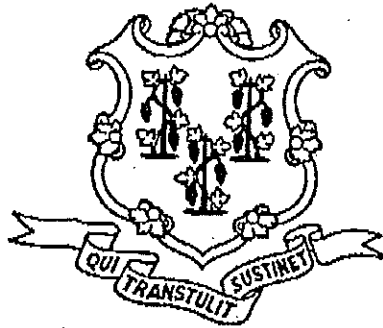


State of Connecticut



15-70

Annual Report of Long-Term Care Facility Cost Year 2015

RECEIVED

FEB 17 2016

DEPT. OF SOCIAL SERVICES
OFFICE OF CON AND RATE SETTINGS

Name of Facility (as licensed) Maefair Health Care Center	
Address (No. & Street, City, State, Zip Code) 21 Maefair Court Trumbull, CT 06611	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

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

Medicaid Provider Numbers:	CCNH 2142C	RHNS	ICF-MR
----------------------------	---------------	------	--------

For Department Use Only

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



**MYERS AND
STAUFFER** LLC
CERTIFIED PUBLIC ACCOUNTANTS

December 11, 2013

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

Subject: Alternative Annual Report Approval

Dear Mr. Mosier:

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

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

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

Sincerely,

Brittany L. Hester, Administrative Assistant

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

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2015	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Maefair Health Care Center [facility name] for the cost report period beginning October 01, 2014 and ending September 30, 2015, 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 penalties 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
<i>Donna S. Orefice</i>		2/10/16	<i>[Signature]</i>		2/10/16
Printed Name (Administrator)			Printed Name (Owner)		
Donna S. Orefice			Lawrence Santilli		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires	
	Conn	2/10/16	<i>[Signature]</i>	2/31/20	
Address of Notary Public					
76 Christine Place Southington CT 06488					

(Notary Seal)

State of Connecticut
Department of Social Services
 25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Maefair Health Care Center	Period Covered:	From 10/1/2014	To 9/30/2015	
Address of Facility 21 Maefair Court Trumbull, CT 06611				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900	Date 2/10/2016		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid..... \$				
2. Laundry wages paid..... \$				
3. Housekeeping wages paid..... \$				
4. Nursing wages paid..... \$				
5. All other wages paid..... \$				
6. Total Wages Paid \$				
7. Total salaries paid..... \$				
8. Total Wages and Salaries Paid (As per page 10 of Report) \$				

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-459-5152		Report for Year Ended 09/30/15		Page 2	of 37
Name of Facility (as shown on license) Maefair Health Care Center			Address (No. & Street, City, State, Zip) 21 Maefair Court Trumbull, CT 06611		
License Numbers:	CCNH 2142C	RHNS	(Specify)	Medicare Provider No. 07-5404	
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Type of Ownership (Check appropriate box)					
<input type="checkbox"/> PROPRIETORSHIP <input type="checkbox"/> LLC <input type="checkbox"/> PARTNERSHIP <input checked="" type="checkbox"/> PROFIT CORP. <input type="checkbox"/> NON-PROFIT CORP. <input type="checkbox"/> GOVERNMENT <input type="checkbox"/> TRUST					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," explain fully.					
Administrator					
Name of Administrator Donna S. Orefice			Nursing Home Administrator's License No.:		001677
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name				License No.:	
Not Applicable					

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2015	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	772.6015	
Debra M Soucey	21 Maefair Court, Trumbull, CT 06611	Secretary		
Michael E. Mosier	21 Maefair Court, Trumbull, CT 06611	Treasurer		
Names of Stockholders Owning at Least 10% of Shares				
Other than noted above:				
Chakalos Nursing Homes, LLC	21 Maefair Court, Trumbull, CT 06611		107.5	
Conservators for Lawrence E. Santilli	21 Maefair Court, Trumbull, CT 06611		119.8985	

General Information and Questionnaire Related Parties*

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	2142C	9/30/2015	4 37

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No				
Shady Knoll Health Care Center	41 Skokorat Street Seymour, CT 06483	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Interest allocation exchange	Page 27, 12D	\$13,613	\$13,613
Laurel Ridge Health Care Center	642 Danbury Road Ridgefield, CT 06877	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Bank Fees	Pg 16m13	\$8,319	\$8,319
Athena Health Care Systems	135 South Road, Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	see attached			
Maefair Landlord, LLC	135 South Rd, Farmington, CT	<input checked="" type="checkbox"/>	<input type="checkbox"/>	lease of facility	Pg 22, Ln 9 and 10b, pg 27, Ln 14a	\$1,364,149	\$1,364,149
Sheriden Woods	321 Stonecrest Drive, Bristol, CT	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Expense reimbursement	pg 22 Ln 6b	\$2,220	\$2,220
Litchfield Woods Health Care	255 Roberts Street, Torrington, CT	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Shared Legal Fees	Pg 15, l e	\$5,076	\$5,076
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				

* Use additional sheets if necessary.

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

Maefair Health Care
RELATED PARTIES
PAGE 4

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No				
Athena Health Care Systems	135 South Road Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Management, Legal, Marketing, Bank Fees, A/R, MIS, mortgage fees, Insurance, Lobbying, Health Insurance Bank Charges, LOC Interest, payroll processing fees Computer conversion, data processing employee relations maintenance & repairs P/S therapy, nursing consulting	Pg 15, 1e & 1g, 1a5 Pg 16, m3, m13, Pg 17 Pg 27, 12D & 14a, Pg 16, L2 Pg 16, m13 Pg 23 D2c, pg 16 m13 Pg 16 L3 Pg 22, 6a Pg 13, B5 & B11	\$2,109,973	\$1,691,463
Athena Health Care Systems 401(k) plan	135 South Road Farmington, CT 06032	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Facility Participates in a multi-facility 401 (k) plan			
Athena Captive LLC	135 South Road Farmington, CT 06032	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Workers Comp Captive	Pg 15, L1a	\$546,414	\$546,414

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	9/30/2015	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 (<i>See listing page 13</i>)
Maintenance and operation of plant.....	Square feet
Property costs (depreciation).....	Square feet
Employee health and welfare.....	Gross salaries
Management services.....	Appropriate cost center involved
All other General Administrative expenses.....	Total of Direct and Allocated Costs

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

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

Not Applicable

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

Not Applicable

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

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

Not Applicable: No Non-Nursing Home Cost Centers

General Information and Questionnaire Leases (Excluding Real Property)

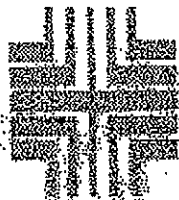
Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

Name of Facility		License No.	Report for Year Ended		Page	of	
Maefair Health Care Center		2142C	9/30/2015		6	37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Putney Bowes, 60 Wellington Rd, Milford, CT 06484	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Postal Equipment	11/22/13	lease restructured.	\$1,091	\$1,091
LEAF Capital Funding, LLC PO Box 979127, Miami, FL 33197-9127	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Copier System	03/06/12	48 months	\$11,333	\$11,333
LEAF Capital Funding, LLC PO Box 979127, Miami, FL 33197-9127	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Copier System	06/18/13	32 months	\$6,465	\$6,465
CISCO Capital, 170 West Tasman Drive, San Jose, CA 95134	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Conference Equipment	07/15/11	60 months	\$2,409	\$2,409
Hewlett Packard Financial Services, PO Box 402582, Atlanta, GA	<input type="checkbox"/>	<input checked="" type="checkbox"/>	PCC Equipment	07/18/13	60 months	\$7,124	\$7,124
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?						<input type="checkbox"/> Yes <input type="checkbox"/> No	Total ***
							\$28,422

* 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.

