		12,812	12,812
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* 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	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2020	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

Not Applicable

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

Not Applicable

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

○ Yes ⊙ No — If "No," explain fully why such allocation was not made.

Not Applicable

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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		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	○	⦿	Postal Equipment	11/22/13	Annual renewal	1,207	1,207
LEAF Capital Funding, LLC PO Box 979127, Miami, FL 33197-9127	○	⦿	Copier System	02/25/16	48 months	15,314	11,485
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⦿ No **Total ***** 12,692

* 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   ○ 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	PKF O'Connor Davies, LLP	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	2019 Audit, Year end financials & tax returns	$	13,600
2	Preparation of Medicare Cost report	$	2,700
3	Line of Credit audit fees - Disallowed	$	1,515
4		$	
	Charge for Services Provided	$	17,815

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

⦿ Yes   ○ No   Pg 15, Line1d

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	Goldman, Gruder & Woods	203-899-8900
2	Trumbull Probate/Conservator fee/Senior Planning Services	203-452-5068
3	Midcap Financial Services	301-860-7600
4	Jackson Lewis P.C./Pilicy & Ryan	
5	Murtha Cullina	

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)(365 Main St, Watertown, CT 06795)
5 280 Trumbull St, Hartford, CT 06103

Services Provided by This Firm (*describe fully*)

1	Collections:Disallowed	$	3,928
2	Conservator:Disallow	$	2,088
3	Line of Credit Services: Disallow	$	3,171
4	Employee Matters: Disallow	$	9,739
5	IDR: Disallow	$	347
	Charge for Services Provided	$	19,273

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

⦿ Yes   ○ No   Pg 15 Line 1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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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						
B. On last day of THIS report period	134	134							134	134		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	132	132			132	132						
B. As of midnight of THIS report period	99	99							99	99		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,833	4,833			4,083	4,083			750	750		
B. Medicaid (Conn.)	36,631	36,631			27,993	27,993			8,638	8,638		
C. Medicaid (other states)												
D. Private Pay	1,115	1,115			1,013	1,013			102	102		
E. State SSI for RCH												
F. Other (Specify) Managed Care	291	291			236	236			55	55		
G. Total Care Days During Period (3A thru F)	42,870	42,870			33,325	33,325			9,545	9,545		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	116	116			116	116						
B. Other Bed Reserve Days	8	8			8	8						
5. ***Total Resident Days*** **(3G + 4A + 4B)**	42,994	42,994			33,449	33,449			9,545	9,545		

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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? ○ Yes ⊙ No
If "YES", provide the following information:

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

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 CCNH	Medicaid CCNH	Medicaid RHNS	Self-Pay CCNH	Self-Pay RHNS	Self-Pay (Specify)	Other State Assisted R.C.H.	Other State Assisted ICF-MR
No. of Residents	3	91		1		4		
Per Diem Rate								
a. One bed rm.	587.43	254.71		636.00		474.78		
b. Two bed rms.	587.43	254.71		624.00		474.78		
c. Three or more bed rms.								

Item	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,071	1,071		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	738	738		
2. Restorative Treatments				
C. Other	3,981	3,981		
D. ***Total Physical Therapy Treatments***	5,790	5,790		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	200	200		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	97	97		
2. Restorative Treatments				
C. Other	634	634		
D. ***Total Speech Therapy Treatments***	931	931		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	810	810		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	514	514		
2. Restorative Treatments				
C. Other	3,713	3,713		
D. ***Total Occupational Therapy Treatments***	5,037	5,037		

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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	9/30/2020	10	37

