State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2021

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 10/1/2020	Report for Year Ending 9/30/2021	

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	9/30/2021	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, 2020 and ending September 30, 2021, 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 1A	of 37
Name of Facility Maefair Health Care Center	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 21 Maefair Court Trumbull, CT 06611				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900		Date 2/10/2022	

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	9/30/2021	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
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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/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
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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	1,227,790	1,227,790
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	295,671	295,671
Laurel Ridge Health Care	135 South Rd, Farmington, CT 06032	○	⊙		Bank Charges		4,616	4,616
		○	⊙					
		⊙	○					
		⊙	○					
		○	⊙					

* Use additional sheets if necessary.

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

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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.

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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	○	⊙	Postal Equipment	11/22/13	Annual renewal	1,207	2,181
LEAF Capital Funding, LLC PO Box 979127, Miami, FL 33197-9127	○	⊙	Copier System	02/25/16	48 months	15,314	13,068
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total** *** 15,249

* 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	Marcum LLP	555 Long Wharf Drive, New Haven, CT

Services Provided by This Firm (*describe fully*)

1	2020 Audit: Credit (Disallowed: Prior Year)	$	(10,400)
2	Preparation of Medicare Cost report	$	2,700
3	Line of Credit audit fees - Disallowed	$	3,418
4	PPP Loan forgiveness Application: Disallowed	$	9,270
		Charge for Services Provided	
		$	4,988

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	Murtha Cullina	
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
4 280 Trumbull St, Hartford, CT 06103
5

Services Provided by This Firm (*describe fully*)

1	Collections:Disallowed	$	46,249
2	Conservator:Disallow	$	1,430
3	Line of Credit Services: Disallow	$	32
4	IDR: Disallow	$	2,515
5		$	
		Charge for Services Provided	
		$	50,226

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

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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	108	108			108	108						
B. As of midnight of THIS report period	127	127							127	127		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,349	5,349			3,959	3,959			1,390	1,390		
B. Medicaid (Conn.)	34,127	34,127			24,334	24,334			9,793	9,793		
C. Medicaid (other states)												
D. Private Pay	1,012	1,012			797	797			215	215		
E. State SSI for RCH												
F. Other (Specify) Managed Care	194	194			186	186			8	8		
G. Total Care Days During Period (3A thru F)	40,682	40,682			29,276	29,276			11,406	11,406		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	69	69							69	69		
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	40,751	40,751			29,276	29,276			11,475	11,475		

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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			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	3	91		1		4		
Per Diem Rate								
a. One bed rm.	556.16	297.69		636.00		357.99		
b. Two bed rms.	556.16	297.69		624.00		357.99		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	1,471	1,471		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	830	830		
2. Restorative Treatments				
C. Other	3,424	3,424		
D. ***Total Physical Therapy Treatments***	5,725	5,725		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	198	198		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	181	181		
2. Restorative Treatments				
C. Other	535	535		
D. ***Total Speech Therapy Treatments***	914	914		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	852	852		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	646	646		
2. Restorative Treatments				
C. Other	3,241	3,241		
D. ***Total Occupational Therapy Treatments***	4,739	4,739		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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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)	129,784	2,032				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	268,504	12,234				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	67,287	2,113				
c. Dietary Workers	496,621	29,968				
6. Housekeeping Service						
a. Head Housekeeper	44,669	2,142				
b. Other Housekeeping Workers	241,085	17,065				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	62,693	2,119				
b. Other Maintenance Workers	49,047	2,049				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	144,238	9,627				
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	168,775	3,077				
b. RN						
1. Direct Care	411,556	9,155				
2. Administrative**	441,891	14,773				
c. LPN						
1. Direct Care	1,394,974	44,814				
2. Administrative**						
d. Aides and Attendants	1,664,296	92,827				
e. Physical Therapists	354,608	9,778				
f. Speech Therapists	88,637	2,093				
g. Occupational Therapists	237,656	5,655				
h. Recreation Workers	218,267	10,701				
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	203,636	7,091				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	6,688,224	279,313				

* 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	9/30/2021	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 (10/1/2020 - 9/30/2021)	129,784			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,032	A2			
Section IV - Assistant Administrators										

*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include **all** other employment worked during the cost year.

