State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2019

Name of Facility (as licensed) Odd Fellows Home of CT, b/d/a Fairview		
Address (No. & Street, City, State, Zip Code) 235 Lestertown Road, Groton, CT 06340		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	258c			07-5288

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	2584		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	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 Odd Fellows Home of CT, b/d/a Fairview [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, 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) Billy Nelson			Printed Name (Owner)	
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 Odd Fellows Home of CT, b/d/a Fairview	Period Covered:		From 10/1/2018	To 9/30/2019
Address of Facility 235 Lestertown Road, Groton, CT 06340				
Report Prepared By Marcum LLP	Phone Number 203-781-9600		Date 1/18/2020	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-445-7478	9/30/2019	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Odd Fellows Home of CT, b/d/a Fairview	235 Lestertown Road, Groton, CT 06340

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	258c			07-5288

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Billy Nelson	1505

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

Name	License No.:
N/A	

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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
N/A		

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
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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
Odd Fellows Home of CT, b/d/a Fairview	235 Lestertown Road, Groton, CT 06340	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Please see attached listing			
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	3B	37

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	%**				
Odd Fellows Healthcare, Inc	235 Lestertown Road, Groton, CT 06340	○	⊙		Management Fees	Pg 16 Ln m12	33,323	33,323
Faith, Hope and Charity	235 Lestertown Road, Groton, CT 06340	○	⊙		Other Accounts Receivable	Pg 32 Ln D7	196,817	196,817
Fellowship Manor	235 Lestertown Road, Groton, CT 06340	○	⊙		Housekeeping Services	Pg 30 Ln IV8	(25,000)	(25,000)
Thames Edge	235 Lestertown Road, Groton, CT 06340	○	⊙		Other Accounts Receivable	Pg 32 Ln D7	2,661,681	2,661,681
Fellowship Manor	235 Lestertown Road, Groton, CT 06340	○	⊙		Other Accounts Receivable	Pg 32 Ln D7	556,658	556,658
Faith, Hope and Charity	235 Lestertown Road, Groton, CT 06340	○	⊙		Other Accounts Payable	Pg 33 Ln A12	164,782	164,782
		○	⊙					
		○	⊙					
		○	⊙					

* 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.

N/A

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.

N/A

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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
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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
N/A	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

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

* 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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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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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 Blum Shapiro & Company, P.C.	29 S. Main Street, West Hartford, CY 06107
2 RKL LLP	3501 Concord Rd. York, PA 17402
3 Marcum LLP	555 Long Wharf Dr., New Haven, CT
4	

Services Provided by This Firm (*describe fully*)

1	403b Audit, 990 Prep, retirement plan audit	$ 58,762
2	Financial Consulting	$ 4,500
3	Medicare and Medicaid Cost Reports	$ 6,742
4		$

Charge for Services Provided $ 70,004

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

⊙ Yes ○ No Page 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Wiggin and Dana LLP	203-498-4400
2	
3	
4	
5	

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

1 One Century Tower New Haven, CT 06508
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	IRS Letter, exemption status, employee handbook, property tax matters	$ 37,001
2		$
3		$
4		$
5		$

Charge for Services Provided $ 37,001

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

⊙ Yes ○ No Page 15, Line 1e

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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 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	120	120			120	120			120	120		
B. On last day of THIS report period	120	120			120	120			120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	113	113			113	113			109	109		
B. As of midnight of THIS report period	108	108			109	109			108	108		
3. Total Number of Days Care Provided During Period												
A. Medicare	3,628	3,628			2,790	2,790			838	838		
B. Medicaid (Conn.)	22,881	22,881			17,152	17,152			5,729	5,729		
C. Medicaid (other states)												
D. Private Pay	12,142	12,142			9,209	9,209			2,933	2,933		
E. State SSI for RCH												
F. Other (Specify)	1,667	1,667			1,137	1,137			530	530		
G. Total Care Days During Period (3A thru F)	40,318	40,318			30,288	30,288			10,030	10,030		
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)**	40,318	40,318			30,288	30,288			10,030	10,030		

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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)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	12	56		40				
Per Diem Rate								
a. One bed rm.	Various	236.52		425.00				
b. Two bed rms.	Various	236.52		380.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	1,766	1,766		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	2,459	2,459		
D. ***Total Physical Therapy Treatments***	4,225	4,225		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	198	198		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,194	1,194		
D. ***Total Speech Therapy Treatments***	1,392	1,392		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,792	1,792		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	2,492	2,492		
D. ***Total Occupational Therapy Treatments***	4,284	4,284		

