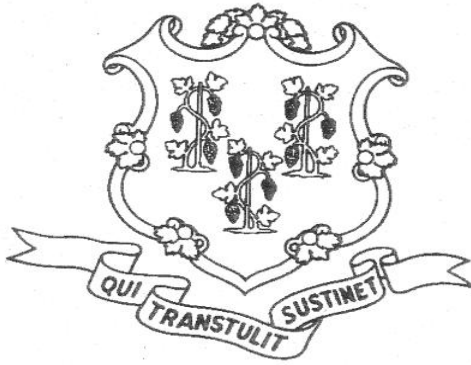


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2016

Name of Facility (as licensed) Autumn Lake Healthcare At Cromwell	
Address (No. & Street, City, State, Zip Code) 385 Main Street, Cromwell, CT 06416	
Type of Facility Chronic and Convalescent Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH) (RHNS)	
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH 2401	RHNS	(Specify)	Medicare Provider 07-5263
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Medicaid Provider Numbers:	CCNH 1427462967	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

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General Information

Name of Facility (as licensed) Autumn Lake Healthcare At Cromwell	License No. 2401	Report for Year Ended 9/30/2016	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 Autumn Lake Healthcare At Cromwell [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under 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) Jessica Garcia			Printed Name (Owner) Aryeh Stern		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

State of Connecticut
Department of Social Services
 55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Autumn Lake Healthcare At Cromwell		Period Covered:	From 10/1/2015	To 9/30/2016
Address of Facility 385 Main Street, Cromwell, CT 06416				
Report Prepared By CJLC LLC		Phone Number 860-610-9009	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. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-635-5613		Report for Year Ended 9/30/2016		Page 2	of 37
Name of Facility (as shown on license) Autumn Lake Healthcare At Cromwell			Address (No. & Street, City, State, Zip) 385 Main Street, Cromwell, CT 06416		
License Numbers:	CCNH 2401	RHNS	(Specify)	Medicare Provider No. 07-5263	
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 checked="" type="radio"/> LLC <input type="radio"/> Partnership <input 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.					
Administrator					
Name of Administrator Jessica Garcia			Nursing Home Administrator's License No.:	001931	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		

General Information and Questionnaire
Related Parties*

Name of Facility Autumn Lake Healthcare At Cromwell	License No. 2401	Report for Year Ended 9/30/2016	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	%**				
Autumn Lake Healthcare LLC	4260 RT 9 South, Howell, NJ 07731	<input type="radio"/>	<input checked="" type="radio"/>		Management Company	16/m12	223,432	223,432
Ultimate Therapy LLC	4260 RT 9 South, Howell, NJ 07731	<input checked="" type="radio"/>	<input type="radio"/>		Therapy Company (ST, PT, OT)	13/5a, 9a, 10a	445,875	436,958
Cromwell Realty	4260 RT 9 South, Howell, NJ 07731	<input type="radio"/>	<input checked="" type="radio"/>		Lease of Building	22/9	774,900	774,900
		<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 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 Autumn Lake Healthcare At Cromwell	License No. 2401	Report for Year Ended 9/30/2016	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	
Autumn Lake Healthcare At Cromwell			2401	9/30/2016			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							
ACPL Hanger Company 4850 Joule Street, Suite A-1, Reno, NV 89502	<input type="radio"/>	<input checked="" type="radio"/>	Omnistim, Omnisound, Megapulse, Omnistim, Omnicycle, Printer, OC, Martel	01/01/15	12 months			15,377	
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input type="radio"/>							
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input type="radio"/> No	Total ***	15,377

* 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 Autumn Lake Healthcare At Cromv	License No. 2401	Report for Year Ended 9/30/2016	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 CJLC LLC	225 Pitkin Street, East Hartford, CT 06108
2 Brand Sonnenchine	299 Broadway, Suite 600, New York, NY 10007
3 David Fisch & Co	3854 Flatsland Ave, Brooklyn, NY 11234
4	

