State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2019

Name of Facility (as licensed) Cook Willow Convalescent Hospital, Inc.		
Address (No. & Street, City, State, Zip Code) 81 Hillside Ave., Plymouth, CT 06782		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	932-C			07-5349

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	7226948		

For Department Use Only

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

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General Information

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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Cook Willow Convalescent Hospital, Inc. [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Jennesa LeClair			Printed Name (Owner) Susan MacDonald	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Cook Willow Convalescent Hospital, Inc.	Period Covered:		From 10/1/2018	To 9/30/2019
Address of Facility 81 Hillside Ave., Plymouth, CT 06782				
Report Prepared By CJLC LLC	Phone Number 860-610-9009		Date 3/13/2020	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-283-8208	9/30/2019	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Cook Willow Convalescent Hospital, Inc.	81 Hillside Ave., Plymouth, CT 06782

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	932-C			07-5349

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Jennesa LeClair		1883

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	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
Cook Willow Convalescent Hospital, Inc.	81 Hillside Ave., Plymouth, CT 06782	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Susan MacDonald	61 Maple Ave., Plymouth, CT 06782	resident/Directo	100
Walter MacDonald	61 Maple Ave., Plymouth, CT 06782	Vice President	
Jennesa LeClair	210 West Hill Rd., Thomaston, CT 06787	Secretary	
Names of Stockholders Owning at Least 10% of Shares			
Susan MacDonald	61 Maple Ave., Plymouth, CT 06782	resident/Directo	100

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
See Attached		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

** Provide the percentage amount of revenue received from non-related parties.

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

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

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

⊙ Yes ○ No If "No," explain fully why such allocation was not made.

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General Information and Questionnaire
Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
NA	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	

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

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

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 CJLC LLC	225 Pitkin Street, East Hartford, CT 06108
2 A/R Solutions	PO Box 592, Wallingford, CT 06492
3	
4	

Services Provided by This Firm (*describe fully*)

1	Medicaid and Medicare Cost Report, Accounting Services, Tax Services	$ 13,750
2	AR Services	$ 4,029
3		$
4		$
		Charge for Services Provided $ 17,779

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

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha Cullina	860-240-600
2 Robert A Zeigler	860-793-1506
3 Treasurer, State of CT	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 185 Asylum St, Hartford CT
2 58 E Main St, Plainville, CT
3
4
5

Services Provided by This Firm (*describe fully*)

1	General legal	$ 175
2	Employee Issues	$ 19,153
3	Filing fees	$ 297
4		$
5		$
		Charge for Services Provided $ 19,625

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

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	60	60			60	60			60	60		
B. On last day of THIS report period	60	60			60	60			60	60		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	59	59			59	59			60	60		
B. As of midnight of THIS report period	60	60			60	60			60	60		
3. Total Number of Days Care Provided During Period												
A. Medicare	750	750			476	476			274	274		
B. Medicaid (Conn.)	15,737	15,737			11,847	11,847			3,890	3,890		
C. Medicaid (other states)												
D. Private Pay	2,378	2,378			1,988	1,988			390	390		
E. State SSI for RCH												
F. Other (Specify) Insurance	2,426	2,426			1,665	1,665			761	761		
G. Total Care Days During Period (3A thru F)	21,291	21,291			15,976	15,976			5,315	5,315		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	21,291	21,291			15,976	15,976			5,315	5,315		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	6	44		9				
Per Diem Rate								
a. One bed rm.	RUGS	229.80		325.00				
b. Two bed rms.				290.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,429	1,429		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	2,321	2,321		
2. Restorative Treatments				
C. Other	2,229	2,229		
D. ***Total Physical Therapy Treatments***	5,979	5,979		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	58	58		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	94	94		
2. Restorative Treatments				
C. Other	200	200		
D. ***Total Speech Therapy Treatments***	352	352		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,177	1,177		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	1,856	1,856		
2. Restorative Treatments				
C. Other	1,493	1,493		
D. ***Total Occupational Therapy Treatments***	4,526	4,526		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)	90,535	1,699				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	86,043	2,731				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	71,040	3,437				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	34,579	2,061				
c. Dietary Workers	242,205	17,787				
6. Housekeeping Service						
a. Head Housekeeper	30,178	2,042				
b. Other Housekeeping Workers	90,582	8,036				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	78,880	4,768				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	59,616	5,493				
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	130,377	3,348				
b. RN						
1. Direct Care	458,822	11,335				
2. Administrative**	150,629	3,741				
c. LPN						
1. Direct Care	417,212	13,193				
2. Administrative**						
d. Aides and Attendants	795,409	49,310				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	74,385	3,987				
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	43,516	2,105				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	31,130	2,001				
A-13. Total Salary Expenditures	2,885,136	137,073				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
*** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Unit Clerk	$ 31,130	2,001				
Total	$ 31,130	2,001	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