Are time records maintained by all individuals receiving compensation? ⦿ Yes ○ 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)	135,329	2,180				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	323,175	13,449				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	69,940	2,125				
c. Dietary Workers	591,749	31,505				
6. Housekeeping Service						
a. Head Housekeeper	43,456	1,872				
b. Other Housekeeping Workers	312,374	19,263				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	69,871	2,191				
b. Other Maintenance Workers	58,172	2,272				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	149,220	9,048				
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	221,097	4,372				
b. RN						
1. Direct Care	520,873	11,572				
2. Administrative**	479,614	15,405				
c. LPN						
1. Direct Care	1,584,413	50,610				
2. Administrative**						
d. Aides and Attendants	2,135,689	111,681				
e. Physical Therapists	413,644	10,681				
f. Speech Therapists	82,817	1,987				
g. Occupational Therapists	239,527	5,412				
h. Recreation Workers	207,871	9,983				
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	271,120	8,204				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	7,909,951	313,812				

* 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
Maefair Health Care Center	2142C	9/30/2020	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.

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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	9/30/2020	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* **										
Rita Lynch	135,329			Health & Life Insurances, Payroll Taxes	Day to day operations of the nursing home facility	2,180	A2	Unknown		
10/1/2019 - 9/30/2020										
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
Maefair Health Care Center	2142C		9/30/2020		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	39,732	946				
2. Dentist	2,680	15				
3. Pharmacist	13,382	73				
4. Podiatrist	38	6				
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,450	59				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**	2,234					
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	1,080	6				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides	1,321	17				
d. Other						
12. Other (Specify)						
See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	96,917	1,122				

* 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	9/30/2020	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Dr. Milla Stelman, 1021 Daniels Farm 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	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, CT 06001	Speech Therapy Services	○	⊙	
Griffin Hospital, 130 Division St, Derby, CT 0641	Physician 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	9/30/2020	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	678,311	678,311		
2. Disability Insurance	$				
3. Unemployment Insurance	$	73,356	73,356		
4. Social Security (F.I.C.A.)	$	565,553	565,553		
5. Health Insurance	$	882,489	882,489		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	33,889	33,889		
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*	$	243,504	243,504		
d. Accounting and Auditing	$	37,088	37,088		
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	57,616	57,616		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	80,478	80,478		
2. Cellular Phones	$	635	635		
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*	$	750	750		
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	799,538	799,538		
Subtotal	$	3,453,207	3,453,207		

* 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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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	9/30/2020	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,453,207	3,453,207		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	3,360	3,360		
3. Gifts to Staff and Residents	$	18,512	18,512		
4. Employee Travel	$	6,374	6,374		
5. Education Expenses Related to Seminars and Conventions	$	4,220	4,220		
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*)	$	9,081	9,081		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	12,258	12,258		
4. Fund-Raising***	$				
5. Medical Records	$	(186)	(186)		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	3,609	3,609		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	2,442	2,442		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	194	194		
9. Subscriptions	$				
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**	$	407,375	407,375		
13. Other (*Specify*) See Attached Schedule	$	128,317	128,317		
C-14 Total Administrative & General Expenditures	$	4,048,763	4,048,763		

* 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	$ 12,258		
Total Other Advertising	$ 12,258	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 2,442		
Total Dues	$ 2,442	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	$ 23,849		
Payroll Processing Fees	$ 29,096		
Employee Physicals	$ 5,984		
Other Professional Fees	$ 168		
Data Processing	$ 48,922		
Licenses	$ 2,113		
CMP LTC-103 / Public Health Citation #2019-58	$ 18,185		
Total Other Administrative and General	$ 128,317	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2020	Page of 17 | 37
Name & Address of Individual or Company Supplying Service	**Cost of Management Service**	**Full Description of Mgmt. Service Provided**	**Indicate Where Costs are Included in Annual Report Page #/Line #**
Athena Health Care Assoc., Inc 135 South Rd Farmington, CT 06032	564,798	Contract Attached to a prior year	See Below
Allocation of the above	3; Direct $101,663	Admin/Gen= 66%; Indirect= 16%; Direct= 18%	Admin/Gen= Pg 16 Line
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.**

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	9/30/2020	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	313,781	313,781		
2. Non-Food Supplies	$	52,772	52,772		
3. Other (*Specify*)____________ Dishes	$	(101)	(101)		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)____________ Management Services	$	90,368	90,368		
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	456,820	456,820		

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

	Question	Yes	No	
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.
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.