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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	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	293,693	2,159				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	448,646	25,558				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	96,252	2,112				
c. Dietary Workers	473,761	32,638				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	183,128	14,138				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	73,561	2,080				
b. Other Maintenance Workers	267,436	14,656				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	137,782	9,936				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant	25,630	742				
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	238,376	4,058				
b. RN						
1. Direct Care	1,074,085	28,737				
2. Administrative**	196,476	7,580				
c. LPN						
1. Direct Care	937,887	33,997				
2. Administrative**						
d. Aides and Attendants	2,269,379	120,537				
e. Physical Therapists	360,457	11,528				
f. Speech Therapists	78,195	2,161				
g. Occupational Therapists	320,228	8,879				
h. Recreation Workers	157,246	10,609				
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	115,861	3,760				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	7,748,079	335,865				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
	0					
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
	0					
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)							
Section I - Operators/Owners										
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)							
Section III - Administrators* **										
James Rosenman (10/1/18-1/16/19)	Open			Health Ins., Pension, Life. Ins., Disability	Administrator	879	A2			
Pamela Klapproth (2/11/19-6/2/19)	Open			Health Ins., Pension, Life. Ins., Disability	Administrator	656	A2			
Billy Nelson (6/3/19-9/30/19)	Open			Health Ins., Pension, Life. Ins., Disability	Administrator	624	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
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	44,590	864				
2. Dentist	8,100	81				
3. Pharmacist	4,085	Contract				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	43,481	647				
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)						
Cardiologist	24,000	520				
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	124,256	2,112				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Linday D'amato, 20 Ferryview Drive, Ferry, CT 06335	Dietician	○	⊙	
Ted Malahias, 115 Bridge Street, Groton, CT 06340	Dentist	○	⊙	
Pharmerica, PO Box 409251, Atlanta, GA 30384	Pharmacist	○	⊙	
Dr. C Wallace Andrias, 88 Payer Lane, Mystic, CT 06355	Cardiologist	○	⊙	
Edward McDermott, 25 Church Street, Groton, CT 06340	Medical Director	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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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
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	179,815	179,815		
2. Disability Insurance	$	23,185	23,185		
3. Unemployment Insurance	$	23,079	23,079		
4. Social Security (F.I.C.A.)	$	577,778	577,778		
5. Health Insurance	$	427,930	427,930		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	9,162	9,162		
7. Pensions (Non-Discriminatory)	$	384,627	384,627		
(not-owners and not-operators)					
8. Uniform Allowance	$	596	596		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	70,004	70,004		
e. Legal (*Services should be fully described on Page 7)*	$	37,001	37,001		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	38,494	38,494		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	13,116	13,116		
2. Cellular Phones	$				
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	$	757,384	757,384		
Subtotal	$	2,542,171	2,542,171		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
	0		
Total	$ -	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
	0		
Total	$ -	$ -	$ -

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,542,171	2,542,171		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	12,331	12,331		
4. Employee Travel	$	32,469	32,469		
5. Education Expenses Related to Seminars and Conventions	$				
6. Automobile Expense (*not purchase or depreciation*)	$	2,395	2,395		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	17,058	17,058		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	10,711	10,711		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	3,140	3,140		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	5,131	5,131		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	8,720	8,720		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	290	290		
9. Subscriptions	$	50,071	50,071		
10. Contributions***	$	250	250		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	426,639	426,639		
12. Administrative Management Services**	$	33,323	33,323		
13. Other (*Specify*)	$	82,667	82,667		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	3,227,366	3,227,366		

* 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)
	0		
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
	0		
Promotional Adverising	$ 10,711		
Total Other Advertising	$ 10,711	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	0		
AANAC	$ 375		
LeadingAge CT	$ 7,830		
CT Association of Healthcare	$ 350		
Infection Control Nurses of CT	$ 40		
NCCDP	$ 125		
Total Dues	$ 8,720	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
	0		
Gifts & Contributions	250		
Total Contributions	$ 250	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	0		
Physicals	$ 11,788		
Background Checks	$ 10,822		
IT Connect Charges	$ 1,479		
IT Equipment	$ 19		
Equipment Rentals	$ 1,811		
Unrealized Loss	$ (5,515)		
Plants for Residents' Families (Disallowed)	$ 2,755		
Safety Program Awards (Disallowed)	$ 250		
Bank Charges (Disallowed $849 non routine)	$ 2,892		
Consultants - Financial	$ 6,013		
DPH License	$ 1,650		
Unemployment Management	$ 2,959		
Bond Expense (Disallowed)	$ 200		
BOD Expense (Disallowed)	$ 2,123		
PBGC Penalty (Disllowed)	$ 43,421		
Total Other Administrative and General	$ 82,667	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	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 #
Odd Fellows Healthcare, Inc., 235 Lestertown Road, Groton, CT 06340	33,323	Management Fee	Page 16, Line M12

