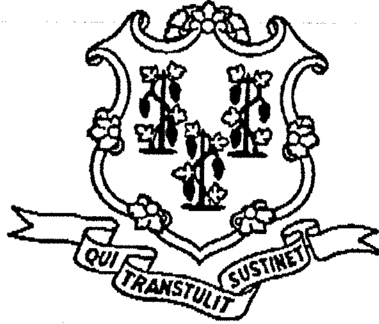
State of Connecticut



Annual Report of Long-Term Care Facility
Cost Year 2016

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 10/1/2015	Report for Year Ending 9/30/2016

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-MR
	2142C		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2016**	**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, 2015** and ending **September 30, 2016**, 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 penalities 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
[signature]		2-15-17	[signature]	2-15-17
Printed Name (Administrator) **Terri Golec**			Printed Name (Owner) **Lawrence Santilli**	
Subscribed and Sworn to before me:	State of Conn	Date 2/15/17	Signed (Notary Public) [signature]	Comm. Expires 3/31/20
Address of Notary Public			41 Terrace Ln Bristol CT 060[illegible]	

(Notary Seal)

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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 **10/1/2015**	To **9/30/2016**
Address of Facility **21 Maefair Court Trumbull, CT 06611**					
Report Prepared By **Athena Health Care Associates, Inc**	Phone Number **(860) 751-3900**			Date **2/15/2017**	
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	Report for Year Ended	Page	of
203-459-5152	09/30/16	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Maefair Health Care Center	**21 Maefair Court Trumbull, CT 06611**

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

Type of Facility (Check appropriate box(es))

- [x] Chronic and Convalescent Nursing Home only (CCNH)
- [ ] Rest Home with Nursing Supervision only (RHNS)
- [ ] (Specify)

Type of Ownership (Check appropriate box)

- [ ] PROPRIETORSHIP
- [ ] LLC
- [ ] PARTNERSHIP
- [x] 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 [x] No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Terri Golec	**000979**

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

Name	License No.:
Not Applicable	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2016**	3	37

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

Name of Partners/Members	Business Address	Title	% Owned
Not Applicable			

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CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2016	3A	37

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

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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G. Santilli	**21 Maefair Court, Trumbull, CT 06611**	**President**	**880.1015**
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:			
Conservators for Lawrence E. Santilli	**21 Maefair Court, Trumbull, CT 06611**		**119.8985**

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2016**	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
Not Applicable

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2016	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	☑	☐	>98%	Interest allocation exchange	Page 27, 12D	$6,825	$6,825
Laurel Ridge Health Care Center	642 Danbury Road Ridgefield, CT 06877	☑	☐	>98%	Bank Fees	Pg 16m13	$8,784	$8,784
Athena Health Care Systems	135 South Road, Farmington, CT 06032	☑	☐	>98%	see attached			
Maefair Landlord, LLC	135 South Rd, Farmington, CT	☑	☐	>98%	lease of facility	Pg 22, Ln 9 and 10b, pg 27, Ln 14a	$1,365,156	$1,365,156
Bayview Health Care Center	301 Rope Ferry Road, Waterford, CT	☑	☐	>98%	Data Processing reimbursement	pg 16m13	$1,511	$1,511
Litchfield Woods Health Care	255 Roberts Street, Torrington, CT	☑	☐	>98%	Shared Legal Fees	Pg 15, l e	$7,276	$7,276
Miscellaneous Facilities	various	☑	☐	>98%	Interfacility Loans	Pg 33, A2		
		☐	☐					
		☐	☐					

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

Maefair Health Care
RELATED PARTIES

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	X		>50%	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 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	$731,223	$283,920
Athena Health Care Systems 401(k) plan	135 South Road Farmington, CT 06032	X		>50%	Facility Participates in a multi-facility 401 (k) plan			
Athena Captive LLC	135 South Road Farmington, CT 06032		X		Workers Comp Captive	Pg 15, L1a	$368,096	$368,096
Athena Health Care Insuranece	135 South Road		X		Health Insurance	Pg 15, 1a5	$1,434,582	$1,434,582

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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**	**9/30/2016**	5	37

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

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

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

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

Not Applicable

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

Not Applicable

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

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

Not Applicable:No Non-Nursing Home Cost Centers

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page 6 of 37
Maefair Health Care Center	**2142C**	**9/30/2016**	6 of 37

Name and Address of Lessor	Related * to Owners, Operators, Officers: Yes	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	lease restructured.	$1,091	$546
LEAF Capital Funding, LLC PO Box 979127, Miami, FL 33197-9127	☐	☑	Copier System	03/06/12	48 months	$11,333	$11,333
LEAF Capital Funding, LLC PO Box 979127, Miami, FL 33197-9127	☐	☑	Copier System	06/18/13	32 months	$6,465	$5,927
CISCO Capital, 170 West Tasman Drive, San Jose, CA 95134	☐	☑	Conference Equipment	07/15/11	60 months	$3,428	$3,428
Hewlett Packard Financial Services, PO Box 402582, Atlanta, GA	☐	☑	PCC Equipment	07/18/13	60 months	$7,125	$6,531
LEAF Capital Funding, LLC PO Box 979127, Miami, FL 33197-9127	☐	☑	Copier System	02/25/16	48 months	$15,314	$8,933
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
						Total ***	$36,698

Is a Mileage Log Book Maintained for All Leased Vehicles ? **Not Applicable - No Vehicles** ☐ Yes ☐ No

* 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.

RENTAL AGREEMENT

1720A Crete Street, Moberly, MO 65270
Phone: 800-662-3759, Fax: 800-426-2626

CUSTOMER LEGAL NAME:	Tax ID#:	Telephone No:
fair Health Care Center Inc	061385355	2034595152

Billing Address:	Equipment Location (if other than Billing Address):
21 Maefiar Court, Trumbull, CT 06611	21 Maefair Court, Trumbull, CT 06611

EQUIPMENT DESCRIPTION: (indicate quantity, new or used and include make, model, serial # and all attachments – see below and/or attached Schedule A)

Unit Quantity	Description of Equipment	Make and Type	Model Number	Serial Number
	* PLEASE REFER TO SCHEDULE A			

BASE TERM IN MONTHS	TOTAL NUMBER OF RENTAL PAYMENTS			
48	48 @ $1,200.00 (plus taxes)	(a) Advance Payment:	$0.00; **	**If more than one rental payment is required as an Advance Payment, the balance will be applied to rental payments in inverse order, starting with the last rental payment. **Your obligation to pay all amounts and perform all other obligations is non-cancellable, absolute, unconditional and not subject to abatement, set-off or defense.**
		(b) Security Deposit:	$0.00;	
		(c) Documentation Fee:	$95.00	
		Total due a + b + c =	$95.00	

TERMS AND CONDITIONS

In this agreement ("Rental"), "we," "our," and "us" refers to **LEAF Capital Funding, LLC** and "you" and "your" refer to the Customer. You agree to rent the Equipment from us upon the following terms and conditions:

1. RENTAL PAYMENTS AND TERM: The Rental is enforceable on you upon your execution. The term of the Rental shall commence on the date the Equipment is delivered to you ("Rental Commencement Date"). The first Rental Payment shall be due on the date we specify in the month following the Rental Commencement Date, as set forth in our invoice, and the remaining Rental Payments will be due on the same day of each subsequent month (each, a "Payment Date") until paid in full. The Base Term shall commence on the date one month prior to the first Payment Date. We may charge you a portion of one Rental Payment for the period from the Rental Commencement Date until the first day of the Base Term ("Interim Rent"). The Interim Rent shall be due as invoiced. We may adjust the Rental Payments up to 15% if the actual costs are different than the estimate used to calculate the Rental Payments.

2. DELIVERY, ACCEPTANCE, USE AND REPAIR: You are responsible for Equipment delivery and installation. Unless you notify us otherwise in writing within 10 days of delivery, you unconditionally accept the Equipment. You authorize us to fill in the Rental Commencement Date, serial numbers and other information. **You will not move the Equipment from the above location without our written consent and are responsible for maintaining the Equipment in good repair.** We are not responsible for Equipment or vendor ...es.

...DEMNIFICATION: You agree to indemnify, defend and hold us harmless from and against any losses, damages, penalties, claims and suits, including attorneys' fees and expenses related to the ordering, manufacture, installation, ownership, condition, use, rental, possession, delivery or return of Equipment.