2

MacFair H&H Case Ctr



Pitney Bowes

Portfolio Management

Phone: 800-848-3826 ext 3409
Fax: 203-617-2654

April 10, 2014

To: Joseph Colaci
From: Faye Druckrey
Re: 15292609862

Dear Joseph Colaci,

This will confirm our conversation regarding the re-structuring of your Lease Account # 4546825-006 with FBGRS for the Pitney Bowes Mailing Equipment.

As was discussed, FBGRS has agreed to re-structure your 42-month lease, resulting in a new payment of \$256.50 New Payment per quarter, excluding tax and Valmax. Your currently pay \$285.00 Old Payment per quarter, excluding tax and Valmax. All other terms and conditions under the lease signed 03/30/2013 remain in full force and effect. This offer expires 04/25/2014.

We value you as a long term Pitney Bowes customer and look forward to a mutually beneficial relationship. Once I receive your signature approval, I will have the contract adjusted to reflect our agreement to re-structure your payments. Please fax it back to my attention at 1-203-617-2654 at your earliest convenience. If you have any additional questions or concerns, please do not hesitate to contact me.

Sincerely,
Faye Druckrey
Account Specialist
800-848-3826 ext 3409

Signature: _____

Print: _____

Date: _____

[Handwritten Signature]
Joseph Colaci
5/10/14

Salvatore Pouletta

CUSTOMER RETENTION ACCOUNT ADJUSTMENT

DATE: May 19, 2014

To Portfolio Administration

From: Matt Perry

Customer Name: MAEFAIR HEALTH CARE CENTER

Lease/Schedule: 4546826-006

Old Comm. Date: 3/30/14

New Comm. Date: 3/30/14

BILLING ADJUSTMENTS:

Current Billing	Adjusted Billing	Discount %
Rent: <u>104.40</u>	<u>93.96</u>	<u>10</u>
EMA: <u>75.60</u>	<u>68.04</u>	<u>10</u>
Meter: <u>105</u>	<u>94.50</u>	<u>10</u>
SFTG _____	_____	_____
VIC _____	_____	_____

METER OR EMA CHANGE ONLY

New Meter \$ _____ New EMAS \$ _____

PARTIAL TERMINATION Ratio % _____

PCN _____ Serial # _____

PCN _____ Serial # _____

PORTFOLIO ADMINISTRATION USE ONLY

Original Contract _____ New Contract _____ Difference _____

Contract Balance W/O _____

Balance Forwards Write Offs

Rent _____ EMA _____ Meter _____ Late Charges _____

Original Term _____ Remaining Term _____ Adjusted Term _____



Every connection is a new opportunity

11/22/13
Larry Z.

EZ LEASE

MAEFAIR HEALTH CARE CENTER	Pitney Bowes
Account No.: 15292609862	Inside Sales Group
Billing Address:	27 Waterview Drive
MAEFAIR HEALTH CARE CENTER 21 MAEFAIR COURT	Shelton, CT 06484
TRUMBULL, CT 06611-4872	SARA SCHULBERG
Install Address (If different from billing address):	District: 0007
21 MAEFAIR COURT	RIDE THE CHANNEL
TRUMBULL CT 06611-4872	LAWRENCE ZARRELLA
New Address (please indicate billing and/or installation address change):	950108
21 MAEFAIR COURT	99
TRUMBULL, CT 06611-4872	3-4061933321

YES, I want to take advantage of protecting my Existing Pitney Bowes Equipment Payment for 42 months.

We are proud to extend our Loyalty offer to you, effective on the day following the expiration date of your existing lease, if this lease is entered during the initial lease term of your existing lease, or on the first day of the next billing period, if this lease is entered during a monthly renewal term of your existing lease (said day is called the "Effective Date"). This opportunity is only being offered to a select group of our long-term Customers. If your current equipment meets your needs, simply acknowledge your acceptance by agreeing to the new lease terms outlined below.

NEW LEASE CONTRACT INFORMATION

This lease is for a fixed term of 42 months.
 Same Quarterly Lease Payment: \$285 (Exclusive of Taxes and Fees for the ValueMAX program)
 Rep ID: 166850 RIDE THE CHANNEL 950108 99

ACKNOWLEDGMENT OF NEW CONTRACT TERMS & CONDITIONS

I understand that Pitney Bowes Global Financial Services LLC will lease to us the equipment currently leased under existing #4546826 - 005 at the same payment and billing frequency, commencing on the Effective Date for the term set forth above. All terms and conditions of the existing lease are hereby incorporated into this new lease except as modified above. The faxed form, when accepted by Lessor, will be the one and only original lease. The person signing below confirms that he/she is authorized to enter into this agreement on behalf of the undersigned lessee.

Lessee Name: _____ Title: DIRECTOR OF PURCHASING AND DINING
 Signature: [Signature] Date: 11/22/13
 Print Name: Salvatore Pouletta E-mail: _____
 Accepted By: Salvatore Pouletta

Fax your confirmation back to 1-203-617-6360

**General Information and Questionnaire
 Accounting Basis**

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2015	Page 7	of 37
-------------------------------------------------------	-----------------------------	-------------------------------------------	------------------	-----------------

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

Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Dworkin, Hilman, LaMorte & Sterczala	Four Corporate Dr, Shelton, CT
2 Marcum LLP	555 Long Wharf Drive, New Haven, CT
3 Dopkins & Co	200 International Dr, Buffalo, NY
4	

Services Provided by This Firm (*describe fully*)

1 2014 Audit, Yearend financials & tax returns	\$ 14,000
2 preparation of Medicare Cost report(Disallowed)	\$ 2,650
3 Key Bank audit (Disallowed)	\$ 1,912
4	\$ -
	Charge for Services Provided
	\$18,562

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

Yes No Pg 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Goldman, Gruder & Woods	203-899-8900
2 Probate, Shiff Harding	
3 Murtha Cullina	860-240-6000
4 Wiggin & Dana	203-498-4400
5	

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

1 200 Connecticut Ave. Norwalk, CT
 2
 3 185 Asylum Street, Hartford, CT
 4 One Century Tower, New Haven, CT
 5

