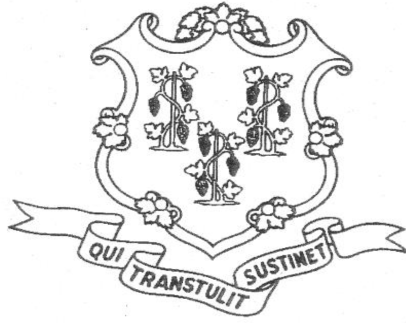
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2023

Name of Facility (as licensed)		
Maefair Health Care center		
Address (No. & Street, City, State, Zip Code) 21 Maefair Trambull, CT 0611		
Type of Facility		
☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☐ (Specify)	☐ (Specify)
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023	

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

Medicaid Provider Numbers:	CCNH / RHNS	(Specify)	(Specify)
	2142C		

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CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Maefair Health Care center [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Rita Pitter			Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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Department of Social Services

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment

Name of Facility	Period Covered:	From	To
Maefair Health Care center		10/1/2022	9/30/2023
Address of Facility: 21 Maefair Trambull, CT 0611			
Report Prepared By: Athena Health Care Associates, Inc	Phone Number: (860) 751-3900	Date	

Item		Total	CCNH / RHNS	(Specify)	(Specify)
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$				
5. All other wages paid	$				
6. ***Total Wages Paid***	$				
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-459-5152	9/30/2023	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Maefair Health Care center	21 Maefair Trambull, CT 0611

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

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined ☐ (Specify) ☐ (Specify)

Type of Ownership (Check appropriate box)

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

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

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

Administrator

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

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

Name	License No.:
Not Applicable	

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	3	37

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	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 Marfair Court, Trumbull, CT 06611	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G. Santilli	21 Maefair Court, Trumbull, CT 06611	President	880.1015
Michael E. Moiser	21 Maefair Court, Trumbull, CT 06611	reasuer/Secretar	
Names of Stockholders Owning at Least 10% of Shares			
Conservators for Lawrence E. Santilli	21 Maefair Court, Trumbull, CT 06611		119.8985

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	4	37

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Maefair landlord, LLC	135 South Rd., Farmington, CT	○	⊙	>95%	Lease of Facility	Pg 22, Ln 9 and 10b	1,271,194	1,271,194
Athena Health care 401k	135 South Rd., Farmington, CT	⊙	○	>50%	Participates in Common 401k Plan			
Athena Health care Systems	135 South Rd., Farmington, CT	⊙	○	>50%	See Attached			
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	⊙	○	<5%	Pharmacy Services	Pg 20, 5a2	508,323	508,323
Athena Captive	135 South Rd, Farmington, CT 06032	○	⊙		Workmens Comp	pg 15 1a1	453,751	453,751
Procare LTC - Note	111 Executive Blvd, Farmingdale, NY 11735	⊙	○	<5%	Pharmacy Services	Pg 34, pg 27 12D	44,816	44,816
		○	⊙					
		○	⊙					
		○	⊙					

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

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	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 costs

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General Information and Questionnaire
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	6	37

Square footage of entire facility.	0

Outpatient Therapy

Does the Facility provide outpatient therapy services?	No

If yes, please complete the following:

	Square footage of therapy space.

Meals on Wheels

Does the facility provide Meals on Wheels?	No

If yes, please complete the following:

	Square footage of kitchen	
	Number of meals served per week	
No	Are meals included in meals served on page 18 of the Annual Report?	
No	Are direct costs included in the Annual Report?	
	If yes, please state where costs are reported.	
No	Are drivers for the program included in the facility's payroll?	
	If yes, please complete the following:	
		Amount Reported
		Annual Report page and line
	Please state the salary amounts of specific cooks and/or dietary aides	
	Please state where the cooks and/or dietary aides are reported in the Annual Report	

Apartments, Independent Living, Assisted Living

Does the facility have apartments, independent living, and/or assisted living?	No

If yes, please complete the following:

	Square footage of apartments
	Square footage of independent living
	Square footage of assisted living
	Please identify the services provided:

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care c	2142C	9/30/2023	7	37

Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care?	No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH / RHNS Level	Total	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	134	134			134	134						
B. On last day of THIS report period	134	134							134	134		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	123	123			123	123						
B. As of midnight of THIS report period	120	120							120	120		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,819	5,819			4,416	4,416			1,403	1,403		
B. Medicaid (Conn.)	36,481	36,481			27,195	27,195			9,286	9,286		
C. Medicaid (other states)												
D. Private Pay	851	851			630	630			221	221		
E. State SSI for RCH												
F. Other (Specify)	255	255			290	290			(35)	(35)		
G. Total Care Days During Period (3A thru F)	43,406	43,406			32,531	32,531			10,875	10,875		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	524	524			362	362			162	162		
B. Other Bed Reserve Days	234	234			184	184			50	50		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	44,164	44,164			33,077	33,077			11,087	11,087		

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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	9/30/2023	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			Change in Beds						Capacity After Change			Reason for Change
	CCNH / RHNS	(Specify)	(Specify)	Lost			Gained			CCNH / RHNS	(Specify)	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	6	102		2		10		
Per Diem Rate								
a. One bed rm.	576.27	308.77		696.00		655.56		
b. Two bed rms.	576.27	308.77		685.00		655.56		
c. Three or more bed rms.								

Item	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
7. Total Number of Physical Therapy Treatments					
A. Medicare - Part B	1,224	1,224			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	974	974			
2. Restorative Treatments					
C. Other	3,338	3,338			
D. ***Total Physical Therapy Treatments***	5,536	5,536			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	203	203			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	41	41			
2. Restorative Treatments					
C. Other	352	352			
D. ***Total Speech Therapy Treatments***	596	596			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	1,116	1,116			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	786	786			
2. Restorative Treatments					
C. Other	3,252	3,252			
D. ***Total Occupational Therapy Treatments***	5,154	5,154			

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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	9/30/2023	10	37

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

Item	Total Cost and Hours								
	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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)	159,292		2,068						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	269,410		10,629						
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor	72,009		2,054						
c. Dietary Workers	566,061		30,347						
6. Housekeeping Service									
a. Head Housekeeper	38,550		1,696						
b. Other Housekeeping Workers	294,428		18,089						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	69,969		2,294						
b. Other Maintenance Workers	47,007		1,904						
8. Laundry Service									
a. Supervisor	167,427		9,282						
b. Other Laundry Workers									
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	250,210		3,854						
b. RN									
1. Direct Care	533,129		10,761						
2. Administrative**	597,157		16,559						
c. LPN									
1. Direct Care	2,281,501		54,257						
2. Administrative**									
d. Aides and Attendants	2,488,079		102,156						
e. Physical Therapists	406,317		10,635						
f. Speech Therapists	62,216		1,269						
g. Occupational Therapists	247,616	(247,616)	5,609						
h. Recreation Workers	204,808		9,391						
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	205,653	(2,382)	5,797						
n. Marketing									
o. Other (Specify) See Attached Schedule									
A-13. Total Salary Expenditures	8,960,839	(249,998)	298,651						

* 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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	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)	(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	9/30/2023	12	37

Name	Salary Paid CCNH / RHNS	Salary Paid (Specify)	Salary Paid (Specify)	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
Section III - Administrators* **										
Rita Pitter	159,292			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility	2,068	A2	Unknown	2,068	159,292
10/1/22-9/30/23										
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	13	37

Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
	Total Cost and 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	71,147		1,259						
2. Dentist	11,390		28						
3. Pharmacist	14,592		364						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	34,250		264						
b. Utilization Review									
(Title 18 and 19 only) monthly meeting									
c. Resident Care**	18	(18)							
d. Administrative Services facility									
1. Infection Control Committee (Quarterly meetings)									
2. Pharmaceutical Committee (Quarterly meetings)									
3. Staff Development Committee (Once annually)									
e. Other (Specify)									
9. Speech Therapist									
a. Resident Care	1,440		4						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	497		4						
2. Administrative***									
b. LPN									
1. Direct Care	31,538		454						
2. Administrative***									
c. Aides	38,187		912						
d. Other									
12. Other (Specify)									
See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	203,059	(18)	3,289						

* 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 in the Adjustment column.