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

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	2142C	9/30/2020	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	16,922	16,922		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Laundry Supplies	$	2,989	2,989		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	19,911	19,911		

3E. Laundry Questionnaire			
F. Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G. Did you receive revenue from employees?	○ 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?	○ Yes	⊙ No	If yes, specify cost.
J. Did you receive revenue from these people?	○ 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.

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	9/30/2020	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	46,373	46,373		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	46,373	46,373		
5. Resident Care (Supplies)** a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Procare		$	229,602	229,602		
b. Medicine Cabinet Drugs		$	7,166	7,166		
c. Medical and Therapeutic Supplies		$	294,535	294,535		
d. Ambulance/Limousine***		$	20,251	20,251		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	9,889	9,889		
f. X-rays and Related Radiological Procedures***		$	20,915	20,915		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	36,436	36,436		
i. Recreation		$	8,060	8,060		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	206,872	206,872		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	833,726	833,726		

* 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	$ 101,663		
Cable TV Fees	$ 47,577		
Oxygen Concentrator Rentals	$ 14,760		
Medical Equip Rentals-Medicaid	$ 21,754		
Physical Therapy Supplies	$ 11,153		
Medical Equip Rentals-Other	$ 239		
Housekeeping	$ 9,726		
Total Other Resident Care	$ 206,872	$ -	$ -

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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	9/30/2020	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	260,628			20	5a2
CWPM	PO Box 415, Plainville, CT 06062	○	◉		Rubbish Removal	36,572			22	6f
ADP	Philadelphia, PA 19170-0351	○	◉		Payroll Processing	19,033			16	m13
Thyssen Krupp Elevator	P.O. Box 933007 Atlanta, GA 31193-3007	○	◉		Elevator Service	19,871			22	6a
Outdoor Lawn Service	P.O. Box 320144 Fairfield, CT 06825	○	◉		Landscaping/ Snow Removal	48,644			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).

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	$ 28,672		
Rubbish Removal	$ 35,207		
Snow Removal	$ 19,973		
Supplies	$ 15,589		
Total Other Repairs and Maintenance	$ 99,441	$ -	$ -

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	9/30/2020	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	105,773	105,773		
b. Heat	$	59,188	59,188		
c. Light & Power	$	132,028	132,028		
d. Water	$	72,202	72,202		
e. Equipment Lease (*Provide detail on page 6*)	$	12,692	12,692		
f. Other (*itemize*)	$	99,441	99,441		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	481,324	481,324		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	2,842	2,842		
b. Building & Building Improvements	$	32,160	32,160		
c. Non-Movable Equipment	$	2,914	2,914		
d. Movable Equipment	$	48,725	48,725		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	86,641	86,641		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	4,390	4,390		
c. Leasehold Improvements	$	25,635	25,635		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	30,025	30,025		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	1,030,820	1,030,820		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	205,074	205,074		
c. Personal property taxes	$	33,700	33,700		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,386,260	1,386,260		

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

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2020	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			53,494	S/L	Various	2,842	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
A-4. Subtotal								2,842
B. **Building and Building Improvements**								
1. Acquired prior to this report period	1,298,324			1,090,859	S/L	Various	32,160	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
B-4. Subtotal								32,160
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	444,838			433,567	SL	Various	2,914	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
C-4. Subtotal								2,914

	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	2019	2,056,071			1,690,164	S/L	Various	47,045	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2020	25,138				S/L	Various	1,680	
D-3. Subtotal												48,725
E. ***Total Depreciation***												86,641

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 peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Non-Movable Equipmen		$ -		$ -	*
Deletions:					
Total deletions for Non-Movable Equipmen		$ -		$ -	**