4. RENTAL EXPIRATION, RENEWAL: Unless you notify us at least 90 days prior to the expiration of the Rental of your election to return the Equipment, this Rental will renew on a month-to-month basis at the same monthly Rental Payment until you provide us with at least 90 days notice and return the Equipment. If you return the Equipment, (i) it must be to the location we designate and you are responsible for all return costs and we may charge a Restocking Fee equal to one Rental Payment, and (ii) you must securely remove all data from any and all disk drives or magnetic media prior to returning the Equipment (and you are solely responsible for selecting an appropriate removal standard that meets your business needs and complies with applicable laws). You will pay us for any loss in value resulting from failure to maintain the Equipment in accordance with this Rental or for damages incurred in shipping and handling.

5. LATE FEES AND CHARGES: If any amount is not paid within five (5) days of when due, you agree to pay us a late charge equal to the lesser of 10% of the amount past due or the maximum legal amount. Amounts which are not paid within 30 days of when due shall accrue interest at 1.5% per month (or if less, the maximum legal rate) until paid. You agree to pay $25 for each pay by phone and $35 for each returned payment.

6. NO WARRANTY: We do not manufacture the Equipment and you have selected the Equipment and the supplier. **WE MAKE NO EXPRESS OR IMPLIED WARRANTIES, INCLUDING THOSE OF MERCHANTABILITY OR FITNESS FOR A PURPOSE AND ARE NOT RESPONSIBLE FOR CONSEQUENTIAL OR INCIDENTAL DAMAGES.**

7. INSURANCE, RISK OF LOSS: You bear all risk of loss or damage to the Equipment from its order until it is returned in the required condition ("Risk Period"). During the Risk Period you will maintain property and liability insurance on the Equipment acceptable to us, naming us loss payee and additional insured. If you do not provide us with proof of such insurance, we may secure insurance on the Equipment to cover our interests (and only our interests). If we obtain such insurance, you will pay us an additional amount for the cost of such insurance and an administrative fee, the cost of which may be more than the cost to obtain your own insurance and on which we may make a profit.

8. OWNERSHIP AND TAXES: We own the Equipment (excluding licensed software). You will pay, when due, all taxes, fines and penalties relating to the purchase, use, renting and/or ownership of the Equipment. For administrative purposes, unless we otherwise direct in writing, you will list Customer as the owner of the Equipment for property tax purposes and file and pay when due any property taxes relating to the Equipment directly to the taxing authority and provide us with evidence of compliance. If we pay any taxes, fees or penalties on your behalf, you will pay us the amount we paid plus an administrative fee. You authorize us to file UCC financing statements and other documents we deem necessary to confirm our interest in the Equipment. You agree to pay us the documentation fee specified above or if not so specified, the greater of either $125 or 0.5% of the Equipment cost. If we require an Equipment site inspection, or you request administrative services, you agree to reimburse our costs.

9. DEFAULT: If you or any guarantor do not pay us any amount within ten (10) days of its due date, or breach any terms of this Rental, any guaranty or any license relating to the Equipment, you will be in default. If you default, we may require you to do any combination of the following: (a) immediately pay all amounts then due, plus the present value of the remaining Rental Payments, Interim Rent and residual value of the Equipment, as determined by us, discounted at an annual rate of 3%; (b) return all of the Equipment; (c) allow us to repossess the Equipment; or (d) use any and all remedies available to us under applicable law. If you default, you agree to pay the cost of repossession and our attorney's fees and costs. In addition to all other charges and as reimbursement for expenses incurred and not as a penalty, we may require you to reimburse us for the phone calls, letters, and any additional expense incurred in the collection or servicing of this Rental to you. If we take possession of the Equipment, we may sell or otherwise dispose of it with or without notice, at a public or private sale, and apply the net proceeds (after we have deducted all costs related to the sale or disposition of the Equipment) to the amounts that you owe us. You agree that if notice of sale is required by law, 10 days' notice shall constitute reasonable notice. You remain responsible for any amounts that are due after we have applied such net proceeds. We may apply any security deposits to your obligations and if you do not default, the balance will be refunded without interest.

10. ASSIGNMENT: You have no right to sell or assign the Equipment or Rental. We may sell or assign our rights in the Rental and/or Equipment and the new owner will have all our rights but will not be subject to any claim or defense you have against us.

11. ARTICLE 2A: You agree this Rental is a "finance lease" as defined in Article 2A of the Uniform Commercial Code. **You waive all rights and remedies conferred upon a lessee by Article 2A (508-522) of the UCC.** You have received a copy of the Supply Contract or been informed of the identity of the Supplier and you may have rights under the Supply Contract and may contact the Supplier for a description of those rights.

12. CREDIT INFORMATION: You authorize us or any of our affiliates to obtain credit bureau reports, and make other credit inquiries that we deem necessary.

13. CHOICE OF LAW: THIS RENTAL WILL BE GOVERNED BY PENNSYLVANIA LAW. YOU CONSENT TO JURISDICTION IN THE STATE OR FEDERAL COURTS IN PENNSYLVANIA AND WAIVE ANY RIGHT TO A TRIAL BY JURY.

14. MISCELLANEOUS: This Rental is the parties' entire agreement and can be amended only in writing signed by both parties. A fax of the Rental with fax signatures may be treated as an original and will be admissible as evidence. You will use the Equipment only for business purposes and not for personal, family or household use.

ACCEPTED BY CUSTOMER: Maefair Health Care Center Inc

Donna C. Orefice
Customer Authorized Signature

Print Name: Donna C. Orefice Title: Administrator
E-Mail Address: administrator@maefairhcf.com Date: 25-Feb-2016

PERSONAL GUARANTY: Undersigned guarantees that Customer will make all payments and perform all other obligations under the Rental when due. Undersigned agrees that this is a guaranty of payment and not of collection, and that we can proceed directly against undersigned without first proceeding against Customer or the Equipment. Undersigned also waives all suretyship defenses and notification if the Customer is in default and consents to any extensions or modifications granted to Customer. Undersigned will pay us all expenses (including ...ys' fees) we incur in enforcing our rights against undersigned or Customer. If more than one person signs this guaranty, each agrees that his/her liability is joint and several. Undersigned ...izes us and our affiliates to obtain credit bureau reports and make inquiries regarding undersigned's personal credit. You consent to jurisdiction in the State or Federal courts in Pennsylvania and expressly waive any right to a trial by jury.

SIGNED X ________ Print Name: ________ E-Mail Address: ________

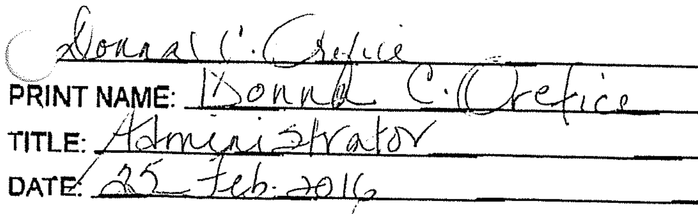
Accepted by:
LEAF CAPITAL FUNDING, LLC By: ________ Title: ________ Date: ________

SCHEDULE A TO RENTAL AGREEMENT
(EQUIPMENT DESCRIPTION)

Rental Application No.: **341804**

QNT	Equipment Description	New/Used	Make	Model	Serial Number
Location: 21 Maefair Court, Trumbull, CT 06611					
7	Xerox WorkCentre 3655X Copier Systems	New	Xerox	WorkCentre 3655X	
1	Xerox WorkCentre 6655 Copier System	New	Xerox	WorkCentre 6655	
1	Xerox WorkCentre 5945 Copier System	New	Xerox	WorkCentre 5945	
1	Xerox 5890 Copier System	New	Xerox	5890	

CUSTOMER: Maefair Health Care Center Inc



PRINT NAME: Donna C. Orefice
TITLE: Administrator
DATE: 25 Feb. 2016

LEAF CAPITAL FUNDING, LLC

BY: ______________________
PRINT NAME: ______________________
TITLE: ______________________
DATE: ______________________

DELIVERY AND ACCEPTANCE CERTIFICATE

Date of Equipment Delivery: 25 Feb. 2016

Application No.: 341804

Maefair Health Care Center Inc ("**Customer**") hereby certifies that all of the equipment, software and other property (collectively, "**Equipment**") referred to in that certain Agreement related to the above referenced application number (the "**Agreement**") by and between Customer and **LEAF Capital Funding, LLC** ("**LEAF**") has been delivered to and been received by Customer at the location(s) set forth in the Agreement, that all installation or other work necessary prior to the use thereof has been completed, that the Equipment has been examined by the Customer and is in good operating order and condition and is in all respects satisfactory to Customer, and that the Equipment is accepted by the Customer for all purposes under the Agreement. Customer represents and warrants that the Date of Equipment Delivery set forth above and the Billing Address and the Equipment Location set forth in the Agreement are correct. By its execution and delivery of this Acceptance Certificate, Customer hereby reaffirms all of the representations, warranties and covenants contained in the Agreement as of the date hereof, and further represents and warrants to LEAF that no Event of Default, and no event or condition which with notice or the passage of time or both would constitute an Event of Default, has occurred and is continuing as of the date hereof. Customer further certifies to LEAF that Customer has selected the Equipment (and to the extent applicable, the vendor of the Equipment) and has received and approved the purchase order, purchase agreement or supply contract under which the Equipment will be acquired for all purposes of the Agreement.