Services Provided by This Firm (*describe fully*)

1 Collections:Disallowed	\$ 14,481
2 HUD Re-fi:\$5077(Disallowed); probate \$923 (disallowed)	\$ 6,000
3 Audit Letter \$872 & Sec. of State Annual Filing \$178:allowed; loan modification \$7,366 and DPH issues \$211:Disallowed	\$ 8,627
4 refund of Prior year fees:Disallowed	\$ (1,247)
5	\$ -
	Charge for Services Provided
	\$27,861

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

State of Connecticut
 Annual Report of Long-Term Care Facility
 CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended		Page	of
		09/30/15	8		
Maefair Health Care Center		2142C		21	
		Period 10/1 Thru 6/30		Period 7/1 Thru 9/30	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total CCNH	Total 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.....	121	121		121	121
B. As of midnight of THIS report period.....	131	131		131	131
3. Total Number of Days Care Provided During Period					
A. Medicare.....	8,481	8,481		1,883	1,883
B. Medicaid (Conn.).....	34,168	34,168		11,055	11,055
C. Medicaid (other states).....					
D. Private Pay.....	3,075	3,075		910	910
E. State SSI for RCH.....					
F. Other (Specify) Managed Care	824	824		72	72
G. Total Care Days During Period (3A thru F).....	46,548	46,548		13,920	13,920
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds					
A. Medicaid Bed Reserve Days.....	373	373		100	100
B. Other Bed Reserve Days.....	3	3			
5. Total Resident Days (3G + 4A + 4B).....	46,924	46,924		14,020	14,020

Schedule of Resident Statistics (Cont'd)

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2015	Page 9	of 37
-------------------------------------------------------	-----------------------------	-------------------------------------------	------------------	-----------------

4. Were there any changes in the certified bed capacity during the report year? YES NO
 If "YES", provide the following information:

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

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

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

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

Item	Medicare		Medicaid		Self-Pay		Other State Assisted	
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H. ICF-MR
No. of Residents	11	101			11		8	
Per Diem Rate								
a. One bed rm.	646.72	239.08			506.00		425.24	
b. Two bed rms.	646.72	239.08			494.00		425.24	
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	10,656	10,656		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	2,217	2,217		
2. Restorative Treatments				
C. Other	18,204	18,204		
D. Total Physical Therapy Treatments	31,077	31,077		

8. Total Number of Speech Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	801	801		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	213	213		
2. Restorative Treatments				
C. Other	1,944	1,944		
D. Total Speech Therapy Treatments	2,958	2,958		

9. Total Number of Occupational Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	3,336	3,336		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,390	1,390		
2. Restorative Treatments				
C. Other	14,607	14,607		
D. Total Occupational Therapy Treatments	19,333	19,333		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Maefair Health Care Center	2142C	9/30/2015	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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)	135,844	2,023				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	271,939	11,362				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	63,071	2,006				
c. Dietary Workers	424,737	28,712				
6. Housekeeping Service						
a. Head Housekeeper	48,804	2,182				
b. Other Housekeeping Workers	178,227	16,303				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	56,997	2,129				
b. Other Maintenance Workers	39,196	2,021				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	128,865	9,981				
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	191,039	3,786				
b. RN						
1. Direct Care	545,411	14,377				
2. Administrative**	475,566	16,713				
c. LPN						
1. Direct Care	1,458,111	50,773				
2. Administrative**						
d. Aides and Attendants	1,658,758	117,586				
e. Physical Therapists	659,645	19,108				
f. Speech Therapists	73,542	1,989				
g. Occupational Therapists	347,990	8,964				
h. Recreation Workers	200,822	10,123				
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	194,518	6,722				
n. Marketing						
o. Other (Specify)						
<i>A-13. Total Salary Expenditures</i>	7,153,082	326,860				

* 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.

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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	9/30/2015		11	37			
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS (Specify)							
Section I - Operators/Owners									
Not Applicable									
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).									
Not Applicable									

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
 ** Include all employment worked during the cost year.

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

Name of Facility (as licensed)		License No.		Report for Year Ended		Page	of		
MaeFair Health Care Center		2142C		9/30/2015		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***									
Sandra Bardsley (10/1/14-5/9/15)	96,928		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	1,365	A2	Rose Garden - Waterbury, CT Village		
Donna S. Orefice (6/8/15-9/30/15)	38,916		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	658	A2	Crest - New Milford, Athena Health Care 135	880	45,963
Thomas Walkuski 5/1/15-6/5/15	3,589		Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	40	P16, M13	South Road Farmington, CT		
Section IV - Assistant Administrators									

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
 ** Include all other employment worked during the cost year.
 *** If more than one Administrator is reported, include dates of employment for each.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Maefair Health Care Center	2142C	9/30/2015	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.....	37,050	1,458				
2. Dentist.....	14,552	36				
3. Pharmacist.....	10,051	155				
4. Podiatrist.....						
5. Physical Therapy						
a. Resident Care.....	59,689	854				
b. Other.....						
6. Social Worker.....						
7. Recreation Worker.....						
8. Physicians						
a. Medical Director (entire facility).....	30,000	45				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**.....						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify) See Attached Schedule	1,950	20				
9. Speech Therapist						
a. Resident Care.....	2,985	9				
b. Other.....						
10. Occupational Therapist						
a. Resident Care.....	1,442	24				
b. Other.....						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	14,340	70				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides.....						
d. Other.....						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	172,059	2,671				

* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.
 ** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.
 *** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

Name of Facility		License No.	Report for Year Ended		Page	of
Maefair Health Care Center		2142C	9/30/2015		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	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Athena Health Care, 135 South Road, Farmington, CT 06032	MDS Fill in	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Common Owners		
Janine Gillum, 19 Eden Hill Road, Newtown, CT	Dietician	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Swallowing Diagnostics, 21 Waterville, Rd, Avon, CT	Therapy Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Health Drive, One Prestige Drive, Meriden, CT	Dentist	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Dr. Iran Gomez, 3690 Main Street, Bridgeport, CT 06606	Medical Staff	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Dr. John Flores MD, 15 Corporate Drive, Trumbull, CT 06611	medical staff	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Omnicare/Value Health Care, 525 Knotter Drive, Cheshire, CT	Pharmacy Consultants	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Access Therapies, PO Box 823461, Philadelphia, PA 19182-3461	Therapy Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Dr. Milla Stellman, 3715 Main Street, Bridgeport, CT 06606	Medical Staff	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Onward Health Care, P.O.Box 27421, New York, NY	Therapy Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Dr. Christopher Luthie, 3690 Main Street, Bridgeport, CT	Medical Staff	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
MVP Recruitment, 59 Saint Lawrence Way, North Attleboro, MA 02760	Placement Fee - Nursing	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Cheryl Maciarakowski, 234 Sherman Ave, Apt 1, Meriden, CT 06450	Dietician	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Amy Palmer, 24 Lufberry Lane, Norwalk, CT 06851	Dietician	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Pinnacle Rehab Services, PO Box 8317, Clearwater, FLA 33758	Therapy services	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			
		<input type="checkbox"/>	<input type="checkbox"/>			