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/31/2019	Replaced Dryer Motor	$ 1,179	10	$ 59	
11/30/2019	Replaced Refrigerator Door	$ 2,125	10	$ 106	
12/31/2019	Chairs	$10,666	15	$356	
7/31/2020	Bed Control Boxes	$1,085	12	$45	
7/31/2020	Bedside Station	$1,422	10	$71	
7/31/2020	Tablets	$1,194	5	$119	
8/31/2020	Oven	$4,419	10	$221	
9/30/2020	Laptop	$708	3	$118	
9/30/2020	Latops	$2,340	2	$585	
Total additions for Movable Equipmen		$ 25,138		$ 1,680	*
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 peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
1/31/2020	New Condensing Unit	$ 7,764	15	$ 259	
9/30/2020	Heat Repair	$ 2,419	10	$ 121	
9/30/2020	Condensate Repair	$2,126	10	$106	
Total additions for Leasehold Improvemen		$ 12,309		$ 486	*
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 9/30/2020	Page 24 of 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. Bed Purchase License	9	1997	15 Years	567,916	371,387	SL	0		
3.									
A-4. Subtotal									
B. **Mortgage Expense** 1.									
2. Finance Fees	2	18	36 Months	13,170	4,390	SL		4,390	
3.									
B-4. Subtotal									4,390
C. **Leasehold Improvements and Other** 1. Acquired prior to this report period	9	2019	Various	288,503	101,508	SL	Variou	25,149	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2020	Various	12,309		SL	Variou	486	
C-4. Subtotal									25,635
D. ***Total Amortization***									30,025

* 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	License No.	Report for Year Ended	Page of
Maefair Health Care Center	2142C	9/30/2020	25 | 37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	04/01/93
2. Date Structure Completed	04/01/94
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	04/01/94
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	322.00%			
d. Term of Mortgage (number of years)	35			
e. Amount of Principal Borrowed	16,336,000			
f. Principal balance outstanding as of ___________	13,896,886			
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	9/30/2020	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*)

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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	9/30/2020	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*) Vendor Interest= $17,872; LOC Interest= $17,872			$	30,620	30,620		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	30,620	30,620		
14. Insurance a. Insurance on Property (buildings only)			$	103,570	103,570		
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)***			$	103,570	103,570		
15. ***Total All Expenditures (A-13 thru C-14)***			$	15,414,235	15,414,235		

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	2142C	9/30/2020	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.			Occupational Therapy	$	239,527	239,527		
4.			Other - See attached Schedule	$	3,682	3,682		
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$	2,234	2,234		
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.			Bad Debts	$	243,504	243,504		
10.			Accounting	$	1,515	1,515		
10a.			Legal	$	19,273	19,273		
11.			Telephone	$				
12.			Cellular Telephone	$	85	85		
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.			Gifts, flowers and coffee shops	$	18,512	18,512		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	$				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	$				
17.			Automobile Expense (e.g. personal use)	$				
18.			Unallowable Advertising *	$	12,258	12,258		
19.			Income Tax / Corporate Business Tax	$	750	750		
20.			Fund Raising / Contributions	$				
21.			Unallowable Management Fees	$	298,727	298,727		
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	42,202	42,202		
Page 18 - Dietary Expenditures								
24.			Meals to employees, guests and others who are not residents	$				
Page 19 - Laundry Expenditures								
25.			Laundry services to employees, guests and others who are not residents	$				
Page 20 - Housekeeping Expenditures								
26.			Housekeeping services to employees, guests and others who are not residents	$				
			Subtotal (Items 1 - 26)	$	882,269	882,269		

* 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	$ 3,682		
Total Other Salaries Adjustment			$ 3,682	$ -	$ -