ACCORDINGLY, CUSTOMER AUTHORIZES LEAF TO PURCHASE THE EQUIPMENT FROM THE APPLICABLE SUPPLIER(S).

DO NOT SIGN THIS DELIVERY AND ACCEPTANCE CERTIFICATE UNTIL YOU HAVE RECEIVED ALL OF THE EQUIPMENT.

CUSTOMER: Maefair Health Care Center Inc

By: Donna C. Orefice

Print Name: Donna C Orefice

Title: Administrator

E-Mail Address: Administrator@maefairhcc.com

Date: 25 Feb 2016

THE ABOVE SIGNATORY AFFIRMS THAT HE/SHE IS A DULY AUTHORIZED CORPORATE OFFICER OR OFFICIAL, MEMBER, PARTNER OR PROPRIETOR OF THE ABOVE NAMED CUSTOMER.

Capital Funding, LLC
c/o Insurance Service Center
P.O. Box 979127
Miami, FL 33197-9127
Phone: (877) 248-5574/Fax: (305) 964-2690

Important Insurance Notice

03/15/12

ATTN: ACCOUNTS PAYABLE
MAEFAIR HEALTH CARE CENTER INC
21 MAEFAIR COURT
TRUMBULL CT 06611-4871

Re: **Required Property Coverage on Your Leased/Financed Equipment**
Agreement Number: 1001436947001
Equipment Description: (1)KYOCERA 6500 & (1)KYOCERA

Welcome to LEAF CAPITAL FUNDING, LLC. . Your business is important to us and we want to enhance your relationship with us by making it easy for you to secure the **required property insurance** coverage on the equipment.

Your lease/finance agreement requires you to maintain property insurance on this leased/financed equipment. We have an insurance program that offers coverage for this specific piece of equipment or you may use your insurance coverage through your own provider. Insuring the equipment provides an efficient means for repair or replacement - minimizing the impact to your company - should the equipment be lost, stolen, destroyed, or damaged. **If you do not arrange insurance, we will insure the equipment at your expense.**

Under the insurance program, LEAF CAPITAL FUNDING, LLC. purchases a property insurance policy through our equipment insurance manager. In addition to fire, theft, and other standard perils, our property policy also covers **power surge, flood,** and **terrorism.** Furthermore, there is **no deductible** for losses over $100 (losses under $100 will not be covered).

If you choose this program by not acquiring your own insurance policy, we will add $33.65 to your monthly invoice.

Please note that your company is not an insured, an additional insured, or a loss payee under our policy.

If you wish to use your own property insurance to protect this equipment, please have your agent contact our insurance center at (877) 248-5574 or fax/e-mail a copy of the certificate with the appropriate coverage to (305) 964-2690/insdoc@assurant.com. Please reference your LEAF CAPITAL FUNDING, LLC. agreement number (as stated above) and verify that:

- your property insurance covers the equipment and includes:
    - "LEAF CAPITAL FUNDING, LLC. , its successors and/or assigns" named as Loss Payee
    - "Special form" coverage including theft
    - Coverage effective as of 03/07/12
    - Equipment description

If your agent does not confirm property insurance coverage on the equipment within thirty (30) days from the date of this letter, the equipment will be insured under our policy and you will be obligated to pay the insurance charge of $33.65 that will be added to your invoice. **The insurance charge may result in profit to the lessor/lienholder and its agents. You retain the option to purchase your own insurance, which may cost less than the insurance charge we will charge.**

Thank you for assuring that the equipment is properly insured. If you have questions regarding the information in this letter, please call the Insurance Center at (877) 248-5574.

Sincerely,

LEAF CAPITAL FUNDING, LLC.

EXHIBIT A TO LEASE AGREEMENT
(EQUIPMENT DESCRIPTION)

Lease Application No.: **143694**

QNT	Equipment Description	New/Used	Make	Model	Serial Number
Location: 21 Maefair Court, Trumbull, CT 06611					
1	Kyocera TASKalfa 6500	New			
Location: 21 MAEFAIR COURT, TRUMBULL, CT 06611					
1	Kyocera TASKalfa 5500i Copier System	New			

LESSEE: Maefair Health Care Center Inc

BY: Jackie Russo

PRINT NAME: Jackie Russo

TITLE: HR. Coord

DATE: 3/6/2012

LEAF CAPITAL FUNDING, LLC

BY: ______

PRINT NAME: ______

TITLE: ______

DATE: ______

LEAF CAPITAL FUNDING, LLC **RENTAL AGREEMENT**

1720A Crete Street, Moberly, MO 65270
Phone: 800-662-3759, Fax: 1-800-426-2626

CUSTOMER LEGAL NAME: Maefair Health Care Center Inc	Tax ID#:	Telephone No: 2034595152
Billing Address: 21 Maefair Court, Trumbull, CT 06611	Equipment Location (if other than Billing Address): 21 MAEFAIR COURT, TRUMBULL, CT 06611	

EQUIPMENT DESCRIPTION: (indicate quantity, new or used and include make, model, serial # and all attachments – attach separate schedule if necessary)

Unit Quantity	Description of Equipment Leased	Make and Type	Model Number	Serial Number
	* PLEASE REFER TO EXHIBIT A(s)			

BASE TERM IN MONTHS	TOTAL NUMBER OF RENTAL PAYMENTS: 48		
48	48 @ $888.00 (plus taxes)	(a) Advance Payment: $0.00;** (b) Security Deposit: $0.00; (c) Documentation Fee: $95.00 Total due a+b+c= $95.00	**If more than one rental payment is required as an Advance Payment, the balance will be applied to rental payments in inverse order, starting with the last rental payment. **Your obligation to pay all amounts and perform all other obligations is non-cancellable, absolute, unconditional and not subject to abatement, set-off or defense.**

TERMS AND CONDITIONS

In this agreement ("Rental"), "we," "our," and "us" refers to **LEAF Capital Funding, LLC** as rentor and "you" and "your" refer to the Customer. You agree to rent the Equipment upon the following terms and conditions:

1. RENTAL PAYMENTS AND TERM: The Rental is enforceable on you upon your execution. The term of the Rental shall commence on the date we accept/book the Rental ("Rental Commencement Date"). The first Rental Payment shall be due on the date we specify in the month following the Rental Commencement Date ("Base Term Commencement Date"), as set forth in our invoice, and the remaining Rental Payments will be due on the same day of each subsequent month until paid in full. The Base Term Commencement Date shall be the start of the Base Term of the Rental. We may charge you a portion of one Rental Payment for the period from the Rental Commencement Date until the day preceding the Base Term Commencement Date ("Interim Rent"). The Interim Rent shall be due as invoiced. We may adjust the Rental Payments up to 15% if the actual costs are different than the estimate used to calculate the Rental Payments.

2. DELIVERY, ACCEPTANCE, USE AND REPAIR: You are responsible for Equipment delivery and installation. Upon delivery and installation of the Equipment you agree to confirm to us in writing or by telephone verification your unconditional acceptance of the Equipment for purposes of this Rental. You authorize us to fill in the Rental Commencement Date, serial numbers and other information. You will keep the Equipment at the above location and are responsible for maintaining the Equipment in good repair. We are not responsible for Equipment or vendor failures.

3. INDEMNIFICATION: You agree to indemnify, defend and hold us harmless from and against any losses, damages, penalties, claims and suits, including attorneys' fees and expenses related to the ordering, manufacture, installation, ownership, condition, use, rental, possession, delivery or return of Equipment.

4. RENTAL EXPIRATION, RENEWAL: Unless you notify us by certified mail between 90 and 180 days prior to Rental expiration or any renewal term, of your election to return the Equipment, this Rental will renew for successive 90 day periods at the same monthly Rental Payment until you provide us with the required notice and return the Equipment. If you return the Equipment, it must be to the location we designate and you are responsible for all return costs and agree to pay us a Restocking Fee equal to one Rental Payment.