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

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Susan MacDonald	90,535				Owner / General Oversight	1,699	A1			
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
Ernie LeClair	46,121				Maintenance	2,353	A7b			
Walter MacDonald	5,289				Office	313	A4			

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Jennesa LeClair	86,043				Administrator	2,731	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	7,980	199				
2. Dentist	6,840	95				
3. Pharmacist	3,868	38				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	110,619	2,228				
b. Other						
6. Social Worker	150	3				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	26,000	200				
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	18,539	190				
b. Other						
10. Occupational Therapist						
a. Resident Care	81,729	1,964				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	255,724	4,918				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Laura Koski, RD 842 Clark Ave, Bristol, CT 06010	Dietary Consultant	○	⊙	
Dr. David Delucia 134 Grandview Ave., Waterbury, CT 06708	Medical Director	○	⊙	
OnmiCare, Inc. Cincinnati, OH	Pharmacy	○	⊙	
Health Drive Medical and Dental 85 Barnes Rd., Suite 207, Wallingford, CT 06492	Podiatrist / Audiology / Hearing	○	⊙	
Precision Rehab. 62 Ridge Rd., Terryville, CT 06786	PT, ST, OT	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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		○	⊙	
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		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

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Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	119,794	119,794		
2. Disability Insurance	$				
3. Unemployment Insurance	$	63,167	63,167		
4. Social Security (F.I.C.A.)	$	221,477	221,477		
5. Health Insurance	$	222,228	222,228		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	4,474	4,474		
7. Pensions (Non-Discriminatory)	$	2,804	2,804		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	17,779	17,779		
e. Legal (*Services should be fully described on Page 7)*	$	19,625	19,625		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$	31,280	31,280		
g. Office Supplies	$	8,448	8,448		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	13,158	13,158		
2. Cellular Phones	$	1,783	1,783		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$	187	187		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	423,700	423,700		
Subtotal	$	1,149,905	1,149,905		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,149,905	1,149,905		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	6,223	6,223		
4. Employee Travel	$	2,836	2,836		
5. Education Expenses Related to Seminars and Conventions	$	5,443	5,443		
6. Automobile Expense (*not purchase or depreciation*)	$	7,944	7,944		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	7,159	7,159		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$				
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	$	2,271	2,271		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	4,534	4,534		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	4,015	4,015		
10. Contributions***	$	225	225		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	4,973	4,973		
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	129,808	129,808		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,325,335	1,325,335		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

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

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 3,744		
ALTCFM	$ 170		
ACHCA	$ 620		
Total Dues	$ 4,534	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
DONATION EXPENSE	$ 225		
Total Contributions	$ 225	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
COMPUTER EXPENSE	$ 46,576		
LICENSES, FEES	$ 3,174		
LATE CHARGES	$ 9,503		
PAYROLL PROCESSING	$ 45,259		
BANK CHARGES	$ 18,050		
OTHER ADMINISTRATIVE EXPENSE	$ 498		
CREDIT CARD FEES	$ 304		
HIRING COSTS	$ 6,443		
Total Other Administrative and General	$ 129,808	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Cook Willow Convalescent Hospital, Inc	932-C	9/30/2019	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	304,030	304,030		
2. Non-Food Supplies	$	21,667	21,667		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	325,698	325,698		