*** If more than one Administrator is reported, include dates of employment for each.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2021	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	40,959	930				
2. Dentist	15,845	152				
3. Pharmacist	12,561	85				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,000	85				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	441	20				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	2,183	11				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	105,865	978				
2. Administrative***						
b. LPN						
1. Direct Care	154,822	2,247				
2. Administrative***						
c. Aides	103,005	2,629				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	471,681	7,137				

* 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	9/30/2021	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	Speech 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	○	⊙	
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	○	⊙	
Dr. Milla Stelman, 1021 Daniels Farm Road, Trum	Medical Director	○	⊙	

* 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	9/30/2021	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	487,780	487,780		
2. Disability Insurance	$				
3. Unemployment Insurance	$	61,513	61,513		
4. Social Security (F.I.C.A.)	$	481,189	481,189		
5. Health Insurance	$	1,009,981	1,009,981		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	23,243	23,243		
(not-owners and not-operators)					
8. Uniform Allowance	$	880	880		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	167,419	167,419		
d. Accounting and Auditing	$	4,988	4,988		
e. Legal (*Services should be fully described on Page 7)*	$	50,226	50,226		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	65,192	65,192		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	107,495	107,495		
2. Cellular Phones	$	562	562		
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*	$	12,073	12,073		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	744,150	744,150		
Subtotal	$	3,216,691	3,216,691		

* 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	9/30/2021		16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,216,691	3,216,691		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	2,656	2,656		
3. Gifts to Staff and Residents	$	10,301	10,301		
4. Employee Travel	$	2,091	2,091		
5. Education Expenses Related to Seminars and Conventions	$	4,639	4,639		
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*)	$	12,030	12,030		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	10,494	10,494		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	5,402	5,402		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	1,869	1,869		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	925	925		
10. Contributions***	$	500	500		
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**	$	409,289	409,289		
13. Other (*Specify*)	$	112,867	112,867		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	3,789,754	3,789,754		

* 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	$ 10,494		
Total Other Advertising	$ 10,494	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 1,869		
Total Dues	$ 1,869	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Donations	$ 500		
Total Contributions	$ 500	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	$ 16,959		
Payroll Processing Fees	$ 20,461		
Employee Physicals	$ 7,508		
Pendulum (Disallow)	$ 3,500		
Data Processing	$ 60,894		
Licenses	$ 3,545		
Total Other Administrative and General	$ 112,867	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2021	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 Road Farmington, CT 06032	567,698	Contract Attached to a Prior Year	See Below
Allocation of the above	Admin/Gen: 374,681 Indirect: 90,832 Direct: 102,185	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 20, Line 5k Pg 20, Line 5j
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	34,608	Admin/Gen - Other Exp	Pg 16, Line 12

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

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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	9/30/2021	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	332,556	332,556		
2. Non-Food Supplies	$	50,671	50,671		
3. Other (*Specify*)_____ Dishes	$	319	319		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____ Indirect Portion of Management Fee	$	90,832	90,832		
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	474,378	474,378		

2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals:	Total no. of meals served per day:*	334	334		

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.	$917
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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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	9/30/2021	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. $	8,655	8,655		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Supplies	$	7,451	7,451		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	16,106	16,106		

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.

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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	9/30/2021	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.	$	54,614	54,614		
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)		$	54,614	54,614		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Procare		$	265,948	265,948		
b. Medicine Cabinet Drugs		$	17,267	17,267		
c. Medical and Therapeutic Supplies		$	280,455	280,455		
d. Ambulance/Limousine***		$	889	889		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	13,247	13,247		
f. X-rays and Related Radiological Procedures***		$	12,497	12,497		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	31,079	31,079		
i. Recreation		$	12,413	12,413		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	242,190	242,190		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	875,985	875,985		

* 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	$ 102,185		
Cable TV Fees	$ 46,298		
Oxygen Concentrator Rentals	$ 14,249		
Medical Equip Rentals-Medicaid	$ 46,876		
Medical Equip Rentals-Other	$ 15,681		
Physical Therapy Supplies	$ 16,901		
Total Other Resident Care	$ 242,190	$ -	$ -