5. LATE FEES AND CHARGES: If any amount is not paid within five (5) days of when due, you agree to pay us a late charge equal to the lesser of 10% of the amount past due or the maximum legal amount. Amounts which are not paid within 30 days of when due shall accrue interest at 1.5% per month (or if less, the maximum legal rate) until paid. You agree to pay $25 for each check by phone and $35 for each returned check.

6. NO WARRANTY: We do not manufacture the Equipment and you have selected the Equipment and the supplier. **WE MAKE NO EXPRESS OR IMPLIED WARRANTIES, INCLUDING THOSE OF MERCHANTABILITY OR FITNESS FOR A PURPOSE AND ARE NOT RESPONSIBLE FOR CONSEQUENTIAL OR INCIDENTAL DAMAGES.**

7. INSURANCE, RISK OF LOSS: You bear all risk of loss or damage to the Equipment from its order until it is returned to us in the required condition ("Risk Period"). During the Risk Period you will maintain property and liability insurance on the Equipment acceptable to us, naming us loss payee and additional insured. If you do not provide us with insurance, we may: (a) purchase such insurance and charge you the cost plus a fee, or (b) charge you a monthly risk fee of 0.25% of the original Equipment cost, but in either case, you shall not be relieved of any obligations under this Rental.

8. OWNERSHIP AND TAXES: We own the Equipment (excluding licensed software). You will pay, when due, all taxes, fines and penalties relating to the purchase, use, leasing and/or ownership of the Equipment. For administrative purposes, unless we otherwise direct in writing, you will list Customer as the owner of the Equipment for property tax purposes and file and pay when due any property taxes relating to the Equipment directly to the taxing authority and provide us with evidence of compliance. If we pay any taxes, fees or penalties on your behalf, you will pay us the amount we paid plus an administrative fee. You authorize us to file UCC financing statements and other documents we deem necessary to confirm our interest in the Equipment. You agree to pay us the documentation fee specified above or if not so specified, the greater of either $125 or 0.5% of the Equipment cost. If we require an Equipment site inspection, or you request administrative services, you agree to reimburse our costs.

9. DEFAULT: If you or any guarantor do not pay us any amount within ten (10) days of its due date, or breach any terms of this Rental, any guaranty or any license relating to the Equipment, you will be in default. If you default, we may require you to do any combination of the following: (a) immediately pay all amounts then due, plus the present value of the remaining Rental Payments, Interim Rent and residual value of the Equipment, as determined by us, discounted at an annual rate of 4%; (b) return all of the Equipment; (c) allow us to repossess the Equipment; or (d) use any and all remedies available to us under applicable law. If you default, you agree to pay the cost of repossession and our attorney's fees and costs. We may apply any security deposits to your obligations and if you do not default, the balance will be refunded without interest.

10. ASSIGNMENT: You have no right to sell or assign the Equipment or Rental. We may sell or assign our rights in the Rental and/or Equipment and the new owner will have all our rights but will not be subject to any claim or defense you have against us.

11. ARTICLE 2A: You agree this Rental is a "finance lease" as defined in Article 2A of the Uniform Commercial Code. You have received a copy of the Supply Contract or been informed of the identity of the Supplier and you may have rights under the Supply Contract and may contact the Supplier for a description of those rights.

12. CHOICE OF LAW: THIS RENTAL WILL BE GOVERNED BY MISSOURI LAW. YOU CONSENT TO JURISDICTION IN THE STATE OR FEDERAL COURTS IN MISSOURI AND WAIVE ANY RIGHT TO A TRIAL BY JURY.

13. ENTIRE AGREEMENT: This Rental is the parties' entire agreement and can be amended only in writing signed by both parties. A fax of the Rental with fax signatures may be treated as an original and will be admissible as evidence.

14. CREDIT INFORMATION: You authorize us or any of our affiliates to obtain credit bureau reports, and make other credit inquiries that we deem necessary.

ACCEPTED BY CUSTOMER: Maefair Health Care Center Inc

X Jackie Russo (signature) — Customer Authorized Signature

Print Name: Jackie Russo Title: AR Coord

E-Mail Address: administration@maefairhc.com Date: 3/6/12

Equipment Delivery and Acceptance: Customer hereby certifies that the Equipment: (a) has been delivered to and installed at the above location(s); and (b) has been examined by the Customer, is in good operating condition and is accepted by Customer for all purposes of the Rental. Customer warrants that the Equipment Delivery Date set forth below is correct. **Customer authorizes LEAF Capital Funding, LLC to pay the Equipment purchase price to the applicable vendor(s).**

Authorized Signature: Jackie Russo (signature) Equipment Delivery Date: 3/6/12

PERSONAL GUARANTY: Undersigned guarantees that Customer will make all payments and perform all other obligations under the Rental when due. Undersigned agrees that this is a guaranty of payment and not of collection, and that we can proceed directly against undersigned without first proceeding against Customer or the Equipment. Undersigned also waives all suretyship defenses and notification if the Customer is in default and consents to any extensions or modifications granted to Customer. Undersigned will pay us all expenses (including attorneys' fees) we incur in enforcing our rights against undersigned or Customer. If more than one person signs this guaranty, each agrees that his/her liability is joint and several. Undersigned authorizes us and our affiliates to obtain credit bureau reports and make inquiries regarding undersigned's personal credit. You consent to jurisdiction in State or Federal courts in Randolph County, Missouri and expressly waive any right to a trial by jury.

SIGNED X ____________ Print Name: ____________ E-Mail Address: ____________

Accepted by:
LEAF CAPITAL FUNDING, LLC By: ____________ Title: ____________ Rental Commencement Date: ____________

DELIVERY AND ACCEPTANCE CERTIFICATE

Date of Equipment Delivery:______________________________

Maefair Health Care Center Inc ("**Customer**") hereby certifies that all of the equipment, software and other property (collectively, "**Equipment**") referred to in that certain Agreement No. 143694 ("**Agreement**") dated as of ___________, 201_ by and between Customer and **LEAF Capital Funding, LLC** ("**LEAF**") has been delivered to and been received by Customer at the location(s) set forth in the Agreement, that all installation or other work necessary prior to the use thereof has been completed, that the Equipment has been examined by the Customer and is in good operating order and condition and is in all respects satisfactory to Customer, and that the Equipment is accepted by the Customer for all purposes under the Agreement. Customer represents and warrants hat the Date of Equipment Delivery set forth above and the Billing Address and the Equipment Location set forth in the Agreement are correct. By its execution and delivery of this Acceptance Certificate, Customer hereby reaffirms all of the representations, warranties and covenants contained in the Agreement as of the date hereof, and further represents and warrants to LEAF that no Event of Default, and no event or condition which with notice or the passage of time or both would constitute an Event of Default, has occurred and is continuing as of the date hereof. Customer further certifies to LEAF that Customer has selected the Equipment and has received and approved the purchase order, purchase agreement or supply contract under which the Equipment will be acquired for all purposes of the Agreement.

ACCORDINGLY, CUSTOMER AUTHORIZES LEAF TO PURCHASE THE EQUIPMENT FROM THE APPLICABLE SUPPLIER(S).

DO NOT SIGN THIS DELIVERY AND ACCEPTANCE CERTIFICATE UNTIL YOU HAVE RECEIVED ALL OF THE EQUIPMENT.

