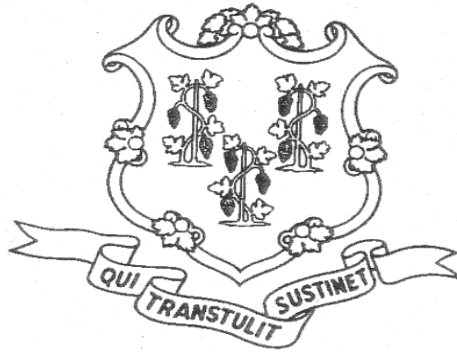


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

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 <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH 932-C	RHNS	(Specify)	Medicare Provider 07-5349
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Medicaid Provider Numbers:	CCNH 7226948	RHNS	ICF-IID
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For Department Use Only

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

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General Information

Name of Facility (as licensed) Cook Willow Convalescent Hospital, Inc.	License No. 932-C	Report for Year Ended 9/30/2017	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Cook Willow Convalescent Hospital, Inc. [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, 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) <i>Susan MacDonald</i>		Date 3/27/18	Signed (Owner) <i>Susan MacDonald</i>		Date 2/27/18
Printed Name (Administrator) Susan MacDonald			Printed Name (Owner) Susan MacDonald		
Subscribed and Sworn to before me:	State of CT	Date 2/27/18	Signed (Notary Public) <i>J. Schott</i>	Comm. Expires 07/31/18	
Address of Notary Public					

(Notary Seal)



JULIE PHELAN SCHOTT
 NOTARY PUBLIC
 STATE OF CONNECTICUT
 MY COMM. EXP. 07-31-18

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 10/1/2016	To 9/30/2017
Address of Facility 81 Hillside Ave., Plymouth, CT 06782				
Report Prepared By CJLC LLC		Phone Number 860-610-9009	Date 3/5/2018	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-283-8208		Report for Year Ended 9/30/2017	Page 2	of 37
Name of Facility (as shown on license) Cook Willow Convalescent Hospital, Inc.		Address (No. & Street, City, State, Zip) 81 Hillside Ave., Plymouth, CT 06782		
License Numbers:	CCNH 932-C	RHNS (Specify)	Medicare Provider No. 07-5349	
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Susan MacDonald		Nursing Home Administrator's License No.:	631	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire
Corporate Owners

Name of Facility Cook Willow Convalescent Hospital, Inc.	License No. 932-C	Report for Year Ended 9/30/2017	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
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	Business Address	Title	No. Shares Held by Each
Susan MacDonald	61 Maple Ave., Plymouth, CT 06782	resident/Directo	100

General Information and Questionnaire
Related Parties*

Name of Facility Cook Willow Convalescent Hospital, Inc.	License No. 932-C	Report for Year Ended 9/30/2017	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
See Attachment		<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 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 Cook Willow Convalescent Hospital, Inc.	License No. 932-C	Report for Year Ended 9/30/2017	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

**General Information and Questionnaire
Leases (Excluding Real Property)**

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

Name of Facility Cook Willow Convalescent Hospital, Inc.			License No. 932-C	Report for Year Ended 9/30/2017			Page 6	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						
N/A	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input type="radio"/> No	Total ***

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

General Information and Questionnaire
Accounting Basis

Name of Facility Cook Willow Convalescent Hospit	License No. 932-C	Report for Year Ended 9/30/2017	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 CJLC LLC 2 A/R Solutions 3 Honkamp Krueger 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin Street, East Hartford, CT 06108 PO Box 592 Wallingford, CT 06492 630 River Drive, Bettendorf, Iowa 52722
--	--

Services Provided by This Firm (*describe fully*)

1 Medicaid and Medicare Cost Report, Accounting Services, Tax Services	\$ 15,000
2 AR Services	\$ 2,035
3 Pension Plan	\$ 1,137
4	\$
	Charge for Services Provided \$ 18,172

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 1 Murtha Cullina 2 Robert A Zeigler 3 4 5	Telephone Number 860-240-600 860-793-1506
---	---

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 Collection Issues - Disallowed	\$ 12,885
2 Employment Issues	\$ 7,499
3	\$
4	\$
5	\$
	Charge for Services Provided \$ 20,384

