State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2020

Name of Facility (as licensed) Autumn Lake Heathcare At Cromwell		
Address (No. & Street, City, State, Zip Code) 385 Main Street, Cromwell, CT 06416		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	1427462967		

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

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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 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 Autumn Lake Heathcare At Cromwell [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, 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) Chaim Scher			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)

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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 Heathcare At Cromwell	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 385 Main Street, Cromwell, CT 06416				
Report Prepared By CJLC LLC	Phone Number 860-610-9009		Date 6/28/2021	

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
860-635-5613	9/30/2020	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Autumn Lake Heathcare At Cromwell	385 Main Street, Cromwell, CT 06416

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2401			07-5263

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.:	
Chaim Scher		2061

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

Name	License No.:

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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
Cromwell Parent LLC	4260 Rte 9, Howell, NJ 07731	NJ

Name of Partners/Members	Business Address	Title	% Owned
Cromwell Parent LLC	4260 Rte 9, Howell, NJ 07731		100

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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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
N/A			
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
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Autumn Lake Heathcare LLC	4260 Rte 9, Howell, NJ 07731	○	◉		Management Company	16/m12	169,047	169,047
Ultimate Therpy	4260 Rte 9, Howell, NJ 07731	◉	○		Therepy Company (ST, PT, OT other)	13/5a, 9a ,10a	420,000	420,000
Cromwell Realty	4260 Rte 9, Howell, NJ 07731	○	◉		Lease of Building	22/9	774,902	774,902
		○	◉					
		○	◉					
		○	◉					
		○	◉					
		○	◉					
		○	◉					

* 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

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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.

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.

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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.

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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
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	

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

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

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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 CJLC LLC	225 Pitkin Street East Hartford, CT 06108
2 Brand Sonnechine	229 Broadway #600 New York, NY 10007
3 MTS Consulting LLC	6677 N. Lincoln Ave, Suite 400, Lincolnwood, IL 60712
4	

Services Provided by This Firm (*describe fully*)

1	Medicaid Cost Report	$ 18,019
2	Financial Statement Preperation & Regular Accounting	$ 41,776
3	Sales tax return preparation and filing	$ 825
4		$
		Charge for Services Provided $ 60,620

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 Goldman, Gruder & Woods LLC	
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 60 Park Pl, Newark, NJ 07102
2 200 CT Ave, Norwalk, CT 06854
3
4
5

Services Provided by This Firm (*describe fully*)

1	Contract negotiations	$ 4,221
2	Medicaid eligibility	$ 1,339
3		$
4		$
5		$
		Charge for Services Provided $ 5,560

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
Pg 15/1e
⊙ Yes ○ No

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Schedule of Resident Statistics

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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	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	119	119			119	119			111	111		
B. As of midnight of THIS report period	117	117			111	111			117	117		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,097	4,097			2,944	2,944			1,153	1,153		
B. Medicaid (Conn.)	33,880	33,880			26,276	26,276			7,604	7,604		
C. Medicaid (other states)												
D. Private Pay	2,675	2,675			1,985	1,985			690	690		
E. State SSI for RCH												
F. Other (Specify) HMO, Private Ins. and Hospice	3,889	3,889			2,838	2,838			1,051	1,051		
G. Total Care Days During Period (3A thru F)	44,541	44,541			34,043	34,043			10,498	10,498		
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)**	44,541	44,541			34,043	34,043			10,498	10,498		

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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	14	80		23				
Per Diem Rate								
a. One bed rm.	654.67	235.70		352.70				
b. Two bed rms.								
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	2,462	2,462		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	111	111		
2. Restorative Treatments	999	999		
C. Other				
D. ***Total Physical Therapy Treatments***	3,572	3,572		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	591	591		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	36	36		
2. Restorative Treatments	322	322		
C. Other				
D. ***Total Speech Therapy Treatments***	949	949		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,474	1,474		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	79	79		
2. Restorative Treatments	707	707		
C. Other				
D. ***Total Occupational Therapy Treatments***	2,260	2,260		

