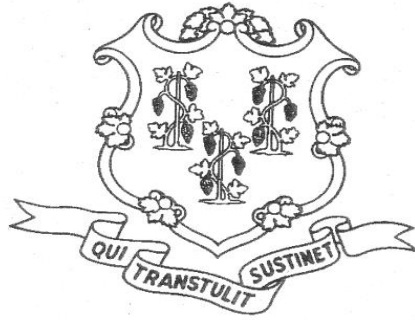


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2024

Name of Facility (as licensed) Autumn Lake Heathcare at New Britain	
Address (No. & Street, City, State, Zip Code) 400 Brittany Farms Rd. New Britain, CT 06053	
Type of Facility Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2023	Report for Year Ending 9/30/2024

License Numbers:	CCNH / RHNS 2402	(Specify)	(Specify)	Medicare Provider 07-5292
------------------	---------------------	-----------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH / RHNS 000010520	(Specify)	(Specify)
----------------------------	--------------------------	-----------	-----------

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at New Britain	2402	9/30/2024	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 IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Autumn Lake Heathcare at New Britain [facility name], for the cost report period beginning October 1, 2023 and ending September 30, 2024, 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) Joshua Schechter			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)

Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Other Lines of Business	6
General Information and Questionnaire - Other Lines of Business (Continued)	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

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 New Britain	Period Covered:	From 10/1/2023	To 9/30/2024	
Address of Facility 400 Brittany Farms Rd. New Britain, CT 06053				
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.

General Information and Questionnaire

Type of Facility - Organization Structure

		Phone No. of Facility 860-224-3111	Report for Year Ended 9/30/2024	Page 2	of 37
Name of Facility (as shown on license) Autumn Lake Heathcare at New Britain		Address (No. & Street, City, State, Zip) 400 Brittany Farms Rd. New Britain, CT 06053			
License Numbers:	CCNH / RHNS 2402	(Specify)	(Specify)	Medicare Provider No. 07-5292	
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <div style="display: inline-block; width: 30%; text-align: center;"> <input type="checkbox"/> (Specify) </div> <div style="display: inline-block; width: 30%; text-align: center;"> <input type="checkbox"/> (Specify) </div>					
Type of Ownership (Check appropriate box) <input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <div style="display: inline-block; width: 30%; text-align: center;"> <input type="radio"/> Yes </div> <div style="display: inline-block; width: 30%; text-align: center;"> <input checked="" type="radio"/> No </div> <div style="display: inline-block; width: 40%;"> If "Yes," explain fully. </div>					
Administrator					
Name of Administrator Joshua Schechter			Nursing Home Administrator's License No.:		
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name			License No.:		

Owner(s) of Facility

General Information and Questionnaire Related Parties*

Name of Facility Autumn Lake Heathcare at New Britain	License No. 2402	Report for Year Ended 9/30/2024	Page 4	of 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	<input type="radio"/>	<input checked="" type="radio"/>		Management Company	16/m12	531,153	531,153
Ultimate Therapy LLC	4260 Rte 9, Howell, NJ 07731	<input checked="" type="radio"/>	<input type="radio"/>		Therapy Company (ST, PT, OT)	13/5a, 9a, 10a	1,409,253	1,409,253
New Britain Realty	4260 Rte 9, Howell, NJ 07731	<input type="radio"/>	<input checked="" type="radio"/>		Lease of Building	22/9, 22/10a	2,025,434	2,025,434
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Autumn Lake Heathcare at New Britain	License No. 2402	Report for Year Ended 9/30/2024	Page 5	of 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 (<i>See listing page 13</i>)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

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

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

☒ Yes ☐ No If "No," explain fully why such allocation was not made.

General Information and Questionnaire

Other Lines of Business

Name of Facility Autumn Lake Healthcare at New Brita	License No. 2402	Report for Year Ended 9/30/2024	Page 6	of 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?
	<i>If yes, please state where costs are reported.</i>
No	Are drivers for the program included in the facility's payroll?
	<i>If yes, please complete the following:</i>
	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:

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcote	2402	9/30/2024	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:

Schedule of Resident Statistics

Name of Facility Autumn Lake Heathcare at New Britain			License No. 2402			Report for Year Ended 9/30/2024			Page 8	of 37		
	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	282	282			282	282						
B. On last day of THIS report period	282	282							282	282		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	242	242			242	242						
B. As of midnight of THIS report period	256	256							256	256		
3. Total Number of Days Care Provided During Period												
A. Medicare	7,104	5,391	1,713		5,391	5,391			1,713		1,713	
B. Medicaid (Conn.)	60,758	46,235	14,523		46,235	46,235			14,523		14,523	
C. Medicaid (other states)												
D. Private Pay	5,572	4,228	1,344		4,228	4,228			1,344		1,344	
E. State SSI for RCH												
F. Other (Specify) HMO, Private Pay, Hospice	17,848	12,489	5,359		12,489	12,489			5,359		5,359	
G. Total Care Days During Period (3A thru F)	91,282	68,343	22,939		68,343	68,343			22,939		22,939	
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	1		1						1		1	
5. Total Resident Days (3G + 4A + 4B)	91,283	68,343	22,940		68,343	68,343			22,940		22,940	