*** 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 Odd Fellows Home of CT, b/d/a Fairview	License No. 258c	Report for Year Ended 9/30/2019	Page of 18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	357,926	357,926		
2. Non-Food Supplies	$	61,856	61,856		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	3,778	3,778		
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	423,560	423,560		

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

G.	Is cost of employee meals included in 2D?	⦿ Yes	○ No		
H.	Did you receive revenue from employees?	⦿ Yes	○ No	If yes, specify amt.	$47,852
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg 30 Line IV 1
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.	Included in above
N.	Is any revenue collected from employees?	⦿ Yes	○ No	If yes, specify amt.	Included in above
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				Pg 30 Line IV 1

* 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
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Chemicals and Laundry Supplies	$	11,767	11,767		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	11,767	11,767		

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
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	28,831	28,831		
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	2,795	2,795		
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	31,626	31,626		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Pharmacy		$	325,538	325,538		
b. Medicine Cabinet Drugs		$	3,224	3,224		
c. Medical and Therapeutic Supplies		$	296,933	296,933		
d. Ambulance/Limousine***		$	581	581		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	2,680	2,680		
f. X-rays and Related Radiological Procedures***		$	30,280	30,280		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	13,455	13,455		
i. Recreation		$	22,103	22,103		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	66,955	66,955		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	761,749	761,749		

* 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)
	0		
Durable Equipment	$ 7,400		
Rental - DME (Patient Specific Disallowed)	$ 6,094		
Ancillary	$ 36,045		
Purchased Services/Consulting	$ 6,353		
Med A Supplies (Disallowed)	$ 829		
Rehab Management Fee	$ 3,443		
Nursing Equipment Rental	$ 6,137		
Equipment Rental - QC	$ 654		
Total Other Resident Care	$ 66,955	$ -	$ -

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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
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	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
Yale New Haven Health	PO Box 120019 Stamford, CT 06912	○	⊙		Laboratory	11,333			20	5h
Mobilex,	96 Ridgebrook Rd. Sparks, MD 21152	○	⊙		Radiology	30,280			20	5f
CVM	780 East Main St. Branford, CT 06405	○	⊙		IT	58,573			16	m11
B & M Landscaping	PO Box 1431 Westerly, RI 02891	○	⊙		Landscaping	40,121			22	6f
CWPM		○	⊙		Waste Removal	11,947			22	6f
ADP, Inc.	PO Box 842875, Boston, MA 02284	○	⊙		Payroll Processing	56,549			16	m11
New England Mechanical-EMCOR		○	⊙		Equipment Maintenance	14,196			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
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	99,530	99,530		
b. Heat	$	39,539	39,539		
c. Light & Power	$	83,221	83,221		
d. Water	$	9,913	9,913		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	89,635	89,635		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	321,838	321,838		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	6,228	6,228		
b. Building & Building Improvements	$	278,914	278,914		
c. Non-Movable Equipment	$	22,962	22,962		
d. Movable Equipment	$	105,575	105,575		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	413,679	413,679		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	4,728	4,728		
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	4,728	4,728		
9. Rental payments on leased real property less real estate taxes included in item 10b	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	3,301	3,301		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	421,708	421,708		

* 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	(Specify)
	0		
Building Contracts	$ 4,178		
Kitchen Equipment Repairs	$ 3,809		
Nursing Equipment Repairs	$ 73		
Purchased Services - Various Mainteance	$ 67,726		
Trash Service	$ 12,247		
Maintenance Equipment Rental	$ 727		
Inspections	$ 875		
Total Other Repairs and Maintenance	$ 89,635	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	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	290,348		290,348	128,103	S/L	Various	6,228	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	4,600		4,600		S/L	Various		
A-4. Subtotal								6,228
B. **Building and Building Improvements**								
1. Acquired prior to this report period	10,927,026		10,927,026	6,656,975	S/L	Various	277,352	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	24,224		24,224		S/L	Various	1,562	
B-4. Subtotal								278,914
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	798,880		798,880	608,388	S/L	Various	21,650	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	114,828		114,828		S/L	Various	1,312	
C-4. Subtotal								22,962

