State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2023

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 (CCNH) & RHNS Combined ☐ (Specify) ☐ (Specify)	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

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

Medicaid Provider Numbers:	CCNH / RHNS 1427462967	(Specify)	(Specify)

Table of Contents

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Autumn Lake Heathcare at Cromwell [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, 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)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1A Rev. 3/2023

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 10/1/2022	To 9/30/2023
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)	(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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 3/2023

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-635-5613	9/30/2023	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)	(Specify)	Medicare Provider No.
	2401			07-5263

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined ☐ (Specify) ☐ (Specify)

Type of Ownership (Check appropriate box)

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

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

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

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.:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	3	37

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	3A	37

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	4	37

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	217,000	217,000
Ultimate Therapy LLC	4260 Rte 9, Howell, NJ 07731	◉	○		Therapy Company (ST, PT, OT)	13/5a, 9a, 10a	618,000	618,000
Cromwell Realty	4260 Rte 9, Howell, NJ 07731	○	◉		Lease of Building	22/9	463,775	463,775
		○	◉					
		○	◉					
		○	◉					
		○	◉					
		○	◉					
		○	◉					

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	5	37

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 3/2023

General Information and Questionnaire
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	6	37

Square footage of entire facility.	0

Outpatient Therapy

Does the Facility provide outpatient therapy services?	No

If yes, please complete the following:

	Square footage of therapy space.

Meals on Wheels

Does the facility provide Meals on Wheels?	No

If yes, please complete the following:

	Square footage of kitchen	
	Number of meals served per week	
No	Are meals included in meals served on page 18 of the Annual Report?	
No	Are direct costs included in the Annual Report?	
	If yes, please state where costs are reported.	
No	Are drivers for the program included in the facility's payroll?	
	If yes, please complete the following:	
		Amount Reported
		Annual Report page and line
	Please state the salary amounts of specific cooks and/or dietary aides	
	Please state where the cooks and/or dietary aides are reported in the Annual Report	

Apartments, Independent Living, Assisted Living

Does the facility have apartments, independent living, and/or assisted living?	No

If yes, please complete the following:

	Square footage of apartments
	Square footage of independent living
	Square footage of assisted living
	Please identify the services provided:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 3/2023

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathca	2401	9/30/2023	7	37

Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care?	No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 3/2023

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	8	37

	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total (Specify)	Period 10/1 Thru 6/30 Total	Period 10/1 Thru 6/30 CCNH / RHNS	Period 10/1 Thru 6/30 (Specify)	Period 10/1 Thru 6/30 (Specify)	Period 7/1 Thru 9/30 Total	Period 7/1 Thru 9/30 CCNH / RHNS	Period 7/1 Thru 9/30 (Specify)	Period 7/1 Thru 9/30 (Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	175	175			175	175						
B. On last day of THIS report period	175	175							175	175		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	158	158			158	158						
B. As of midnight of THIS report period	151	151							151	151		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,525	4,525			3,763	3,763			762	762		
B. Medicaid (Conn.)	42,373	42,373			31,843	31,843			10,530	10,530		
C. Medicaid (other states)												
D. Private Pay	5,222	5,222			3,641	3,641			1,581	1,581		
E. State SSI for RCH												
F. Other (Specify) HMO, Private Pay, Hospice	5,336	5,336			3,934	3,934			1,402	1,402		
G. Total Care Days During Period (3A thru F)	57,456	57,456			43,181	43,181			14,275	14,275		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	38	38			38	38						
B. Other Bed Reserve Days	4	4			4	4						
5. ***Total Resident Days*** **(3G + 4A + 4B)**	57,498	57,498			43,223	43,223			14,275	14,275		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-9 Rev. 3/2023

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH / RHNS	(Specify)	(Specify)	Lost			Gained			CCNH / RHNS	(Specify)	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

Change in Resident Days	CCNH / RHNS	(Specify)	(Specify)
1st change			
2nd change			
3rd change			
4th change			

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	11	114		26				
Per Diem Rate								
a. One bed rm.	752.27	278.95		389.81				
b. Two bed rms.								
c. Three or more bed rms.								

