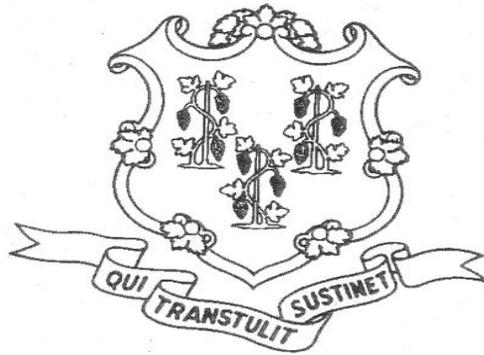


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) Maefair Health Care Center	
Address (No. & Street, City, State, Zip Code) 21 Maefair Court Trumbull, CT 06611	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022

License Numbers:	CCNH 2142C	RHNS	(Specify)	Medicare Provider 07-5404
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Medicaid Provider Numbers:	CCNH 2142C	RHNS	ICF-IID
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**For Department Use Only**

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

### General Information

Name of Facility (as licensed) Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2022	Page 1	of 37
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#### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Maefair Health Care Center [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, 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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State of Connecticut  
**Department of Social Services**  
 55 Farmington Avenue, Hartford, Connecticut 06105

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Maefair Health Care Center		Period Covered:	From 10/1/2021	To 9/30/2022
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)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility 203-459-5152		Report for Year Ended 9/30/2022		Page 2	of 37
Name of Facility (as shown on license) Maefair Health Care Center			Address (No. & Street, City, State, Zip) 21 Maefair Court Trumbull, CT 06611		
License Numbers:	CCNH 2142C	RHNS	(Specify)	Medicare Provider No. 07-5404	
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No   If "Yes," explain fully.					
<b>Administrator</b>					
Name of Administrator Rita Pitter			Nursing Home Administrator's License No.:	1514	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		



**General Information and Questionnaire  
 Corporate Owners**

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2022	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation Maefair Health Care Center, Inc	Business Address 21 Maefair Court, Trumbull, CT 06611	State(s) in Which Incorporated 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	



**General Information and Questionnaire**  
**Related Parties\***

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2022	Page 4	of 37
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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	<input type="radio"/>	<input checked="" type="radio"/>		lease of facility	Pg 22, Ln 9 and 10b, pg	1,329,150	1,329,150
Athena Health Care 401k	135 South Rd, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	>98%	Participates in Common 401k Plan		243,803	243,803
Athena Health Care Systems	135 South Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	<50%	see attached			
Procure LTC	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Pharmacy Services	Pg 20, 5a2	224,208	224,208
Laurel Ridge Health Care	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Bank Charges		3,068	3,068
Procure LTC-Note	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Pharmacy Services	Pg 34, B3	59,756	59,756
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

\* 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 Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2022	Page 5	of 37
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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 ( <i>See listing page 13</i> )
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

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

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.

## 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	9/30/2022			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Pitney Bowes, 60 Wellington Rd, Milford, CT 06484	<input type="radio"/>	<input checked="" type="radio"/>	Postal Equipment	11/22/13	Annual renewal	1,207	1,207
LEAF Capital Funding, LLC PO Box 979127, Miami, FL 33197-9127	<input type="radio"/>	<input checked="" type="radio"/>	Copier System	02/25/16	48 months	15,314	15,314
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
						<b>Total ***</b>	16,521

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes       No

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

**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2022	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 PKF O'Connor Davies, LLP	Four Corporate Dr, Shelton, CT
2 Marcum LLP	555 Long Wharf Drive, New Haven, CT
3 Midcap Financial Services, LLC	7255 Woodmont ave, Bethesda, MD
4	

Services Provided by This Firm (*describe fully*)

1 2021 Audit	\$ 17,200
2 Preparation of Medicare Cost report	\$ 2,750
3 Line of Credit audit fees - Disallowed	\$ 4,865
4	\$
	<b>Charge for Services Provided</b>
	\$ 24,815

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

- Yes     No    Pg 15, Line 1d

**Legal Services Information**

Name of Legal Firm or Independent Attorney	Telephone Number
1 Goldman, Gruder & Woods	203-899-8900
2 Trumbull Probate/Conservator fee/Senior Planning Services	203-452-5068
3 Midcap Financial Services	301-860-7600
4 Murtha Cullina	
5 Pilicy & Ryan/ Heidell, Pitoni, Murphy & Bach	