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Maefair Health Care Center	2142C	9/30/2015		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation.....	\$ 546,414	546,414			
2. Disability Insurance.....	\$				
3. Unemployment Insurance.....	\$ 161,030	161,030			
4. Social Security (F.I.C.A.).....	\$ 530,873	530,873			
5. Health Insurance.....	\$ 1,065,935	1,065,935			
6. Life Insurance (employees only) (not-owners and not-operators).....	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators).....	\$ 29,347	29,347			
8. Uniform Allowance.....	\$				
9. Other (<i>Specify</i>)..... See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*.....	\$ 75,184	75,184			
d. Accounting and Auditing.....	\$ 18,562	18,562			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 27,861	27,861			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*.....	\$				
g. Office Supplies.....	\$ 75,286	75,286			
h. Telephone and Cellular Phones.....					
1. Telephone & Pagers.....	\$ 37,033	37,033			
2. Cellular Phones.....	\$ 1,659	1,659			
i. Appraisal (<i>Specify purpose and attach copy</i>)*.....	\$				
j. Corporation Business Taxes (<i>franchise tax</i>).	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 807,630	807,630			
Subtotal	\$ 3,376,814	3,376,814			

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
Maefair Health Care Center	2142C	9/30/2015		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	3,376,814	3,376,814			
i. Travel and Entertainment					
1. Resident Travel and Entertainment.....	\$				
2. Holiday Parties for Staff.....	\$ 6,145	6,145			
3. Gifts to Staff and Residents.....	\$ 17,538	17,538			
4. Employee Travel.....	\$ 7,879	7,879			
5. Education Expenses Related to Seminars and Conventions	\$ 7,818	7,818			
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).....	\$ 1,875	1,875			
2. Advertising Telephone Directory (all such expenses)***	\$				
3. Advertising Other (Specify)***.....	\$ 35,487	35,487			
See Attached Schedule					
4. Fund-Raising***.....	\$				
5. Medical Records.....	\$ 6,223	6,223			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***.....	\$ 14,264	14,264			
7. Postage.....	\$ 9,658	9,658			
* 8. Dues and Membership Fees to Professional Associations (Specify).....	\$ 8,404	8,404			
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions.....	\$ 859	859			
10. Contributions***.....	\$ 50	50			
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**.....	\$ 466,674	466,674			
13. Other (Specify).....	\$ 159,616	159,616			
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$ 4,119,304	4,119,304			

* 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	\$ 35,487		
Total Other Advertising	\$ 35,487	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 8,404		
Total Dues	\$ 8,404	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Miscellaneous	\$ 50		
Total Contributions	\$ 50	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Lobbying Fees	\$ 4,169		
Bank Charges	\$ 8,777		
Payroll Processing Fees	\$ 23,492		
Employee Physicals	\$ 15,415		
MDS consulting(\$20,000) and Compliance Consulting(\$31,276)	\$ 51,276		
Data Processing	\$ 36,225		
Licenses	\$ 485		
P/S Administrator fill-in (3,589) and Temporary bookkeeping help (\$1,275)	\$ 4,864		
CMS case #2015-01-LTC-194 and #2015-01-LTC-022	\$ 8,223		
State of CT - citations #2015-77 and 2015-78	\$ 1,440		
Medicaid Applications	\$ 5,250		
Total Other Administrative and General	\$ 159,616	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	2142C	9/30/2015	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	\$641,965	Contract Attached to a Prior Year	See Below
Allocation of the above	\$423,697 \$102,714 \$115,554	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 18, Line 2C Pg 20, Line 5J
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	\$42,977	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	9/30/2015		18	37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food.....	\$ 280,488	280,488			
2. Non-Food Supplies.....	\$ 33,834	33,834			
3. Other (Specify) _____ Dishes = \$1,012	\$ 1,012	1,012			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Management Services**.....	\$ 102,714	102,714			
d. Other (Specify) _____	\$				
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 418,048	418,048			
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)	
G. Resident Meals: Total no. of meals served per day:*	383	383			
H. Is cost of employee meals included in 2E?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No			
I. Did you receive revenue from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.		
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, specify cost. = \$3568		
L. Is any revenue collected from these people?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.		
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.		
O. Is any revenue collected from employees?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.		
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

**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	9/30/2015		19	37
Item	Total	CCNH	RHNS	(Specify)	
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$	13,746	13,746		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Management Services**	\$				
d. Other (Specify) Supplies = \$7,338	\$	7,338	7,338		
3E. Total Laundry Expenditures (3a + b + c + d)	\$	21,084	21,084		
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.	
H. Did you receive revenue from employees?		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.	
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify cost.	
K. Did you receive revenue from these people?		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, specify amount.	
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
 All allocations should add to total recorded in 3E.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 *** Pounds of Laundry only required for multi-level facilities.

**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
Macfair Health Care Center		2142C	9/30/2015		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies + Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	41,947	41,947		
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$				
c.	Management Services*	\$				
d.	Other (<i>Specify</i>)	\$				
4E.	Total Housekeeping Expenditures (4a + b + c + d)....	\$	41,947	41,947		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy.....	\$				
	2. Purchased from Omnicare	\$	510,854	510,854		
b.	Medicine Cabinet Drugs.....	\$	10,756	10,756		
c.	Medical and Therapeutic Supplies.....	\$	253,969	253,969		
d.	Ambulance/Limousine***	\$	1,720	1,720		
e.	Oxygen					
	1. For Emergency Use.....	\$				
	2. Other***	\$	39,023	39,023		
f.	X-rays and Related Radiological Procedures***	\$	19,717	19,717		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	27,340	27,340		
i.	Recreation.....	\$	22,112	22,112		
j.	Other (Specify)**** See Attached Schedule	\$	223,496	223,496		
5K.	Total Resident Care Expenditures (5a - 5j).....	\$	1,108,987	1,108,987		

* 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	\$ 115,554		
Cable TV Fees	\$ 31,799		
Oxygen Concentrator Rentals	\$ 5,514		
Medical Equip Rentals-Medicaid	\$ 14,406		
Physical Therapy Supplies	\$ 32,538		
Medical Equip Rentals-Other	\$ 23,601		
Speech Therapy Supplies	\$ 84		
Total Other Resident Care	\$ 223,496	\$ -	\$ -