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

H.	Is cost of employee meals included in 2E?	⦿ Yes	○ No		
I.	Did you receive revenue from employees?	○ Yes	⦿ No	If yes, specify amt.	
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	⦿ Yes	○ No	If yes, specify cost.	
L.	Is any revenue collected from these people?	⦿ Yes	○ No	If yes, specify amt.	$72,804
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				30/IV1
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	⦿ Yes	○ No	If yes, specify cost.	
O.	Is any revenue collected from employees?	○ Yes	⦿ No	If yes, specify amt.	
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility	License No.	Report for Year Ended	Page
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	1,969	1,969		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Supplies	$	9,107	9,107		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	11,077	11,077		

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	33,990	33,990		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	33,990	33,990		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	57,128	57,128		
b. Medicine Cabinet Drugs		$	22,840	22,840		
c. Medical and Therapeutic Supplies		$	65,406	65,406		
d. Ambulance/Limousine***		$	5,137	5,137		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	5,658	5,658		
f. X-rays and Related Radiological Procedures***		$				
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	129	129		
i. Recreation		$	14,384	14,384		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	37,579	37,579		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	208,261	208,261		

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

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

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
IV CONSULT MEDICAID	$ 4,063		
URINARY INCONTINENCE	$ 26,629		
TUBE FEEDING SUPPLIES	$ 189		
OUTSIDE MED SERVICES MED A	$ 3,967		
MANAGED CARE/HMO	$ 2,730		
Total Other Resident Care	$ 37,579	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* List all contracted services over $10,000. Use additional sheets if necessary.
** Refer to Page 4 for definition of related.
*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended	Page of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	44,093	44,093		
b. Heat	$	30,279	30,279		
c. Light & Power	$	59,561	59,561		
d. Water	$	52,528	52,528		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	12,380	12,380		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	198,842	198,842		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	51	51		
b. Building & Building Improvements	$	144,613	144,613		
c. Non-Movable Equipment	$	5,290	5,290		
d. Movable Equipment	$	47,619	47,619		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	197,573	197,573		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	27,779	27,779		
c. Leasehold Improvements	$	11,223	11,223		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	39,002	39,002		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	475,644	475,644		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	73,594	73,594		
c. Personal property taxes	$	8,023	8,023		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	793,835	793,835		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
GARBOLOGIST	$ 10,319		
GROUND MAINT	$ 2,061		
Total Other Repairs and Maintenance	$ 12,380	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	3,509		3,509	3,319			51	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								51
B. **Building and Building Improvements**								
1. Acquired prior to this report period	5,413,714		5,413,714	4,210,090			144,613	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								144,613
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	76,600		76,600	63,270			4,169	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	11,209						1,121	
C-4. Subtotal								5,290

	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. 2005 Chevy Trailblazer		X	1	2007	20,610		20,610	20,610		5		
b. 2014 Ford Explorer		X	5	2015	44,851		44,851	30,648		5	8,970	
c. 2016 Ford F250 W/Plow	X		11	2015	48,916		48,916	28,534		5	9,783	
d. 2006 Ford E350		X	10	2015	14,000		14,000	8,400		5	2,800	
2. Movable Equipment												
a. Acquired prior to this report period			Var	Var	717,187		717,187	571,309		Var	25,959	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					529						106	
D-3. Subtotal												47,618
E. ***Total Depreciation***												197,572