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

- 1 200 Connecticut Ave. Norwalk, CT
- 2 (5866 Main Street, Trumbull, CT) (100 Blvd of the Americas, Lakewood NJ, 08701)
- 3 7255 Woodmont Ave, Bethesda, MD
- 4 280 Trumbull St, Hartford, CT 06103
- 5

Services Provided by This Firm (*describe fully*)

1 Collections:Disallowed	\$ 37,415
2 Conservator:Disallow	\$ 2,741
3 Line of Credit Services: Disallow	\$ 1,272
4 Annual Report Filing: Allow	\$ 150
5 Collections:Disallowed	\$ 1,593
	<b>Charge for Services Provided</b>
	\$ 43,171

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

- Yes     No    Pg 15, Line 1e

**Schedule of Resident Statistics**

Name of Facility Maefair Health Care Center			License No. 2142C			Report for Year Ended 9/30/2022				Page 8		of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	134	134			134	134							
B. On last day of THIS report period	134	134							134	134			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	127	127			127	127							
B. As of midnight of THIS report period	123	123							123	123			
3. Total Number of Days Care Provided During Period													
A. Medicare	3,811	3,811			2,547	2,547			1,264	1,264			
B. Medicaid (Conn.)	39,702	39,702			19,820	19,820			19,882	19,882			
C. Medicaid (other states)													
D. Private Pay	1,164	1,164			619	619			545	545			
E. State SSI for RCH													
F. Other (Specify) Managed Care	259	259			218	218			41	41			
G. Total Care Days During Period (3A thru F)	44,936	44,936			23,204	23,204			21,732	21,732			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	152	152			152	152							
B. Other Bed Reserve Days	18	18			18	18							
5. <b>Total Resident Days (3G + 4A + 4B)</b>	45,106	45,106			23,374	23,374			21,732	21,732			

### Schedule of Resident Statistics (Cont'd)

Name of Facility Maefair Health Care Center			License No. 2142C			Report for Year Ended 9/30/2022			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(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)			
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	8		101		2		12						
Per Diem Rate													
a. One bed rm.	528.00		290.16		666.00		387.83						
b. Two bed rms.	528.00		290.16		655.00		387.83						
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								3,624	3,624				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								2,789	2,789				
2. Restorative Treatments													
C. Other								6,920	6,920				
D. <b>Total Physical Therapy Treatments</b>								13,333	13,333				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								680	680				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								407	407				
2. Restorative Treatments													
C. Other								933	933				
D. <b>Total Speech Therapy Treatments</b>								2,020	2,020				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								3,651	3,651				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								2,469	2,469				
2. Restorative Treatments													
C. Other								7,160	7,160				
D. <b>Total Occupational Therapy Treatments</b>								13,280	13,280				

### Report of Expenditures - Salaries & Wages

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2022	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	155,112	2,145				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	271,011	11,960				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	73,536	2,114				
c. Dietary Workers	530,165	30,573				
6. Housekeeping Service						
a. Head Housekeeper	46,437	2,220				
b. Other Housekeeping Workers	255,547	16,941				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	63,673	2,165				
b. Other Maintenance Workers	58,231	2,278				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	138,347	8,743				
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	186,939	3,332				
b. RN						
1. Direct Care	355,531	6,790				
2. Administrative**	426,817	14,450				
c. LPN						
1. Direct Care	1,865,935	48,907				
2. Administrative**						
d. Aides and Attendants	2,067,609	92,267				
e. Physical Therapists	377,927	10,228				
f. Speech Therapists	73,785	1,778				
g. Occupational Therapists	242,992	5,765				
h. Recreation Workers	213,765	10,515				
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	211,929	6,454				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	7,615,288	279,625				

\* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

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

\*\*\* This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.