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	9/30/2015			22 37
Item	Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance..... \$	137,889	137,889			
b. Heat..... \$	70,185	70,185			
c. Light & Power..... \$	131,202	131,202			
d. Water..... \$	72,898	72,898			
e. Equipment Lease (Provide detail on page 6)..... \$	28,422	28,422			
f. Other (itemize)..... \$	97,616	97,616			
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)..... \$	538,212	538,212			
7. Depreciation (complete schedule page 23*)					
a. Land Improvements..... \$	4,085	4,085			
b. Building & Building Improvements..... \$	103,759	103,759			
c. Non-Movable Equipment..... \$	17,533	17,533			
d. Movable Equipment..... \$	81,495	81,495			
*7e. Total Depreciation Costs (7a + b + c + d)..... \$	206,872	206,872			
8. Amortization (Complete att. Schedule Page 24*)					
a. Organization Expense..... \$					
b. Mortgage Expense..... \$					
c. Leasehold Improvements..... \$	8,725	8,725			
d. Other (Specify)..... \$					
*8e. Total Amortization Costs (8a + b + c + d)..... \$	8,725	8,725			
9. Rental payments on leased real property less real estate taxes included in item 10b..... \$	1,066,697	1,066,697			
10. Property Taxes					
a. Real estate taxes paid by owner..... \$					
b. Real estate taxes paid by lessor..... \$	208,795	208,795			
c. Personal property taxes..... \$	20,882	20,882			
11. Total Property Expenses (7e + 8e + 9 + 10)..... \$	1,511,971	1,511,971			

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

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Oct-14	paving	\$ 13,719	8	\$ 857
Sep-15	outside conduit installation	\$ 7,843	8	\$ 490
Total additions for Land Improvements		\$ 21,562		\$ 1,348
Deletions:				
Total deletions for Land Improvements		\$ -		\$ -

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Oct-14	conveyor drive	\$ 1,094	10	\$ 55
Total additions for Non-Movable Equipment		\$ 1,094		\$ 55
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ -

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended		Page	of			
		2142C	9/30/2015			24	37	
Item	Date of Acquisition	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. Organization Expense								
1.								
2.								
3.								
A-4. Subtotal.....								
B. Mortgage Expense								
1.								
2. Finance Fees								
3. Finance Fees								
B-4. Subtotal.....								
C. Leasehold Improvements and Other (Specify)								
1. Acquired prior to this report period	9	2014	Various	607,840	373,204	SL	Var	2,475
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	9	2015	Various	88,255		SL	Var	6,250
C-4. Subtotal.....								
D. Total Amortization								8,725
								8,725

* Straight-line method must be used.
 ** Specify which of the following bases were used:
 A. Minimum of 5 years or 60 months.
 B. Life of mortgage; OR
 C. Remaining Life of Lease; OR
 D. Actual Life if owned by Related Party.

Amortization Schedule - Detail of Leasehold Improvements & Other

Name of Facility	License No.		Report for Year Ended		Page	of		
Maefair Health Care Center	2142C		9/30/2015		24A	37		
C. Leasehold Improvements (Specify)								
1. Acquired prior to this report period	9	2014	Various	39,924	1,817	SL	various	2,475
2. Disposals (attach schedule)								
3. Acquired during this report period	9	2015	various	88,255		SL	various	6,250
C-4. Subtotal.....								8,725
C. Other (Specify)								
1. Bed Purchase License	9	1997	15 yrs	567,916	371,387	SL		6.67%
2.								
C-4. Subtotal.....								
Total Acquired prior to this report period	9	2014	Various	607,840	373,204	SL	Var	2,475
Total Disposals								
Total Acquired during this report period	9	2015	Various	88,255		SL	Var	6,250

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

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2015	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party*? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
*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.				
If "Yes," complete Part B. If "No," complete Part C.				
Description		Total		
1. Date Land Purchased		4/1/1993		
2. Date Structure Completed		4/1/1994		
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure		4/1/1994		
5. Total Licensed Bed Capacity		134		
6. Square Footage				
7. Acquisition Cost				
a. Land		1,260,000		
b. Building		7,823,776		
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)		HUD		
b. Date Mortgage Obtained		03/29/12		
c. Interest Rate for the Cost Year		3.22%		
d. Term of Mortgage (number of years)		35		
e. Amount of Principal Borrowed		16,336,000		
f. Principal balance outstanding as of 9/30/2015		15,424,673		
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	9/30/2015			26	37
Item			Total	CCNH	RHNS	(Specify)	
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage.....			\$				
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage.....			\$				
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage.....			\$				
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage.....			\$				
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount.....			\$				
2. Loan Origination Date.....							
3. Interest Rate %.....							
4. Term.....							
5. CHEFA Interest Expense.....							
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$				

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended			Page	of
Maefair Health Care Center	2142C	9/30/2015			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).....		\$	106,945	106,945		
Vender Interest = \$21,074; Line of Credit Interest = \$23,641; Key Bank Loan Interest & Fees = \$62,230						
13. Total All Interest Expense (12B7 + 12C3 + 12D).....		\$	106,945	106,945		
14. Insurance						
a. Insurance on Property (buildings only).....		\$	93,588	93,588		
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)...		\$	93,588	93,588		
15. Total All Expenditures (A-13 thru C-14).....		\$	15,285,227	15,285,227		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Maefair Health Care Center			2142C	9/30/2015	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs.....	\$			
2.			Salaries not related to Resident Care....	\$			
3.	10	A12g	Occupational Therapy.....	\$ 347,990	347,990		
4.	Var	Var	Other - See attached Schedule.....	\$ 2,863	2,863		
Page 13 - Professional Fees							
5.			Resident Care Physicians **.....	\$			
6.	13	B10a	Occupational Therapy.....	\$ 1,442	1,442		
7.			Other - See attached Schedule.....	\$			
Pages 15 & 16 - Administrative and General							
8.	15	1a9	Discriminatory Benefits.....	\$			
9.	15	1c	Bad Debts.....	\$ 75,184	75,184		
10.	15	1d&e	Accounting & Legal.....	\$ 31,373	31,373		
11.	30	IV3	Telephone.....	\$			
12.	15	1h2	Cellular Telephone.....	\$ 939	939		
13.			Life insurance premiums on the life of Owners, Partners, Operators.....	\$			
14.	16	13	Gifts, flowers and coffee shops.....	\$ 17,538	17,538		
15.	16	15	Education expenditures to colleges or universities for tuition and related costs for owners and employees.....	\$ 789	789		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative....	\$			
17.			Automobile Expense (e.g. personal use).	\$			
18.	16	m2&3	Unallowable Advertising *.....	\$ 35,487	35,487		
19.			Income Tax / Corporate Business Tax...	\$			
20.	16	m4&10	Fund Raising / Contributions.....	\$ 50	50		
21.	16	m12	Unallowable Management Fees.....	\$ 276,217	276,217		
	18	2c		\$ 66,962	66,962		
	20	5j		\$ 75,332	75,332		
22.	16	m6	Barber and Beauty.....	\$ 14,264	14,264		
23.	Var	Var	Other - See attached Schedule.....	\$ 79,135	79,135		
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents.....	\$ 6,308	6,308		
Page 19 - Laundry Expenditures							
25.	19	3d	Laundry services to employees, guests and others who are not residents.....	\$			
Page 20 - Housekeeping Expenditures							
26.	20	4d	Housekeeping services to employees and others who are not residents.....	\$			
Subtotal (Items 1 - 26)				\$ 1,031,873	1,031,873		

* 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.