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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)	24,000	156				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	129,497	2,160				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	293,739	10,886				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	355,457	21,432				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	135,541	5,656				
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	105,208	5,010				
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	148,200	4,733				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	9,602	718				
A-13. Total Salary Expenditures	1,201,243	50,750				

* 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**
Salaries Medical Records	$ 9,602	718				
Total	$ 9,602	718	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Aryeh Stern (10/1/19-9/30/20)	24,000				Oversees Buildings, High level executive decisions, Etc.	156	A1			
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* **										
Chaim Scher (10/1/19-9/30/20)	129,497				Administrator	2,160	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total Cost and Hours					
Item	CCNH	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	35,975	1,180				
2. Dentist	6,650	80				
3. Pharmacist	19,376	Contracted				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	228,416	Contracted				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	24,000	216				
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	54,831	Contracted				
b. Other						
10. Occupational Therapist						
a. Resident Care	136,753	Contracted				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	1,220,001	15,372				
2. Administrative***	685,479	Contracted				
b. LPN						
1. Direct Care	2,579,022	52,595				
2. Administrative***						
c. Aides	3,017,166	97,584				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	8,007,669	167,026				

* 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
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
HealthDrive Dental	Dentist	○	⊙	
Prescription	Pharmacy Consultant	○	⊙	
Ultimate Therapy, 4201 Rte 9, Howell, NJ 07731	Physical Therapist, Occupational Therapist, Speech Therapist	⊙	○	
RADD, 503 Wolcott Road, Wolcott, CT 06716	Medical Director	○	⊙	
Accurate Staffing, Inc. (ASI), 14C 53rd Street, Brooklyn, NY 11232	Nurse Services	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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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

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Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	37,527	37,527		
2. Disability Insurance	$				
3. Unemployment Insurance	$	21,938	21,938		
4. Social Security (F.I.C.A.)	$	87,932	87,932		
5. Health Insurance	$	72,396	72,396		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$	667	667		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	276,203	276,203		
d. Accounting and Auditing	$	60,620	60,620		
e. Legal (*Services should be fully described on Page 7)*	$	5,560	5,560		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	49,775	49,775		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	37,010	37,010		
2. Cellular Phones	$	2,915	2,915		
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	$	799,538	799,538		
Subtotal	$	1,452,080	1,452,080		

* 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)
Total	$ -	$ -	$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,452,080	1,452,080		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	8,021	8,021		
4. Employee Travel	$	14,852	14,852		
5. Education Expenses Related to Seminars and Conventions	$	5,386	5,386		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	58,979	58,979		
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 (*Specify*) See Attached Schedule	$				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions***	$	10,000	10,000		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	169,047	169,047		
13. Other (*Specify*)	$	436,397	436,397		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,154,763	2,154,763		

* 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	$ 15,446		
Advertising	$ 43,533		
Total Other Advertising	$ 58,979	$ -	$ -

Schedule of Dues

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

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Contributions	$ 10,000		
Total Contributions	$ 10,000	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Fiscal Services	$ 305,941		
Licenses	$ 1,408		
Employee Background Check	$ 2,446		
Data Processing	$ 38,051		
Consultants	$ 84,407		
Bank Charges	$ 4,144		
Total Other Administrative and General	$ 436,397	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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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	169,047	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.**

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

Name of Facility	License No.	Report for Year Ended	Page of
Autumn Lake Heathcare At Cromwell	2401	9/30/2020	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	281,198	281,198		
2. Non-Food Supplies	$	35,382	35,382		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	199,497	199,497		
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	516,077	516,077		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	3	3		

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ 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.