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

Schedule of Resident Statistics

Name of Facility		License No.			Report for Year Ended				Page	of			
Cook Willow Convalescent Hospital, Inc.		932-C			9/30/2017				8	37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	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	58	58			58	58			50	50			
B. As of midnight of THIS report period	49	49			50	50			49	49			
3. Total Number of Days Care Provided During Period													
A. Medicare	1,209	1,209			961	961			248	248			
B. Medicaid (Conn.)	14,395	14,395			10,771	10,771			3,624	3,624			
C. Medicaid (other states)													
D. Private Pay	1,952	1,952			1,374	1,374			578	578			
E. State SSI for RCH													
F. Other (Specify) Insurance / Managed Care	543	543			417	417			126	126			
G. Total Care Days During Period (3A thru F)	18,099	18,099			13,523	13,523			4,576	4,576			
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)	18,099	18,099			13,523	13,523			4,576	4,576			

Schedule of Resident Statistics (Cont'd)

Name of Facility Cook Willow Convalescent Hospital, Inc.			License No. 932-C			Report for Year Ended 9/30/2017			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 (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH	RHNS	(Specify)	
				(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH		CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID				
No. of Residents													
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.													
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									1,827	1,827			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									181	181			
C. Other									3,526	3,526			
D. Total Physical Therapy Treatments									5,534	5,534			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									189	189			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									19	19			
C. Other									460	460			
D. Total Speech Therapy Treatments									668	668			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									1,819	1,819			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									143	143			
C. Other									3,205	3,205			
D. Total Occupational Therapy Treatments									5,167	5,167			

Report of Expenditures - Salaries & Wages

Name of Facility Cook Willow Convalescent Hospital, Inc.	License No. 932-C	Report for Year Ended 9/30/2017	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	83,044	1,947				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	138,803	6,863				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	259,248	21,527				
6. Housekeeping Service						
a. Head Housekeeper	28,522	1,951				
b. Other Housekeeping Workers	82,482	7,520				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	61,673	4,264				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	61,008	5,537				
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	102,666	2,258				
b. RN						
1. Direct Care	414,582	11,717				
2. Administrative**	77,263	2,228				
c. LPN						
1. Direct Care	424,288	14,123				
2. Administrative**						
d. Aides and Attendants	655,749	43,591				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	49,179	3,310				
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	41,534	2,079				
n. Marketing						
o. Other (Specify) See Attached Schedule	23,325	1,500				
<i>A-13. Total Salary Expenditures</i>	2,503,368	130,415				

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

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

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

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Cook Willow Convalescent Hospital, Inc.				932-C	9/30/2017			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
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).										
Jennessa LeClair (10/1/16 to 9/30/17)	53,910			Standard	Office Manager	2,291	A4			
Ernie LeClair (10/1/16 to 9/30/17)	38,978			Standard	Maintenance	2,198	A7b			
Walter MacDonald (10/1/16 to 9/30/17)	6,516			Standard	Office, Housekeeping, Maintenance	434	A4, A6b, A7			

* 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	
Cook Willow Convalescent Hospital, Inc.				932-C	9/30/2017			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Susand MacDonald (10/1/16 to 9/30/17)	83,044			Standard	Administrator	1,947	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.

Annual Report of Long-Term Care Facility

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2017	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	8,420	211				
2. Dentist	6,840	96				
3. Pharmacist	4,529	46				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	108,108	1,737				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	12,697	98				
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	20,779	531				
b. Other						
10. Occupational Therapist						
a. Resident Care	112,277	1,604				
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	273,650	4,322				

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

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

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2017	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 103,920	103,920		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 55,266	55,266		
4. Social Security (F.I.C.A.)	\$ 187,957	187,957		
5. Health Insurance	\$ 164,959	164,959		
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 9,728	9,728		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 2,306	2,306		
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 18,172	18,172		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 20,384	20,384		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$ 37,109	37,109		
g. Office Supplies	\$ 5,530	5,530		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 8,732	8,732		
2. Cellular Phones	\$ 4,738	4,738		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$ 331	331		
3. Resident Day User Fee	\$ 349,205	349,205		
Subtotal	\$ 968,338	968,338		