	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
7. Total Number of Physical Therapy Treatments					
A. Medicare - Part B	3,959	3,959			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	148	148			
2. Restorative Treatments					
C. Other	1,335	1,335			
D. ***Total Physical Therapy Treatments***	5,442	5,442			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	1,246	1,246			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	26	26			
2. Restorative Treatments					
C. Other	233	233			
D. ***Total Speech Therapy Treatments***	1,505	1,505			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	1,958	1,958			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	81	81			
2. Restorative Treatments					
C. Other	725	725			
D. ***Total Occupational Therapy Treatments***	2,764	2,764			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
A. Salaries and Wages*									
1. Operators/Owners (Complete also Sec. I of Schedule A1)	207,462		117						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	188,463		2,080						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	355,948		7,343						
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor									
c. Dietary Workers	557,004		26,566						
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers									
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance									
b. Other Maintenance Workers	128,635		5,207						
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	116,985		4,999						
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	194,112		6,066						
n. Marketing									
o. Other (Specify)									
See Attached Schedule	26,634		1,557						
A-13. Total Salary Expenditures	1,775,243		53,935						

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH / RHNS			(Specify)			(Specify)		
Position	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**	**$**	**Adjustment**	**Hours**
Salaries Medical Records	$ 26,634		1,557						
Total	$ 26,634	$ -	1,557	$ -	$ -	-	$ -	$ -	-

Schedule of Other Fees (Page 13)

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-11 Rev. 10/2005

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 Heathcare at Cromwell	2401	9/30/2023	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)	(Specify)							
Section I - Operators/Owners										
Aryeh Stern	207,462				Oversees buildings, high level executive decisions, etc.	117	A1	Owns multiple buildings in NJ, MD and CT.		
								Portion of 2022 were dedicated to overseeing CT buildings.		
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

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 Heathcare at Cromwell	2401	9/30/2023	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)	(Specify)							
Section III - Administrators* **										
Chaim Scher	188,463				Administrator	2,080	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 3/2023

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	13	37

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)									
1. Dietitian	139,383		1,186						
2. Dentist	11,277		140						
3. Pharmacist	29,288		208						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	359,692		5,995						
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	36,000		260						
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	62,819		1,047						
b. Other									
10. Occupational Therapist									
a. Resident Care	195,490	(195,490)	3,258						
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	915,927		10,430						
2. Administrative***	601,699		11,987						
b. LPN									
1. Direct Care	3,343,764		61,443						
2. Administrative***									
c. Aides	3,897,780		119,153						
d. Other									
12. Other (Specify) See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	9,593,118	(195,490)	215,107						

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	14	37

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 St., Brooklyn, NY 11232	Nurse Services	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 3/2023

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended					Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023					15	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	22,961	22,961					
2. Disability Insurance	$							
3. Unemployment Insurance	$	15,128	15,128					
4. Social Security (F.I.C.A.)	$	114,837	114,837					
5. Health Insurance	$	93,073	93,073					
6. Life Insurance (employees only)								
(not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory)	$	48,058	48,058					
(not-owners and not-operators)								
8. Uniform Allowance	$	1,709	1,709					
9. Other (*Specify*)	$	5,410	5,410					
See Attached Schedule								
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$	441,370	441,370	(441,370)				
d. Accounting and Auditing	$	68,623	68,623					
e. Legal (*Services should be fully described on Page 15b)*	$	27,777	27,777					
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	72,283	72,283					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	24,794	24,794					
2. Cellular Phones	$	1,401	1,401					
i. Appraisal (*Specify purpose and attach copy*)*	$							
j. Corporation Business Taxes (*franchise tax*)	$	210,000	210,000	(209,750)				
k. Other Taxes (*Not related to property - See Page 22)*								
1. Income*	$							
2. Other (*Specify*)	$							
See Attached Schedule								
3. Resident Day User Fee	$	1,069,335	1,069,335					
Subtotal	$	2,216,759	2,216,759	(651,120)				

