State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2024

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 (CCNH) & RHNS Combined	☐ (Specify)	☐ (Specify)
Report for Year Beginning 10/1/2023	Report for Year Ending 9/30/2024	

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

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2024	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, 2023 and ending September 30, 2024, 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			Page 1A	of 37
Name of Facility Maefair Health Care Center	Period Covered:		From 10/1/2023	To 9/30/2024
Address of Facility 21 Maefair Court Trumbull, CT 06611				
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	9/30/2024	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 2142C	(Specify)	(Specify)	Medicare Provider No. 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.

No change of ownership during the 2024 cost report year, there was a sale/ change of ownership on 10/10/2024

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	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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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	9/30/2024	3A	37

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

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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G. Santilli	21 Maefair Court, Trumbull, CT 06611	President	880.1015
Michael E. Mosier	21 Maefair Court, Trumbull, CT 06611	reasurer/Secreta	
Names of Stockholders Owning at Least 10% of Shares			
Other than noted above:			
Conservators for Lawrence E. Santilli	21 Maefair Court, Trumbull, CT 06611		119.8985

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ⊙ Yes ○ No

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Maefair Landlord, LLC	135 South Rd, Farmington, CT	○	⊙		Lease of Facility	Pg 22, Ln 9 and 10b, p	1,216,946	1,216,946
Athena Captive	135 South Rd, Farmington, CT 06032	⊙	○		Workmens Comp	pg 15 1a1	470,744	470,744
Athena Health Care Systems	135 South Road, Farmington, CT 06032	⊙	○	>50%	see attached			
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	○	⊙	<5%	Pharmacy Services	Pg 20, 5a2	263,817	263,817
Athena Health Care Insurance	135 South Rd, Farmington, CT 06032	⊙	○		Health and General Insurance	Pg 15 1a5	932,482	932,482
		○	⊙					
Athena Health Care 401k	135 South Rd, Farmington, CT 06032	○	⊙		Participates in Common 401k Plan			
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

Not Applicable

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

Not Applicable

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

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

Not Applicable: No Non-Nursing Home Cost Centers

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General Information and Questionnaire
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
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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:

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General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
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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 (Specify)	Total (Specify)	Period 10/1 Thru 6/30 Total	Period 10/1 Thru 6/30 CCNH / RHNS	Period 10/1 Thru 6/30 (Specify)	Period 10/1 Thru 6/30 (Specify)	Period 7/1 Thru 9/30 Total	Period 7/1 Thru 9/30 CCNH / RHNS	Period 7/1 Thru 9/30 (Specify)	Period 7/1 Thru 9/30 (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	120	120			120	120						
B. As of midnight of THIS report period	116	116							116	116		
3. Total Number of Days Care Provided During Period												
A. Medicare	6,040	6,040			4,863	4,863			1,177	1,177		
B. Medicaid (Conn.)	36,156	36,156			27,294	27,294			8,862	8,862		
C. Medicaid (other states)												
D. Private Pay	1,579	1,579			1,019	1,019			560	560		
E. State SSI for RCH												
F. Other (Specify) Managed Care	132	132			128	128			4	4		
G. Total Care Days During Period (3A thru F)	43,907	43,907			33,304	33,304			10,603	10,603		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	43,907	43,907			33,304	33,304			10,603	10,603		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH / RHNS	(Specify)	(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	14	96		6				
Per Diem Rate								
a. One bed rm.	576.27	######		726.00		655.56		
b. Two bed rms.	576.27	######		715.00		655.56		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	2,391	2,391			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	1,361	1,361			
2. Restorative Treatments					
C. Other	8,269	8,269			
D. ***Total Physical Therapy Treatments***	12,021	12,021			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	879	879			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	79	79			
2. Restorative Treatments					
C. Other	2,167	2,167			
D. ***Total Speech Therapy Treatments***	3,125	3,125			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	3,302	3,302			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	1,115	1,115			
2. Restorative Treatments					
C. Other	8,091	8,091			
D. ***Total Occupational Therapy Treatments***	12,508	12,508			