Schedule of Resident Statistics (Cont'd)

Name of Facility Autumn Lake Heathcare at New Britain				License No. 2402				Report for Year Ended 9/30/2024				Page 9		of 37	
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:															
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change		
	CCNH / RHNS	(Specify)	(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	18	155		83				
Per Diem Rate								
a. One bed rm.	774.60	#####		419.64				
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments				TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B				4,225	4,225			
B. Medicaid (Exclusive of Part B)								
1. Maintenance Treatments				490	490			
2. Restorative Treatments				4,413	4,413			
C. Other								
D. Total Physical Therapy Treatments				9,128	9,128			

8. Total Number of Speech Therapy Treatments								
A. Medicare - Part B				1,067	1,067			
B. Medicaid (Exclusive of Part B)								
1. Maintenance Treatments				96	96			
2. Restorative Treatments				867	867			
C. Other								
D. Total Speech Therapy Treatments				2,030	2,030			

9. Total Number of Occupational Therapy Treatments								
A. Medicare - Part B				7,825	7,825			
B. Medicaid (Exclusive of Part B)								
1. Maintenance Treatments				737	737			
2. Restorative Treatments				6,631	6,631			
C. Other								
D. Total Occupational Therapy Treatments				15,193	15,193			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility Autumn Lake Healthcare at New Britain	License No. 2402	Report for Year Ended 9/30/2024	Page 10	of 37					
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No									
	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
A. Salaries and Wages*									
1. Operators/Owners (Complete also Sec. I of Schedule A1)	234,423		78						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	229,456		2,080						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	1,160,417		30,982						
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor									
c. Dietary Workers	1,103,725		54,114						
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers									
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance									
b. Other Maintenance Workers	217,525		9,714						
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	254,062		11,352						
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	199,978		7,361						
n. Marketing									
o. Other (Specify)									
See Attached Schedule	47,728		2,203						
A-13. Total Salary Expenditures	3,447,313		117,884						

* 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.

Position	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
Medical Records	\$ 47,728		2,203						
Total	\$ 47,728	\$ -	2,203	\$ -	\$ -	-	\$ -	\$ -	-

[illegible]

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 New Britain				2402		9/30/2024			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	234,423				Oversees buildings, high level executive decisions, etc.	78	A1	Owens 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.

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 New Britain				2402		9/30/2024			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***										
Joshua Schechter	229,456				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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.			Report for Year Ended				Page	of
Autumn Lake Heathcare at New Britain	2402			9/30/2024				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	221,572		2,375						
2. Dentist	20,913		258						
3. Pharmacist	51,293		314						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	522,107		7,911						
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	84,000		530						
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) Cardiology	43,000		483						
9. Speech Therapist									
a. Resident Care	102,547		1,578						
b. Other									
10. Occupational Therapist									
a. Resident Care	784,598	(784,598)	12,071						
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	1,434,500		15,230						
2. Administrative***	1,700,900		29,740						
b. LPN									
1. Direct Care	4,932,800		92,269						
2. Administrative***									
c. Aides	7,313,800		228,500						
d. Other									
12. Other (Specify) See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	17,212,031	(784,598)	391,258						

* 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.