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Procaire, LLC, P.O. Box 801, Tolland, CT 06084	Respiratory/Oxygen Therapy	○	⊙	
NOA Diagnostic, 6851 Jericho Turnpike Suite 240, Syosset, NY 11791	Radiology	○	⊙	
CT Dental Partners, 300 Church St, Suite 203, Wallingford, CT 06492	Dental	○	⊙	
HealthDrive, Dr. Kothary, 1 Prestige Drive Suite 107, Meriden, CT 06450	Podiatrist	○	⊙	
Harvest Health Care, 21 Waterville Rd, Avon, CT 06001	Psychologist/Psychiatrist	○	⊙	
Laura Svenson, P.O Box 213 Gerogetown, CT 06829-0213	Dietician	○	⊙	
Procare LTC, 111 Executive Blvd, Farmingdale NY 11735	Pharmacist	⊙	○	Common Owners: Minority Interest
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* 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	9/30/2023	15	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	453,751	453,751					
2. Disability Insurance	$							
3. Unemployment Insurance	$	62,226	62,226					
4. Social Security (F.I.C.A.)	$	660,762	660,762					
5. Health Insurance	$	1,049,868	1,049,868					
6. Life Insurance (employees only) (not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	210,801	210,801					
8. Uniform Allowance	$	10,314	10,314					
9. Other (*Specify*) See Attached Schedule	$							
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$		175,273	(175,273)				
d. Accounting and Auditing	$	9,235	10,235	(1,000)				
e. Legal (*Services should be fully described on Page 15b)*	$		48,104	(48,104)				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	38,186	38,186					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	51,246	51,246					
2. Cellular Phones	$	360	360					
i. Appraisal (*Specify purpose and attach copy*)*	$							
j. Corporation Business Taxes (*franchise tax*)	$							
k. Other Taxes (*Not related to property - See Page 22)*								
1. Income*	$							
2. Other (*Specify*) See Attached Schedule	$							
3. Resident Day User Fee	$	807,000	807,000					
Subtotal	$	3,353,749	3,578,126	(224,377)				

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	15b	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	PKF O'Connor Davies, LLP	Four Corporate Dr, Shelton, CT
2	Marcum LLP	555 Long Wharf Drive, New Haven, CT
3		
4		

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	Tax	$ 7,400
2	Preparation of Medicare Cost report	$ 2,835
3		$
4		$
	Charge for Services Provided	$ 10,235

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

(•) Yes ( ) No — Pg 15, Line1d

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	Goldman, Gruder & Woods	203-899-8900
2	Trumbull Probate/Conservator fee/State Marshall	203-452-5068
3	LOVEJOY AND RIMER, P.C.	203-853-4400
4		
5		

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

1 200 Connecticut Ave. Norwalk, CT
2 (5866 Main Street, Trumbull, CT) (100 Blvd of the Americas, Lakewood NJ, 08701)
3 65 East Ave. Norwalk, CT
4
5

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	Collections:Disallowed	$ 42,270
2	Conservator:Disallow	$ 1,440
3	Collections:Disallowed	$ 4,394
4		$
5		$
	Charge for Services Provided	$ 48,104