CUSTOMER: Maefair Health Care Center Inc

By: Jackie Russo

Print Name: Jackie Russo

Title: H.R. Coord

E-Mail Address: administration@maefairhcc.com

Date: 3/6/12

THE ABOVE SIGNATORY AFFIRMS THAT HE/SHE IS A DULY AUTHORIZED CORPORATE OFFICER OR OFFICIAL, MEMBER, PARTNER OR PROPRIETOR OF THE ABOVE NAMED CUSTOMER.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2016	7	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*)

	Service	Amount
1	2015 Audit, Yearend financials & tax returns	$ 14,000
2	Preparation of Medicare Cost report	$ 2,650
3	Key Bank audit (Disallowed)	$ 926
4		$ -
	Charge for Services Provided	$17,576

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	**Probate, Shiff Harding**	
3	**Murtha Cullina**	**860-240-6000**
4	**Shipman & Goodwin**	**860-251-5000**
5		

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

1 **200 Connecticut Ave. Norwalk, CT**
2
3 **185 Asylum Street, Hartford, CT**
4 **One Constitution Plaza, Hartford, CT**
5

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	Collections:Disallowed	$ 23,154
2	KEY Bank:$2685(Disallowed); probate $1045 (disallowed)	$ 3,730
3	Audit Letter & Sec. of State Annual Filing $1425:allowed; Mgmt agreement amendment $29 and general ssues $319:Disallowed	$ 1,772
4	Employee Matters: Disallow	$ 8,095
5		$ -
	Charge for Services Provided	$36,751

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

☑ Yes ☐ No **Pg 15, Line 1e**

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	09/30/16	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period.........	134	134			134	134			134	134		
B. On last day of THIS report period................	134	134			134	134			134	134		
2. Number of Residents												
A. As of midnight of PREVIOUS report period.....	131	131			133	133			131	131		
B. As of midnight of THIS report period............	131	131			134	134			131	131		
3. Total Number of Days Care Provided During Period												
A. Medicare..	7,530	7,530			5,759	5,759			1,771	1,771		
B. Medicaid (Conn.).................................	36,710	36,710			27,442	27,442			9,268	9,268		
C. Medicaid (other states)...........................												
D. Private Pay..	3,036	3,036			2,131	2,131			905	905		
E. State SSI for RCH.................................												
F. Other (Specify) Managed Care	569	569			467	467			102	102		
G. Total Care Days During Period (3A thru F)......	47,845	47,845			35,799	35,799			12,046	12,046		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days....................	585	585			476	476			109	109		
B. Other Bed Reserve Days........................	9	9			9	9						
5. ***Total Resident Days*** **(3G + 4A + 4B)........**	48,439	48,439			36,284	36,284			12,155	12,155		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2016**	9	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 CCNH (1)	Place of Change RHNS (2)	Place of Change (Specify) (3)	Lost (1)	Lost (2)	Lost (3)	Gained (1)	Gained (2)	Gained (3)	Capacity After Change CCNH	Capacity After Change RHNS	Capacity After Change (Specify)	Reason for Change

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

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

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

Item	Medicare CCNH	Medicaid CCNH	Medicaid RHNS	Self-Pay CCNH	Self-Pay RHNS	Self-Pay (Specify)	Other State Assisted R.C.H.	Other State Assisted ICF-MR
No. of Residents	9	108		8		6		
Per Diem Rate								
a. One bed rm.	555.98	244.87		526.00		497.66		
b. Two bed rms.	555.98	244.87		514.00		497.66		
c. Three or more bed rms.								

Item	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	6,494	6,494		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,764	1,764		
2. Restorative Treatments				
C. Other	14,912	14,912		
D. ***Total Physical Therapy Treatments***	23,170	23,170		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	481	481		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	266	266		
2. Restorative Treatments				
C. Other	1,380	1,380		
D. ***Total Speech Therapy Treatments***	2,127	2,127		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,709	3,709		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,231	1,231		
2. Restorative Treatments				
C. Other	12,006	12,006		
D. ***Total Occupational Therapy Treatments***	16,946	16,946		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2016**	10	37

Are time records maintained by all individuals receiving compensation? ☑ Yes ☐ No

Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
	Total Cost and 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)	114,176	2,005				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	291,780	12,543				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	61,400	2,207				
c. Dietary Workers	456,549	30,879				
6. Housekeeping Service						
a. Head Housekeeper	52,567	2,413				
b. Other Housekeeping Workers	194,772	17,027				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	51,046	2,109				
b. Other Maintenance Workers	41,319	2,229				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	133,319	10,359				
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	214,749	4,168				
b. RN						
1. Direct Care	493,920	12,491				
2. Administrative**	514,690	18,501				
c. LPN						
1. Direct Care	1,564,827	55,335				
2. Administrative**						
d. Aides and Attendants	1,743,521	120,559				
e. Physical Therapists	616,432	18,199				
f. Speech Therapists	71,746	1,973				
g. Occupational Therapists	337,578	8,613				
h. Recreation Workers	224,402	11,511				
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	184,311	6,299				
n. Marketing						
o. Other (Specify)						
A-13. Total Salary Expenditures	7,363,104	339,420				

* 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)

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

Schedule of Physician: Other Fees (Page 13)

Service	$ CCNH	Hours CCNH	$ RHNS	Hours RHNS	$ (Specify)	Hours (Specify)
Medical Staff	$ 1,350	9				
Total	$ 1,350	9	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2016**	11	37

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

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

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

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Maefair Health Care Center				**2142C**		**9/30/2016**			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* **										
Donna S. Orefice (10/1/15-7/25/16)	96,373			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	1,639	A2	Sheiden Woods 321 Stonecrest Dr Bristol, CT 06010	427	25,939
Terri Golec (9/1/16-9/30/16)	7,286			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	117	A2	Golden Hill, Milford CT and Cheshire Rehab, Cheshire, CT	1,920	110,000
David Fife (7/26/16-8/31/16)	10,517			Health & life insuranece, payroll taxes	Day to day operations of the nursing home facility.	249	A2	See attached		
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.

Maefair Health Care
David Fife

Facility	Hours Worked	Compensation Received
Abbott Terrace 44 Abbott Terrace Waterbury, CT 06703	48	$1,523.00
Countryside Manor 1660 Stafford Ave Bristol, CT 06010	1120	$48,471.00
Laurel Ridge 642 Danbury RD Ridgefield CT 06877	403	$17,420.00

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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		9/30/2016		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	38,444	1,013				
2. Dentist	10,754	11				
3. Pharmacist	10,511	162				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	25,000	56				
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	1,350	9				
9. Speech Therapist						
a. Resident Care	10,286	29				
b. Other						
10. Occupational Therapist						
a. Resident Care	60,358	1,028				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	24,891	228				
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	181,594	2,536				

* 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
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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
Amy Palmer, 24 Lufberry Lane, Norwalk, CT 06851	Dietician	☐	☑	
Swallowing Diagnostics, 21 Waterville, Rd, Avon, CT	Therapy Services	☐	☑	
Health Drive, One Prestige Drive, Meriden, CT	Dentist	☐	☑	
Dr. Iran Gomez, 3690 Main Street, Bridgeport, CT 06606	Medical Staff	☐	☑	
Dr. John Flores MD, 15 Corporate Drive, Trumbull, CT 06611	medical staff	☐	☑	
Omnicare/Value Health Care,525 Knotter Drive, Cheshire, CT	Pharmacy Consultants	☐	☑	
Access Therapies, PO Box 823461, Philadelphia, PA 19182-3461	Therapy Services	☐	☑	
Dr. Milla Stellman, 3715 Main Street, Bridgeport, CT 06606	Medical Staff	☐	☑	
Dr. Christopher Luthie, 3690 Main Street, Bridgeport, CT	Medical Staff	☐	☑	
Laura Svenson, P.O.Box 213, Georgetown, CT 06829	Dietician	☐	☑	
Mallie Guerini Associates, 222 Boston Ave, Stratford, CT 06614	Placement Fee - Nursing	☐	☑	
CT Dental, 240 Pomeroy Ave, Suite 205, Meriden, CT 06450	Dentist	☐	☑	
		☐	☑	
		☐	☑	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

* 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**	**9/30/2016**	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation...............	$	601,437	601,437		
2. Disability Insurance......................	$				
3. Unemployment Insurance.................	$	143,842	143,842		
4. Social Security (F.I.C.A.).................	$	547,699	547,699		
5. Health Insurance..........................	$	1,155,480	1,155,480		
6. Life Insurance (employees only) (not-owners and not-operators)..........	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)..........	$	38,930	38,930		
8. Uniform Allowance........................	$	287	287		
9. Other (*Specify*)........................... See Attached Schedule	$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*..	$	80,659	80,659		
d. Accounting and Auditing........................	$	17,576	17,576		
e. Legal (*Services should be fully described on Page 7)*	$	36,751	36,751		
f. Insurance on Lives of Owners and Operators (*Specify*)*......................	$				
g. Office Supplies..................................	$	79,551	79,551		
h. Telephone and Cellular Phones................					
1. Telephone & Pagers.........................	$	39,527	39,527		
2. Cellular Phones.	$	1,660	1,660		
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*....................................	$	250	250		
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	860,201	860,201		
Subtotal	$	3,603,850	3,603,850		

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

(Carry Subtotals forward to next page)