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

Name of Facility Autumn Lake Healthcare at New Britain		License No. 2402		Report for Year Ended 9/30/2024	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
HealthDrive Dental	Dentist	<input type="radio"/>	<input checked="" type="radio"/>			
Prescription	Pharmacy Consultant	<input type="radio"/>	<input checked="" type="radio"/>			
Procare LTC Pharmacy, 1492 Highland Ave., Cheshire, CT 06410	Pharmacy Consultant	<input type="radio"/>	<input checked="" type="radio"/>			
Ultimate Therapy, 4201 Rte 9, Howell, NJ 07731	Physical Therapist, Occupational Therapist, Speech Therapist	<input checked="" type="radio"/>	<input type="radio"/>			
Accurate Staffing, Inc. (ASI), 14C 53rd St., Brooklyn, NY 11232	Nurse Services	<input type="radio"/>	<input checked="" type="radio"/>			
Jeffrey Kagan, MD, 365 Willard Ave. Ste 2D, Newington, CT 06111	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Lexington Cardiology Associates, 1 Liberty Square, New Britain, CT 06050	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
ProHealth Physicians of Farmington, 21 South Rd., Farmington, CT 06032	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Real Life Medical	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Starling Physicians	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended					Page	of
Autumn Lake Heathcare at New Britain	2402	9/30/2024					15	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 49,142	49,142						
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 25,402	25,402						
4. Social Security (F.I.C.A.)	\$ 233,591	233,591						
5. Health Insurance	\$ 261,208	261,208						
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 1,041	1,041						
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 112,451	112,451						
8. Uniform Allowance	\$ 2,138	2,138						
9. Other (<i>Specify</i>) See Attached Schedule	\$ 62,916	62,916						
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$							
c. Bad Debts*	\$ 0	1,057,288	(1,057,288)					
d. Accounting and Auditing	\$ 73,848	73,848						
e. Legal (<i>Services should be fully described on Page 15b</i>)	\$ 32,394	32,394						
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$							
g. Office Supplies	\$ 126,208	126,208						
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$ 23,130	23,130						
2. Cellular Phones	\$ 3,800	6,900	(3,100)					
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$							
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 250	200,000	(199,750)					
k. Other Taxes (<i>Not related to property - See Page 22</i>)								
1. Income*	\$							
2. Other (<i>Specify</i>) See Attached Schedule	\$							
3. Resident Day User Fee	\$ 1,185,490	1,185,490						
Subtotal	\$ 2,193,008	3,453,146	(1,260,138)					

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

(Carry Subtotals forward to next page)

General Information and Questionnaire

Accounting Basis

Name of Facility Autumn Lake Healthcare at New Br	License No. 2402	Report for Year Ended 9/30/2024	Page 15b	of 37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes If "No," explain. <input type="radio"/> No				
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 (<i>describe fully</i>)				
1 Medicaid Cost Report and Accounting Services		\$ 19,252		
2 Financial Statement Preparation & Regular Account Work		\$ 54,596		
3		\$		
4		\$		
			Charge for Services Provided	
			\$ 73,848	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No 15/1d				
Legal Services Information				
Name of Legal Firm or Independent Attorney			Telephone Number	
1 Fisher & Phillips			404-231-1400	
2 Davidson Law Group			516-543-0627	
3 Freeman Mathis			770-818-000	
4 Goldman, Gruder & Woods			203-899-8900	
5				
Address (<i>No. & Street, City, State, Zip Code</i>)				
1 PO Box 117253, Atlanta, GA 30368				
2 15 Glen Street, Ste 302A, Glen Cove, New York 11542				
3 100 Galleria Parkway, Ste 1600, Atlanta, GA 30339				
4 200 CT Ave, Norwalk, CT 06854				
5				
Services Provided by This Firm (<i>describe fully</i>)				
1 EPLI Claims		\$ 12,171		
2 Laq inquiries		\$ 674		
3 EPLI Claims		\$ 4,617		
4 Medicaid Eligibility		\$ 14,933		
5		\$		
			Charge for Services Provided	
			\$ 32,394	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No 15/1e				

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

Name of Facility Autumn Lake Healthcare at New Britain	License No. 2402	Report for Year Ended 9/30/2024					Page 16	of 37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
Subtotals Brought Forward:	2,193,008	3,453,146	(1,260,138)					
1. Travel and Entertainment								
1. Resident Travel and Entertainment \$								
2. Holiday Parties for Staff \$	21,019	21,019						
3. Gifts to Staff and Residents \$	29,429	29,429						
4. Employee Travel \$	54,786	95,644	(40,858)					
5. Education Expenses Related to Seminars and Conventions \$	2,821	2,821						
6. Automobile Expense (<i>not purchase or depreciation</i>) \$								
7. Other (<i>Specify</i>) \$								
See Attached Schedule								
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (<i>all such expenses</i>) \$	14,100	14,100						
2. Advertising Telephone Directory (<i>all such expenses</i>)*** \$								
3. Advertising Other (<i>Specify</i>)*** \$	0	96,638	(96,638)					
See Attached Schedule								
4. Fund-Raising*** \$								
5. Medical Records \$								
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)*** \$								
7. Postage \$								
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) \$								
See Attached Schedule								
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$								
9. Subscriptions \$								
10. Contributions*** \$		31,100	(31,100)					
See Attached Schedule								
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>) \$								
12. Administrative Management Services** \$	531,153	531,153						
13. Other (<i>Specify</i>) \$	994,673	995,346	(673)					
See Attached Schedule								
C-14 Total Administrative & General Expenditures \$	3,840,990	5,270,397	(1,429,407)					