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Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/23/2018	Washing Machine	$ 11,209	10	$ 1,121	
Total additions for Non-Movable Equipment		$ 11,209		$ 1,121	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
3/7/2019	Kitchen Freezer	$ 529	5	$ 106	
Total additions for Movable Equipment		$ 529		$ 106	*
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:					
10/31/2018	Fire Door	$ 1,372	15	$ 91	
10/9/2018	Wamder Alarm	$ 2,632	10	$ 263	
11/9/2018	Security Cameras	$ 5,094	10	$ 509	
11/9/2018	Door Openers	$ 3,499	10	$ 350	
11/9/2018	Metal Door	$ 1,372	15	$ 91	
11/11/2018	Clark Plumbing	$ 2,695	10	$ 270	
3/14/2019	New Door and Frame	$ 877	15	$ 58	
4/25/2019	Security Upgrades	$ 2,918	10	$ 292	
4/23/2019	Railings & Paint	$ 881	10	$ 88	
5/24/2019	Security Upgrades	$ 3,498	10	$ 350	
5/31/2019	Security Upgrades	$ 2,191	10	$ 219	
9/23/2019	DGB Carpentry	$ 650	10	$ 65	
Total additions for Leasehold Improvement		$ 27,680		$ 2,647	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	24	37

Item	Date of Acquisition Month	Date of Acquisition Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1. HUD Mortgage Acq Fees - New	9	2001	30 Yrs	329,805	187,806			10,994	
2. HUD Mortgage Acq Fees - Extensio	9	2001	30 Yrs	453,482	258,232			15,116	
3. Extension Fees	12	2002	30 Yrs	50,070	27,955			1,669	
B-4. Subtotal									27,779
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	Var	Var	Var	207,735	120,707			8,575	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				27,680				2,647	
C-4. Subtotal									11,223
D. ***Total Amortization***									39,001

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital,	932-C	9/30/2019	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	07/30/74
2. Date Structure Completed	07/30/74
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	07/30/74
5. Total Licensed Bed Capacity	60
6. Square Footage	34,196
7. Acquisition Cost	
a. Land	19,780
b. Building	95,220

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	08/20/10			
c. Interest Rate for the Cost Year	4.85%			
d. Term of Mortgage (number of years)	27			
e. Amount of Principal Borrowed	3,987,600			
f. Principal balance outstanding as of _____	3,284,302			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

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

Name of Facility	License No.	Report for Year Ended	Page of
Cook Willow Convalescent Hospital.	932-C	9/30/2019	26 | 37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Cook Willow Convalescent Hospit	932-C	9/30/2019	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $	22,766	22,766		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	22,766	22,766		
14. Insurance				
a. Insurance on Property (buildings only) $	74,762	74,762		
b. Insurance on Automobiles $	5,076	5,076		
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)*** $	79,838	79,838		
15. ***Total All Expenditures (A-13 thru C-14)*** $	6,140,503	6,140,503		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	10A	Occupational Therapy $	81,729	81,729		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.			Accounting $				
10a.			Legal $				
11.			Telephone $				
12.	15	1h.2	Cellular Telephone $	343	343		
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators $	31,280	31,280		
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.	16	L6	Automobile Expense (e.g. personal use) $	3,972	3,972		
18.			Unallowable Advertising * $				
19.	15	k1	Income Tax / Corporate Business Tax $	187	187		
20.	16	m9	Fund Raising / Contributions $	225	225		
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	10,305	10,305		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $	38,820	38,820		
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	166,861	166,861		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	LATE CHARGES	$ 9,503		
16	m13	OTHER ADMINISTRATIVE EXPENSE	$ 498		
16	m13	CREDIT CARD FEES	$ 304		
Total Other A&G Adjustments			$ 10,305	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	166,861	166,861		
Page 20 - Resident Care Supplies***							
27.	20	5A2	Prescription Drugs $	57,128	57,128		
28.	20	5D	Ambulance/Limousine $	5,137	5,137		
29.			X-rays, etc $				
30.	20	5H	Laboratory $	129	129		
31.			Medical Supplies $				
32.	20	5E	Oxygen (non emergency) $	5,658	5,658		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	10,490	10,490		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.	22	7d	Depreciation on Unallowable Motor Vehicles $	13,170	13,170		
37.			Unallowable Property and Real Estate Taxes $	4,755	4,755		
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $	5,804	5,804		
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.	27	14b	Property Insurance $	2,538	2,538		
Other - Miscellaneous							
42.			Other - Indirect $				
43.			Interest Income on Account Rec. $				
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49. ***Total Amount of Decrease (Items 1 - 48)***			$	271,670	271,670		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Attachment Page 29