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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	9/30/2021	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	295,671			20	5a2
CWPM	PO Box 415, Plainville, CT 06062	○	⊙		Rubbish Removal	31,617			22	6f
ADP	Philadelphia, PA 19170-0351	○	⊙		Payroll Processing	15,819			16	m13
Thyssen Krupp Elevator	P.O. Box 933007 Atlanta, GA 31193-3007	○	⊙		Elevator Service	80,268			22	6a
Outdoor Lawn Service	P.O. Box 320144 Fairfield, CT 06825	○	⊙		Landscaping/ Snow Removal	42,649			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	$ 19,656		
Rubbish Removal	$ 36,386		
Snow Removal	$ 22,508		
Supplies	$ 22,471		
Total Other Repairs and Maintenance	$ 101,021	$ -	$ -

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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	9/30/2021	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	119,471	119,471		
b. Heat	$	53,797	53,797		
c. Light & Power	$	130,154	130,154		
d. Water	$	63,760	63,760		
e. Equipment Lease (*Provide detail on page 6*)	$	15,249	15,249		
f. Other (*itemize*)	$	101,021	101,021		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	483,452	483,452		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	2,746	2,746		
b. Building & Building Improvements	$	26,845	26,845		
c. Non-Movable Equipment	$	1,306	1,306		
d. Movable Equipment	$	45,908	45,908		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	76,805	76,805		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	1,463	1,463		
c. Leasehold Improvements	$	24,758	24,758		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	26,221	26,221		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	869,043	869,043		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	201,915	201,915		
c. Personal property taxes	$	26,008	26,008		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,199,992	1,199,992		

* 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
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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			56,336	S/L	Various	2,746	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
A-4. Subtotal								2,746
B. **Building and Building Improvements**								
1. Acquired prior to this report period	1,298,324			1,123,019	S/L	Various	26,845	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
B-4. Subtotal								26,845
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	444,838			436,481	SL	Various	1,306	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					SL	Various		
C-4. Subtotal								1,306

	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	2020	2,081,209			1,738,889	S/L	Various	45,356	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2021	11,042				S/L	Various	552	
D-3. Subtotal												45,908
E. ***Total Depreciation***												76,805

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:					
1/31/2021	Washer Motor	$ 1,602	10	$ 80	
5/31/2021	Slicer	$ 2,096	10	$ 105	
6/30/2021	Ice Machine	5653	10	282.65	
9/30/2021	Food Blender	1691	10	84.55	
Total additions for Movable Equipmen		$ 11,042		$ 552	*
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:					
4/30/2021	Elevator Upgrade	$ 59,630	20	$ 1,491	
4/30/2021	Water Pump Repair	$ 4,983	15	$ 166	
4/30/2021	RTU Replacement	22918	10	1145.9	
5/31/2021	RTU Repair	2755	10	137.75	
7/31/2021	Elevator Repair	2829	20	70.725	
9/30/2021	HVAC Fan Replacement	4324	20	108.1	
Total additions for Leasehold Improvemer		$ 97,439		$ 3,119	*
Deletions:					
Total deletions for Leasehold Improvemer		$ -		$ -	**

***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	9/30/2021	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. Bed License	9	1997	15 Years	567,916	371,387	SL	7		
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2. Finance Fees	2	2018	36 Months	13,170	1,463	SL		1,463	
3.									
B-4. Subtotal									1,463
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2020	Various	300,812	127,143	SL	variou	21,639	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2021	Various	97,439			variou	3,119	
C-4. Subtotal									24,758
D. ***Total Amortization***									26,221

* 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
Maefair Health Care Center	2142C	9/30/2021	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	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 _____	13,838,275			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)	HUD			
h. Date of Refinancing	12/30/20			
i. New Interest Rate	2.95%			
j. Term of Mortgage (number of years)	30			
k. Amount of Principal Borrowed	14,038,500			
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	9/30/2021	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*) $	14,950	14,950		
Vendor Interst				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	14,950	14,950		
14. Insurance				
a. Insurance on Property (buildings only) $	137,523	137,523		
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)*** $	137,523	137,523		
15. ***Total All Expenditures (A-13 thru C-14)*** $	14,206,659	14,206,659		