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2016**	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,603,850	3,603,850		
l. Travel and Entertainment					
1. Resident Travel and Entertainment..........................	$				
2. Holiday Parties for Staff................................	$	7,860	7,860		
3. Gifts to Staff and Residents................................	$	12,693	12,693		
4. Employee Travel...	$	4,387	4,387		
5. Education Expenses Related to Seminars and Conventions	$	7,898	7,898		
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*)..........	$	4,161	4,161		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***...............................	$	18,624	18,624		
See Attached Schedule					
4. Fund-Raising***..	$				
5. Medical Records..	$	(92)	(92)		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***.........	$	9,603	9,603		
7. Postage..	$	10,623	10,623		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	9,875	9,875		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions...	$	1,226	1,226		
10. Contributions*** See Attached Schedule	$	250	250		
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**................	$	475,847	475,847		
13. Other (*Specify*) See Attached Schedule	$	114,340	114,340		
C-14 Total Administrative & General Expenditures	$	4,281,145	4,281,145		

* 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	$ 18,624		
Total Other Advertising	$ 18,624	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 9,875		
Total Dues	$ 9,875	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Miscellaneous	$ 250		
Total Contributions	$ 250	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Lobbying Fees	$ 4,487		
Bank Charges	$ 11,707		
Payroll Processing Fees	$ 24,052		
Employee Physicals	$ 12,847		
Compliance Consulting	$ 9,908		
Data Processing	$ 42,452		
Licenses	$ 1,745		
Energy Audit	$ 381		
Medicaid Applications	$ 5,250		
JDA settlement:disallowed	$ 1,511		
Total Other Administrative and General	$ 114,340	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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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	$662,744	Contract Attached to a Prior Year	See Below
Allocation of the above	$437,411 $106,039 $119,294	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	$38,436	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**	**9/30/2016**	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food..........................	$	284,411	284,411		
2. Non-Food Supplies.....................	$	35,884	35,884		
3. Other (*Specify*)________________	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**.....................	$	106,039	106,039		
d. Other (*Specify*)__________________	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	426,334	426,334		

2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*	392	392		

	Question	Yes	No	
H.	Is cost of employee meals included in 2E?	☑ Yes	☐ No	
I.	Did you receive revenue from employees?	☐ Yes	☑ 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?	☑ Yes	☐ No	If yes, specify cost. = $1290
L.	Is any revenue collected from these people?	☐ Yes	☑ 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?	☐ Yes	☑ No	If yes, specify cost.
O.	Is any revenue collected from employees?	☐ Yes	☑ 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	9/30/2016	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	16,858	16,858		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**.....................	$				
d. Other (*Specify*) **Supplies = $6,692**	$	6,692	6,692		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	23,550	23,550		

3F. Laundry Questionnaire			
G. Is cost of employee laundry included in 3E?	☐ Yes	☑ No	If yes, specify cost.
H. Did you receive revenue from employees?	☐ Yes	☑ 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?	☐ Yes	☑ No	If yes, specify cost.
K. Did you receive revenue from these people?	☐ Yes	☑ 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.

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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
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Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	47,077	47,077		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	68	68		
c. Management Services*..................................		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)....		$	47,145	47,145		
5. Resident Care (Supplies)** a. Prescription Drugs***						
1. Own Pharmacy......................................		$				
2. Purchased from **Omnicare**		$	533,148	533,148		
b. Medicine Cabinet Drugs................................		$	3,083	3,083		
c. Medical and Therapeutic Supplies......................		$	244,865	244,865		
d. Ambulance/Limousine***................................		$	6,285	6,285		
e. Oxygen						
1. For Emergency Use..................................		$				
2. Other***..		$	40,596	40,596		
f. X-rays and Related Radiological Procedures***..........		$	12,243	12,243		
g. Dental (*Not dentists who should be included under salaries or fees*)......................		$				
h. Laboratory***..		$	32,752	32,752		
i. Recreation..		$	18,180	18,180		
j. Other (Specify)**** See Attached Schedule		$	243,704	243,704		
5K. ***Total Resident Care Expenditures*** (5a - 5j).............		$	1,134,856	1,134,856		

* 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.

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Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Management Fee Direct	$ 119,294		
Cable TV Fees	$ 34,798		
Oxygen Concentrator Rentals	$ 4,050		
Medical Equip Rentals-Medicaid	$ 15,643		
Physical Therapy Supplies	$ 37,663		
Medical Equip Rentals-Other	$ 32,256		
Total Other Resident Care	$ 243,704	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
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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
Omnicare	Columbus, OH 43271-5268	☐	☑		Pharmacy	547,656			20	5a2
CWPM	PO Box 415, Plainville, CT 06062	☐	☑		Rubbish Removal	30,280			22	6f
ADP	Philadelphia, PA 19170-0351	☐	☑		Payroll Processing	24,052			16	m13
Fairfield County Groundskeeping LLC	P.O.Box 320774, Fairfield, CT 06825	☐	☑		landscaping/snow removal	17,810			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).

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**	**9/30/2016**			22 | 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance.................................. $		117,199	117,199		
b. Heat.. $		60,195	60,195		
c. Light & Power.. $		124,468	124,468		
d. Water.. $		68,204	68,204		
e. Equipment Lease (*Provide detail on page 6*)........ $		36,698	36,698		
f. Other (*itemize*).. $		96,454	96,454		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)........... $		503,218	503,218		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements.................................... $		5,362	5,362		
b. Building & Building Improvements.................. $		98,401	98,401		
c. Non-Movable Equipment............................... $		17,587	17,587		
d. Movable Equipment.................................... $		77,770	77,770		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)................ $		199,120	199,120		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense.................................. $					
b. Mortgage Expense...................................... $					
c. Leasehold Improvements............................... $		18,090	18,090		
d. Other (*Specify*).. $					
*8e. ***Total Amortization Costs*** (8a + b + c + d)................ $		18,090	18,090		
9. Rental payments on leased real property less real estate taxes included in item 10b...................... $		1,067,704	1,067,704		
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................................ $		19,936	19,936		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)............ $		1,513,645	1,513,645		

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

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Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	$ 8,407		
Rubbish Removal	$ 30,280		
Snow Removal	$ 12,927		
Supplies	$ 44,840		
Total Other Repairs and Maintenance	$ 96,454	$ -	$ -

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2016**	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	63,904		63,904	34,821	S/L	Various	5,362	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
A-4. Subtotal								5,362
B. **Building and Building Improvements**								
1. Acquired prior to this report period	1,298,324		1,298,324	804,286	S/L	Various	98,401	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
B-4. Subtotal								98,401
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	444,838		444,838	383,664	SL	Various	17,587	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
C-4. Subtotal								17,587

	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	2015	1,706,288		1,706,288	1,476,648	S/L	Various	73,148	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2016	55,367		55,367		S/L	Various	4,622	
D-3. Subtotal												77,770
E. ***Total Depreciation***												199,120

Schedule of Land Improvements Acquired during this report period

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

* next to Total additions; ** next to Total deletions

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

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

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Oct-15	patient furniture	$ 2,437	15	$ 81
Dec-15	laptops	$ 655	3	$ 109
Dec-15	laptops	$ 1,264	3	$ 211
Dec-15	laptops	$ 2,120	3	$ 353
Dec-15	laptops	$ 1,734	3	$ 289
Dec-15	computer equipment	$ 598	5	$ 60
Dec-15	televisions-resident rooms	$ 1,356	5	$ 136
Dec-15	wheelchair	$ 817	5	$ 82
Jan-16	serve-well food table	$ 2,830	15	$ 94
Jan-16	dishwasher motor and sheave	$ 1,930	10	$ 97
Jan-16	auto start controller	$ 7,229	5	$ 723
Feb-16	wound surface mattresses	$ 6,558	5	$ 656
Feb-16	televisions-resident rooms	$ 1,318	5	$ 132
Apr-16	resident recliners	$ 1,650	15	$ 55
Apr-16	laptops	$ 547	3	$ 91
May-16	floor scrubber	$ 6,955	5	$ 696
Jun-16	wound vac	$ 5,982	10	$ 299
Jun-16	lounge chairs	$ 8,818	10	$ 441
Jul-16	glass table top	$ 569	15	$ 19
Total additions for Movable Equipment		$ 55,367		$ 4,622 *
Deletions:				
Total deletions for Movable Equipment		$ -		$ - **