Services Provided by This Firm (*describe fully*)

1 Medicaid and Medicare Cost Report and Accounting Services	\$ 11,542
2 Financial Statements Preparation & Regular Accounting Work	\$ 39,963
3 401K Audit Report	\$ 1,000
4	\$
	Charge for Services Provided
	\$ 52,505

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

- Yes No Pg 15/1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Jasinski	
2 Martin LLP	
3 Murtha Cullina	
4 Schutjer Bogar LLC	
5	

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

1 60 Park Place, Newark NJ 07102
2 262 Harbor Dr, Stamford, CT
3 Asylum Street, Hartford, CT
4 Harrisburg PA
5

Services Provided by This Firm (*describe fully*)

1 Labor / Employment Law	\$ 5,528
2 Litigations, Lawsuits	\$ 10,508
3 Regulatory Law	\$ 5,582
4 Medicaid eligibility & reimbursement	\$ 200
5	\$
	Charge for Services Provided
	\$ 21,817

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

- Yes No Pg 15/1e

Schedule of Resident Statistics

Name of Facility Autumn Lake Healthcare At Cromwell			License No. 2401		Report for Year Ended 9/30/2016				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	175	175			175	175			175	175			
B. On last day of THIS report period	175	175			175	175			175	175			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	127	127			127	127			103	103			
B. As of midnight of THIS report period	108	108			103	103			108	108			
3. Total Number of Days Care Provided During Period													
A. Medicare	2,738	2,738			1,616	1,616			1,122	1,122			
B. Medicaid (Conn.)	34,827	34,827			26,697	26,697			8,130	8,130			
C. Medicaid (other states)													
D. Private Pay	222	222			125	125			97	97			
E. State SSI for RCH													
F. Other (Specify) Insurance, hospice, HMO	2,831	2,831			2,414	2,414			417	417			
G. Total Care Days During Period (3A thru F)	40,618	40,618			30,852	30,852			9,766	9,766			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	6	6			6	6							
B. Other Bed Reserve Days													
5. Total Resident Days (3G + 4A + 4B)	40,624	40,624			30,858	30,858			9,766	9,766			

Schedule of Resident Statistics (Cont'd)

Name of Facility Autumn Lake Healthcare At Cromwell			License No. 2401			Report for Year Ended 9/30/2016			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-IID				
No. of Residents													
Per Diem Rate													
a. One bed rm.	529.93				300.59								
b. Two bed rms.													
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments										TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B										3,070	3,070		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments										183	183		
2. Restorative Treatments										1,649	1,649		
C. Other													
D. Total Physical Therapy Treatments										4,902	4,902		
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B										972	972		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments										24	24		
2. Restorative Treatments										221	221		
C. Other													
D. Total Speech Therapy Treatments										1,217	1,217		
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B										3,018	3,018		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments										172	172		
2. Restorative Treatments										1,548	1,548		
C. Other													
D. Total Occupational Therapy Treatments										4,738	4,738		

Report of Expenditures - Salaries & Wages

Name of Facility Autumn Lake Healthcare At Cromwell	License No. 2401	Report for Year Ended 9/30/2016	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
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)	12,000	390				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	103,267	2,103				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	107,189	7,148				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	324,684	24,993				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	113,965	6,838				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses						
b. RN						
1. Direct Care						
2. Administrative**						
c. LPN						
1. Direct Care						
2. Administrative**						
d. Aides and Attendants						
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	131,321	7,077				
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	146,093	7,247				
n. Marketing						
o. Other (Specify) See Attached Schedule	39,064	2,042				
<i>A-13. Total Salary Expenditures</i>	<i>977,583</i>	<i>57,837</i>				

* 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	
Autumn Lake Healthcare At Cromwell				2401	9/30/2016			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Aryeh Stern	12,000				Oversees buildings; high level executive decisions	390	A1	See Other Related Cost Reports		
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.