* 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 in 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	\$ 38,852	\$ (38,852)				
Advertising	\$ 57,786	\$ (57,786)				
Total Other Advertising	\$ 96,638	\$ (96,638)	\$ -	\$ -	\$ -	\$ -

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	\$ 31,100	\$ (31,100)				
Total Contributions	\$ 31,100	\$ (31,100)	\$ -	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Fiscal Services	\$ 701,084					
Internet	\$ 12,234					
Licenses	\$ 11,164					
Employee Background Check	\$ 6,593					
Data Processing	\$ 79,147					
Consultants	\$ 166,618					
Bank Charges	\$ 17,833					
Penalties	\$ 343	\$ (343)				
Resident Pd. Claims (cb)	\$ 330	\$ (330)				
Total Other Administrative and General	\$ 995,346	\$ (673)	\$ -	\$ -	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Autumn Lake Heathcare at New Britain	License No. 2402	Report for Year Ended 9/30/2024	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Autumn Lake Healthcare, LLC	531,153	Management Services	16/m12

*** In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.**

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

Name of Facility Autumn Lake Healthcare at New Britain		License No. 2402	Report for Year Ended 9/30/2024				Page 18	of 37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 743,026	743,026						
2. Non-Food Supplies	\$ 58,601	58,601						
3. Other (Specify) _____	\$							
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 120,272	120,272						
c. Other (Specify) _____	\$							
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 921,899	921,899						
2E. Dietary Questionnaire	Total	CCNH / RHNS	(Specify)		(Specify)			
F. Resident Meals: Total no. of meals served per day:*								
G. Is cost of employee meals included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No							
H. Did you receive revenue from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify amt.					
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)								
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.					
K. Is any revenue collected from these people?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify amt.					
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)								
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.					
N. Is any revenue collected from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify amt.					
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)								

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

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

Name of Facility Autumn Lake Healthcare at New Britain		License No. 2402	Report for Year Ended 9/30/2024				Page 19	of 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)		\$ 719,288	719,288					
c. Other (Specify) Laundry Supplies		\$ 1,069	1,069					
3D. Total Laundry Expenditures (3a + b + c)		\$ 720,357	720,357					
3E. Laundry Questionnaire								
F. Is cost of employee laundry included in 3D?		<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.				
G. Did you receive revenue from employees?		<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify amt.				
H. Where is the revenue received reported in the Cost Report?		(Page/Line Item)						
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?		<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.				
J. Did you receive revenue from these people?		<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify amt.				
K. Where is the revenue received reported in the Cost Report?		(Page/Line Item)						

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility		License No.	Report for Year Ended					Page	of
Autumn Lake Healthcare at New Britain		2402	9/30/2024					20	37
Item			Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4.	Housekeeping	Sq. Ft. Serviced by Personnel							
a.	In-House Care	Amt.	\$						
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)								
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel							
		Amt.	\$ 1,151,339	1,151,339					
C.	Other (<i>Specify</i>)		\$ 52,788	52,788					
	Housekeeping Supplies								
4D.	Total Housekeeping Expenditures (4a + b + c)		\$ 1,204,127	1,204,127					
5.	Resident Care (Supplies)**								
a.	Prescription Drugs***								
1.	Own Pharmacy		\$						
2.	Purchased from		\$ (0)	457,968	(457,968)				
b.	Medicine Cabinet Drugs		\$ 11,540	11,540					
c.	Medical and Therapeutic Supplies		\$ 212,767	231,777	(19,010)				
d.	Ambulance/Limousine***		\$ 0	77,232	(77,232)				
e.	Oxygen								
1.	For Emergency Use		\$						
2.	Other***		\$ (0)	7,348	(7,348)				
f.	X-rays and Related Radiological Procedures***		\$ 0	15,320	(15,320)				
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$						
h.	Laboratory***		\$ (0)	70,193	(70,193)				
i.	Recreation		\$ 21,574	21,574					
j.	Direct Management Services*		\$						
k.	Indirect Management Services*		\$						
l.	Cable TV		\$ 37,778	37,778					
m.	Other (Specify)**** See Attached Schedule		\$ 278,800	368,809	(90,009)				
n.	Physical Therapy Expense		\$ 2,734	2,734					
o.	Speech Therapy Expense		\$						
5P.	Total Resident Care Expenditures (5a - 5o)		\$ 565,192	1,302,272	(737,080)				

* 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	\$ 148,177					
Medical Waste	\$ 2,247					
Mattresses	\$ 9,456					
M'caid - I/v	\$ 65,721	\$ (65,721)				
IV Supplies	\$ 23,788	\$ (23,788)				
Picc/midline Insertion	\$ 34,888					
Medical Equipment (Minor)	\$ 54,270					
Diagnostic Testing	\$ 2,744					
PPE Expense (Covid)	\$ 27,020					
Respiratory Therapy	\$ 500	\$ (500)				
Total Other Resident Care	\$ 368,809	\$ (90,009)	\$ -	\$ -	\$ -	\$ -