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Union Training & Upgrade	$ 5,410					
Total	$ 5,410	$ -	$ -	$ -	$ -	$ -

Schedule of Other Taxes

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15b Rev. 3/2023

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwe	2401	9/30/2023	15b	37

The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 CJLC LLC	225 Pitkin St., East Hartford, CT 06108
2 Brand Sonnenchine	299 Broadway #600, New York, NY 10007
3	
4	

Services Provided by This Firm (*describe fully*)

1	Medicaid Cost Report	$ 15,691
2	Fianancial Statement Preperation & Regular Account Work	$ 52,932
3		$
4		$
		Charge for Services Provided $ 68,623

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

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Goldman, Gruder & Woods LLC	203-899-8900
2 Arbella Mutual	
3 Carlton Fields PA	813-223-700
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 200 Connecticut Ave., Norwalk, CT 06854
2
3 PO Box 3239, Tampa, Florida 33601-3230
4
5

Services Provided by This Firm (*describe fully*)

1	Medicaid Eligibility	$ 24,704
2	Claim against facility	$ 1,421
3	Defense for EPLI Case	$ 1,652
4		$
5		$
		Charge for Services Provided $ 27,777

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-16 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	16	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:		2,216,759	2,216,759	(651,120)				
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$	9,400	9,400					
3. Gifts to Staff and Residents	$	10,710	10,710					
4. Employee Travel	$	65,088	65,088					
5. Education Expenses Related to Seminars and Conventions	$	26,885	26,885					
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*)	$	1,287	1,287					
2. Advertising Telephone Directory (*all such expenses*)***	$							
3. Advertising Other (*Specify*)*** See Attached Schedule	$	48,405	48,405	(48,405)				
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*** See Attached Schedule	$	7,125	7,125	(7,125)				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$							
12. Administrative Management Services**	$	217,000	217,000					
13. Other (*Specify*) See Attached Schedule	$	454,122	454,122	(4,833)				
C-14 Total Administrative & General Expenditures	$	3,056,781	3,056,781	(711,483)				

* Do not include Subscriptions, which should go in item 9.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
*** Facility should self-disallow the expensein the Adjustment column.

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Office Marketing	$ 20,503	$ (20,503)				
Advertising	$ 27,902	$ (27,902)				
Total Other Advertising	$ 48,405	$ (48,405)	$ -	$ -	$ -	$ -

Schedule of Dues

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

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Contributions	$ 7,125	$ (7,125)				
Total Contributions	$ 7,125	$ (7,125)	$ -	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Employee Paid Claims	$ 4,785	$ (4,785)				
Fiscal Services	$ 287,829					
INTERNET	$ 10,904					
Licenses	$ 3,908					
Employee Background Check	$ 3,402					
Data Processing	$ 35,006					
Consultants	$ 95,533					
Bank Charges	$ 12,707					
Penalties	$ 48	$ (48)				
Total Other Administrative and General	$ 454,122	$ (4,833)	$ -	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	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	217,000	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.**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 3/2023

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	9/30/2023	18	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	366,741	366,741					
2. Non-Food Supplies	$	49,470	49,470					
3. Other (*Specify*)_____	$							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	71,797	71,797					
c. Other (*Specify*)_____	$							
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	488,008	488,008					

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 3/2023

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	9/30/2023	19	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
3. Laundry								
a. In-House Processing*	Lbs.							
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $							
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.							
	Amt. $							
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.							
	Amt. $							
4. Repair and/or purchase of linens.***	Lbs.							
	Amt. $							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	296,925	296,925					
c. Other (*Specify*) Laundry Supplies	$	1,247	1,247					
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	298,172	298,172					