	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. Ford Truck with Plow	X		4	2000	2,183		2,183	2,183	S/L	5		
b. Wheelchair Van	X		3	2013	11,690		11,690	11,690	S/L	5		
c. Ford Truck	X		11	2017	26,599		26,599	5,541	S/L	5	6,650	
d. 2018 Ford Transit T-350	X		8	2018	41,054		41,054	855	S/L	5	10,263	
2. Movable Equipment												
a. Acquired prior to this report period			Var	Var	2,443,622		2,443,622	1,919,739	S/L	Various	88,451	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			Var	Var	7,136		7,136		S/L	Various	211	
D-3. Subtotal												105,575
E. ***Total Depreciation***												413,679

Schedule of Land Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
9/30/2019	Asphalt Work	$ 4,600	10	$ -	
Total additions for Land Improvement		$ 4,600		$ -	*
Deletions:					
Total deletions for Land Improvement		$ -		$ -	**

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

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

Schedule of Building Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Various	See attached depreciation schedule	$ 24,224	Various	$ 1,562	
Total additions for Building Improvemen		$ 24,224		$ 1,562	*
Deletions:					
Total deletions for Building Improvement		$ -		$ -	**

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

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

Schedule of Non-Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Various	See attached depreciation schedule	$ 114,828	Various	$ 1,312	
Total additions for Non-Movable Equipmen		$ 114,828		$ 1,312	*
Deletions:					
Total deletions for Non-Movable Equipmen		$ -		$ -	**

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

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

Schedule of Movable Equipment Acquired during this report peri

Acquisition Dat	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Various	See attached depreciation schedule	$ 7,136	15	$ 211	
Total additions for Movable Equipmen		$ 7,136		$ 211	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report peri

Acquisition Dat	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Leasehold Improvemer		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvemer		$ -		$ -	**

***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
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	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. Amortization Expense	11	2013	240	11,318	2,883	SL			
2. Amortization Expense	3	2017	360	141,743	16,647	SL		4,728	
3.									
B-4. Subtotal									4,728
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									4,728

* 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
Odd Fellows Home of CT, b/d/a Fairv	258c	9/30/2019	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	1961/1979
2. Date Structure Completed	Various - Final 5/1/07
3. If **NOT** Original Owner, Date of Purchase	N/A
4. Date of Initial Licensure	03/06/05
5. Total Licensed Bed Capacity	120
6. Square Footage	98,767
7. Acquisition Cost	
a. Land	126,746
b. Building	6,983,623

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Variable			
b. Date Mortgage Obtained	03/09/17			
c. Interest Rate for the Cost Year	2.67%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	6,691,765			
f. Principal balance outstanding as of 9/30/2019	6,447,848			
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
Odd Fellows Home of CT, b/d/a Fairv	258c	9/30/2019	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	$	6,691,765			
2. Loan Origination Date		03/09/17			
3. Interest Rate %		2.67%			
4. Term		30			
5. CHEFA Interest Expense		254,516	254,516		
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)	$	254,516	254,516		

(*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
Odd Fellows Home of CT, b/d/a Fa	258c	9/30/2019	27 | 37

Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				254,516	254,516		
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*)			$				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	254,516	254,516		
14. Insurance							
a. Insurance on Property (buildings only)			$	23,252	23,252		
b. Insurance on Automobiles			$	3,483	3,483		
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*)			$	14,257	14,257		
2. Fire and Extended Coverage			$				
3. Other (*Specify*)			$	126,927	126,927		
General Liability, D&O, Crime							
14d. ***Total Insurance Expenditures (14a + b + c)***			$	167,919	167,919		
15. ***Total All Expenditures (A-13 thru C-14)***			$	13,494,384	13,494,384		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.	10	A12g	Occupational Therapy $	320,228	320,228		
4.			Other - See attached Schedule $	142,208	142,208		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $	24,000	24,000		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.	15	1d	Accounting $	507	507		
10a.			Legal $				
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.	16	m13	Gifts, flowers and coffee shops $	2,755	2,755		
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.	16	m2/3	Unallowable Advertising * $	10,711	10,711		
19.			Income Tax / Corporate Business Tax $				
20.	16	m10	Fund Raising / Contributions $	250	250		
21.	16	m12	Unallowable Management Fees $	33,323	33,323		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	77,420	77,420		
Page 18 - Dietary Expenditures							
24.	30	IV 1	Meals to employees, guests and others who are not residents $	47,852	47,852		
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	659,254	659,254		