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Macfair Health Care Center			2142C	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,031,873	1,031,873		
Page 20 - Resident Care Supplies***							
27.	20	5a1&2	Prescription Drugs.....	\$ 510,854	510,854		
28.	20	5d	Ambulance/Limousine.....	\$ 1,720	1,720		
29.	20	5f	X-rays, etc.....	\$ 19,717	19,717		
30.	20	5h	Laboratory.....	\$ 27,340	27,340		
31.	20	5c	Medical Supplies.....	\$ 16,533	16,533		
32.	20	5e2	Oxygen (non emergency).....	\$ 39,023	39,023		
33.			Occupational Therapy.....	\$			
34.	Var	Var	Other - See Attached Schedule.....	\$ 23,601	23,601		
Page 22 - Maintenance and Property							
35.	Var	Var	Excess Movable Equipment Depreciation See Attached Schedule.....	\$ 4,917	4,917		
36.			Depreciation on Unallowable Motor Vehicles.....	\$			
37.			Unallowable Property and Real Estate Taxes.....	\$			
38.			Rental of Building Space or Rooms.....	\$			
39.			Other - See Attached Schedule.....	\$			
Page 27 - Insurance							
40.			Mortgage Insurance.....	\$			
41.			Property Insurance.....	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities.....	\$			
43.	30	IV4	Radio and Television Revenue.....	\$ 28,289	28,289		
44.			Vending Machine Revenue.....	\$			
45.			Purchase Discounts and Allowances.....	\$			
46.			Duplications of functions or services....	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest.....	\$			
48.	30	IV5	Interest Income on Accounts Rec.....	\$ 27	27		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule.....	\$			
Not For Profit Providers Only							
50.	Var	Var	Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule.....	\$			
51. Total Amount of Decrease (Items 1 - 50)				\$ 1,703,894	1,703,894		

*** 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.

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page of
Maefair Health Care Center	2142C	9/30/2015			30 37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (CT only).....	\$ 16,966,150	16,966,150			
b. Medicaid Room and Board Contractual Allowance **.....	\$ (8,710,285)	(8,710,285)			
2. a. Medicaid (All other states).....	\$				
b. Other States Room and Board Contractual Allowance **.....	\$				
3. a. Medicare Residents (all inclusive).....	\$ 2,202,216	2,202,216			
b. Medicare Room and Board Contractual Allowance **.....	\$ 676,982	676,982			
4. a. Private-Pay Residents and Other.....	\$ 3,763,861	3,763,861			
b. Private-Pay Room and Board Contractual Allowance **.....	\$ (193,274)	(193,274)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare.....	\$ 249,382	249,382			
b. Prescription Drugs - Medicare Contractual Allowance **.....	\$ (249,382)	(249,382)			
c. Prescription Drugs - Non-Medicare.....	\$ 291,686	291,686			
d. Prescription Drugs - Non-Medicare Contractual Allowance **.....	\$ (291,686)	(291,686)			
2. a. Medical Supplies - Medicare.....	\$ 3,133	3,133			
b. Medical Supplies - Medicare Contractual Allowance **.....	\$ (1,595)	(1,595)			
c. Medical Supplies - Non-Medicare.....	\$ 1,878	1,878			
d. Medical Supplies - Non-Medicare Contractual Allowance **.....	\$ (1,878)	(1,878)			
3. a. Physical Therapy - Medicare.....	\$ 1,102,644	1,102,644			
b. Physical Therapy - Medicare Contractual Allowance **.....	\$ (835,207)	(835,207)			
c. Physical Therapy - Non-Medicare.....	\$ 543,226	543,226			
d. Physical Therapy - Non-Medicare Contractual Allowance **.....	\$ (543,226)	(543,226)			
4. a. Speech Therapy - Medicare.....	\$ 178,432	178,432			
b. Speech Therapy - Medicare Contractual Allowance **.....	\$ (149,680)	(149,680)			
c. Speech Therapy - Non-Medicare.....	\$ 138,928	138,928			
d. Speech Therapy - Non-Medicare Contractual Allowance **.....	\$ (138,928)	(138,928)			
5. a. Occupational Therapy - Medicare.....	\$ 726,544	726,544			
b. Occupational Therapy - Medicare Contractual Allowance **.....	\$ (624,668)	(624,668)			
c. Occupational Therapy - Non-Medicare.....	\$ 457,407	457,407			
d. Occupational Therapy - Non-Medicare Contractual Allowance **.....	\$ (457,407)	(457,407)			
6. a. Other (Specify) - Medicare.....	\$				
b. Other (Specify) - Non-Medicare.....	\$ 2,241	2,241			
III Total Resident Revenue (Section I.thru Section II.).....	\$ 15,107,494	15,107,494			
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).....	\$ 27	27			
6. Private Duty Nurses' Fees.....	\$				
7. Barber, Coffee, Beauty and Gift shops.....	\$ 20,815	20,815			
8. Other (Specify).....	\$ 11,627	11,627			
V. Total Other Revenue (1 thru 8).....	\$ 32,469	32,469			
VI. Total All Revenue (III + V).....	\$ 15,139,963	15,139,963			

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

** Facility should report all contractual allowances and/or payer discounts..

Schedule of Other Resident Revenue - Medicare

Related Exp Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Retroactives	\$ 2,241		
Total Other Resident Revenue		\$ 2,241	\$ -	\$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
pg 31, E A2	Interest on A/R	NA	\$ 27		
Total Interest Income			\$ 27	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
15, 1c	Bad Debt Recoveries	\$ 11,627		
Total Other Revenue		\$ 11,627	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>).....			\$	187,493
2. Resident Accounts Receivable (Less Allowance for Bad Debts).....			\$	940,051
3. Other Accounts Receivable (Excluding Owners or Related Parties).....			\$	
4. Inventories.....			\$	24,706
5. Prepaid Expenses.....			\$	178,837
a. Prepaid Insurance	175,950			
b. Ppd exp -Fire alarm monitoring (6/15-5/16)	2,887			
c. _____				
d. _____				
6. Interest Receivable.....			\$	
7. Medicare Final Settlement Receivable.....			\$	
8. Other Current Assets (<i>itemize</i>).....			\$	456,020
Due from Related Parties	456,020			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,787,107
B. Fixed Assets				
1. Land.....			\$	
2. Land Improvements	*Historical Cost.....	63,905	\$	29,084
	Accum. Depreciation	(34,821) Net.....		
3. Buildings	*Historical Cost.....	1,299,096	\$	494,038
	Accum. Depreciation	(805,058) Net.....		
4. Leasehold Improvements	*Historical Cost.....	128,179	\$	117,637
	Accum. Depreciation	(10,542) Net.....		
5. Non-Movable Equipment	*Historical Cost.....	444,830	\$	61,174
	Accum. Depreciation	(383,656) Net.....		
6. Movable Equipment	*Historical Cost.....	1,700,332	\$	223,683
	Accum. Depreciation	(1,476,649) Net.....		
7. Motor Vehicles	*Historical Cost.....		\$	
	Accum. Depreciation	Net.....		
8. Minor Equipment-Not Depreciable.....			\$	
9. Other Fixed Assets (<i>itemize</i>).....			\$	(14,098)
Equipment Carryforward adjustments	5,957			
Depr adjustment due to conversion	(20,055)			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	911,518