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

(•) Yes ( ) No — Pg 15 Line 1e

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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	9/30/2023	16	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:		3,353,749	3,578,126	(224,377)				
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$							
3. Gifts to Staff and Residents	$		26,372	(26,372)				
4. Employee Travel	$	1,219	1,219					
5. Education Expenses Related to Seminars and Conventions	$	6,804	6,804					
6. Automobile Expense (*not purchase or depreciation*)	$							
7. Other (*Specify*)	$							
See Attached Schedule								
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (*all such expenses*)	$	3,030	3,030					
2. Advertising Telephone Directory (*all such expenses*)***	$		5,100	(5,100)				
3. Advertising Other (*Specify*)***	$							
See Attached Schedule								
4. Fund-Raising***	$							
5. Medical Records	$							
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$							
7. Postage	$	3,887	4,087	(200)				
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	8,419	8,419					
See Attached Schedule								
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$	2,872	2,872					
10. Contributions***	$	200	200					
See Attached Schedule								
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$							
12. Administrative Management Services**	$	253,092	8,652	244,440				
13. Other (*Specify*)	$	175,596	211,296	(35,700)				
See Attached Schedule								
C-14 Total Administrative & General Expenditures	$	3,808,868	3,856,177	(47,309)				

* 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 expensein the Adjustment column.

Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Total Other Travel and Entertainment	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Total Other Advertising	$ -	$ -	$ -	$ -	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
AHCA	$ 372					
CAHCF	$ 8,047					
Total Dues	$ 8,419	$ -	$ -	$ -	$ -	$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Miscellaneous	$ 200					
Total Contributions	$ 200	$ -	$ -	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Bank Charges	$ 36,122	$ (23,550)				
Payroll Processing Fees	$ 20,344					
Employee Physicals	$ 8,556					
Medicare Compliance Assessments	$ 56,100	$ (2,400)				
Data Processing	$ 78,836					
Licenses	$ 1,588					
CMS Penalty - 2022-01LTC-024	$ 9,750	$ (9,750)				
Total Other Administrative and General	$ 211,296	$ (35,700)	$ -	$ -	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care center	2142C	9/30/2023	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc, 135 South Road, Farmington, CT 06032	370,364	Contract Attached to a Prior Year	See Below
Allocation of the above	244,440	Admin/Gen 66%	Pg 16, Line 12
	59,258	Indirect 16%	Pg 18, Line 2C
	66,665	direct 18%	Pg 20, Line 5J
Athena Health Care Assoc., Inc, 135 South Road, Farmington, CT 06032		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	9/30/2023	18	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	424,235	424,902	(667)				
2. Non-Food Supplies	$	53,768	53,768					
3. Other (*Specify*)______________________ Dishes	$	3,538	3,538					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*)__________________________	$							
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	481,541	482,208	(667)				

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

	Question	Yes	No	If yes, specify	
G.	Is cost of employee meals included in 2D?	⦿ Yes	○ No		
H.	Did you receive revenue from employees?	○ Yes	⦿ No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	⦿ Yes	○ No	If yes, specify cost.	667
K.	Is any revenue collected from these people?	○ Yes	⦿ No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⦿ No	If yes, specify cost.	
N.	Is any revenue collected from employees?	○ Yes	⦿ No	If yes, specify amt.	
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	19	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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. $	11,303	11,303					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*) Supplies	$	1,166	1,166					
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	12,469	12,469					

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	20	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4. Housekeeping	Sq. Ft. Serviced							
a. In-House Care	by Personnel							
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt. $	51,060	51,060					
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel							
(Complete Schedule C-2 att. Page 21)	Amt. $							
C. Other (*Specify*)	$							
4D. ***Total Housekeeping Expenditures*** (4a + b + c)	$	51,060	51,060					
5. Resident Care (Supplies)**								
a. Prescription Drugs***								
1. Own Pharmacy	$							
2. Purchased from Procare	$		423,299	(423,299)				
b. Medicine Cabinet Drugs	$	15,018	22,825	(7,807)				
c. Medical and Therapeutic Supplies	$	272,215	288,735	(16,520)				
d. Ambulance/Limousine***	$		3,909	(3,909)				
e. Oxygen								
1. For Emergency Use	$							
2. Other***	$		50,004	(50,004)				
f. X-rays and Related Radiological Procedures***	$		19,713	(19,713)				
g. Dental (*Not dentists who should be included under salaries or fees)*	$							
h. Laboratory***	$		36,347	(36,347)				
i. Recreation	$	25,379	25,379					
j. Direct Management Services*	$	66,665		66,665				
k. Indirect Management Services*	$	59,258		59,258				
l. Cable TV	$	3,600	61,110	(57,510)				
m. Other (Specify)**** See Attached Schedule	$	74,084	95,590	(21,506)				
n. Physical Therapy Expense	$							
o. Speech Therapy Expense	$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)	$	516,219	1,026,911	(510,692)				