**Schedule 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	9/30/2022				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)							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Maefair Health Care Center				2142C	9/30/2022			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Rita Lynch (10/1/2021 - 9/30/2022)	155,112			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	2,145	A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of		
Maefair Health Care Center	2142C	9/30/2022	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b>						
(For all such services complete Schedule B1)						
1. Dietitian	56,728	1,004				
2. Dentist	7,309	18				
3. Pharmacist	13,152	30				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,000	90				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	4,328	12				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	172,549	1,429				
2. Administrative***						
b. LPN						
1. Direct Care	410,508	5,907				
2. Administrative***						
c. Aides	493,760	11,792				
d. Other						
12. Other (Specify)						
See Attached Schedule						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>1,194,334</b>	<b>20,282</b>				

\* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

\*\* This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

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

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

Name of Facility Maefair Health Care Center		License No. 2142C	Report for Year Ended 9/30/2022	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Dr Wayne Levin, 66 Deepdene Road, Trumbull, CT 06611	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Athena Health Care, 135 South Road, Farmington, CT 06032	MDS Fill in	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners	
Healthdrive Eye Care Group, 888 Worcester Street, Wellesley, MA 02482	Eye Care	<input type="radio"/>	<input checked="" type="radio"/>		
Swallowing Diagnostics, 21 Waterville, Rd, Avon, CT	Speech Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>		
CT Dental, 240 Pomeroy Ave, Suite 205, Meriden, CT 06450	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
Quest Diagnostics, 3404 Collection CTR Dt, Chicago IL, 60693	Lab Services	<input type="radio"/>	<input checked="" type="radio"/>		
Yale New Haven Hospital, 1450 Chapel St, New Haven, CT 06511	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Masstex Imaging LLC, 3 Electronics Ave Suite 201, Danvers MA, 01923-1099	Speech Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>		
Yale Medical Group, 789 Howard Ave #2, New Haven, CT 06519	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Urological Associates, 51-53 Kenosia Ave, Danbury, CT 06810	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Christopher Luthie, 3690 Main Street, Bridgeport, CT	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Laura Svenson, P.O Box 213 Gerogetown, CT 06829-0213	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
ProHealth, P.O. Box 150472, Hartford, CT 06115	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Orthopaedic Specialty Group, 305 Black Rock Turnpike, Fairfield, CT 06825	Orthopaedic Services	<input type="radio"/>	<input checked="" type="radio"/>		
St. Vincent's Medical Center, 2800 Main St, Bridgeport, CT 06606	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Bridgeport Hospital, 267 Grant St, Bridgeport, CT 06610	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Northeast Medical Group, Inc, 20 York St, New Haven, CT 06510	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Procure LTC, 111 Executive Blvd, Farmingdale NY 11735	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>	Common Owners: Minority Interest	
Southern CT Vascular Center, LLC, P.O. Box 40, Windsor CT 06095	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
Connecticut Image Guided Surgery, P.O. Box 416139, Boston, MA 02241	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>		
SDX Dysphagia Experts, 21 Waterville Rd, Avon, CT 06001	Speech Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Milla Stelman, 1021 Daniels Farm Road, Trum	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		

\* Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

### C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2022	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 195,157	195,157		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 62,481	62,481		
4. Social Security (F.I.C.A.)	\$ 537,604	537,604		
5. Health Insurance	\$ 1,008,684	1,008,684		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 80,033	80,033		
8. Uniform Allowance	\$ 4,707	4,707		
9. Other ( <i>Specify</i> ) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 124,493	124,493		
d. Accounting and Auditing	\$ 24,815	24,815		
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 43,171	43,171		
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 60,950	60,950		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 63,224	63,224		
2. Cellular Phones	\$ 1,860	1,860		
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$			
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$			
k. Other Taxes ( <i>Not related to property - See Page 22</i> )				
1. Income*	\$ 4,410	4,410		
2. Other ( <i>Specify</i> ) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 868,000	868,000		
<b>Subtotal</b>	<b>\$ 3,079,589</b>	<b>3,079,589</b>		

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

(Carry Subtotals forward to next page)



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

Name of Facility	License No.	Report for Year Ended		Page	of
Maefair Health Care Center	2142C	9/30/2022		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>	3,079,589	3,079,589			
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 3,360	3,360			
3. Gifts to Staff and Residents	\$ 17,577	17,577			
4. Employee Travel	\$ 2,333	2,333			
5. Education Expenses Related to Seminars and Conventions	\$ 3,275	3,275			
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$				
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 15,150	15,150			
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 10,770	10,770			
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	\$ 4,840	4,840			
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 6,657	6,657			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 388	388			
10. Contributions*** See Attached Schedule	\$ 1,110	1,110			
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$				
12. Administrative Management Services**	\$ 304,144	304,144			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 130,380	130,380			
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 3,579,573	3,579,573			

\* Do not include Subscriptions, which should go in item 9.