Cook Willow Convalescent Hospital, Inc.
9/30/2019

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV THERAPY EXPENSE	$ 4,063		
20	5j	OUTSIDE MED SERVICES MED A	$ 3,697		
20	5j	MANAGED CARE/HMO	$ 2,730		
Total Other Ancillary Costs			$ 10,490	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		Apartment Allocation	$ 5,267		
		Meals on Wheels Allocation	$ 537		
Total Other Property Adjustments			$ 5,804	$ -	$ -

Schedule of Other Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc	932-C	9/30/2019	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	5,836,095	5,836,095		
b. Medicaid Room and Board Contractual Allowance **	$	(1,896,158)	(1,896,158)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	369,813	369,813		
b. Medicare Room and Board Contractual Allowance **	$	19,789	19,789		
4. a. Private-Pay Residents and Other	$	1,325,805	1,325,805		
b. Private-Pay Room and Board Contractual Allowance **	$	105,402	105,402		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	38,357	38,357		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	11,633	11,633		
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	$	137,738	137,738		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	79,139	79,139		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	26,306	26,306		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	9,970	9,970		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	114,064	114,064		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	52,566	52,566		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	(158,426)	(158,426)		
b. Other *(Specify)* - Non-Medicare	$	(77,094)	(77,094)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	5,994,999	5,994,999		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	72,804	72,804		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	25	25		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	19,539	19,539		
V. Total Other Revenue (1 thru 8)	$	92,369	92,369		
VI. Total All Revenue (III +V)	$	6,087,367	6,087,367		

* *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)
	X-RAY - MEDICARE A	$ 540		
	LAB - MEDICARE A	$ 3,104		
	CONT ALW MEDICARE A	$ (150,719)		
	CONT ALW ANCILL MEDICARE B	$ (11,351)		
Total Other Resident Revenue - Medicare		$ (158,426)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	IV THERAPY - EVERCARE	$ 404		
	X-RAY - INSURANCE	$ 493		
	LAB - INSURANCE	$ 1,285		
	LAB -EVERCARE	$ 6,256		
	CONT ALW ANCILL INSURANCE	$ (87,807)		
	CONT ALW ANCILL EVERCARE	$ (4,445)		
	EVERCARE DIVIDENDS	$ 6,720		
Total Other Resident Revenue		$ (77,094)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
31 A1	INTEREST INCOME		$ 25		
Total Interest Income			$ 25	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	MISC. REVENUE	$ 19,539		
Total Other Revenue		$ 19,539	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Ir	932-C	9/30/2019	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 669,794
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,692,778
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 4,807
5. Prepaid Expenses				$ 6,870
a.				
b.				
c.				
d. See Schedule		6,870		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 71,410
See Schedule		71,410		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,445,658
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	3,509		$ 140
	Accum. Depreciation	3,369	Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	235,414		$ 103,484
	Accum. Depreciation	131,930	Net	
5. Non-Movable Equipment	*Historical Cost	87,810		$ 19,250
	Accum. Depreciation	68,560	Net	
6. Movable Equipment	*Historical Cost	717,716		$ 120,342
	Accum. Depreciation	597,374	Net	
7. Motor Vehicles	*Historical Cost	128,377		$ 18,631
	Accum. Depreciation	109,746	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (7,854)
See Schedule		(7,854)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 253,992