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours								
Item	CCNH / 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)	164,236		2,030						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	266,301		10,239						
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor	74,753		2,118						
c. Dietary Workers	591,668		30,590						
6. Housekeeping Service									
a. Head Housekeeper	52,364		2,180						
b. Other Housekeeping Workers	276,032		16,075						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	65,204		2,156						
b. Other Maintenance Workers	54,151		2,165						
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers	181,325		9,950						
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	283,877		4,043						
b. RN									
1. Direct Care	588,859		11,053						
2. Administrative**	635,229		17,344						
c. LPN									
1. Direct Care	2,066,655		51,428						
2. Administrative**									
d. Aides and Attendants	2,372,321		97,394						
e. Physical Therapists	349,207		8,965						
f. Speech Therapists	80,417		1,655						
g. Occupational Therapists	256,762	(256,762)	5,876						
h. Recreation Workers	213,379		9,433						
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	232,664		6,498						
n. Marketing									
o. Other (Specify) See Attached Schedule									
A-13. Total Salary Expenditures	8,805,404	(256,762)	291,192						

* 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
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	(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).										

* 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
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	(Specify)							
Section III - Administrators* **										
Rita Pitter (10/1/23-9/30/24)	164,236			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home	2,030	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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	64,229		1,259						
2. Dentist	8,040		28						
3. Pharmacist	17,661		364						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	38,400		264						
b. Utilization Review (Title 18 and 19 only) monthly meeting									
c. Resident Care**	3,335	(3,335)							
d. Administrative Services facility									
1. Infection Control Committee (Quarterly meetings)									
2. Pharmaceutical Committee (Quarterly meetings)									
3. Staff Development Committee (Once annually)									
e. Other (Specify)									
9. Speech Therapist									
a. Resident Care	2,016		6						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	15,224		130						
2. Administrative***									
b. LPN									
1. Direct Care	35,401		428						
2. Administrative***									
c. Aides	6,450		157						
d. Other									
12. Other (Specify) See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	190,756	(3,335)	2,637						

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2024	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
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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		○	⊙	
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		○	⊙	
		○	⊙	

* 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	9/30/2024	15	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	470,744	470,744					
2. Disability Insurance	$							
3. Unemployment Insurance	$	59,020	59,020					
4. Social Security (F.I.C.A.)	$	636,280	636,280					
5. Health Insurance	$	985,079	985,079					
6. Life Insurance (employees only) (not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	208,032	208,032					
8. Uniform Allowance	$	1,245	1,245					
9. Other (*Specify*) See Attached Schedule	$							
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$		548,372	(548,372)				
d. Accounting and Auditing	$	11,285	11,285					
e. Legal (*Services should be fully described on Page 15b)*	$		18,909	(18,909)				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	36,892	36,892					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	51,759	51,759					
2. Cellular Phones	$	2,113	2,113					
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	$	795,880	795,880					
Subtotal	$	3,258,329	3,825,610	(567,281)				

* 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	$ -	$ -	$ -	$ -	$ -	$ -

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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	9/30/2024	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	If "No," explain.
	○ No	

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*)

1	Year end audit	$ 8,400
2	Preparation of Medicare Cost report	$ 2,885
3		$
4		$
		Charge for Services Provided $ 11,285

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 Mitchell & Sheahan	
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
4
5

Services Provided by This Firm (*describe fully*)

1	Collections:Disallowed	$ 11,764
2	Conservator:Disallow	$ 1,145
3	Employee settlement	$ 6,000
4		$
5		$
		Charge for Services Provided $ 18,909

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	9/30/2024	16	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:		3,258,329	3,825,610	(567,281)				
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$	3,360	3,360					
3. Gifts to Staff and Residents	$		9,832	(9,832)				
4. Employee Travel	$	487	487					
5. Education Expenses Related to Seminars and Conventions	$	9,200	9,200					
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*)	$							
2. Advertising Telephone Directory (*all such expenses*)***	$							
3. Advertising Other (*Specify*)***	$		16,118	(16,118)				
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	$	3,810	3,810					
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	1,614	1,614					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$	102	102					
10. Contributions*** See Attached Schedule	$							
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$							
12. Administrative Management Services**	$	769,550	769,550					
13. Other (*Specify*) See Attached Schedule	$	79,679	157,143	(77,464)				
C-14 Total Administrative & General Expenditures	$	4,126,131	4,796,826	(670,695)				