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

(Carry Total forward to next page)

Cost Year	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Totals
	Excess Over CON Adj #1	Excess Over CON Adj #2	Excess Over CON Adj #3	Excess Over CON Adj #4	Excess Over CON Adj #5	Bed Addition Adj	Heritage Furn 2007 Profit	Heritage Furn 2007 Profit	Heritage Furn 2008 Profit	Heritage Furn 2009 Profit	Heritage Furn 2010 Profit	TV's 2010 Cost Report			
Cost Term	\$ 15,968	\$ 1,336	\$ 94,539	\$ 6,375	\$ 2,125	\$ 18,232	\$ 735	\$ 44,130	\$ 2,220	\$ 151	\$ 119	\$ 716	\$ 189,646		
Deprec	\$ 1,697	\$ 84	\$ 4,727	\$ 279	\$ 53								\$ 6,840		
Book Value	\$ 15,271	\$ 1,252	\$ 89,812	\$ 8,096	\$ 2,072								\$ 116,503		
Deprec	\$ 3,394	\$ 167	\$ 9,454	\$ 558	\$ 106								\$ 13,679		
Book Value	\$ 11,877	\$ 1,085	\$ 80,358	\$ 7,538	\$ 1,966								\$ 102,824		
Deprec	\$ 3,394	\$ 167	\$ 9,454	\$ 558	\$ 106	\$ 1,216							\$ 106,161		
Book Value	\$ 8,483	\$ 918	\$ 70,904	\$ 6,980	\$ 1,860	\$ 17,016							\$ 14,895		
Deprec	\$ 3,394	\$ 167	\$ 9,454	\$ 558	\$ 106	\$ 1,216							\$ 14,895		
Book Value	\$ 5,089	\$ 751	\$ 61,450	\$ 6,422	\$ 1,754	\$ 15,800							\$ 91,266		
Deprec	\$ 3,394	\$ 167	\$ 9,454	\$ 558	\$ 106	\$ 1,216							\$ 14,895		
Book Value	\$ 1,695	\$ 584	\$ 51,996	\$ 5,864	\$ 1,648	\$ 14,584							\$ 76,371		
Deprec	\$ 1,695	\$ 167	\$ 9,454	\$ 558	\$ 106	\$ 1,216							\$ 13,196		
Book Value	\$ -	\$ 417	\$ 42,542	\$ 5,306	\$ 1,542	\$ 13,368							\$ 63,175		
Deprec	\$ -	\$ 167	\$ 9,454	\$ 558	\$ 106	\$ 1,216							\$ 11,501		
Book Value	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -							\$ 51,674		
Deprec	\$ 250	\$ 33,088	\$ 4,748	\$ 1,436	\$ 12,152								\$ 11,501		
Book Value	\$ 167	\$ 9,454	\$ 558	\$ 106	\$ 1,216								\$ 40,173		
Deprec	\$ 83	\$ 23,634	\$ 4,180	\$ 1,330	\$ 10,936								\$ 11,417		
Book Value	\$ 83	\$ 9,454	\$ 558	\$ 106	\$ 1,216								\$ 28,756		
Deprec	\$ -	\$ -	\$ 14,180	\$ 3,632	\$ 1,224	\$ 9,720							\$ 11,334		
Book Value	\$ -	\$ 9,454	\$ 558	\$ 106	\$ 1,216								\$ 17,422		
Deprec	\$ 4,726	\$ 3,074	\$ 1,118	\$ 8,504									\$ 6,606		
Book Value	\$ 4,726	\$ 558	\$ 106	\$ 1,216									\$ 10,816		
Deprec	\$ -	\$ -	\$ 2,516	\$ 1,012	\$ 7,288								\$ 1,880		
Book Value	\$ -	\$ 558	\$ 106	\$ 1,216									\$ 8,936		
Deprec	\$ 1,958	\$ 906	\$ 6,072				\$ 148	\$ 4,414					\$ 6,442		
Book Value	\$ 1,400	\$ 800	\$ 4,856	\$ 1,216			\$ 587	\$ 39,716					\$ 47,359		
Deprec	\$ 558	\$ 106	\$ 1,216				\$ 148	\$ 4,414	\$ 112				\$ 6,554		
Book Value	\$ 842	\$ 694	\$ 3,640	\$ 2,109			\$ 439	\$ 35,302	\$ 2,109				\$ 43,026		
Deprec	\$ 284	\$ 558	\$ 1,216	\$ 1,216			\$ 148	\$ 4,414	\$ 223	\$ 15			\$ 6,680		
Book Value	\$ 284	\$ 558	\$ 2,424	\$ 1,886			\$ 291	\$ 30,888	\$ 1,886	\$ 136			\$ 36,497		
Deprec	\$ -	\$ -	\$ 482	\$ 1,208	\$ 1,208		\$ 143	\$ 26,474	\$ 1,663	\$ 105	\$ 12		\$ 6,434		
Book Value	\$ -	\$ 376	\$ 1,208	\$ 1,208			\$ 143	\$ 4,414	\$ 223	\$ 31	\$ 25		\$ 30,182		
Deprec	\$ -	\$ 106	\$ -	\$ -			\$ -	\$ 22,060	\$ 1,440	\$ 74	\$ 82		\$ 6,150		
Book Value	\$ -	\$ 270	\$ -	\$ -			\$ -	\$ 4,414	\$ 223	\$ 31	\$ 25		\$ 24,032		
Deprec	\$ -	\$ 106	\$ -	\$ -			\$ -	\$ 17,646	\$ 1,217	\$ 43	\$ 57		\$ 4,799		
Book Value	\$ -	\$ 106	\$ -	\$ -			\$ -	\$ 4,414	\$ 223	\$ 31	\$ 25		\$ 19,233		
Deprec	\$ -	\$ 164	\$ -	\$ -			\$ -	\$ 13,232	\$ 994	\$ 12	\$ 32		\$ 4,871		
Book Value	\$ -	\$ 106	\$ -	\$ -			\$ -	\$ 4,414	\$ 223	\$ 12	\$ 25		\$ 15,078		
Deprec	\$ -	\$ 58	\$ -	\$ -			\$ -	\$ 8,818	\$ 771	\$ 7	\$ 502		\$ 4,923		
Book Value	\$ -	\$ 58	\$ -	\$ -			\$ -	\$ 4,414	\$ 223	\$ 7	\$ 143		\$ 10,155		
Deprec	\$ -	\$ -	\$ -	\$ -			\$ -	\$ 4,404	\$ 548	\$ -	\$ 359		\$ 4,845		
Book Value	\$ -	\$ -	\$ -	\$ -			\$ -	\$ 4,404	\$ 223	\$ -	\$ 143		\$ 5,310		
Deprec	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	\$ 223	\$ -	\$ 216		\$ 4,770		
Book Value	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	\$ 223	\$ -	\$ 143		\$ 5,40		
Deprec	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	\$ 223	\$ -	\$ 143		\$ 366		
Book Value	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	\$ 223	\$ -	\$ 143		\$ 174		
Deprec	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	\$ 223	\$ -	\$ 143		\$ 174		
Book Value	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	\$ 223	\$ -	\$ 143		\$ 174		