* 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	
31	A5	PREPAID INSURANC	$ 1,646
31	A5	PREPAID INTEREST	$ 174
31	A5	PREPAID PERSONAL PROP TAXES	$ 5,050
Total Prepaid Expenses			$ 6,870

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

Page Ref	Line Ref	Description	
31	A8	WEBSTER RECEIVABLE	$ 71,410
Total Other Current Assets (Itemize)			$ 71,410

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

Page Ref	Line Ref	Description	
31	B9	BOOK VS COST REPORT	$ (7,854)
Total Other Other Fixed Assets (Itemize)			$ (7,854)

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	
33	A2	NOTE PAYABLE UNITED BANK	$ (1,617)
33	A2	NOTE PAYABLE VALUE HEALTH	$ 4,934
33	A2	NOTE PAYABLE - HUNTINGTON N.B.	$ 7,916
33	A2	NOTE PAYABLE - CITIZENS	$ 19,199
Total Notes Payable			$ 30,432

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

Page Ref	Line Ref	Description	
33	A12	PREPAID WATER & SEWER	$ 38,907
33	A12	DUE TO MEDICAID USER FEE	$ 211,562
Total Other Current Liabilities (Itemize)			$ 250,469

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, I	932-C	9/30/2019	32	37

	Account				Amount
			Total Brought Forward:	$	2,699,650
C.	Leasehold or like property recorded for Equity Purposes.				
	1. Land			$	96,281
	2. Land Improvements	*Historical Cost			
		Accum. Depreciation	Net	$	
	3. Buildings	*Historical Cost	5,413,714		
		Accum. Depreciation	4,354,703 Net	$	1,059,011
	4. Non-Movable Equipment	*Historical Cost			
		Accum. Depreciation	Net	$	
	5. Movable Equipment	*Historical Cost			
		Accum. Depreciation	Net	$	
	6. Motor Vehicles	*Historical Cost			
		Accum. Depreciation	Net	$	
	7. Minor Equipment-Not Depreciable			$	
C-8	***Total Leasehold or Like Properties*** (C1 thru 7)			$	1,155,292
D.	Investment and Other Assets				
	1. Deferred Deposits			$	331,585
	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*)			$	316,697
	Name and Address	Amount	Loan Date		
	Various	316,697	Various		
	7. Other Assets (*itemize*)			$	
	See Schedule				
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)			$	648,282
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	4,503,224

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 1,531,041
	2. Notes Payable (*itemize*)				$ 30,432
	See Schedule			30,432	
	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*)				$ 277,353
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 51,617
	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*)				$ 250,469
	See Schedule			250,469	
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,140,912

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	34	37

Account	Amount
Total Brought Forward:	2,140,912
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 2,140,912

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

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital,	932-C	9/30/2019	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$ 96,281
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$ 1,203,624
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$ 359,364
	6. Total Reserves	$ 1,659,269
B.	**Net Worth**	
	1. Owner's Capital	$ 1,820
	2. Capital Stock	$ 515,923
	3. Paid-in Surplus	$ 9,340
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 229,096
	6. Gain or Loss for Period 10/1/2018 thru 9/30/2019	$ (53,136)
	7. Total Net Worth	$ 703,043
C.	***Total Reserves and Net Worth***	$ 2,362,312
D.	***Total Liabilities, Reserves, and Net Worth***	$ 4,503,224

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, In	932-C	9/30/2019	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2018			$ 398,608
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 6,087,367
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 6,140,503
D.	Net Income or Deficit			$ (53,136)
E.	Balance			$ 345,472
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*** 09/30/19			$ 345,472

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2019	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer	
CJLC, LLC	
Addres Address	Phone Number
225 Pitkin Street, East Hartford, CT 06108	860-610-9009
Annual Report Contact	Phone Number
annualreports@cjlc.com	860-610-9009
Annual Report Contact Email Address	
annualreports@cjlc.com	