\*\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 10,770		
<b>Total Other Advertising</b>	\$ 10,770	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 5,317		
AHCA	\$ 1,340		
<b>Total Dues</b>	\$ 6,657	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Miscellaneous	\$ 1,110		
<b>Total Contributions</b>	\$ 1,110	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	\$ 23,550		
Payroll Processing Fees	\$ 20,292		
Employee Physicals	\$ 17,832		
Medicare Compliance Assessments	\$ 2,400		
Data Processing	\$ 64,153		
Licenses	\$ 2,153		
<b>Total Other Administrative and General</b>	\$ 130,380	\$ -	\$ -

### Schedule C-1 - Management Services\*

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2022	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	421,497	Contract Attached to a Prior Year	See Below
Allocation of the above	Admin/Gen: 278,188 Indirect: 67,440 Direct: 75,869	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 20, Line 5k Pg 20, Line 5j
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	25,956	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 Maefair Health Care Center		License No. 2142C	Report for Year Ended 9/30/2022	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 421,231	421,231		
2.	Non-Food Supplies	\$ 44,602	44,602		
3.	Other (Specify) _____	\$ 166	166		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)					
c. Other (Specify) _____					
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>		\$ 465,999	465,999		
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F.	Resident Meals: Total no. of meals served per day:*	369	369		
G.	Is cost of employee meals included in 2D?	<input checked="" type="radio"/> Yes	<input type="radio"/> No		
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input checked="" type="radio"/> Yes	<input type="radio"/> No	If yes, specify cost. \$478	
K.	Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
N.	Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

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

Name of Facility Maefair Health Care Center		License No. 2142C	Report for Year Ended 9/30/2022	Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$	11,168	11,168		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$				
c. Other (Specify) Supplies	\$	3,112	3,112		
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	14,280	14,280		
<b>3E. Laundry Questionnaire</b>					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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	9/30/2022		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	50,719	50,719		
b.	Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	Sq. Ft. Serviced by Personnel				
		Amt. \$				
C. Other ( <i>Specify</i> )		\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c)</b>		\$	50,719	50,719		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from Procure	\$	236,158	236,158		
b.	Medicine Cabinet Drugs	\$	7,549	7,549		
c.	Medical and Therapeutic Supplies	\$	272,528	272,528		
d.	Ambulance/Limousine***	\$	1,320	1,320		
e.	Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	33,464	33,464		
f.	X-rays and Related Radiological Procedures***	\$	9,688	9,688		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h.	Laboratory***	\$	21,806	21,806		
i.	Recreation	\$	22,252	22,252		
j.	Direct Management Services*	\$	75,869	75,869		
k.	Indirect Management Services*	\$	67,440	67,440		
l.	Other (Specify)**** See Attached Schedule	\$	136,877	136,877		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>		\$	884,951	884,951		

\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

\*\* Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

\*\*\* Facility should self-disallow the expense on Page 29 of the Cost Report.

\*\*\*\* ICFMR's should provide a detailed schedule of all Day Program Costs.

**Schedule of Other Resident Care**

Description	CCNH	RHNS	(Specify)
Cable TV Fees	\$ 55,278		
Oxygen Concentrator Rentals	\$ 4,155		
Medical Equip Rentals-Medicaid	\$ 63,667		
Physical Therapy Supplies	\$ 13,777		
<b>Total Other Resident Care</b>	\$ 136,877	\$ -	\$ -

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

Name of Facility Maefair Health Care Center			License No. 2142C		Report for Year Ended 9/30/2022			Page of 21   37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Procure LTC	Suite 121, Farmingdale NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners: Minority Interest	Pharmacy					
CWPM	PO Box 415, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish Removal					
ADP	Philadelphia, PA 19170-0351	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Processing					
Thyssen Krupp Elevator	P.O. Box 933007 Atlanta, GA 31193-3007	<input type="radio"/>	<input checked="" type="radio"/>		Elevator Service					
Outdoor Lawn Service	P.O. Box 320144 Fairfield, CT 06825	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping/ Snow Removal					
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