**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	
Autumn Lake Healthcare At Cromwell				2401	9/30/2016			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Jessica Garcia (12/14/16 to 9/30/2016)	79,250			Standard	Administrator	1,560	A2			
Valerie Romano (10/1/15 to 12/3/2015)	24,017			Standard	Administrator	543	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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Autumn Lake Healthcare At Cromwell	2401	9/30/2016	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	8,139	61				
3. Pharmacist	6,000	57				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	201,315	Outsourced				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,000	228				
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	49,980	Outsourced				
b. Other						
10. Occupational Therapist						
a. Resident Care	194,580	Outsourced				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	1,031,200	15,999				
2. Administrative***	995,440	Outsourced				
b. LPN						
1. Direct Care	2,047,500	50,959				
2. Administrative***						
c. Aides	2,747,000	119,310				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	7,317,154	186,613				

* 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.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Autumn Lake Healthcare At Cromwell	2401	9/30/2016		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 38,829	38,829			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 39,114	39,114			
4. Social Security (F.I.C.A.)	\$ 73,953	73,953			
5. Health Insurance	\$ 59,363	59,363			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 2,768	2,768			
8. Uniform Allowance	\$ 8,174	8,174			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 480	480			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 16,669	16,669			
d. Accounting and Auditing	\$ 52,504	52,504			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 21,815	21,815			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 81,090	81,090			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 20,396	20,396			
2. Cellular Phones	\$ 4,111	4,111			
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*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 783,767	783,767			
Subtotal	\$ 1,203,033	1,203,033			

* 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
Autumn Lake Healthcare At Cromwell	2401	9/30/2016		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:					
	1,203,033	1,203,033			
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$ 1,062	1,062			
4. Employee Travel	\$ 15,927	15,927			
5. Education Expenses Related to Seminars and Conventions	\$ 3,585	3,585			
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>)	\$				
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)***	\$ 19,061	19,061			
See Attached Schedule					
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$				
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>)	\$				
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions***	\$				
See Attached Schedule					
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$ 223,432	223,432			
13. Other (<i>Specify</i>)	\$ 434,382	434,382			
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$ 1,900,482	1,900,482			

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
OFFICE MARKETING	\$ 9,383		
Advertising	\$ 9,678		
Total Other Advertising	\$ 19,061	\$ -	\$ -

Schedule of Dues

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

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Fiscal Services	\$ 302,943		
Employee Background Check	\$ 1,314		
Data Processing	\$ 32,222		
Consultants	\$ 76,520		
Bank Charges	\$ 4,030		
Penalties	\$ 1,091		
Hmo Wx Account	\$ 16,262		
Total Other Administrative and General	\$ 434,382	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Autumn Lake Healthcare At Cromwell	2401	9/30/2016	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 #
Autumn Lake Healthcare, LLC	223,432	Management Services	16/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.**

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

Name of Facility Autumn Lake Healthcare At Cromwell		License No. 2401	Report for Year Ended 9/30/2016	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 360,643	360,643		
2.	Non-Food Supplies	\$ 36,575	36,575		
3.	Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$ 155,004	155,004		
c. Management Services**		\$			
d. Other (Specify) _____		\$			
2E. Total Dietary Expenditures (2a + b + c + d)		\$ 552,222	552,222		
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*					
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No					
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility		License No.	Report for Year Ended	Page	of
Autumn Lake Healthcare At Cromwell		2401	9/30/2016	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)		\$	164,823	164,823	
c. Management Services**		\$			
d. Other (Specify)		\$			
3E. Total Laundry Expenditures (3a + b + c + d)		\$	164,823	164,823	
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
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 laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K. Did you receive revenue 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)			

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3E.