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 3/2023

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	9/30/2023	20	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4. Housekeeping	Sq. Ft. Serviced by Personnel							
a. In-House Care								
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt. $							
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel							
	Amt. $	411,521	411,521					
C. Other (*Specify*) Housekeeping Supplies	$	31,931	31,931					
4D. ***Total Housekeeping Expenditures*** (4a + b + c)	$	443,452	443,452					
5. Resident Care (Supplies)**								
a. Prescription Drugs***								
1. Own Pharmacy	$							
2. Purchased from	$	152,251	152,251	(152,251)				
b. Medicine Cabinet Drugs	$	9,926	9,926					
c. Medical and Therapeutic Supplies	$	164,916	164,916	(32,891)				
d. Ambulance/Limousine***	$	123,769	123,769	(123,769)				
e. Oxygen								
1. For Emergency Use	$							
2. Other***	$	(1,254)	(1,254)	1,254				
f. X-rays and Related Radiological Procedures***	$	8,379	8,379	(8,379)				
g. Dental (*Not dentists who should be included under salaries or fees)*	$							
h. Laboratory***	$	28,945	28,945	(28,945)				
i. Recreation	$	14,405	14,405					
j. Direct Management Services*	$							
k. Indirect Management Services*	$							
l. Cable TV	$	24,169	24,169					
m. Other (Specify)**** See Attached Schedule	$	249,832	249,832	(55,481)				
n. Physical Therapy Expense	$	249	249					
o. Speech Therapy Expense	$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)	$	775,587	775,587	(400,462)				

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

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

*** Facility should self-disallow the expense in the Adjustment column.

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

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Diapers	$ 68,100					
Resident PD Claims (cb)	$ 934	$ (934)				
Medical Waste	$ 936					
Mattresses	$ 18,176					
M'caid - I/v	$ 31,184	$ (31,184)				
IV Supplies	$ 23,363	$ (23,363)				
Picc/midline Insertion	$ 24,370					
Medical Equipment (Minor)	$ 49,001					
PPE Expense (covid)	$ 33,768					
Total Other Resident Care	$ 249,832	$ (55,481)	$ -	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	(Specify)	Pg	Line
Ed's Lawn Care LLC	124 Shunpike Rd., Cromwell, CT 06416	○	⊙		Landscaping	27,790			22	6a
Waste Wanted Solutions	178 Rt 59, Ste 303, Monsey, NY 10952	○	⊙		Garbage	40,315			22	6a
Healthcare Services	3220 Tillman Dr. #300, Bensalem, PA 19020	○	⊙		Dietary Services	77,780			18	2b
Effectv		○	⊙		Advertising	25,608			16	m3
Healthcare Services	3220 Tillman Dr. #300, Bensalem, PA 19020	○	⊙		Laundry Services	296,924			19	3b
Future Care Consultants	14 53rd St., Suite 220, Brooklyn, NY 11232	○	⊙		Billing and A/P and Payroll Services	240,000			16	m13
Accurate Staffing	14 53rd St. Ste 220, Brooklyn, NY 11232	○	⊙		Outsourced Nursing Staff/Employees	8,759,170			13	
Network Dr		○	⊙		Contract (provide computers, software etc)	46,775			16	m13
Griffin Health	New Haven County, CT 06418	○	⊙		Labs	28,449			20	5h
Point Click Care	PO Box 674802, Detroit, MI 48267	○	⊙		Data Processing	18,574			16	m13
Hospitality Consulting	Blvd, Jersey City, NJ 07304	○	⊙		Purchasing for Food and Dietary Supplies	63,875			18	
Western Environmental Solutions, LLC	Blvd, Jersey City, NJ 07304	○	⊙		Maintenance Consulting and purchasing services	34,586			22	6a
Healthcare Services	3220 Tillman Dr. #300, Bensalem, PA 19020	○	⊙		Housekeeping Services	411,521			20	4b
		○	⊙							

* 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).