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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
Autumn Lake Heathcare At Cromwell	2401	9/30/2020	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)*	$	204,715	204,715		
c. Other (*Specify*) Supplies	$	2,298	2,298		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	207,012	207,012		

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

*** 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
Autumn Lake Heathcare At Cromwell	2401	9/30/2020	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.	$				
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	271,642	271,642		
C. Other (*Specify*)		$	20,355	20,355		
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	291,997	291,997		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	179,306	179,306		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	126,319	126,319		
d. Ambulance/Limousine***		$	57,037	57,037		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	5,650	5,650		
f. X-rays and Related Radiological Procedures***		$	13,289	13,289		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	1,172	1,172		
i. Recreation		$	29,510	29,510		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	231,128	231,128		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	643,411	643,411		

* 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)
Diapers	$ 51,198		
Resident PD Claims (cb)	$ 91		
Medical Waste	$ 768		
Mattresses	$ 17,009		
M'caid - I/V	$ 19,604		
IV supplies	$ 10,413		
Picc/midline insertion	$ 12,508		
Medical Equipment (Minor)	$ 53,320		
PPE Expense (covid)	$ 66,167		
Therapy Supplies	$ 49		
Total Other Resident Care	$ 231,128	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Ed's Lawn Care LLC	124 Shunpike Rd., Cromwell, CT 06416	○	⊙		Snow Removal	18,090			22	6a
Ed's Lawn Care LLC	124 Shunpike Rd., Cromwell, CT 06416	○	⊙		Landscaping	15,049			22	6a
Waste Wanted Solutions	178 Rt 59, Ste 303, Monsey, NY 10952	○	⊙		Garbage	25,947			22	6a
Healthcare Services	3220 Tillman Dr. #300, Bensalem, PA 19020	○	⊙		Dietary Services	71,994			18	2b
Healthcare Services	3220 Tillman Dr. #300, Bensalem, PA 19020	○	⊙		Laundry Services	217,190			19	3b
Healthcare Services	3220 Tillman Dr. #300, Bensalem, PA 19020	○	⊙		Housekeeping Services	274,164			20	4b
Future Care Consultants	14 53rd st bklyn ny 11232	○	⊙		Billing and A/P and Payroll Services	240,000			16	m13
Accurate Staffing	14 53rd St. Ste 220, Brooklyn, NJ 11232	○	⊙		Outsourced Nursing Staff/Employees	7,501,668			13	
Computer Associates	Englewood Cliffs, NJ 07632	○	⊙		Contract (provide computers, software etc)	61,481			16	m13
Collaborative Laboratory	114 Woodland St., Hartford CT 06105	○	⊙		Labs	27,598			20	5h
Point Click Care	PO Box 674802, Detroit, MI 48267	○	⊙		Data Processing	21,110			16	m13
Healthcare Services	3220 Tillman Dr. #300, Bensalem, PA 19020	○	⊙		Dietician	139,764			18	2b
Hospitality Consulting	Blvd, Jersey City, NJ 07304	○	⊙		Purchasing for Food and Dietary Supplies	64,050			18	
Western Environmental Solutions, LLC	Blvd, Jersey City, NJ 07304	○	⊙		Maintenance Consulting and purchasing services	20,357			22	

* 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
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Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	174,820	174,820		
b. Heat	$	70,254	70,254		
c. Light & Power	$	123,945	123,945		
d. Water	$	79,897	79,897		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	448,915	448,915		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	339,010	339,010		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	89,138	89,138		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	428,148	428,148		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	159,178	159,178		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	159,178	159,178		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	774,902	774,902		
10. Property Taxes					
a. Real estate taxes paid by owner	$	189,802	189,802		
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,552,030	1,552,030		

* 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)
Total Other Repairs and Maintenance	$ -	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	10,170,286		10,170,286	1,610,296	SL	30	339,010	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								339,010
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			Var	Var	946,828		946,828	819,528	SL	5	80,299	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					44,194						8,839	
D-3. Subtotal												89,138
E. ***Total Depreciation***												428,148

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Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/1/2019	Body Exerciser	$ 4,385	5	$ 877	
1/2/2020	Door Intercom	$ 1,694	5	$ 339	
12/20/2019	Copier	$ 38,115	5	$ 7,623	
Total additions for Movable Equipment		$ 44,194		$ 8,839	*
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 perioc