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2015	32	37
Account			Amount	
Total Brought Forward:			\$	2,698,625
C. Leasehold or like property recorded for Equity Purposes.				
1. Land.....			\$	1,260,000
2. Land Improvements			*Historical Cost.....	
			Accum. Depreciation	Net.....
3. Buildings			*Historical Cost..... 7,823,776	
			Accum. Depreciation	(5,607,045) Net.....
4. Non-Movable Equipment			*Historical Cost.....	
			Accum. Depreciation	Net.....
5. Movable Equipment			*Historical Cost.....	
			Accum. Depreciation	Net.....
6. Motor Vehicles			*Historical Cost.....	
			Accum. Depreciation	Net.....
7. Minor Equipment-Not Depreciable.....			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$ 3,476,731	
D. Investment and Other Assets				
1. Deferred Deposits.....			\$	
2. Escrow Deposits.....			\$	
3. Organization Expense			*Historical Cost.....	
			Accum. Depreciation	Net.....
4. Goodwill (Purchased Only).....			\$	
5. Investments Related to Resident Care (<i>itemize</i>).....			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$ (8,734,040)	
Name and Address		Amount	Loan Date	
Related Party Investment		(8,734,040)	3/29/2012	
7. Other Assets (<i>itemize</i>).....			\$ 196,529	
Unamortized Bed License		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)			\$ (2,362,155)	

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2015	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable.....			\$	947,557
2. Notes Payable (<i>itemize</i>).....			\$	416,000
Key Bank Line of Credit				416,000
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>).....			\$	
Name of Lender		Purpose	Amount	Date Due
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>).....			\$	257,097
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>).....			\$	
6. Accrued Payroll Taxes Payable.....			\$	11,228
7. Medicare Final Settlement Payable.....			\$	
8. Medicare Current Financing Payable.....			\$	
9. Mortgage Payable (<i>Current Portion</i>).....			\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>).....			\$	2,670
11. Accrued Income Taxes*.....			\$	
12. Other Current Liabilities (<i>itemize</i>).....			\$	249,829
Security Deposits-Private Pay				11,670 **
Acc'd Int-Private Pay Security Deposits				4,273
Acc'd Operating Expenses				24,271
Acc'd Expense - Sales Tax				508
Provider Taxes Due				209,107
A-13. Total Current Liabilities (Lines A1 thru 12).....			\$	1,884,381

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

(Carry Total forward to next page)

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

Maefair health Care
Accd expenses
9/30/2015

IBNR (CTCARE)-9/30/15	(\$33,817.89)
Food rebate	\$2,739.97
audit fee	(\$14,000.00)
Medical Director	(\$5,000.00)
Health Drive Dental	(\$1,212.70)
Mgmt fee adjmt	\$34,121.29
Office supplies	(\$97.09)
payroll processing fees	(\$371.22)
Data Processing	(\$1,155.70)
Repair & Maintenance	(\$4,979.89)
Nursing	(\$497.72)

(\$24,270.95)

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Maefair Health Care Center		2142C	9/30/2015	34	37
Account				Amount	
Total Brought Forward:				1,884,381	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>).....\$					
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable.....\$					
3. Loans from Owners or Related Parties (<i>itemize</i>).....\$					
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities (<i>itemize</i>).....\$ (294,599)					
Related Party		(867,505)			
Key Bank Note Payable		572,906			
B-5. Total Long-Term Liabilities (Lines B1 thru 4).....\$ (294,599)					
C. Total All Liabilities (Lines A-13 + B-5).....\$ 1,589,782					

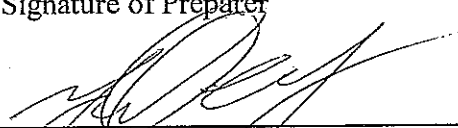
G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2015	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land.....			\$	1,260,000
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized.....			\$	2,216,731
3. Reserve for depreciation value of leased personal property (<i>Equity</i>) ..			\$	
4. Reserve for leasehold real properties on which fair rental value is based.....			\$	
5. Reserve for funds set aside as donor restricted.....			\$	
6. Total Reserves.....			\$	3,476,731
B. Net Worth				
1. Owner's Capital.....			\$	
2. Capital Stock.....			\$	2,000
3. Paid-in Surplus.....			\$	
4. Treasury Stock.....			\$	
5. Cumulated Earnings.....			\$	(7,285,404)
6. Gain or Loss for Period				
	10/1/2014	thru	9/30/2015	\$ (145,264)
7. Total Net Worth.....			\$	(7,428,668)
C. Total Reserves and Net Worth			\$	(3,951,937)
D. Total Liabilities, Reserves, and Net Worth			\$	(2,362,155)

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2015	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	(7,371,656)
B. Total Revenue (From Statement of Revenue Page 30)			\$	15,139,963
C. Total Expenditures (From Statement of Expenditures Page 27)			\$	15,285,227
D. Net Income or Deficit.....			\$	(145,264)
E. Balance.....			\$	(7,516,920)
F. Additions				
1. Additional Capital Contributed (itemize)				
		61,823		
	2015 computer conversion depr adjustment	19,702		
	Swap Value Net Change	6,727		
2. Other (itemize)				
F-3. Total Additions.....			\$	88,252
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			\$	(7,428,668)
				09/30/15

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2015	37	37
<i>Check appropriate category</i>				
CCNH	RHNS	Other (Specify)		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
	CEO	2/12/14		
Printed Name of Preparer				
Athena Health Care Associates, Inc				
Address		Phone Number		
135 South Road Farmington, CT 06032		(860) 751-3900		

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