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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	9/30/2021	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 $	237,656	237,656		
4.			Other - See attached Schedule $	4,072	4,072		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $	441	441		
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $	167,419	167,419		
10.			Accounting $	2,288	2,288		
10a.			Legal $	50,226	50,226		
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $	10,301	10,301		
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 * $	10,494	10,494		
19.			Income Tax / Corporate Business Tax $	12,073	12,073		
20.			Fund Raising / Contributions $	500	500		
21.			Unallowable Management Fees $	319,473	319,473		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	20,459	20,459		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $	917	917		
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) $	836,319	836,319		

* 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	12m	Marketing Salaries & Benefits	$ 4,072		
Total Other Salaries Adjustment			$ 4,072	$ -	$ -

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	$ 16,959		
16	M13	Pendulum (Disallow)	$ 3,500		
Total Other A&G Adjustments			$ 20,459	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	2142C	9/30/2021	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	836,319	836,319		
Page 20 - Resident Care Supplies***								
27.			Prescription Drugs	$	265,948	265,948		
28.			Ambulance/Limousine	$	889	889		
29.			X-rays, etc	$	12,497	12,497		
30.			Laboratory	$	31,079	31,079		
31.			Medical Supplies	$	24,849	24,849		
32.			Oxygen (non emergency)	$	13,247	13,247		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	75,430	75,430		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$	5,419	5,419		
36.			Depreciation on Unallowable Motor Vehicles	$				
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$				
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
Other - Miscellaneous								
42.			Other - Indirect	$				
43.			Interest Income on Account Rec.	$				
44.			Other - Miscellaneous Administrative	$				
45.			Management Fees Direct	$	57,505	57,505		
46.			Management Fees Indirect	$	51,116	51,116		
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)***			$	1,374,298	1,374,298		

*** 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	$ 15,681		
20	5b	EBOX	$ 17,051		
20	5j	Radio + Television Revenue	$ 42,698		
Total Other Ancillary Costs			$ 75,430	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Movable Equipment (See Attached)	$ 5,419		
Total Excess Movable Equipment Depreciation			$ 5,419	$ -	$ -

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)
Total Other Adjustments			$ -	$ -	$ -

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	9/30/2021	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	21,422,577	21,422,577		
b. Medicaid Room and Board Contractual Allowance **	$	(11,936,444)	(11,936,444)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,691,723	1,691,723		
b. Medicare Room and Board Contractual Allowance **	$	96,605	96,605		
4. a. Private-Pay Residents and Other	$	2,515,826	2,515,826		
b. Private-Pay Room and Board Contractual Allowance **	$	(667,915)	(667,915)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	133,220	133,220		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(130,883)	(130,883)		
c. Prescription Drugs - Non-Medicare	$	165,280	165,280		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(165,280)	(165,280)		
2. a. Medical Supplies - Medicare	$	11,449	11,449		
b. Medical Supplies - Medicare Contractual Allowance **	$	(260,957)	(260,957)		
c. Medical Supplies - Non-Medicare	$	240	240		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(240)	(240)		
3. a. Physical Therapy - Medicare	$	459,192	459,192		
b. Physical Therapy - Medicare Contractual Allowance **	$	(214,150)	(214,150)		
c. Physical Therapy - Non-Medicare	$	324,422	324,422		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(324,422)	(324,422)		
4. a. Speech Therapy - Medicare	$	151,720	151,720		
b. Speech Therapy - Medicare Contractual Allowance **	$	(76,245)	(76,245)		
c. Speech Therapy - Non-Medicare	$	148,170	148,170		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(148,170)	(148,170)		
5. a. Occupational Therapy - Medicare	$	365,094	365,094		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(203,190)	(203,190)		
c. Occupational Therapy - Non-Medicare	$	283,131	283,131		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(283,131)	(283,131)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	(713,765)	(713,765)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	12,643,857	12,643,857		
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*)	$	44,165	44,165		
V. Total Other Revenue (1 thru 8)	$	44,165	44,165		
VI. Total All Revenue (III +V)	$	12,688,022	12,688,022		

* *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)
	Misc Revenue from CRF funding	$ (713,765)		
Total Other Resident Revenue		$ (713,765)	$ -	$ -