* 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 in the Adjustment column.
**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Oxygen concentrator rentals	$ 2,816					
Medical Equipment rentals Medicaid	$ 62,774					
physical therapy supplies	$ 8,494					
Medical Equipment rentals	$ 21,506	$ (21,506)				
Total Other Resident Care	$ 95,590	$ (21,506)	$ -	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
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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)	(Specify)	Pg	Line
Procare LTC	Suite 121, Farmingdale NY 11735	○	⊙	Common Owners: Minority Interest	Pharmacy	483,050			29	5a2
CWPM	PO Box 415, Plainville, CT 06062	○	⊙			38,309			22	6f
ADP	Philadelphia, PA 19170-0351	○	⊙			18,287			16	m13
Thyssen Krupp Elevator	P.O. Box 933007 Atlanta, GA 31193-3007	○	⊙			41,916			22	6a
Outdoor Lawn Service	P.O. Box 320144 Fairfield, CT 06825	○	⊙			34,529			22	6f
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* List all contracted services over $10,000. Use additional sheets if necessary.
** Refer to Page 4 for definition of related.
*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	22	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	116,030	116,030					
b. Heat	$	53,851	53,851					
c. Light & Power	$	119,095	119,095					
d. Water	$	67,918	67,918					
e. Equipment Lease (*Provide detail on page 22b*)	$	10,993	10,993					
f. Other (*itemize*)	$	97,633	97,633					
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	465,520	465,520					
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$	1,602	1,602					
b. Building & Building Improvements	$	22,578	22,578					
c. Non-Movable Equipment	$	931	931					
d. Movable Equipment	$	46,793	46,793					
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	71,904	71,904					
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$	38,672	38,672					
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	38,672	38,672					
9. Rental payments on leased real property less real estate taxes included in item 10b	$	986,495	986,495					
10. Property Taxes								
a. Real estate taxes paid by owner	$							
b. Real estate taxes paid by lessor	$	130,622	130,622					
c. Personal property taxes	$	40,213	40,213					
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,267,906	1,267,906					

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

Schedule of Other Repairs and Maintenance

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Groundskeeping	$ 15,866					
Rubbish Removal	$ 39,990					
Snow Removal	$ 22,167					
Supplies	$ 19,610					
Total Other Repairs and Maintenance	$ 97,633	$ -	$ -	$ -	$ -	$ -

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	22b	37

Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	○	⦿	Postal Equipment	11/22/13	Annual renewal	1,543	1,543
LEAF Capital Funding, LLC PO Box 979127, Miami, FL 33197-9127	⦿	○	Copier System	02/25/20	48 months	9,450	9,450
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					
	○	⦿					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⦿ No **Total ***** 10,993

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	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			61,777	S/L	Various	1,348	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	4,063				S/L	Various	254	
A-4. Subtotal								1,602
B. **Building and Building Improvements**								
1. Acquired prior to this report period	1,298,324			1,174,481	S/L	Various	22,578	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
B-4. Subtotal								22,578
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	444,838			438,886	S/L	Various	931	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
C-4. Subtotal								931

	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	2022	2,161,057			1,852,167	S/L	Various	46,636	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative			9	2023	1,568						157	
d. Standard Resident												
e. Specialized Resident												
Total Acquired during this report period					1,568						157	
D-3. Subtotal												46,793
E. ***Total Depreciation***												71,904

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
2/28/2023	Outdoor Lawn - Parking Lot Ashpalt Patching	$ 4,063	8	$ 254	
Total additions for Land Improvements		$ 4,063		$ 254	*
Deletions:					
Total deletions for Land Improvements		$ -		$ -	**