* 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
Promotional	$ 16,118	$ (16,118)				
Total Other Advertising	$ 16,118	$ (16,118)	$ -	$ -	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF	$ 1,614					
Total Dues	$ 1,614	$ -	$ -	$ -	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Bank charges	$ 23,964	$ (23,964)				
Payroll processing fees	$ 22,560					
Employee physicals/ background checks	$ 5,537					
Facility license	$ 1,110					
Medicare Compliance Assessments	$ 53,500	$ (53,500)				
Data processing fees	$ 50,472					
Total Other Administrative and General	$ 157,143	$ (77,464)	$ -	$ -	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2024	Page 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	737,826	Contract Attached to a prior year	see below
Allocation of the above	486,965	Admin/ Gen 66%	Pg 16, line 12
	118,052	Indirect 16%	Pg 18, Line 2C
	132,809	Direct 18%	Pg 20, Line 5J
Athena Health Care Assoc., Inc. 135 South Road, Farmington, CT 06032	8,652	Admin/ Gen -Other Exp	Pg 16, line 12

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2024	18	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	422,335	423,002	(667)				
2. Non-Food Supplies	$	61,230	61,230					
3. Other (*Specify*)_____	$	1,836	1,836					
Dishes								
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)	$	485,401	486,068	(667)				

2E. Dietary Questionnaire	Total	CCNH / RHNS	(Specify)	(Specify)
F. Resident Meals: Total no. of meals served per day:*	360	360		

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

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

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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	9/30/2024	19	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
3. Laundry								
a. In-House Processing*	Lbs.							
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $							
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.							
	Amt. $							
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.							
	Amt. $							
4. Repair and/or purchase of linens.***	Lbs.							
	Amt. $	6,018	6,018					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*) Supplies	$	23,362	23,362					
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	29,380	29,380					

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2024	20	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4. Housekeeping	Sq. Ft. Serviced by Personnel							
a. In-House Care								
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt. $	54,110	54,110					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel							
	Amt. $							
C. Other (*Specify*)	$							
4D. ***Total Housekeeping Expenditures*** (4a + b + c)	$	54,110	54,110					
5. Resident Care (Supplies)**								
a. Prescription Drugs***								
1. Own Pharmacy	$							
2. Purchased from	$		318,260	(318,260)				
b. Medicine Cabinet Drugs	$	40,128	47,935	(7,807)				
c. Medical and Therapeutic Supplies	$	338,449	354,969	(16,520)				
d. Ambulance/Limousine***	$							
e. Oxygen								
1. For Emergency Use	$							
2. Other***	$		44,465	(44,465)				
f. X-rays and Related Radiological Procedures***	$		22,915	(22,915)				
g. Dental (*Not dentists who should be included under salaries or fees*)	$							
h. Laboratory***	$		54,639	(54,639)				
i. Recreation	$	21,498	21,498					
j. Direct Management Services*	$							
k. Indirect Management Services*	$							
l. Cable TV	$	66,821	66,821					
m. Other (Specify)**** See Attached Schedule	$	92,239	83,533	8,706				
n. Physical Therapy Expense	$							
o. Speech Therapy Expense	$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)	$	559,135	1,015,035	(455,900)				

* 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
	0	0					
		0					
Medical Equip Rentals-Medicaid		77182					
Physical Therapy Supplies		15057					
Medical Equip Rentals		-8706	$ 8,706				
		0					
		0					
		0					
		0					
		0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
		0					
Total Other Resident Care		$ 83,533	$ 8,706	$ -	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2024	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	(Specify)	Pg	Line
Procare LTC	Suite 121, Farmingdale NY 11735	○	⊙	Common Owners: Minority Interest	Pharmacy	263,817			20	5a2
CWPM	PO Box 415, Plainville, CT 06062	○	⊙		Rubbish Removal	40,059			22	6f
ADP	Philadelphia, PA 19170-0351	○	⊙		Payroll Processing	22,560			16	m13
		⊙	○							
Outdoor Lawn Service	P.O. Box 320144 Fairfield, CT 06825	○	⊙		landscaping/snow removal	52,185			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	9/30/2024	22	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	115,991	115,991					
b. Heat	$	60,814	60,814					
c. Light & Power	$	131,953	131,953					
d. Water	$	73,753	73,753					
e. Equipment Lease (*Provide detail on page 22b*)	$	12,871	12,871					
f. Other (*itemize*)	$	123,173	123,173					
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	518,555	518,555					
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$	508	508					
b. Building & Building Improvements	$	22,578	22,578					
c. Non-Movable Equipment	$	763	763					
d. Movable Equipment	$	41,907	42,025	(118)				
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	65,756	65,874	(118)				
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$	48,816	48,816					
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	48,816	48,816					
9. Rental payments on leased real property less real estate taxes included in item 10b	$	1,216,946	1,216,946					
10. Property Taxes								
a. Real estate taxes paid by owner	$							
b. Real estate taxes paid by lessor	$							
c. Personal property taxes	$	25,314	25,314					
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,356,832	1,356,950	(118)				