***Ties to Page 23, Line D2c**

****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Oct-15	fire alarm monitor valve	$ 1,053	10	$ 53
Nov-15	signage	$ 1,893	10	$ 95
Jan-16	circulator pump	$ 4,467	10	$ 223
Feb-16	elevator boards and sensors	$ 9,000	20	$ 225
Feb-16	roof replacement	$ 43,650	10	$ 2,183
Mar-16	phone jacks	$ 1,196	10	$ 60
Apr-16	wood posts/fencing	$ 3,794	8	$ 237
Jul-16	hatco booster	$ 3,957	10	$ 198
Total additions for Leasehold Improvements		$ 69,010		$ 3,273 *
Deletions:				
Total deletions for Leasehold Improvements		$ -		$ - **

*Ties to Page 24, Line C3
**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2016**	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
	Month	Year							
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	2015	Various	696,095	381,929	SL	Var	14,817	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2016	Various	69,010		SL	Var	3,273	
C-4. Subtotal....................................									18,090
D. ***Total Amortization***									18,090

* 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		9/30/2016			24A	37
C. **Leasehold Improvements** (Specify) 1. Acquired prior to this report period	9	2015	Various	128,179	10,542	SL	variou	14,817	
2. Disposals (attach schedule)									
3. Acquired during this report period	9	2016	various	69,010		SL	variou	3,273	
C-4. Subtotal..............................									18,090
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	2015	Various	696,095	381,929	SL	Var	14,817	
Total Disposals									
Total Acquired during this report period	9	2016	Various	69,010		SL	Var	3,273	

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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	9/30/2016	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 9/30/2016	15,138,445			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	**2142C**	**9/30/2016**	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*)..............			$	66,285	66,285		
Vender Interest = $2,398; Line of Credit Interest = $31,346; Key Bank Loan Interest & Fees = $32,541							
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)......$				66,285	66,285		
14. Insurance a. Insurance on Property (buildings only).......			$	90,749	90,749		
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)...			$	90,749	90,749		
15. ***Total All Expenditures (A-13 thru C-14)*.........			$	15,631,625	15,631,625		

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	2142C	9/30/2016	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....................	$	337,578	337,578		
4.	Var	Var	Other - See attached Schedule...........	$	3,036	3,036		
Page 13 - Professional Fees								
5.			Resident Care Physicians **.............	$				
6.	13	B10a	Occupational Therapy..................	$	60,358	60,358		
7.			Other - See attached Schedule...........	$				
Pages 15 & 16 - Administrative and General								
8.	15	1a9	Discriminatory Benefits..................	$				
9.	15	1c	Bad Debts..............................	$	80,659	80,659		
10.	15	1d&e	Accounting & Legal......................	$	36,253	36,253		
11.	30	IV3	Telephone................................	$				
12.	15	1h2	Cellular Telephone........................	$	939	939		
13.			Life insurance premiums on the life of Owners, Partners, Operators..........	$				
14.	16	l3	Gifts, flowers and coffee shops...........	$	12,693	12,693		
15.	16	l5	Education expenditures to colleges or universities for tuition and related costs for owners and employees...............	$	875	875		
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 *...............	$	18,624	18,624		
19.	15	1j&k1 &2	Income Tax / Corporate Business Tax...	$	250	250		
20.	16	m4&10	Fund Raising / Contributions.............	$	250	250		
21.	16	m12	Unallowable Management Fees...........	$	295,220	295,220		
	18	2c		$	71,568	71,568		
	20	5j		$	80,515	80,515		
22.	30	IV7	Barber and Beauty.........................	$	13,455	13,455		
23.	Var	Var	Other - See attached Schedule...........	$	32,863	32,863		
Page 18 - Dietary Expenditures								
24.	18	2a1	Meals to employees, guests and others who are not residents.....................	$	2,895	2,895		
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)	$	1,048,031	1,048,031		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A12M	Marketing Salaries & Benefits	3,036		
Total Other Salaries Adjustment			$ 3,036	$ -	$ -

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	11,707		
16	M13	Lobbying Fees	4,487		
16	M13	MDS & Compliance Consulting	9,908		
16	M13	Medicaid Applications	5,250		
16	M13	JDA settlement	1,511		
Total Other A&G Adjustments			$ 32,863	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	**2142C**	**9/30/2016**	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	1,048,031	1,048,031		
Page 20 - Resident Care Supplies*								
27.	20	5a1&2	Prescription Drugs......................	$	533,148	533,148		
28.	20	5d	Ambulance/Limousine.................	$	6,285	6,285		
29.	20	5f	X-rays, etc.............................	$	12,243	12,243		
30.	20	5h	Laboratory..............................	$	32,752	32,752		
31.	20	5c	Medical Supplies........................	$	18,519	18,519		
32.	20	5e2	Oxygen (non emergency)...............	$	40,596	40,596		
33.			Occupational Therapy..................	$				
34.	Var	Var	Other - See Attached Schedule........	$	32,256	32,256		
Page 22 - Maintenance and Property								
35.	Var	Var	Excess Movable Equipment Depreciation See Attached Schedule....................	$	5,181	5,181		
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.	20	5j	Radio and Television Revenue...........	$	31,198	31,198		
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........	$	80	80		
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)***	$	1,760,289	1,760,289		

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental	32,256		
Total Other Ancillary Costs			$ 32,256	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excess Movable Equipment Depreciation	5,181		
Total Excess Movable Equipment Depreciation			5,181		

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
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Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	19,284,109	19,284,109		
b. Medicaid Room and Board Contractual Allowance **	$	(10,118,644)	(10,118,644)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents (*all inclusive*)	$	2,273,429	2,273,429		
b. Medicare Room and Board Contractual Allowance **	$	639,636	639,636		
4. a. Private-Pay Residents and Other	$	3,403,642	3,403,642		
b. Private-Pay Room and Board Contractual Allowance **	$	(319,919)	(319,919)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	352,904	352,904		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(352,904)	(352,904)		
c. Prescription Drugs - Non-Medicare	$	268,578	268,578		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(268,578)	(268,578)		
2. a. Medical Supplies - Medicare	$	5,119	5,119		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	1,041,226	1,041,226		
b. Physical Therapy - Medicare Contractual Allowance **	$	(788,205)	(788,205)		
c. Physical Therapy - Non-Medicare	$	432,775	432,775		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(432,775)	(432,775)		
4. a. Speech Therapy - Medicare	$	137,235	137,235		
b. Speech Therapy - Medicare Contractual Allowance **	$	(112,658)	(112,658)		
c. Speech Therapy - Non-Medicare	$	118,375	118,375		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(118,375)	(118,375)		
5. a. Occupational Therapy - Medicare	$	791,161	791,161		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(634,975)	(634,975)		
c. Occupational Therapy - Non-Medicare	$	376,025	376,025		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(376,025)	(376,025)		
6. a. Other (*Specify*) - Medicare	$				
b. Other (*Specify*) - Non-Medicare	$	(15,994)	(15,994)		
III *Total Resident Revenue* (Section I.thru Section II.)	$	15,585,162	15,585,162		
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*)	$	80	80		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	13,455	13,455		
8. Other (*Specify*)	$	7,600	7,600		
V. Total Other Revenue (1 thru 8)	$	21,135	21,135		
VI. Total All Revenue (III + V)	$	15,606,297	15,606,297		

* *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	$ (15,994)		
Total Other Resident Revenue		$ (15,994)	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
pg 31, L A2	Interest on A/R	NA	$ 80		
Total Interest Income			$ 80	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
15, 1c	Bad Debt Recoveries	$ 7,600		
Total Other Revenue		$ 7,600	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 127,576
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,267,417
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 24,617
5. Prepaid Expenses				$ 300,778
a. Prepaid Insurance		167,442		
b. Ppd exp-health insurance & maintenance repairs		132,392		
c. Ppd exp-October copier lease payment		944		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 484,548
Due from Related Parties		456,020		
Cost settlement		28,528		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,204,936
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	63,905		$ 23,722
	Accum. Depreciation	(40,183)	Net	
3. Buildings	*Historical Cost	1,299,096		$ 395,637
	Accum. Depreciation	(903,459)	Net	
4. Leasehold Improvements	*Historical Cost	197,189		$ 168,558
	Accum. Depreciation	(28,631)	Net	
5. Non-Movable Equipment	*Historical Cost	444,830		$ 43,587
	Accum. Depreciation	(401,243)	Net	
6. Movable Equipment	*Historical Cost	1,758,206		$ 203,787
	Accum. Depreciation	(1,554,419)	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (16,605)
Equipment Carryforward adjustments		3,450		
Depr adjustment due to conversion		(20,055)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 818,686

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

(Carry Total forward to next page)