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
4/30/2023	Geritric Medical - Defibrillator (AED)	Administrative	$ 1,568	5	$ 157	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			$ 1,568		$ 157	*
Deletions:						
Total deletions for Movable Equipment			$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
2/23/2024	FCS Fire - Fire Alarm Repair	$ 7,800	10	$ 390	
7/23/2024	Air Temp - Laundry Room Compressor	$ 7,892	15	$ 263	
9/23/2024	Air Temp - Boiler	$ 318,252	20	$ 7,956	
9/23/2024	Air Temp - Repipe Water Heater	$ 4,860	10	$ 243	
9/23/2024	TK Elevator - Elevator	$ 8,681	10	$ 434	
Total additions for Leasehold Improvement		$ 347,485		$ 9,286	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

***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	9/30/2023	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.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2022	Various	423,133	180,666	S/L	Variou	29,386	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2023	Various	347,485				9,286	
C-4. Subtotal									38,672
D. ***Total Amortization***									38,672

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care center	2142C	9/30/2023	25 | 37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ⦿ Yes ○ No If "Yes," complete Part B. If "No," complete Part C.

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

Description	Total
1. Date Land Purchased	04/01/93
2. Date Structure Completed	04/01/94
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	04/01/94
5. Total Licensed Bed Capacity	134
6. Square Footage	
7. Acquisition Cost	
a. Land	1,260,000
b. Building	7,823,776

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	12/30/20			
c. Interest Rate for the Cost Year	2.95%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	14,038,500			
f. Principal balance outstanding as of ___________	13,240,228			
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
Maefair Health Care center	2142C	9/30/2023	26	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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	9/30/2023	27	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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*) Vender Interest	$	19,666	19,666					
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)	$	19,666	19,666					
14. Insurance a. Insurance on Property (buildings only)	$	170,483	170,483					
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)***	$	170,483	170,483					
15. ***Total All Expenditures (A-13 thru C-14)***	$	15,707,614	16,516,298	(808,684)				

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care center	2142C	9/30/2023	30 | 37

Item		Total	CCNH / RHNS	(Specify)	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	24,784,213	24,784,213		
b. Medicaid Room and Board Contractual Allowance **	$	(13,721,750)	(13,721,750)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,694,947	1,694,947		
b. Medicare Room and Board Contractual Allowance **	$	(400,023)	(400,023)		
4. a. Private-Pay Residents and Other	$	3,320,058	3,320,058		
b. Private-Pay Room and Board Contractual Allowance **	$	(928,396)	(928,396)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	83,324	83,324		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(83,324)	(83,324)		
c. Prescription Drugs - Non-Medicare	$	185,093	185,093		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(185,093)	(185,093)		
2. a. Medical Supplies - Medicare	$	3,120	3,120		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	455,771	455,771		
b. Physical Therapy - Medicare Contractual Allowance **	$	(139,904)	(139,904)		
c. Physical Therapy - Non-Medicare	$	417,920	417,920		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(417,920)	(417,920)		
4. a. Speech Therapy - Medicare	$	125,210	125,210		
b. Speech Therapy - Medicare Contractual Allowance **	$	(37,648)	(37,648)		
c. Speech Therapy - Non-Medicare	$	111,895	111,895		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(111,895)	(111,895)		
5. a. Occupational Therapy - Medicare	$	406,102	406,102		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(114,539)	(114,539)		
c. Occupational Therapy - Non-Medicare	$	396,970	396,970		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(396,970)	(396,970)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	61,956	61,956		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	15,509,117	15,509,117		
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)*	$	70,462	70,759	(297)	
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	205,067	205,067		
V. Total Other Revenue (1 thru 8)	$	275,529	275,826	(297)	
VI. Total All Revenue (III +V)	$	15,784,646	15,784,943	(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)	(Specify)
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
Pg 30, 6b	Medicaid Retro	$ 56,588		
Pg 30, 6b	Medicare Retro	$ 5,368		
Total Other Resident Revenue		$ 61,956	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH / RHNS	(Specify)	(Specify)
pg 31, L A1	Interest on A/R	NA	$ 133		
pg 31, L A1	ERC Interest	NA	$ 70,626	$ (297)	
Total Interest Income			$ 70,759	$ (297)	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
15, 1c	Bad Debt Recoveries	$ 205,067		
Total Other Revenue		$ 205,067	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care center	2142C	9/30/2023	31 | 37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 35,621
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 3,440,649
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 24,375
5. Prepaid Expenses				$ 512,377
a. Prepaid Insurance		112,957		
b. Ppd exp-health insurance & maintenance repairs		101,412		
c. Ppd exp-Other		298,008		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 4,013,022
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	67,967		$ 4,588
	Accum. Depreciation	63,379	Net	
3. Buildings	*Historical Cost	1,299,096		$ 101,265
	Accum. Depreciation	1,197,831	Net	
4. Leasehold Improvements	*Historical Cost	770,617		$ 551,280
	Accum. Depreciation	219,337	Net	
5. Non-Movable Equipment	*Historical Cost	444,830		$ 5,021
	Accum. Depreciation	439,809	Net	
6. Movable Equipment	*Historical Cost	2,162,625		$ 263,665
	Accum. Depreciation	1,898,960	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 52,722
Project Development		52,722		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 978,541