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

Name of Facility Autumn Lake Heathcare at New Britain				License No. 2402	Report for Year Ended 9/30/2024				Page 21	of 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
Waste Wanted Solutions	178 Route 59, Ste. 303, Monsey, NY 10952	<input type="radio"/>	<input checked="" type="radio"/>		Garbage	67,443			22	6a
Healthcare Services	3220 Tillman Dr. #300, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Dietary Services	120,272			18	3b
Accurate Staffing LLC	14 53rd St., Ste 220, Brooklyn, NY 11232	<input type="radio"/>	<input checked="" type="radio"/>		Nursing	15,672,000			13	
Network Dr.	Englewood Cliffs, NY 07632	<input type="radio"/>	<input checked="" type="radio"/>		Contract (provide computers/software, etc.)	83,901			16	m13
Future Care Consultants	14 53rd St., Ste 220, Brooklyn, NY 11232	<input type="radio"/>	<input checked="" type="radio"/>		Billing and AR	617,183			16	m13
Hospitality	Blvd., Jersey City, NJ 07304	<input type="radio"/>	<input checked="" type="radio"/>		Purchasing for Food and Dietary Supplies	103,212			18	
Healthcare Services	3220 Tillman Dr. #300, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Services	719,288			19	3b
Point Click Care	PO Box 674802 Detroit MI 48267	<input type="radio"/>	<input checked="" type="radio"/>		Data Processing	30,263			16	m13
Healthcare Services	3220 Tillman Dr. #300, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>		Housekeeping Services	1,151,339			20	4b
On Shift	1621 Euclid Ave., Cleveland, OH 44115	<input type="radio"/>	<input checked="" type="radio"/>		Data Processing	21,210			16	m13
Brightview Landscapes LLC	Turnpike, Windsor Locks, CT 06096	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping	14,244			22	6a
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

* List all contracted services over \$10,000. Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility Autumn Lake Healthcare at New Britain		License No. 2402	Report for Year Ended 9/30/2024				Page 22	of 37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$	239,133	239,133					
b. Heat	\$	80,183	80,183					
c. Light & Power	\$	238,745	238,745					
d. Water	\$	108,000	108,000					
e. Equipment Lease (<i>Provide detail on page 22b</i>)	\$	26,499	26,499					
f. Other (<i>itemize</i>)	\$							
See Attached Schedule								
6g. Total Maint. & Operating Expense (6a - 6f)		\$ 692,559	692,559					
7. Depreciation (<i>complete schedule page 23*</i>)								
a. Land Improvements	\$							
b. Building & Building Improvements	\$	363,634	363,634					
c. Non-Movable Equipment	\$							
d. Movable Equipment	\$	86,996	86,996					
*7e. Total Depreciation Costs (7a + b + c + d)		\$ 450,630	450,630					
8. Amortization (<i>Complete att. Schedule Page 24*</i>)								
a. Organization Expense	\$							
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$	141,837	141,837					
d. Other (<i>Specify</i>)	\$							
*8e. Total Amortization Costs (8a + b + c + d)		\$ 141,837	141,837					
9. Rental payments on leased real property less real estate taxes included in item 10b		\$ 1,597,466	1,597,466					
10. Property Taxes								
a. Real estate taxes paid by owner	\$	427,968	427,968					
b. Real estate taxes paid by lessor	\$							
c. Personal property taxes	\$							
11. Total Property Expenses (7e + 8e + 9 + 10)		\$ 2,617,901	2,617,901					

* 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	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

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 Autumn Lake Healthcare at New Britain			License No. 2402		Report for Year Ended 9/30/2024		Page 22b	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
DeLage Landen Financial Services	<input type="radio"/>	<input checked="" type="radio"/>	Kyocera-MA5500IFX	03/01/24	63	19,808	19,808	
DeLage Landen Financial Services	<input type="radio"/>	<input checked="" type="radio"/>	Kyocera-M3655IDN / Kyocera-M2540DW	02/22/22	63	6,691	6,691	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input checked="" type="radio"/> Yes <input type="radio"/> No	
Total ***							26,499	

* 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.