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

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

**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	
Autumn Lake Healthcare At Cromwell	2401	9/30/2016	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. \$				
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. \$	248,836	248,836		
c. Management Services*	\$				
d. Other (<i>Specify</i>) Hskpng Supply	\$	25,656	25,656		
4E. Total Housekeeping Expenditures (4a + b + c + d)	\$	274,492	274,492		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	245,361	245,361		
b. Medicine Cabinet Drugs	\$	3,202	3,202		
c. Medical and Therapeutic Supplies	\$	135,792	135,792		
d. Ambulance/Limousine***	\$	3,225	3,225		
e. Oxygen					
1. For Emergency Use	\$	8,103	8,103		
2. Other***	\$	8,235	8,235		
f. X-rays and Related Radiological Procedures***	\$	4,047	4,047		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	6,546	6,546		
i. Recreation	\$	41,376	41,376		
j. Other (Specify)**** See Attached Schedule	\$	91,435	91,435		
5K. Total Resident Care Expenditures (5a - 5j)	\$	547,322	547,322		

* 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.

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

Name of Facility Autumn Lake Healthcare At Cromwell			License No. 2401	Report for Year Ended 9/30/2016	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
Edward D'Amato	124 Shunpike Rd., Cromwell, CT 06416	<input type="radio"/>	<input checked="" type="radio"/>		Snow Removal	27,332			22	6a
Healthcare Services	3220 Tillman Dr. #300, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Dietary Services	155,004			18	2b
Healthcare Services	3220 Tillman Dr. #300, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Services	164,823			19	3b
Healthcare Services	3220 Tillman Dr. #300, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Housekeeping Services	248,836			20	4b
Ed's Lawn Care LLC	124 Shunpike Rd., Cromwell, CT 06416	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping	13,123			22	6a
CWPM LLC	PO Box 415, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Garbage	24,544			22	6a
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input 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	License No.	Report for Year Ended	Page	of
Autumn Lake Healthcare At Cromwell	2401	9/30/2016	22	37
Item	Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance	\$ 258,177	258,177		
b. Heat	\$ 58,093	58,093		
c. Light & Power	\$ 110,382	110,382		
d. Water	\$ 65,103	65,103		
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 15,377	15,377		
f. Other (<i>itemize</i>)	\$			
See Attached Schedule				
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 507,132	507,132		
7. Depreciation (<i>complete schedule page 23*</i>)				
a. Land Improvements	\$			
b. Building & Building Improvements	\$ 339,010	339,010		
c. Non-Movable Equipment	\$			
d. Movable Equipment	\$ 152,961	152,961		
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 491,970	491,970		
8. Amortization (<i>Complete att. Schedule Page 24*</i>)				
a. Organization Expense	\$			
b. Mortgage Expense	\$			
c. Leasehold Improvements	\$ 51,290	51,290		
d. Other (<i>Specify</i>)	\$			
*8e. Total Amortization Costs (8a + b + c + d)	\$ 51,290	51,290		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 774,900	774,900		
10. Property Taxes				
a. Real estate taxes paid by owner	\$ 205,479	205,479		
b. Real estate taxes paid by lessor	\$			
c. Personal property taxes	\$			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,523,640	1,523,640		