* 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	A2	Administrator - see attached	$ 58,739		
10	A7b	Maintenance Supervisor - see attached	$ 14,712		
10	A4	Other Admin Salaries - see attached	$ 63,631		
10	A11a	Head Accountant - see attached	$ 5,126		
Total Other Salaries Adjustment			$ 142,208	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B8e	Cardiologist	$ 24,000		
Total Other Fees Adjustments			$ 24,000	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	Various	Administrator's Benefits - see attached	$ 12,324		
15	Various	Other Admin Benefits - see attached	$ 17,512		
16	M7	Postage - see attached	$ 37		
16	m11, m13	IT Charges - see attached	$ 704		
16	m13	Safety Program Awards (Disallowed)	$ 250		
16	m13	Bank Charges (Disallowed $849 non routine)	$ 849		
16	m13	Bond Expense (Disallowed)	$ 200		
16	m13	BOD Expense (Disallowed)	$ 2,123		
16	m13	PBGC Penalty (Dislllowed)	$ 43,421		
Total Other A&G Adjustments			$ 77,420	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	659,254	659,254		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	325,538	325,538		
28.	20	5d	Ambulance/Limousine $	581	581		
29.	20	5f	X-rays, etc $	30,280	30,280		
30.	20	5h	Laboratory $	13,455	13,455		
31.			Medical Supplies $				
32.	20	5e2	Oxygen (non emergency) $	2,680	2,680		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	12,573	12,573		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $				
44.			Other - Miscellaneous Administrative $	57,666	57,666		
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49.	***Total Amount of Decrease (Items 1 - 48)***		$	1,102,027	1,102,027		

*** 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.

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5i	Cable (see attached)	$ 5,650		
20	5l	Rental - DME (Patient Specific Disallowed)	$ 6,094		
20	5l	Med A Supplies (Disallowed)	$ 829		
Total Other Ancillary Costs			$ 12,573	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)

Total Other Adjustments			$ -	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV 8	Housekeeping Services (Disallowed)	$ 25,000		
30	IV 8	Rental Income (Disallowed)	$ 2,600		
30	IV 8	Transportation Income (Disallowed)	$ 6,985		
30	IV 8	Misc. Income	$ 22,499		
30	IV 5	Interest Income	$ 582		
Total Other Adjustments			$ 57,666	$ -	$ -

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	8,201,699	8,201,699		
b. Medicaid Room and Board Contractual Allowance **	$	(2,918,295)	(2,918,295)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,953,062	1,953,062		
b. Medicare Room and Board Contractual Allowance **	$	(591,070)	(591,070)		
4. a. Private-Pay Residents and Other	$	4,472,727	4,472,727		
b. Private-Pay Room and Board Contractual Allowance **	$	(738,928)	(738,928)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	161,603	161,603		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	53,858	53,858		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	595,950	595,950		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	247,056	247,056		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	106,425	106,425		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	36,075	36,075		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	947,990	947,990		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	377,056	377,056		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	(154,709)	(154,709)		
b. Other *(Specify)* - Non-Medicare	$	19,743	19,743		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	12,770,242	12,770,242		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	47,852	47,852		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	582	582		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	(2,444,951)	(2,444,951)		
V. Total Other Revenue (1 thru 8)	$	(2,396,517)	(2,396,517)		
VI. Total All Revenue (III +V)	$	10,373,725	10,373,725		