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended					Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023					22	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	219,090	219,090					
b. Heat	$	104,155	104,155					
c. Light & Power	$	139,989	139,989					
d. Water	$	91,661	91,661					
e. Equipment Lease (*Provide detail on page 22b*)	$							
f. Other (*itemize*)	$							
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	554,895	554,895					
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$							
b. Building & Building Improvements	$	339,010	339,010					
c. Non-Movable Equipment	$							
d. Movable Equipment	$	96,594	96,594					
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	435,604	435,604					
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$							
c. Leasehold Improvements	$	221,814	221,814					
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	221,814	221,814					
9. Rental payments on leased real property less real estate taxes included in item 10b	$	463,775	463,775					
10. Property Taxes								
a. Real estate taxes paid by owner	$	220,225	220,225					
b. Real estate taxes paid by lessor	$							
c. Personal property taxes	$							
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,341,418	1,341,418					

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

Schedule of Other Repairs and Maintenance

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Total Other Repairs and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22b Rev. 3/2023

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 Heathcare at Cromwell	2401	9/30/2023	22b	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	○	⊙					
	⊙	○					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2022

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
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	2,627,326	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	1,305,314		1,305,314	1,045,638	SL	5	73,720	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative					114,372						22,874	
d. Standard Resident												
e. Specialized Resident												
Total Acquired during this report period					114,372						22,874	
D-3. Subtotal												96,594
E. ***Total Depreciation***												435,604

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 perioc

Acquisition Date	Description of Item	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
	See attachment	Administrative	$ 114,372	5	$ 22,874	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			$ 114,372		$ 22,874	*
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:					
	See attachment	$ 896,425	15	$ 59,762	
Total additions for Leasehold Improvement		$ 896,425		$ 59,762	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	Var	Var		2,420,424	924,030			162,052	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				896,425				59,762	
C-4. Subtotal									221,814
D. ***Total Amortization***									221,814

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total
1. Date Land Purchased	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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	26	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage $							
Name of Lender / Rate							
Address of Lender							
2. Second Mortgage $							
Name of Lender / Rate							
Address of Lender							
3. Third Mortgage $							
Name of Lender / Rate							
Address of Lender							
4. Fourth Mortgage $							
Name of Lender / Rate							
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount $							
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $							

(*Carry Subtotals forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 3/2023

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

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromw	2401	9/30/2023	27	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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*) $	5,084	5,084					
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	5,084	5,084					
14. Insurance							
a. Insurance on Property (buildings only) $	251,577	251,577					
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)*** $	251,577	251,577					
15. ***Total All Expenditures (A-13 thru C-14)*** $	18,583,335	18,583,335	(1,307,435)				