[illegible]

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	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
10/6/2023	Electric Std Bed	Standard Resident	\$ 2,728	5	\$ 546
1/1/2024	Chev Silverado	Administrative	\$ 41,565	5	\$ 8,313
11/17/2023	Blasius Pre Owned	Administrative	\$ 9,500	5	\$ 1,900
12/4/2023	Installed Plow ASY	Administrative	\$ 9,615	5	\$ 1,923
9/6/2023	Food Processor	Administrative	\$ 5,710	5	\$ 1,142
10/26/2023	Blasius Pre Owned	Administrative	\$ 500	5	\$ 100
10/11/2023	Steamer	Administrative	\$ 2,828	5	\$ 566
6/1/2023	Tech Support for Avaya IP Office	Administrative	\$ 598	5	\$ 120
12/7/2023	Apple Tablet	Administrative	\$ 761	5	\$ 152
9/1/2023	Dual-Jack Patient Station	Standard Resident	\$ 1,113	5	\$ 223
9/19/2023	Keypads/MAG Lock	Administrative	\$ 10,106	5	\$ 2,021
10/24/2023	Ice Machine	Administrative	\$ 741	5	\$ 148
10/27/2023	Evaporator Coil Fan Motor	Administrative	\$ 612	5	\$ 122
12/29/2023	Food Blender	Administrative	\$ 1,253	5	\$ 251
1/12/2024	Ice Maker	Administrative	\$ 4,170	5	\$ 834
8/9/2024	Ice Machine	Administrative	\$ 4,721	5	\$ 944
9/5/2024	Washer	Administrative	\$ 9,500	5	\$ 1,900
3/6/2024	Mixing Value	Administrative	\$ 1,840	5	\$ 368
4/12/2024	Dell Notebook	Administrative	\$ 798	5	\$ 160
5/16/2024	Dell Notebook	Administrative	\$ 1,319	5	\$ 264
11/20/2023	Freezer	Administrative	\$ 3,500	5	\$ 700
6/18/2024	Bladder Scanner	Standard Resident	\$ 6,250	5	\$ 1,250
11/6/2023	Keypad	Administrative	\$ 783	5	\$ 157
1/15/2024	Electric Std Bed	Standard Resident	\$ 1,819	5	\$ 364
		PICK A CATEGORY			
Total additions for Movable Equipment			\$ 122,331		\$ 24,466 *
Deletions:					
Total deletions for Movable Equipment			\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/3/2023	Plumbing	\$ 1,598	15	\$ 107
10/25/2023	Mixing Value	\$ 1,400	15	\$ 93
10/18/2023	Upgrade Fire Alarm Panel	\$ 24,285	15	\$ 1,619
9/19/2023	PM on Generator	\$ 775	15	\$ 52
11/27/2023	Boiler and Tank	\$ 22,752	15	\$ 1,517
10/10/2023	Electrical Infrared	\$ 1,170	15	\$ 78
9/30/2023	Prior Period CT State & Use Tax	\$ (2,286)	15	\$ (152)
9/30/2024	Parking Lot Upgrade	\$ 7,850	15	\$ 523
1/1/2024	Lobby Renovations	\$ 660	15	\$ 44
8/28/2024	Shower Room Modification	\$ 4,041	15	\$ 269
5/29/2024	Installation Equipment	\$ 22,447	15	\$ 1,496
9/30/2023	Prior Period that was posted twice)	\$ (725)	15	\$ (48)
2/27/2024	Batteries for Unit	\$ 2,845	15	\$ 190
3/7/2024	Major PM Inspection on Unit	\$ 1,625	15	\$ 108
5/26/2024	Exhaust Fan	\$ 3,488	15	\$ 233
5/29/2024	Boiler Condensate	\$ 5,844	15	\$ 390
7/9/2024	Refrigerant Updates	\$ 9,297	15	\$ 620
7/19/2024	Fan Motor	\$ 3,084	15	\$ 206
Total additions for Leasehold Improvement		\$ 110,151		\$ 7,343 *
Deletions:				

Total deletions for Leasehold Improvement		\$ -		\$ -

ges 23 24

**

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

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 New Britain			2402		9/30/2024			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	Var	Var		2,032,263	491,091			134,493	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				110,151				7,343	
C-4. Subtotal									141,837
D. Total Amortization									141,837

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.

B. Life of mortgage; OR

C. Remaining Life of Lease; OR

D. Actual Life if owned by Related Party.

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

Name of Facility Autumn Lake Healthcare at New Britain	License No. 2402	Report for Year Ended 9/30/2024	Page 25	of 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					
3. If NOT Original Owner, Date of Purchase	01/01/15				
4. Date of Initial Licensure	01/01/15				
5. Total Licensed Bed Capacity	282				
6. Square Footage					
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.