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	$ 23,849		
16	M13	Penalties	$ 18,185		
16	M13	Other Professional Fees	$ 168		
Total Other A&G Adjustments			$ 42,202	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
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Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	882,269	882,269		
Page 20 - Resident Care Supplies*								
27.			Prescription Drugs	$	229,602	229,602		
28.			Ambulance/Limousine	$	20,251	20,251		
29.			X-rays, etc	$	20,915	20,915		
30.			Laboratory	$	36,436	36,436		
31.			Medical Supplies	$	18,721	18,721		
32.			Oxygen (non emergency)	$	9,889	9,889		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	7,095	7,095		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$	5,640	5,640		
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	$	43,977	43,977		
43.			Interest Income on Account Rec.	$				
44.			Other - Miscellaneous Administrative	$				
45.			Management Fees Direct	$	53,771	53,771		
46.			Management Fees Indirect	$	47,796	47,796		
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)***	$	1,376,362	1,376,362		

*** 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	$ 239		
20	5a2	Ebox	$ 6,856		
Total Other Ancillary Costs			$ 7,095	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excess Movable Equipment Depreciation	$ 5,640		
Total Excess Movable Equipment Depreciation			$ 5,640	$ -	$ -

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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)
20	5j	Radio & Television Revenue	$ 43,977		
Total Other Adjustments			$ 43,977	$ -	$ -

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	9/30/2020	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	22,661,073	22,661,073		
b. Medicaid Room and Board Contractual Allowance **	$	(13,167,165)	(13,167,165)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,764,302	1,764,302		
b. Medicare Room and Board Contractual Allowance **	$	134,851	134,851		
4. a. Private-Pay Residents and Other	$	2,231,895	2,231,895		
b. Private-Pay Room and Board Contractual Allowance **	$	(537,309)	(537,309)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	143,650	143,650		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(143,650)	(143,650)		
c. Prescription Drugs - Non-Medicare	$	142,972	142,972		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(142,972)	(142,972)		
2. a. Medical Supplies - Medicare	$	5,321	5,321		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	464,924	464,924		
b. Physical Therapy - Medicare Contractual Allowance **	$	(329,862)	(329,862)		
c. Physical Therapy - Non-Medicare	$	278,960	278,960		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(278,960)	(278,960)		
4. a. Speech Therapy - Medicare	$	161,675	161,675		
b. Speech Therapy - Medicare Contractual Allowance **	$	(88,705)	(88,705)		
c. Speech Therapy - Non-Medicare	$	92,950	92,950		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(92,950)	(92,950)		
5. a. Occupational Therapy - Medicare	$	454,036	454,036		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(261,380)	(261,380)		
c. Occupational Therapy - Non-Medicare	$	247,820	247,820		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(247,820)	(247,820)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	344,757	344,757		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	13,838,413	13,838,413		
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)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	117,888	117,888		
V. Total Other Revenue (1 thru 8)	$	117,888	117,888		
VI. Total All Revenue (III +V)	$	13,956,301	13,956,301		

* *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)
Pg 30 Line	Ancillary Allow:MC B	$ (214,564)		
Pg 30 Line	Misc Revenue from CRF Funding	$ 559,321		
Total Other Resident Revenue		$ 344,757	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Misc Income	$ 11,520		
15, 1c	Bad Debt Recoveries	$ 106,368		
Total Other Revenue		$ 117,888	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 191,530
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,832,108
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (889,100)
4 Inventories				$ 19,854
5. Prepaid Expenses				$ 148,873
a. Prepaid Insurance		141,706		
b. Ppd exp-health insurance & maintenance repairs		4,743		
c. Ppd exp-fmla license		2,424		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$ (350,000)
8. Other Current Assets (*itemize*)				$ 125,655
Due from Related Parties		125,655		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,078,920
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	63,905		$ 7,569
	Accum. Depreciation	56,336	Net	
3. Buildings	*Historical Cost	1,299,096		$ 175,305
	Accum. Depreciation	1,123,791	Net	
4. Leasehold Improvements	*Historical Cost	300,811		$ 173,669
	Accum. Depreciation	127,142	Net	
5. Non-Movable Equipment	*Historical Cost	444,830		$ 8,359
	Accum. Depreciation	436,471	Net	
6. Movable Equipment	*Historical Cost	2,070,665		$ 331,773
	Accum. Depreciation	1,738,892	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 13,406
Equipment Carryforward adjustments		10,543		
See Schedule		2,863		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 710,081