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
15	Unemployment Tax Refund	$ 110		
16, m13	Bank Charges Refund (Disallowed)	$ 30		
15, 1c	Bad Debt Recoveries	$ 44,025		
Total Other Revenue		$ 44,165	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2021	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 34,831
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,651,280
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (913,478)
4 Inventories				$ 20,245
5. Prepaid Expenses				$ 66,561
a. Prepaid Insurance		(67,857)		
b. Ppd exp-health insurance & maintenance repairs		9,051		
c. Ppd exp-Other		125,367		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$ (121,704)
8. Other Current Assets (*itemize*)				$ 148,323
Due from Related Parties		148,323		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,886,058
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	63,905		$ 4,823
	Accum. Depreciation	59,082	Net	
3. Buildings	*Historical Cost	1,299,096		$ 148,459
	Accum. Depreciation	1,150,637	Net	
4. Leasehold Improvements	*Historical Cost	398,250		$ 246,350
	Accum. Depreciation	151,900	Net	
5. Non-Movable Equipment	*Historical Cost	444,830		$ 7,053
	Accum. Depreciation	437,777	Net	
6. Movable Equipment	*Historical Cost	2,086,417		$ 301,617
	Accum. Depreciation	1,784,800	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (14,222)
Equipment Carryforward adjustments		5,833		
See Schedule		(20,055)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 694,080

* 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	
		Depr Adj due to conversion/ Project Development	$ (20,055)
Total Other Other Fixed Assets (Itemize)			$ (20,055)

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Unamortized Bed License	$ 196,529
Total Other Assets			$ 196,529

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	9/30/2021	32	37

Account				Amount
		Total Brought Forward:	$	2,580,138
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			$	1,260,000
2. Land Improvements	*Historical Cost	7,823,776		
	Accum. Depreciation	7,171,800 Net	$	651,976
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)			$	1,911,976
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*)			$	196,529
See Attachecd				
See Schedule	196,529			
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$	(8,537,511)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	(4,045,397)

* 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	9/30/2021	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 2,153,128
2. Notes Payable (*itemize*)				$ 646,599
Midcap Line of Credit		(457,387)		
Due to Related Parties		(367,476)		
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*)				$ 288,904
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 369,785
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*)				$ 1,555,582
		Provider Taxes Due	1,331,134	
		Accd Health Insurance	10,264	
Acc'd Operating Expenses	214,035			
Acc'd Expense - Sales Tax	149	See Schedule		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 5,013,998

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

(Carry Total forward to next page)

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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	9/30/2021	34	37

Account	Amount
Total Brought Forward:	5,013,998
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*)		$ (127,985)
Related Party	(127,985)	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ (127,985)
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 4,886,013

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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	9/30/2021	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	$ 651,976
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	$ 1,911,976
B.	**Net Worth**	
1.	Owner's Capital	$
2.	Capital Stock	$ 2,000
3.	Paid-in Surplus	$
4.	Treasury Stock	$
5.	Cumulated Earnings	$ (9,326,749)
6.	Gain or Loss for Period 10/1/2020 thru 9/30/2021	$ (1,518,637)
7.	Total Net Worth	$ (10,843,386)
C.	***Total Reserves and Net Worth***	$ (8,931,410)
D.	***Total Liabilities, Reserves, and Net Worth***	$ (4,045,397)

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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	9/30/2021	36	37

	Account		Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2020		$ (9,991,875)
B.	Total Revenue (*From Statement of Revenue Page 30*)		$ 12,688,022
C.	Total Expenditures (*From Statement of Expenditures Page 27*)		$ 14,206,659
D.	Net Income or Deficit		$ (1,518,637)
E.	Balance		$ (11,510,512)
F.	Additions		
	1. Additional Capital Contributed (*itemize*)		
	2020 AJE - health insurance	(197,292)	
	AJE #5 Adj Rent to LL	(24,378)	
	Deferred HHS Funds 2020	889,100	
	Leaf 2020 Lease Expense	(302)	
	2. Other (*itemize*)		
	Rounding	(2)	
F-3.	Total Additions		$ 667,126
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*** 09/30/21		$ (10,843,386)

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

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2021	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. 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 Road Farmington, CT 06032	(860) 751-3900

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

Contact Email Address
lrinadli@athenahealthcare.com