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

Name of Facility Autumn Lake Heathcare at New Britain		License No. 2402	Report for Year Ended 9/30/2024				Page 26	of 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)

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

Name of Facility Autumn Lake Healthcare at New Bl			License No. 2402		Report for Year Ended 9/30/2024			Page 27	of 37
Item					Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment (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)					\$ 17,879	17,879			
13. Total All Interest Expense (12B7 + 12C3 + 12D)					\$ 17,879	17,879			
14. Insurance									
a. Insurance on Property (buildings only)					\$ 495,380	495,380			
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)					\$ 495,380	495,380			
15. Total All Expenditures (A-13 thru C-14)					\$ 30,951,029	33,902,114	(2,951,085)		

F. Statement of Revenue

Name of Facility Autumn Lake Heathcare at New Britain		License No. 2402		Report for Year Ended 9/30/2024		Page 30	of 37
Item				Total	CCNH / RHNS	(Specify)	(Specify)
I. Resident Room, Board & Routine Care Revenue							
1. a. Medicaid Residents (<i>CT only</i>)				\$ 21,294,404	21,294,404		
b. Medicaid Room and Board Contractual Allowance **				\$			
2. a. Medicaid (<i>All other states</i>)				\$			
b. Other States Room and Board Contractual Allowance **				\$			
3. a. Medicare Residents (<i>all inclusive</i>)				\$ 10,455,630	10,455,630		
b. Medicare Room and Board Contractual Allowance **				\$ (152,935)	(152,935)		
4. a. Private-Pay Residents and Other				\$ 1,936,324	1,936,324		
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				\$ 839	839		
b. Medical Supplies - Medicare Contractual Allowance **				\$ (839)	(839)		
c. Medical Supplies - Non-Medicare				\$ 13,381	13,381		
d. Medical Supplies - Non-Medicare Contractual Allowance **				\$			
3. a. Physical Therapy - Medicare				\$ 1,028,688	1,028,688		
b. Physical Therapy - Medicare Contractual Allowance **				\$ (823,866)	(823,866)		
c. Physical Therapy - Non-Medicare				\$			
d. Physical Therapy - Non-Medicare Contractual Allowance **				\$			
4. a. Speech Therapy - Medicare				\$ 462,524	462,524		
b. Speech Therapy - Medicare Contractual Allowance **				\$ (317,701)	(317,701)		
c. Speech Therapy - Non-Medicare				\$			
d. Speech Therapy - Non-Medicare Contractual Allowance **				\$			
5. a. Occupational Therapy - Medicare				\$ 1,217,285	1,217,285		
b. Occupational Therapy - Medicare Contractual Allowance **				\$ (844,737)	(844,737)		
c. Occupational Therapy - Non-Medicare				\$			
d. Occupational Therapy - Non-Medicare Contractual Allowance **				\$			
6. a. Other (<i>Specify</i>) - Medicare				\$ 915,855	915,855		
b. Other (<i>Specify</i>) - Non-Medicare				\$ 5,200	5,200		
III. Total Resident Revenue (Section I. thru Section II.)				\$ 35,190,051	35,190,051		
IV. Other Revenue*							
1. Meals sold to guests, employees & others				\$			
2. Rental of rooms to non-residents				\$			
3. Telephone				\$			
4. Rental of Television and Cable Services				\$			
5. Interest Income (<i>Specify</i>)				\$ 322	322		
6. Private Duty Nurses' Fees				\$			
7. Barber, Coffee, Beauty and Gift shops				\$			
8. Other (<i>Specify</i>)				\$			
V. Total Other Revenue (1 thru 8)				\$ 322	322		
VI. Total All Revenue (III +V)				\$ 35,190,373	35,190,373		

* 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	\$ 13,663		
	Phneumonia	\$ (500)		
	Optum (Part B Capitated)	\$ 866,150		
	Other Rev Mcre B -glucose	\$ 44,383		
	Other Rev Mcre B-flu Shot	\$ 2,138		
	Revenue-medicare Prior	\$ (9,979)		
Total Other Resident Revenue - Medicare		\$ 915,855	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	Contra - Mcre B - Flu	\$ (2,138)		
	Other Revenue B - NM	\$ 691		
	Contra Mcr B -NM	\$ (691)		
	Other Rev Mcre B -TL	\$ 8,392		
	Contra Rev Mcre B -TL	\$ (1,053)		
	Other Rev Mcr B - Covid	\$ 1,203		
	Contra - Mcre B - Covid A	\$ (1,203)		
Total Other Resident Revenue		\$ 5,200	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
	Interest Income		\$ 322		
Total Interest Income			\$ 322	\$ -	\$ -

Schedule of Other Revenue

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

G. Balance Sheet

Name of Facility Autumn Lake Heathcare at New Britain	License No. 2402	Report for Year Ended 9/30/2024	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	1,750,291
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	4,085,122
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4 Inventories			\$	
5. Prepaid Expenses			\$	121,021
a. _____				
b. _____				
c. _____				
d. See Schedule _____ 121,021				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