* 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	
Total Prepaid Expenses			$ -

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	$ 2,863
Total Other Other Fixed Assets (Itemize)			$ 2,863

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	7	Taxes	$ 6,157
Total Other Assets			$ 6,157

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)			$ -

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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	9/30/2020	32 | 37

	Account				Amount
				Total Brought Forward:	$ 1,789,001
C.	Leasehold or like property recorded for Equity Purposes.				
	1. Land				$ 1,260,000
	2. Land Improvements	*Historical Cost	7,823,776		
		Accum. Depreciation	6,911,008	Net	$ 912,768
	3. Buildings	*Historical Cost			
		Accum. Depreciation		Net	$
	4. Non-Movable Equipment	*Historical Cost			
		Accum. Depreciation		Net	$
	5. Movable Equipment	*Historical Cost			
		Accum. Depreciation		Net	$
	6. Motor Vehicles	*Historical Cost			
		Accum. Depreciation		Net	$
	7. Minor Equipment-Not Depreciable				$
C-8	***Total Leasehold or Like Properties*** (C1 thru 7)				$ 2,172,768
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*)				$ 204,149
	Deferred Finance Fees		1,463		
	Unamortized Bed License		196,529		
	See Schedule		6,157		
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (8,529,891)
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ (4,568,122)

* 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	9/30/2020	33 | 37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 1,200,637
2. Notes Payable (*itemize*)				$ 812,353
Midcap Line of Credit		263,483		
Due to Related Parties		(922,592)		
PPP Loan		1,471,462		
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*)				$ 277,472
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 264,977
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*)				$ 923,157
Acc'd Operating Expenses	330,806			
Acc'd Expense - Sales Tax	189			
Provider Taxes Due	586,984			
Accd Health insurance	5,178	See Schedule		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 3,478,596

* 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	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2020	34	37

Account				Amount
			Total Brought Forward:	3,478,596
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*)				$ (227,611)
Related Party		(227,611)		
See Schedule				
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ (227,611)
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 3,250,985

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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	9/30/2020	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	$ 912,768
	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	$ 2,172,768
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 2,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (8,535,941)
	6. Gain or Loss for Period 10/1/2019 thru 9/30/2020	$ (1,457,934)
	7. Total Net Worth	$ (9,991,875)
C.	***Total Reserves and Net Worth***	$ (7,819,107)
D.	***Total Liabilities, Reserves, and Net Worth***	$ (4,568,122)

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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	9/30/2020	36 | 37

	Account		Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2019		$ (8,383,453)
B.	Total Revenue (*From Statement of Revenue Page 30*)		$ 13,956,301
C.	Total Expenditures (*From Statement of Expenditures Page 27*)		$ 15,414,235
D.	Net Income or Deficit		$ (1,457,934)
E.	Balance		$ (9,841,387)
F.	Additions		
	1. Additional Capital Contributed (*itemize*)		
	2019 AJE - health insurance	(147,930)	
	Rounding	(5)	
	Prior Year Ppd Exp LEAF	(2,553)	
	2. Other (*itemize*)		
F-3.	Total Additions		$ (150,488)
G.	Deductions		
	1. Drawings of Owners/Operators/Partners (*Specify*)		$

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

		Amount
	2. Other Withdrawings (*Specify*)	$

Purpose	Amount

			Amount
	3. Total Deductions		$
H.	***Balance at End of Period***	09/30/20	$ (9,991,875)

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2020	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer

Athena Health Care Associates, Inc

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

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Michael Baldassarre	(860) 751-3900

Contact Email Address

mbaldassarre@athenahealthcare.com