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
9/14/2016	Bed Spreads	\$ 4,160	5	\$ 832
9/26/2016	Patient Furniture	\$ 32,894	5	\$ 6,579
6/30/2016	Slicer	\$ 1,607	5	\$ 321
Total additions for Movable Equipment		\$ 38,660		\$ 7,732 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/8/2015	Designer Fee	585	10	\$ 59
8/31/2016	Electrical	17,690	20	\$ 885
6/30/2016	Wallpaper / Flooring	13,033	10	\$ 1,303
11/30/2015	Designer Fee	47,500	10	\$ 4,750
12/31/2015	Designer Fee	647	10	\$ 65
4/30/2016	Wallpaper / Flooring	62,780	10	\$ 6,278
6/30/2016	Designer Fee	2,354	10	\$ 235
6/30/2016	Designer Fee	2,812	10	\$ 281
9/30/2016	Wallpaper / Flooring	21,092	10	\$ 2,109
9/30/2016	Attached Curtains	20,446	10	\$ 2,045
9/15/2016	Wallpaper / Flooring	442	10	\$ 44
9/15/2016	Wallpaper / Flooring	2,878	10	\$ 288
8/10/2016	Wallpaper / Flooring	13,975	10	\$ 1,398
7/26/2016	Wallpaper / Flooring	5,803	10	\$ 580
5/19/2016	Wallpaper / Flooring	3,478	10	\$ 348
9/21/2016	Cabinets	12,491	10	\$ 1,249
4/18/2016	Painting	110,000	10	\$ 11,000
4/7/2016	Flooring	46,106	10	\$ 4,611
7/13/2016	Electrical	12,147	20	\$ 607
4/18/2016	Renovation	71,349	20	\$ 3,567
10/20/2015	Boiler	22,546	20	\$ 1,127
11/4/2016	Renovation	17,422	20	\$ 871
7/13/2016	sidewalk	14,996	20	\$ 750
7/23/2016	Boiler room	3,270	20	\$ 164
7/19/2016	Conveyor	9,673	5	\$ 1,935
Total additions for Leasehold Improvement		\$ 535,515		\$ 46,548 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility Autumn Lake Healthcare At Cromwell			License No. 2401		Report for Year Ended 9/30/2016			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							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	Var	Var		47,427	4,743			4,743	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	Var	Var	Various	535,515				46,548	
C-4. Subtotal									51,290
D. Total Amortization									51,290

* 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) - Interest

Name of Facility		License No.	Report for Year Ended			Page	of
Autumn Lake Healthcare At Cromwe		2401	9/30/2016			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. Total Building Interest Expense (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
Autumn Lake Healthcare At Cromy		2401		9/30/2016		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify) Interest Expense				\$	8,538	8,538	
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	8,538	8,538	
14. Insurance							
a. Insurance on Property (buildings only)				\$	184,185	184,185	
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$	184,185	184,185	
15. Total All Expenditures (A-13 thru C-14)				\$	13,957,572	13,957,572	

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Autumn Lake Healthcare At Cromwell				2401	9/30/2016	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	b10a	Occupational Therapy	\$ 194,580	194,580		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 16,669	16,669		
10.			Accounting & Legal	\$			
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 2,671	2,671		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
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	m3	Unallowable Advertising *	\$ 19,061	19,061		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 17,354	17,354		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
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)				\$ 250,335	250,335		

* 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)
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Penalties	\$ 1,091		
16	m13	Hmo Wx Account	\$ 16,262		
Total Other A&G Adjustments			\$ 17,354	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Autumn Lake Healthcare At Cromwell			2401	9/30/2016	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 250,335	250,335		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 245,361	245,361		
28.	20	5d	Ambulance/Limousine	\$ 3,225	3,225		
29.	20	5f	X-rays, etc	\$ 4,047	4,047		
30.	20	5h	Laboratory	\$ 6,546	6,546		
31.			Medical Supplies	\$ 11,461	11,461		
32.	20	5e2	Oxygen (non emergency)	\$ 8,235	8,235		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 26,912	26,912		
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.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 556,122	556,122		

*** 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.

Autumn Lake Healthcare At Cromwell
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	M'caid - I/v	\$ 26,840		
20	5j	Resident PD Claims (cb)	\$ 72		
Total Other Ancillary Costs			\$ 26,912	\$ -	\$ -