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
8/4/2020	Dinex Colossus Wax Base Heater	$ 12,928	15	$ 862	
2/16/2020	Roof Repairs	$ 12,319	15	$ 821	
9/29/2020	Generator	$ 122,196	15	$ 8,146	
8/26/2020	Kitchen Tiles	$ 9,111	15	$ 607	
10/31/2019	Doors	$ 2,472	15	$ 165	
10/21/2019	Doors	$ 2,472	15	$ 165	
10/24/2019	Doors	$ 1,452	15	$ 97	
11/19/2019	Blower Motor	$ 1,783	15	$ 119	
4/23/2020	Repairs	$ 13,294	15	$ 886	
6/30/2020	Flat Panel Lights	$ 4,531	15	$ 302	
7/29/2020	Flat Panel Lights	$ 2,178	15	$ 145	
9/29/2020	Light Fixtures throughout building	$ 2,796	15	$ 186	
Total additions for Leasehold Improvement		$ 187,532		$ 12,502	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	Var	Var		1,821,316	439,920			146,676	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)				187,532				12,502	
C-4. Subtotal									159,178
D. ***Total Amortization***									159,178

* 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
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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	01/01/15
2. Date Structure Completed	01/01/67
3. If **NOT** Original Owner, Date of Purchase	01/01/15
4. Date of Initial Licensure	01/01/15
5. Total Licensed Bed Capacity	175
6. Square Footage	57,824
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
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
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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*)

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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
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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*) $	4,524	4,524		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	4,524	4,524		
14. Insurance				
a. Insurance on Property (buildings only) $	153,905	153,905		
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)*** $	153,905	153,905		
15. ***Total All Expenditures (A-13 thru C-14)*** $	15,181,547	15,181,547		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
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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 $	136,753	136,753		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	276,203	276,203		
10.			Accounting $				
10a.			Legal $				
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	115	115		
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 * $	58,979	58,979		
19.			Income Tax / Corporate Business Tax $				
20.	16	m10	Fund Raising / Contributions $	10,000	10,000		
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $				
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) $	482,050	482,050		

* 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)
Total Other A&G Adjustments			$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Autumn Lake Heathcare At Cromwell	2401	9/30/2020	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	482,050	482,050		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	179,306	179,306		
28.	20	5d	Ambulance/Limousine $	57,037	57,037		
29.	20	5f	X-rays, etc $	13,289	13,289		
30.	20	5h	Laboratory $	1,172	1,172		
31.	20	5c	Medical Supplies $	7,599	7,599		
32.	20	5e2	Oxygen (non emergency) $	5,650	5,650		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	30,108	30,108		
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 $				
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)***			$	776,211	776,211		

*** 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

Autumn Lake Heathcare At Cromwell
9/30/2020

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV	$ 30,017		
20	5j	Resident PD Claims	$ 91		
Total Other Ancillary Costs			$ 30,108	$ -	$ -

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 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
Autumn Lake Heathcare At Cromwell	2401	9/30/2020	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$				
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	12,232,485	12,232,485		
b. Medicare Room and Board Contractual Allowance **	$	(25,348)	(25,348)		
4. a. Private-Pay Residents and Other	$	966,431	966,431		
b. Private-Pay Room and Board Contractual Allowance **	$	42,516	42,516		
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	$	425,106	425,106		
b. Physical Therapy - Medicare Contractual Allowance **	$	(347,545)	(347,545)		
c. Physical Therapy - Non-Medicare	$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	335,385	335,385		
b. Speech Therapy - Medicare Contractual Allowance **	$	(262,477)	(262,477)		
c. Speech Therapy - Non-Medicare	$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	382,173	382,173		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(332,789)	(332,789)		
c. Occupational Therapy - Non-Medicare	$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	43,513	43,513		
b. Other *(Specify)* - Non-Medicare	$	2,848,720	2,848,720		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	16,308,170	16,308,170		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	752	752		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	32,058	32,058		
V. Total Other Revenue (1 thru 8)	$	32,809	32,809		
VI. Total All Revenue (III +V)	$	16,340,979	16,340,979		