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

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

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2022			Page 22	of 37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 103,394	103,394				
b. Heat	\$ 43,952	43,952				
c. Light & Power	\$ 138,687	138,687				
d. Water	\$ 69,868	69,868				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 16,521	16,521				
f. Other ( <i>itemize</i> )	\$ 109,896	109,896				
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 482,318</b>	<b>482,318</b>				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 2,695	2,695				
b. Building & Building Improvements	\$ 24,617	24,617				
c. Non-Movable Equipment	\$ 1,099	1,099				
d. Movable Equipment	\$ 47,178	47,178				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 75,589</b>	<b>75,589</b>				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 28,766	28,766				
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 28,766</b>	<b>28,766</b>				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,054,741	1,054,741				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 128,671	128,671				
c. Personal property taxes	\$ 25,153	25,153				
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 1,312,920</b>	<b>1,312,920</b>				

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



### Depreciation Schedule

Name of Facility Maefair Health Care Center			License No. 2142C		Report for Year Ended 9/30/2022			Page 23	of 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			
<b>A. Land Improvements</b>													
1. Acquired prior to this report period			63,904			59,082	S/L		2,695				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal										2,695			
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period			1,298,324			1,149,864	S/L		24,617				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal										24,617			
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period			444,838			437,787	S/L		1,099				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal										1,099			
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost	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	Exclusive of Land							
<b>D. Movable Equipment</b>													
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	2021	2,092,251		1,784,797	S/L	Various	40,908	
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative					9	2022	63,635					6,111	
d. Standard Resident					9	2022	3,171					159	
e. Specialized Resident													
Total Acquired during this report period							66,806					6,270	
D-3. Subtotal													47,178
<b>E. Total Depreciation</b>													75,589



## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
<b>Additions:</b>					
12/1/2021	Office Furniture	Administrative	\$ 5,050	10	\$ 252
5/1/2022	Computer Equipment	Administrative	\$ 58,585	5	\$ 5,859
7/1/2022	Dishwasher Repair	Standard Resident	\$ 3,171	10	\$ 159
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
<b>Total additions for Movable Equipment</b>			\$ 66,806		\$ 6,270 *
<b>Deletions:</b>					
<b>Total deletions for Movable Equipment</b>			\$ -		\$ - **

\*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
2/1/2022	Heat Pump Repair	\$ 7,702	10	\$ 385
2/1/2022	Heat Pipe Repair	\$ 4,807	15	\$ 160
2/1/2022	House Pump Repair	4136	15	138
2/1/2022	HVAC Filter Replacement	5271	15	176
9/1/2022	Pipe Insulation	2966	15	99
<b>Total additions for Leasehold Improvement</b>		\$ 24,882		\$ 958 *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Annual Report of Long-Term Care Facility**

**Amortization Schedule\***

Name of Facility Maefair Health Care Center			License No. 2142C		Report for Year Ended 9/30/2022			Page 24	of 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							
<b>A. Organization Expense</b>									
1.									
2. Bed License	9	1997	15 Years	567,916	371,387	SL	7		
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period	9	2021	Various	398,251	151,901	SL		27,808	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2022	Various	24,882				958	
C-4. Subtotal									28,766
<b>D. Total Amortization</b>									28,766

\* 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 Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2022	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> 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 <b>NOT</b> 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		
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd 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 _____		13,530,465		
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
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				
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
Maefair Health Care Center		2142C	9/30/2022			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$					

*(Carry Subtotals forward to next page)*

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

Name of Facility		License No.		Report for Year Ended		Page	of
Maefair Health Care Center		2142C		9/30/2022		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify)				\$	12,066	12,066	
Vendor Interest 8,852 Key Bank Interest 3,214							
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)				\$	12,066	12,066	
14. Insurance							
a. Insurance on Property (buildings only)				\$	151,932	151,932	
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. <b>Total Insurance Expenditures (14a + b + c)</b>				\$	151,932	151,932	
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$	15,764,380	15,764,380	