* 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	$ 25,989					
Rubbish Removal	$ 40,792					
Snow Removal	$ 26,196					
Supplies	$ 30,196					
0	$ -					
0	$ -					
0	$ -					
0	$ -					
0	$ -					
0	$ -					
0	$ -					
Total Other Repairs and Maintenance	$ 123,173	$ -	$ -	$ -	$ -	$ -

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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	9/30/2024	22b	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	○	⊙	Postal Equipment	11/22/13	Annual renewal	1,543	1,161
LEAF Capital Funding, LLC PO Box 979127, Miami, FL 33197-9127	○	⊙	Copier System	02/25/20	48 months	14,051	11,710
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ⊙ Yes ○ No **Total ***** 12,871

* 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	9/30/2024	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	67,967		67,967	63,378	S/L	Various	508	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
A-4. Subtotal								508
B. **Building and Building Improvements**								
1. Acquired prior to this report period	1,298,324		1,298,324	1,197,059	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	444,830		444,830	439,809	SL	Various	763	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
C-4. Subtotal								763

	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	2023	2,162,625		2,162,625	1,898,961	S/L	Various	41,498	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative												
d. Standard Resident			9	2024	9,257		9,257		S/L	Various	527	
e. Specialized Resident												
Total Acquired during this report period					9,257		9,257				527	
D-3. Subtotal												42,025
E. ***Total Depreciation***												65,874

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		$ -		$ -	**

***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:						
5/31/2024	food chopper	Standard Resident	$ 5,365	10	$ 268	
6/30/2024	motor (food processor)	Standard Resident	$ 1,278	5	$ 128	
9/30/2024	cubicle curtains	Standard Resident	$ 2,614	10	$ 131	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			$ 9,257		$ 527	*
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:					
10/31/2023	actuator	$ 4,860	10	$ 243	
11/30/2023	fire alarm system repair	$ 11,848	10	$ 592	
7/31/2024	fire alarm system repair	$ 4,909	5	$ 491	
Total additions for Leasehold Improvement		$ 21,617		$ 1,326	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2024	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2. Finance Fees						SL			
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2023	Various	770,619	219,338	SL	variou	47,490	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)	9	2024	various	21,617		SL	variou	1,326	
C-4. Subtotal									48,816
D. ***Total Amortization***									48,816

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2024	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	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 _____	12,806,772			
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	9/30/2024	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			(54)				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $			(54)				

(*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	9/30/2024	27	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:			(54)				
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*) $	26,651	26,651					
Vendor Interest $26,651							
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	26,597	26,651	(54)				
14. Insurance							
a. Insurance on Property (buildings only) $	8,165	8,165					
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)*** $	8,165	8,165					
15. ***Total All Expenditures (A-13 thru C-14)*** $	15,900,369	17,287,900	(1,387,531)				

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Maefair Health Care Center	2142C	9/30/2024	30 | 37

Item		Total	CCNH / RHNS	(Specify)	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	25,266,214	25,266,214		
b. Medicaid Room and Board Contractual Allowance **	$	(13,993,244)	(13,993,244)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,582,704	1,582,704		
b. Medicare Room and Board Contractual Allowance **	$	(223,597)	(223,597)		
4. a. Private-Pay Residents and Other	$	3,932,337	3,932,337		
b. Private-Pay Room and Board Contractual Allowance **	$	(1,076,811)	(1,076,811)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	118,556	118,556		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(118,556)	(118,556)		
c. Prescription Drugs - Non-Medicare	$	190,422	190,422		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(182,242)	(182,242)		
2. a. Medical Supplies - Medicare	$	8,682	8,682		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	345,277	345,277		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	378,680	378,680		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(378,680)	(378,680)		
4. a. Speech Therapy - Medicare	$	156,225	156,225		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	94,375	94,375		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(94,375)	(94,375)		
5. a. Occupational Therapy - Medicare	$	438,068	438,068		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	401,690	401,690		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(401,690)	(401,690)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	(298,398)	(298,398)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	16,145,637	16,145,637		
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)*	$	54	54		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	304,633	304,633		
V. Total Other Revenue (1 thru 8)	$	304,687	304,687		
VI. Total All Revenue (III +V)	$	16,450,324	16,450,324		