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			$ -

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care center	2142C	9/30/2023	32 | 37

Account				Amount
		Total Brought Forward:		$ 4,991,563
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	7,693,385	Net	$ 130,391
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$ 1,390,391
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$ (8,734,040)
Name and Address	Amount	Loan Date		
Related Party Investment	(8,734,040)	3/29/12		
7. Other Assets (*itemize*)				$ 196,529
Unamortized Bed License		196,529		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (8,537,511)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ (2,155,557)

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care center	2142C	9/30/2023	33 | 37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 3,193,888
2. Notes Payable (*itemize*)				$ (745,039)
Midcap Line of Credit		(745,039)		
See Schedule				
3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 449,254
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 388,929
7. Medicare Final Settlement Payable				$
8. Medicare Current Financing Payable				$
9. Mortgage Payable (*Current Portion*)				$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 2,930,863
Acc'd Operating Expenses	(75,452)			
Acc'd Expense - Sales Tax	182			
Provider Taxes Due	3,006,133			
		See Schedule		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 6,217,895

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care center	2142C	9/30/2023	34 | 37

Account				Amount
Total Brought Forward:				6,217,895
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$ 351,096
Name and Address of Lender	Amount	Loan Date		
Procare Note	351,096			
4. Other Long-Term Liabilities (*itemize*)				$ (2,825,577)
Related Party		(2,825,577)		
See Schedule				
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ (2,474,481)
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 3,743,414

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	9/30/2023	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	$ 130,391
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$ 1,390,391
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 2,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (6,560,005)
	6. Gain or Loss for Period 10/1/2022 thru 9/30/2023	$ (731,357)
	7. Total Net Worth	$ (7,289,362)
C.	***Total Reserves and Net Worth***	$ (5,898,971)
D.	***Total Liabilities, Reserves, and Net Worth***	$ (2,155,557)

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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	9/30/2023	36 | 37

	Account			Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2022			$ (9,138,310)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$
D.	Net Income or Deficit			$
E.	Balance			$
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	ERC Entry	2,580,305		
	2. Other (*itemize*)			
F-3.	Total Additions			$ 2,580,305
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose	Amount		
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/23		$ 2,580,305

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care center	2142C	9/30/2023	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☐ (Specify)	☐ (Specify)

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Athena Health Care Associates, Inc

Addres Address	Phone Number
135 South Road, Farmington, CT 06032	(860) 751-3900
Contacted Person Regarding Additional Information Needed Regarding This Report	**Phone Number**
Amanda Doncet	(860) 751-3900

Contact Email Address
adoncet@athenahealthcare.com