### D. Adjustments to Statement of Expenditures

Name of Facility Maefair Health Care Center			License No. 2142C	Report for Year Ended 9/30/2022	Page 28	of 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$ 242,992	242,992		
4.			Other - See attached Schedule	\$ 4,194	4,194		
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$ 124,493	124,493		
10.			Accounting	\$ 4,865	4,865		
10a.			Legal	\$ 43,021	43,021		
11.			Telephone	\$			
12.			Cellular Telephone	\$ 1,140	1,140		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$ 17,577	17,577		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.			Unallowable Advertising *	\$ 10,770	10,770		
19.			Income Tax / Corporate Business Tax	\$ 4,410	4,410		
20.			Fund Raising / Contributions	\$ 1,110	1,110		
21.			Unallowable Management Fees	\$ 71,016	71,016		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 25,950	25,950		
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$ 478	478		
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 552,016	552,016		

\* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

## Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12m	Marketing Salaries & Benefits	\$ 4,194		
<b>Total Other Salaries Adjustment</b>			\$ 4,194	\$ -	\$ -

## Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Fees Adjustments</b>			\$ -	\$ -	\$ -

## Schedule of Other A&amp;G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Charges	\$ 23,550		
16	M13	Other Professional Fees	\$ 2,400		
<b>Total Other A&amp;G Adjustments</b>			\$ 25,950	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Maefair Health Care Center			2142C	9/30/2022	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 552,016	552,016		
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$ 236,158	236,158		
28.			Ambulance/Limousine	\$ 1,320	1,320		
29.			X-rays, etc	\$ 9,688	9,688		
30.			Laboratory	\$ 21,806	21,806		
31.			Medical Supplies	\$ 24,849	24,849		
32.			Oxygen (non emergency)	\$ 33,464	33,464		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 59,110	59,110		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 4,116	4,116		
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$ 297	297		
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$ 19,368	19,368		
46.			Management Fees Indirect	\$ 17,216	17,216		
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 979,408	979,408		

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

## Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5b	EBOX	\$ 7,432		
20	5j	Radio + Television Revenue	\$ 51,678		
<b>Total Other Ancillary Costs</b>			\$ 59,110	\$ -	\$ -

## Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Excluded Movable Equipment (See Attached)	\$ 4,116		
<b>Total Excess Movable Equipment Depreciation</b>			\$ 4,116	\$ -	\$ -

## Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended			Page	of
Maefair Health Care Center	2142C	9/30/2022			30	37
Item	Total	CCNH	RHNS	(Specify)		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 25,974,385	25,974,385				
b. Medicaid Room and Board Contractual Allowance **	\$ (14,268,452)	(14,268,452)				
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,057,152	1,057,152				
b. Medicare Room and Board Contractual Allowance **	\$ 42,282	42,282				
4. a. Private-Pay Residents and Other	\$ 2,472,592	2,472,592				
b. Private-Pay Room and Board Contractual Allowance **	\$ (626,814)	(626,814)				
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 73,844	73,844				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (73,844)	(73,844)				
c. Prescription Drugs - Non-Medicare	\$ 190,453	190,453				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (190,453)	(190,453)				
2. a. Medical Supplies - Medicare	\$ 10,555	10,555				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (354,867)	(354,867)				
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 419,362	419,362				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (155,306)	(155,306)				
c. Physical Therapy - Non-Medicare	\$ 410,670	410,670				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (410,670)	(410,670)				
4. a. Speech Therapy - Medicare	\$ 118,675	118,675				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (46,731)	(46,731)				
c. Speech Therapy - Non-Medicare	\$ 160,750	160,750				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (160,750)	(160,750)				
5. a. Occupational Therapy - Medicare	\$ 422,203	422,203				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (152,829)	(152,829)				
c. Occupational Therapy - Non-Medicare	\$ 380,650	380,650				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (380,650)	(380,650)				
6. a. Other ( <i>Specify</i> ) - Medicare	\$					
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 1,659,544	1,659,544				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 16,571,751	16,571,751				
<b>IV. Other Revenue*</b>						
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 ( <i>Specify</i> )	\$ 297	297				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 8,308	8,308				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 8,605	8,605				
<b>VI. Total All Revenue</b> (III +V)	\$ 16,580,356	16,580,356				

\* 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)
<b>Total Other Resident Revenue - Medicare</b>		\$ -	\$ -	\$ -

**Schedule of Other Non-Medicare Resident Revenue**

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Misc Revenue from CRF funding	\$ 188,082		
	Gain on Sale of Asset	\$ 1,471,462		
<b>Total Other Resident Revenue</b>		\$ 1,659,544	\$ -	\$ -