See Schedule _____				
A-9. Total Current Assets (Lines A1 thru 8)			\$	5,956,434
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 2,142,413			\$	1,509,486
Accum. Depreciation 632,927 Net				
5. Non-Movable Equipment *Historical Cost _____			\$	
Accum. Depreciation _____ Net				
6. Movable Equipment *Historical Cost _____			\$	
Accum. Depreciation _____ Net				
7. Motor Vehicles *Historical Cost _____			\$	
Accum. Depreciation _____ Net				
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

See Schedule _____				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,509,486

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

G. Balance Sheet (cont'd)

Name of Facility Autumn Lake Healthcare at New Britain	License No. 2402	Report for Year Ended 9/30/2024	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 7,465,920	
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$ 1,000,000	
2. Land Improvements *Historical Cost _____ Accum. Depreciation _____ Net			\$	
3. Buildings *Historical Cost 10,909,021 Accum. Depreciation 3,545,432 Net			\$ 7,363,589	
4. Non-Movable Equipment *Historical Cost _____ Accum. Depreciation _____ Net			\$	
5. Movable Equipment *Historical Cost 1,618,959 Accum. Depreciation 1,381,194 Net			\$ 237,765	
6. Motor Vehicles *Historical Cost _____ Accum. Depreciation _____ Net			\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$ 8,601,354	
D. Investment and Other Assets				
1. Deferred Deposits			\$ 30,240	
2. Escrow Deposits			\$	
3. Organization Expense *Historical Cost _____ Accum. Depreciation _____ Net			\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>) _____			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>) _____ _____ See Schedule			\$	
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 30,240	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 16,097,514	

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

G. Balance Sheet (cont'd)

Name of Facility Autumn Lake Heathcare at New Britain		License No. 2402		Report for Year Ended 9/30/2024		Page 33 of 37	
Account						Amount	
Liabilities							
A. Current Liabilities							
1. Trade Accounts Payable						\$	4,732,960
2. Notes Payable (<i>itemize</i>)						\$	349,507
See Schedule 349,507							
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)						\$	
Name of Lender		Purpose		Amount	Date Due		
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)						\$	
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)						\$	
6. Accrued Payroll Taxes Payable						\$	21,101
7. Medicare Final Settlement Payable						\$	
8. Medicare Current Financing Payable						\$	
9. Mortgage Payable (<i>Current Portion</i>)						\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)						\$	
11. Accrued Income Taxes*						\$	
12. Other Current Liabilities (<i>itemize</i>)						\$	(317,645)
See Schedule (317,645)							
A-13. Total Current Liabilities (Lines A1 thru 12)						\$	4,785,923

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Autumn Lake Heathcare at New Britain	2402	9/30/2024	34	37
Account			Amount	
Total Brought Forward:			4,785,923	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)			\$ 4,398,849	
Name and Address of Lender	Amount	Loan Date		
Stern/Autumn Lake/Landlord	4,398,849	Various		
4. Other Long-Term Liabilities (<i>itemize</i>)			\$	
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$ 4,398,849	
C. Total All Liabilities (Lines A-13 + B-5)			\$ 9,184,772	

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

Name of Facility Autumn Lake Healthcare at New Britain	License No. 2402	Report for Year Ended 9/30/2024	Page 35	of 37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	8,591,506
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	8,591,506
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	(2,967,023)
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	
6. Gain or Loss for Period			\$	1,288,259
				10/1/2023 thru 9/30/2024
7. Total Net Worth			\$	(1,678,764)
C. Total Reserves and Net Worth			\$	6,912,742
D. Total Liabilities, Reserves, and Net Worth			\$	16,097,514

H. Changes in Total Net Worth

Name of Facility Autumn Lake Heathcare at New Britain	License No. 2402	Report for Year Ended 9/30/2024	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2023			\$	(1,202,869)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	35,190,373
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	33,902,114
D. Net Income or Deficit			\$	1,288,259
E. Balance			\$	85,390
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions				
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)	Title	Amount		
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose	Amount			
3. Total Deductions			\$	
H. Balance at End of Period			\$	85,390

I. Preparer's/Reviewer's Certification

Name of Facility Autumn Lake Healthcare at New Britain	License No. 2402	Report for Year Ended 9/30/2024	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> Home (CCNH) & RHNS Combined	<input type="checkbox"/> (Specify)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report in the Adjustments columns. Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
CJLC LLC				
Address Address		Phone Number		
225 Pitkin St., East Hartford, CT 06108		860-610-9009		
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number		
CJLC LLC		860-610-9009		
Contact Email Address				
annualreports@cjlc.com				