Prepaid expenses
#1580
as of 9/30/16

Health Insueance Accrual	$7,559.88
OCT Health insurance	$118,072.90
OCT Health insurance	$6,132.60
ThysennKrupp	$627.00
Leaf October lease	$944.00
TOTAL	**$133,336.38**

Maefair Moveable Equipment Carryforward Schedule

Cost Year		Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount		Amount	Totals
		Excess Over CON Adj #1	Excess Over CON Adj #2	Excess Over CON Adj #3	Excess Over CON Adj #4	Excess Over CON Adj #5	Bed Addition Adj	Heritage Furn 2007 Profit	Heritage Furn 2007 Profit	Heritage Furn 2008 Profit	Heritage Furn 2009 Profit	Heritage Furn 2010 Profit	TV's 2013 Cost Report		TV's 2016 Cost Report	
	Cost	16,968	1,336	94,539	8,375	2,125	18,232	735	44,130	2,220	151	119	716	719	$2,674	193,039
	Term	5	8	10	15	20	15	5	10	10	5	5	5	5	5	
1995	Deprec	1,697	84	4,727	279	53										6,840
1995	Book Value	15,271	1,252	89,812	8,096	2,072										116,503
1996	Deprec	3,394	167	9,454	558	106										13,679
1996	Book Value	11,877	1,085	80,358	7,538	1,966										102,824
1997	Deprec	3,394	167	9,454	558	106	1,216									14,895
1997	Book Value	8,483	918	70,904	6,980	1,860	17,016									106,161
1998	Deprec	3,394	167	9,454	558	106	1,216									14,895
1998	Book Value	5,089	751	61,450	6,422	1,754	15,800									91,266
1999	Deprec	3,394	167	9,454	558	106	1,216									14,895
1999	Book Value	1,695	584	51,996	5,864	1,648	14,584									76,371
2000	Deprec	1,695	167	9,454	558	106	1,216									13,196
2000	Book Value	-	417	42,542	5,306	1,542	13,368									63,175
2001	Deprec		167	9,454	558	106	1,216									11,501
2001	Book Value		250	33,088	4,748	1,436	12,152									51,674
2002	Deprec		167	9,454	558	106	1,216									11,501
2002	Book Value		83	23,634	4,190	1,330	10,936									40,173
2003	Deprec		83	9,454	558	106	1,216									11,417
2003	Book Value		-	14,180	3,632	1,224	9,720									28,756
2004	Deprec			9,454	558	106	1,216									11,334
2004	Book Value			4,726	3,074	1,118	8,504									17,422
2005	Deprec			4,726	558	106	1,216									6,606
2005	Book Value			-	2,516	1,012	7,288									10,816
2006	Deprec				558	106	1,216									1,880
2006	Book Value				1,958	906	6,072									8,936
2007	Deprec				558	106	1,216	148	4,414							6,442
2007	Book Value				1,400	800	4,856	587	39,716							47,359
2008	Deprec				558	106	1,216	148	4,414	112						6,554
2008	Book Value				842	694	3,640	439	35,302	2,109						43,026
2009	Deprec				558	106	1,216	148	4,414	223	15					6,680
2009	Book Value				284	588	2,424	291	30,888	1,886	136					36,497
2010	Deprec				284	106	1,216	148	4,414	223	31	12				6,434
2010	Book Value				-	482	1,208	143	26,474	1,663	105	107				30,182
2011	Deprec					106	1,208	143	4,414	223	31	25				6,150
2011	Book Value					376	-	-	22,060	1,440	74	82				24,032
2012	Deprec					106			4,414	223	31	25				4,799
2012	Book Value					270			17,646	1,217	43	57				19,233
2013	Deprec					106			4,414	223	31	25	72			4,871
2013	Book Value					164			13,232	994	12	32	645			15,078
2014	Deprec					106			4,414	223	12	25	143	-		4,923
2014	Book Value					58			8,818	771	-	7	502	-		10,155
2015	Deprec					58			4,414	223		7	143	72		4,917
2015	Book Value					-			4,404	548		-	359	647		5,957
2016	Deprec								4,404	223			143	144	267	5,181
2016	Book Value								-	325			216	503	2,407	3,450
2017	Deprec									223			143	144	535	1,045
2017	Book Value									102			73	359	1,872	2,405
2018	Deprec									102			73	144	535	853
2018	Book Value									-			-	215	1,337	1,552
2019														144	535	679
2019														71	802	873
2020														71	535	606
2020														-	267	267
															267	267
															0	0

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	**2142C**	**9/30/2016**	32 | 37

Account				Amount
			Total Brought Forward:	$ 3,023,622
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	$ 2,216,731
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 (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$ (8,734,040)
Name and Address	Amount	Loan Date		
Related Party Investment	(8,734,040)	3/29/2012		
7. Other Assets (*itemize*)				$ 219,423
IRS Deposits		22,894		
Unamortized Bed License		196,529		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (8,514,617)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ (2,014,264)

* 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**	**9/30/2016**	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 941,665
2. Notes Payable (*itemize*)				$ 678,000
Key Bank Line of Credit		496,000		
Due to Related Parties		182,000		
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*)				$ 390,444
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 16,132
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*)				$ 2,141
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 313,310
Security Deposits-Private Pay		11,670	**	
Acc'd Int-Private Pay Security Deposits		4,917		
Acc'd Operating Expenses		77,962		
Acc'd Expense - Sales Tax		489		
Provider Taxes Due		218,272		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,341,692

* 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
9/30/2016

Account	**2170**

FYE 9/30/16

	FYE 9/30/16
Frontier	$1,547.07
United Illuminating	$13,099.60
Emerald resources	$1,058.24
Melite Design	$250.00
Triple A	$469.58
Triple A	$254.97
TransClean	$505.16
RFMS	$364.90
UPS	$37.74
9/30/16 Audit fee	$14,000.00
Mckesson	$1,463.18
Mckesson	$1,463.06
Quarterly mgmt fee adjmt	$33,448.01
wage enhancement	$10,000.00
	$77,961.51

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2016**	34	37

Account	Amount
Total Brought Forward:	2,341,692
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

Account		Amount
4. Other Long-Term Liabilities (*itemize*)		$ (490,970)
Related Party	**(767,574)**	
Key Bank Note Payable	**276,604**	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ (490,970)
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 1,850,722

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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**	**9/30/2016**	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 *(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	$	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	$	(7,318,389)
6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$	(25,328)
7. Total Net Worth	$	(7,341,717)
C. ***Total Reserves and Net Worth***	$	(3,864,986)
D. ***Total Liabilities, Reserves, and Net Worth***	$	(2,014,264)

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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**	**9/30/2016**	36	37

	Account	Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015	$ (7,428,668)
B.	Total Revenue (*From Statement of Revenue Page 30*)	$ 15,606,297
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$ 15,631,625
D.	Net Income or Deficit...	$ (25,328)
E.	Balance...	$ (7,453,996)
F.	Additions	
	1. Additional Capital Contributed (*itemize*) **106,039**	
	Swap Value Net Change **6,240**	
	2. Other (*itemize*)	
F-3.	Total Additions..	$ 112,279
G.	Deductions	
	1. Drawings of Owners/Operators/Partners (*Specify*).................................	$

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

	Account	Amount
	2. Other Withdrawings (Specify)..	$

Purpose	Amount

	Account	Amount
	3. Total Deductions..	$
H.	***Balance at End of Period*** 09/30/16	$ (7,341,717)

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I. Preparer's/Reviewer's Certification

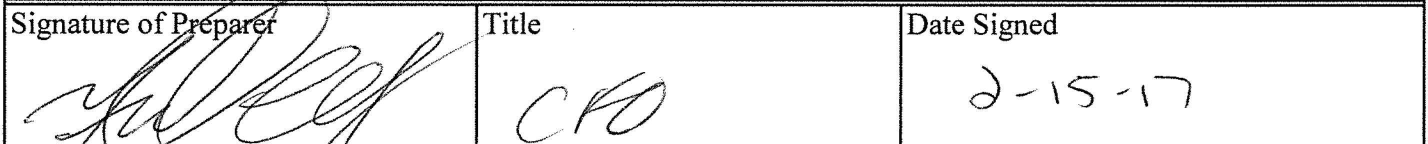
Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	**2142C**	**9/30/2016**	37	37

Check appropriate category

CCNH	RHNS	Other (*Specify*)
☑	☐	☐

Preparer/Reviewer Certification

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



Signature of Preparer	Title	Date Signed
	CFO	2-15-17

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.