* *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)
		$ (299,366)		
	Medicaid retro	$ 968		
Total Other Resident Revenue		$ (298,398)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
	Interest on A/R ??		$ 54		
	0		$ -		
	0		$ -		
	0				
Total Interest Income			$ 54	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	0	$ -		
	0	$ -		
	0	$ -		
	0	$ -		
	0	$ -		
	0	$ -		
	Bad Debt Recoveries	$ 304,331		
	Misc income	$ 302		
Total Other Revenue		$ 304,633	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2024	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ (109,055)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 3,928,710
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 24,375
5. Prepaid Expenses				$ 312,157
a.				
b.				
c.				
d. See Schedule		312,157		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 4,156,187
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	67,967		$ 4,081
	Accum. Depreciation	63,886	Net	
3. Buildings	*Historical Cost	1,299,096		$ 78,687
	Accum. Depreciation	1,220,409	Net	
4. Leasehold Improvements	*Historical Cost	800,463		$ 532,309
	Accum. Depreciation	268,154	Net	
5. Non-Movable Equipment	*Historical Cost	444,830		$ 4,258
	Accum. Depreciation	440,572	Net	
6. Movable Equipment	*Historical Cost	2,171,763		$ 230,777
	Accum. Depreciation	1,940,986	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 48,614
See Schedule		48,614		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 898,726

* 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	
		Prepaid Insurance	$ 121,892
		Ppd exp-health insurance & maintenance repairs	$ -
		Ppd exp-Other	$ 190,265
		0	$ -
Total Prepaid Expenses			$ 312,157

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	
		Project Development	$ 48,496
		carryforward depr adjustment	$ 118
Total Other Other Fixed Assets (Itemize)			$ 48,614

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Deferred Finance Fees	$ -
		Unamortized Bed License	$ 196,529
		Taxes	$ -
Total Other Assets			$ 196,529

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			

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

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

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

Page Ref	Line Ref	Description	
		0	$ -
Total Other Current Liabilities (Itemize)			

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2024	32	37

Account				Amount
			Total Brought Forward:	$ 5,054,913
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	7,823,776	Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$ 1,260,000
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$ (8,734,040)
Name and Address	Amount	Loan Date		
Related Party Investment	(8,734,040)	3/29/12		
7. Other Assets (*itemize*)				$ 196,529
See Schedule		196,529		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (8,537,511)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ (2,222,598)

* 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	9/30/2024	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 4,076,930
	2. Notes Payable (*itemize*)				$ (275,154)
	Midcap Line of credit		(354,470)		
	Due to/ from other facilities		79,316		
	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*)				$ 486,075
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 427,255
	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*)				$ 4,130,995
	Acc'd Operating Expenses		328,981		
	Provider taxes due		3,802,014		
	See Schedule				
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 8,846,101

* 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	9/30/2024	34	37

Account	Amount
Total Brought Forward:	8,846,101
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*)	$ 461,401

Name and Address of Lender	Amount	Loan Date
Procare Note	461,401	

4. Other Long-Term Liabilities (*itemize*)	$ (4,640,725)
Related party (4,640,725)	
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ (4,179,324)
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 4,666,777

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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	9/30/2024	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	$
	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	$ 1,260,000
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 2,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (7,313,799)
	6. Gain or Loss for Period 10/1/2023 thru 9/30/2024	$ (837,576)
	7. Total Net Worth	$ (8,149,375)
C.	***Total Reserves and Net Worth***	$ (6,889,375)
D.	***Total Liabilities, Reserves, and Net Worth***	$ (2,222,598)

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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	9/30/2024	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2023			$ (7,289,362)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 16,450,324
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 17,287,900
D.	Net Income or Deficit			$ (837,576)
E.	Balance			$ (8,126,938)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Prior year AJE-rent exp adjmt		(22,432)	
	rounding		(5)	
	2. Other (*itemize*)			
F-3.	Total Additions			$ (22,437)
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***	09/30/24		$ (8,149,375)

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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	9/30/2024	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 in the Adjustments columns. 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 RoadFarmington, CT 06032	(860) 751-3900

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Lynn Rinaldi	860-751-3955

Contact Email Address
lrinaldi@athenahealthcare.com