**Interest Income**

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
pg 31, L A	Interest on A/R	NA	\$ 297		
<b>Total Interest Income</b>			\$ 297	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
15, 1c	Bad Debt Recoveries	\$ 8,308		
<b>Total Other Revenue</b>		\$ 8,308	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2022	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	68,972
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	3,082,576
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	20,245
5. Prepaid Expenses			\$	411,226
a. Prepaid Insurance	157,666			
b. Ppd exp-health insurance & maintenance repairs	5,220			
c. Ppd exp-Other	248,340			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	3,583,019
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	63,905	\$	2,127
	Accum. Depreciation	61,778		Net
3. Buildings	*Historical Cost	1,299,096	\$	123,843
	Accum. Depreciation	1,175,253		Net
4. Leasehold Improvements	*Historical Cost	423,132	\$	242,466
	Accum. Depreciation	180,666		Net
5. Non-Movable Equipment	*Historical Cost	444,830	\$	5,952
	Accum. Depreciation	438,878		Net
6. Movable Equipment	*Historical Cost	2,157,340	\$	325,362
	Accum. Depreciation	1,831,978		Net
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation			Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	5,250
Equipment Carryforward adjustments	1,717			
See Schedule	3,533			
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	705,000

\* 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	
<b>Total Prepaid Expenses</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Current Assets (Itemize)</b>			\$ -

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

Page Ref	Line Ref	Description	
		Depr Adj due to conversion/ Project Development	\$ 3,533
<b>Total Other Other Fixed Assets (Itemize)</b>			\$ 3,533

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Unamortized Bed License	\$ 196,529
<b>Total Other Assets</b>			\$ 196,529

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Maefair Health Care Center	2142C	9/30/2022	32	37
<b>Account</b>			<b>Amount</b>	
Total Brought Forward:			\$	4,288,019
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
1. Land			\$	1,260,000
2. Land Improvements		*Historical Cost <u>7,823,776</u>		
	Accum. Depreciation	7,432,593	Net	\$ 391,183
3. Buildings		*Historical Cost _____		
	Accum. Depreciation		Net	\$
4. Non-Movable Equipment		*Historical Cost _____		
	Accum. Depreciation		Net	\$
5. Movable Equipment		*Historical Cost _____		
	Accum. Depreciation		Net	\$
6. Motor Vehicles		*Historical Cost _____		
	Accum. Depreciation		Net	\$
7. Minor Equipment-Not Depreciable				\$
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	1,651,183
<b>D. Investment and Other Assets</b>				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense		*Historical Cost _____		
	Accum. Depreciation		Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
_____				
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	(8,734,040)
Name and Address		Amount	Loan Date	
Related Party Investment		(8,734,040)	3/29/12	
7. Other Assets ( <i>itemize</i> )			\$	196,529
_____				
See Schedule				196,529
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	(8,537,511)
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	(2,598,309)

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



### G. Balance Sheet (cont'd)

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2022	Page 34	of 37
Account				Amount
Total Brought Forward:				5,124,158
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				
				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$ 284,568
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ (519,908)
Related Party		(519,908)		
_____				
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ (235,340)
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 4,888,818

**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	9/30/2022	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	1,260,000
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	391,183
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	1,651,183
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	2,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(9,956,286)
6. Gain or Loss for Period	10/1/2021	thru 9/30/2022	\$	815,976
7. Total Net Worth			\$	(9,138,310)
<b>C. Total Reserves and Net Worth</b>			\$	(7,487,127)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	(2,598,309)

### H. Changes in Total Net Worth

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2022	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2021			\$	(10,843,386)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	16,580,356
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	15,764,380
D. Net Income or Deficit			\$	815,976
E. Balance			\$	(10,027,410)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
Deferred HHS Funds	889,100			
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	889,100
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>	Title	Amount		
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose	Amount			
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	(9,138,310)

### I. Preparer's/Reviewer's Certification

Name of Facility Maefair Health Care Center	License No. 2142C	Report for Year Ended 9/30/2022	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Athena Health Care Associates, Inc				
Address Address			Phone Number	
135 South Road Farmington, CT 06032			(860) 751-3900	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Lynn Rinaldi			(860) 751-3900	
Contact Email Address				
lrinaldi@athenahealthcare.com				