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev. 3/2023

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	30	37

Item		Total	CCNH / RHNS	(Specify)	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	11,859,370	11,859,370		
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)*	$	5,421,806	5,421,806		
b. Medicare Room and Board Contractual Allowance **	$	(39,139)	(39,139)		
4. a. Private-Pay Residents and Other	$	2,071,414	2,071,414		
b. Private-Pay Room and Board Contractual Allowance **	$				
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	$	528,200	528,200		
b. Physical Therapy - Medicare Contractual Allowance **	$	(407,680)	(407,680)		
c. Physical Therapy - Non-Medicare	$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	214,656	214,656		
b. Speech Therapy - Medicare Contractual Allowance **	$	(113,137)	(113,137)		
c. Speech Therapy - Non-Medicare	$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	399,011	399,011		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(338,147)	(338,147)		
c. Occupational Therapy - Non-Medicare	$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	42,534	42,534		
b. Other *(Specify)* - Non-Medicare	$	359,368	359,368		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	19,998,256	19,998,256		
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)*	$	136	136		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$				
V. Total Other Revenue (1 thru 8)	$	136	136		
VI. Total All Revenue (III +V)	$	19,998,392	19,998,392		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	Fluenza Billing	$ 22,836		
	Pneumonia billing	$ 6,653		
	Other Rev Mcre A -med Sup	$ 12,986		
	Contra Mcre A - Med Sup	$ (12,986)		
	Other Rev Mcre A - Glucos	$ 487		
	Contra Rev Mcre A - Gluco	$ (487)		
	Other Rev Mcre B -glucose	$ 17,369		
	Other Rev Mcre B-Pneumoni	$ (2,453)		
	Contra - Mcre B - Glucose	$ (1,871)		
	Other Rev Mcr B - pneumo	$ 200		
	Contra - Mcre B - Pneumon	$ (200)		
Total Other Resident Revenue - Medicare		$ 42,534	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	Optum (part B Capitated)	$ 356,569		
	Other Rev Mcre B-flu Shot	$ 2,453		
	Other Rev Mcre B -TL	$ 446		
	Contra Rev Mcre B -TL	$ (100)		
	Other Rev Mcr B - Covid	$ 3,791		
	Contra - Mcre B - Covid A	$ (3,791)		
Total Other Resident Revenue		$ 359,368	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH / RHNS	(Specify)	(Specify)
	Interest Income		$ 136		
Total Interest Income			$ 136	$ -	$ -

Schedule of Other Revenue

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 307,375
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 674,449
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 98,425
a.				
b.				
c.				
d. See Schedule		98,425		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (77,844)
See Schedule		(77,844)		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,002,405
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	3,316,849		$ 2,171,006
	Accum. Depreciation	1,145,843	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)				$ 2,171,006

* 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	$ 69,797
		Prepaid Interest	$ 811
		Prepaid Expenses	$ 27,817
Total Prepaid Expenses			$ 98,425

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

Page Ref	Line Ref	Description	
		Diversion	$ (77,844)
Total Other Current Assets (Itemize)			$ (77,844)

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 Lease Payable	$ 13,189
		Insurance adj	$ 117,472
Total Notes Payable			$ 130,661

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

Page Ref	Line Ref	Description	
		Due to Medicare	$ 5,422
		Due to/from previous owne	$ (337,549)
Total Other Current Liabilities (Itemize)			$ (332,127)

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	32	37

Account				Amount
		Total Brought Forward:	$	3,173,411
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	2,966,333 Net	$	7,203,952
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation	Net	$	
5. Movable Equipment	*Historical Cost	1,419,686		
	Accum. Depreciation	1,142,233 Net	$	277,453
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation	Net	$	
7. Minor Equipment-Not Depreciable			$	
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)			$	8,602,064
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)			$	11,818,555

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 4,948,188
	2. Notes Payable (*itemize*)				$ 130,661
	See Schedule			130,661	
	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				$ 12,904
	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*)				$ (332,127)
	See Schedule			(332,127)	
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 4,759,626

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	34	37

Account	Amount
Total Brought Forward:	4,759,626
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*)	$ 3,887,189

Name and Address of Lender	Amount	Loan Date
Stern/Autumn Lake/Landlord	3,887,189	Various

4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 3,887,189
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 8,646,815

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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	9/30/2023	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	$ 8,576,660
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$ 8,576,660
B.	**Net Worth**	
	1. Owner's Capital	$ (1,564,457)
	2. Capital Stock	$ (5,255,520)
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$
	6. Gain or Loss for Period 10/1/2022 thru 9/30/2023	$ 1,415,057
	7. Total Net Worth	$ (5,404,920)
C.	***Total Reserves and Net Worth***	$ 3,171,740
D.	***Total Liabilities, Reserves, and Net Worth***	$ 11,818,555

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at Cromwell	2401	9/30/2023	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2022			$ (10,018,384)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 19,998,392
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 18,583,335
D.	Net Income or Deficit			$ 1,415,057
E.	Balance			$ (8,603,327)
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***	09/30/23		$ (8,603,327)