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			\$ -	\$ -	\$ -

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Autumn Lake Healthcare At Cromwell	2401	9/30/2016			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 7,689,386	7,689,386				
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,218,527	2,218,527				
b. Medicare Room and Board Contractual Allowance **	\$ (25,585)	(25,585)				
4. a. Private-Pay Residents and Other	\$ 123,436	123,436				
b. Private-Pay Room and Board Contractual Allowance **	\$ 99,312	99,312				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$					
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$					
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	\$ 367,398	367,398				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (274,910)	(274,910)				
c. Physical Therapy - Non-Medicare	\$					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 165,861	165,861				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (98,197)	(98,197)				
c. Speech Therapy - Non-Medicare	\$					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 394,569	394,569				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (299,942)	(299,942)				
c. Occupational Therapy - Non-Medicare	\$					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 10,359,855	10,359,855				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 50	50				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 6,141	6,141				
V. Total Other Revenue (1 thru 8)	\$ 6,191	6,191				
VI. Total All Revenue (III +V)	\$ 10,366,046	10,366,046				

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue		\$ -	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/IV5	Interest Income	\$ 58,442	\$ 50		
Total Interest Income			\$ 50	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30/IV8	Other Rev. Misc.	\$ 6,141		
Total Other Revenue		\$ 6,141	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Healthcare At Cromwell	2401	9/30/2016	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	238,720
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,009,345
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	110,703
a. Prepaid Insurance	104,712			
b. Prepaid Interest	5,991			
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	322,695
Due to Ultimate	(9,375)			
Due to/from previous owne	332,070			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,681,463
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>582,942</u>		\$	526,909
	Accum. Depreciation <u>56,033</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	470,926
Construction in progress	470,926			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	997,835

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Autumn Lake Healthcare At Cromwell	License No. 2401	Report for Year Ended 9/30/2016	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$	2,679,299
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	1,120,658
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	10,170,286		
	Accum. Depreciation	593,267	Net	\$
4. Non-Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment				
	*Historical Cost	764,805		
	Accum. Depreciation	261,883	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	11,200,599
D. Investment and Other Assets				
1. Deferred Deposits			\$	40,580
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>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	

D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	40,580
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	13,920,478

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Autumn Lake Healthcare At Cromwell		2401	9/30/2016	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	5,749,288
2. Notes Payable (<i>itemize</i>)				\$	47,967
Capital Lease Payable				53,231	
Capital lease payable \$584.93				(5,264)	
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	5,368
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	103,432
Due to owner				103,432	
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	5,906,054

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Autumn Lake Healthcare At Cromwell	License No. 2401	Report for Year Ended 9/30/2016	Page 34	of 37
Account			Amount	
Total Brought Forward:			5,906,054	
Liabilities (cont'd)				
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>)				\$ 634,657
Name and Address of Lender	Amount	Loan Date		
Stern/Autumn/Lake/Landlord	634,657	Various		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$

B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 634,657
C. Total All Liabilities (Lines A-13 + B-5)				\$ 6,540,711

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

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Healthcare At Cromwel	2401	9/30/2016	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 (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	12,071,008
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	12,071,008
B. Net Worth				
1. Owner's Capital			\$	(43,327)
2. Capital Stock			\$	(1,056,389)
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	
6. Gain or Loss for Period			\$	(3,591,526)
	10/1/2015	thru	9/30/2016	
7. Total Net Worth			\$	(4,691,241)
C. Total Reserves and Net Worth			\$	7,379,767
D. Total Liabilities, Reserves, and Net Worth			\$	13,920,478

H. Changes in Total Net Worth

Name of Facility Autumn Lake Healthcare At Cromwell	License No. 2401	Report for Year Ended 9/30/2016	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2015			\$	(1,417,413)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	10,366,046
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	13,957,572
D. Net Income or Deficit			\$	(3,591,526)
E. Balance			\$	(5,008,939)
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
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. Balance at End of Period			\$	(5,008,939)
				09/30/16

I. Preparer's/Reviewer's Certification

Name of Facility Autumn Lake Healthcare At Cromwell	License No. 2401	Report for Year Ended 9/30/2016	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)		
Preparer/Reviewer Certification				
<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				
CJLC LLC				
Address			Phone Number	
225 Pitkin Street, East Hartford, CT 06108			860-610-9009	