* *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)
30/IIa	Fluenza Billing	$ 4,524		
30/IIa	Pneumonia billing	$ 2,826		
30/IIa	Other Rev Mcre B -glucose	$ 19,539		
30/IIa	Other Rev Mcre B-flu Shot	$ 8,546		
30/IIa	Other Rev Mcre B-Pneumoni	$ 8,078		
Total Other Resident Revenue - Medicare		$ 43,513	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30/IIb	Grant Income	$ 983,985		
30/IIb	CT Grant	$ 360,255		
30/IIb	PPP LOAN	$ 1,245,200		
30/IIb	Optum (part B Capitated)	$ 259,280		
Total Other Resident Revenue		$ 2,848,720	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/IV5	Interest income		$ 752		
Total Interest Income			$ 752	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30/IV8	Other revenue misc.	$ 32,058		
Total Other Revenue		$ 32,058	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare At Cromwell	2401	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 3,023,800
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,169,095
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 75,373
a.				
b.				
c.				
d. See Schedule	75,373			
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 337,391
See Schedule	337,391			
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 4,605,659
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	2,008,849		$ 1,409,751
	Accum. Depreciation	599,098	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 (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,409,751

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
		Prepaid Insurance	$ 36,283
		Prepaid Interest	$ 6,524
		Prepaid Expenses	$ 32,566
Total Prepaid Expenses			$ 75,373

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

Page Ref	Line Ref	Description	
		Due to/From Previous Owner	$ 337,391
Total Other Current Assets (Itemize)			$ 337,391

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
		Capital Leases Payable	$ 40,143
		Medicare Advance Loans	$ 410,555
Total Notes Payable			$ 450,698

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

Page Ref	Line Ref	Description	
		Due to Medicare	$ 5,090
		Due to Medicaid	$ 90,111
Total Other Current Liabilities (Itemize)			$ 95,201

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare At Cromwell	2401	9/30/2020	32	37

Account				Amount
		Total Brought Forward:	$	6,015,409
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	1,949,305 Net	$	8,220,981
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation	Net	$	
5. Movable Equipment	*Historical Cost	991,022		
	Accum. Depreciation	908,666 Net	$	82,356
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation	Net	$	
7. Minor Equipment-Not Depreciable			$	
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)			$	9,423,995
D. Investment and Other Assets				
1. Deferred Deposits			$	43,080
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*)			$	
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$	43,080
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	15,482,484

* 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
Autumn Lake Heathcare At Cromwell	2401	9/30/2020	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 9,108,155
	2. Notes Payable (*itemize*)				$ 450,698
	See Schedule			450,698	
	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*)				$
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 6,525
	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*)				$ 95,201
	See Schedule			95,201	
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 9,660,580

* 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
Autumn Lake Heathcare At Cromwell	2401	9/30/2020	34	37

Account	Amount
Total Brought Forward:	9,660,580
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*)	$ 4,311,025

Name and Address of Lender	Amount	Loan Date
Stern/Autumn Lake/Landlord	4,311,025	Various

4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 4,311,025
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 13,971,605

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

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare At Cromwell	2401	9/30/2020	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	$ 9,795,595
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$ 9,795,595
B.	**Net Worth**	
	1. Owner's Capital	$ (275,000)
	2. Capital Stock	$ (9,169,149)
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$
	6. Gain or Loss for Period 10/1/2019 thru 9/30/2020	$ 1,159,433
	7. Total Net Worth	$ (8,284,716)
C.	***Total Reserves and Net Worth***	$ 1,510,879
D.	***Total Liabilities, Reserves, and Net Worth***	$ 15,482,484

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare At Cromwell	2401	9/30/2020	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2019			$ (14,221,092)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 16,340,979
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 15,181,547
D.	Net Income or Deficit			$ 1,159,433
E.	Balance			$ (13,061,659)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
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*** 09/30/20			$ (13,061,659)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare At Cromwell	2401	9/30/2020	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. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer

CJLC LLC

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225 Pitkin St., East Hartford, CT 06108	860/610-9009

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