* *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)
		0		
30 II 6a	Lab	$ 10,583		
30 II 6a	Xray	$ 22,477		
30 II 6a	Contractual Allowance	$ (187,769)		
Total Other Resident Revenue - Medicare		$ (154,709)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
		0		
30 II 6b	Oxygen	$ 900		
30 II 6b	Lable	$ 1,510		
30 II 6b	Xray	$ 17,333		
Total Other Resident Revenue		$ 19,743	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
			0		
30 IV 5	Interest Income	Various Accounts	$ 582		
Total Interest Income			$ 582	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
		0		
30 IV8	Misc. Income (Disallowed)	$ 22,499		
30 IV8	Housekeeping Services (Disallowed)	$ 25,000		
30 IV8	TE Services (No associated expense)	$ 24,000		
30 IV8	TE/FSM Income (No associated expense)	$ 24,000		
30 IV8	Rental Income (Disallowed)	$ 2,600		
30 IV8	Transportation Income (Disallowed)	$ 6,985		
30 IV8	TR Contribution (No associated expense)	$ 400		
30 IV8	Transfer Income (No associated expense)	$ 42,000		
30 IV8	Change in FMV of Swap (No associated expense)	$ (407,592)		
30 IV8	Change in Minimum Pension Liability (No associated expense)	$ (2,184,843)		
Total Other Revenue		$ (2,444,951)	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 956,540
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 776,232
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 57,938
a. Prepaid Insurance		26,849		
b. Prepaid Expenses		31,089		
c.				
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,790,710
B. Fixed Assets				
1. Land				$ 180,600
2. Land Improvements	*Historical Cost	294,948		$ 160,617
	Accum. Depreciation	134,331	Net	
3. Buildings	*Historical Cost	10,951,250		$ 4,015,361
	Accum. Depreciation	6,935,889	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	913,708		$ 282,358
	Accum. Depreciation	631,350	Net	
6. Movable Equipment	*Historical Cost	2,450,758		$ 442,357
	Accum. Depreciation	2,008,401	Net	
7. Motor Vehicles	*Historical Cost	81,526		$ 44,344
	Accum. Depreciation	37,182	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 27,362
CIP		89,952		
See Schedule		(62,590)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 5,152,999

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

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

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

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

Page Ref	Line Ref	Description	
31	B9	CR vs FS Net Book Value	$ (62,590)
Total Other Other Fixed Assets (Itemize)			$ (62,590)

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

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

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

Page Ref	Line Ref	Description	
34	B4	Loan Payable	$ 6,447,848
34	B4	Accrued Interest	$ 16,356
34	B4	FMV of SWAP	$ 355,852
34	B4	Deferred Financing	$ (129,177)
34	B4	Pension Liability	$ 5,880,060
Total Other Current Liabilities (Itemize)			$ 12,570,939

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	32	37

Account				Amount
			Total Brought Forward:	$ 6,943,709
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
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				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
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*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 3,415,156
Due from Related Parties		3,415,156		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 3,415,156
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 10,358,865

* 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
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 630,059
2. Notes Payable (*itemize*)					$
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*)					$ 471,468
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 52,828
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*)					$ 253,242
Patient Trust Liabilities	23,192	TSA 403(b)	5,801		
Nursing Fund	3,698	Employee Life Insurance	210		
Outstanding Gift Certificates	(3,229)	Lease Liability	41,221		
Accrued Provider Tax	182,349	See Schedule			
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 1,407,597

* 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
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	34	37

Account	Amount
Total Brought Forward:	1,407,597
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*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 12,570,939
See Schedule	12,570,939	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 12,570,939
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 13,978,536

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

Name of Facility	License No.	Report for Year Ended	Page	of
Odd Fellows Home of CT, b/d/a Fairvi	258c	9/30/2019	35	37

Account					Amount	
A. **Reserves**						
1. Reserve for value of leased land					$	
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					$	
B. **Net Worth**						
1. Owner's Capital					$	
2. Capital Stock					$	
3. Paid-in Surplus					$	
4. Treasury Stock					$	
5. Cumulated Earnings					$	(502,023)
6. Gain or Loss for Period	10/1/2018	thru	9/30/2019		$	(3,117,648)
7. Total Net Worth					$	(3,619,671)
C. ***Total Reserves and Net Worth***					$	(3,619,671)
D. ***Total Liabilities, Reserves, and Net Worth***					$	10,358,865

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2018			$ (415,014)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 10,373,725
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 13,491,373
D.	Net Income or Deficit			$ (3,117,648)
E.	Balance			$ (3,532,662)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Total Expenses per Pg 27	13,494,384		
	CR vs FS Depreciation	(3,011)		
	Total Expenses	13,491,373		
	2. Other (*itemize*)			
	Prior Period Adj.	(87,009)		
F-3.	Total Additions			$ (87,009)
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***	09/30/19		$ (3,619,671)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Odd Fellows Home of CT, b/d/a Fairview	258c	9/30/2019	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Matthew S. Bavolack

Addres Address	Phone Number
555 Long Wharf Drive, New Haven, CT 06511	203-781-9600

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Jamie Spencer	860-445-7478

Contact Email Address
spencerj@fairviewct.org