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2017		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	968,338	968,338			
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$	6,360	6,360		
4. Employee Travel	\$	2,334	2,334		
5. Education Expenses Related to Seminars and Conventions	\$	5,052	5,052		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	2,526	2,526		
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	4,951	4,951		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$	375	375		
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	2,476	2,476		
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	\$	2,595	2,595		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	4,369	4,369		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	719	719		
10. Contributions*** See Attached Schedule	\$	1,175	1,175		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	1,999	1,999		
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$	66,214	66,214		
C-14 Total Administrative & General Expenditures	\$	1,069,482	1,069,482		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
ADVERTISING OTHER	\$ 2,476		
Total Other Advertising	\$ 2,476	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 4,144		
ALTCFM	\$ 225		
Total Dues	\$ 4,369	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
DONATION EXPENSE	\$ 1,175		
Total Contributions	\$ 1,175	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
CONSULTANT	\$ 8,945		
FINES AND PENALTIES	\$ 4,966		
COMPUTER EXPENSE	\$ 28,264		
LICENSES, FEES	\$ 2,785		
PAYROLL PROCESSING	\$ 16,040		
CREDIT CARD FEES	\$ 544		
BANK CHARGES	\$ 1,585		
OTHER ADMINISTRATIVE EXPENSE	\$ 380		
HIRING COSTS	\$ 2,705		
Total Other Administrative and General	\$ 66,214	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Cook Willow Convalescent Hospital, Inc	License No. 932-C	Report for Year Ended 9/30/2017	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 #
N/A			

* 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		License No.	Report for Year Ended		Page	of
Cook Willow Convalescent Hospital, Inc.		932-C	9/30/2017		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 191,539	191,539			
2.	Non-Food Supplies	\$ 17,317	17,317			
3.	Other (Specify) _____ Cook Willow Only Food	\$ 111,261	111,261			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Management Services**		\$				
d. Other (Specify) _____		\$				
2E. Total Dietary Expenditures (2a + b + c + d)		\$ 320,117	320,117			
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)	
G. Resident Meals: Total no. of meals served per day:*						
H. Is cost of employee meals included in 2E? <input checked="" type="radio"/> Yes <input type="radio"/> No						
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.						
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify cost.						
L. Is any revenue collected from these people? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify amt.						
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input checked="" type="radio"/> Yes <input type="radio"/> No If yes, specify cost.						
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.						
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)						

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

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

Name of Facility		License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.		932-C	9/30/2017	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. \$	1,589	1,589		
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 (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	865	865		
c. Management Services**	\$				
d. Other (<i>Specify</i>) Supplies	\$	12,519	12,519		
3E. Total Laundry Expenditures (3a + b + c + d)	\$	14,973	14,973		
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
 All allocations should add to total recorded in 3E.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 *** Pounds of Laundry only required for multi-level facilities.

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

Name of Facility		License No.	Report for Year Ended		Page	of
Cook Willow Convalescent Hospital, Inc.		932-C	9/30/2017		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	28,115	28,115		
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. \$	3,127	3,127		
c.	Management Services*		\$			
d.	Other (<i>Specify</i>)		\$			
4E.	Total Housekeeping Expenditures (4a + b + c + d)		\$ 31,242	31,242		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	61,306	61,306		
b.	Medicine Cabinet Drugs	\$	7,644	7,644		
c.	Medical and Therapeutic Supplies	\$	88,973	88,973		
d.	Ambulance/Limousine***	\$	5,037	5,037		
e.	Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	6,885	6,885		
f.	X-rays and Related Radiological Procedures***	\$				
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	2,981	2,981		
i.	Recreation	\$	13,672	13,672		
j.	Other (Specify)**** See Attached Schedule	\$	15,312	15,312		
5K.	Total Resident Care Expenditures (5a - 5j)		\$ 201,809	201,809		

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

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

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

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

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

Name of Facility Cook Willow Convalescent Hospital, Inc.			License No. 932-C		Report for Year Ended 9/30/2017				Page of 21 37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
N/A		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2017			22	37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	33,222	33,222			
b. Heat	\$	25,213	25,213			
c. Light & Power	\$	56,963	56,963			
d. Water	\$	41,909	41,909			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$	15,555	15,555			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	172,862	172,862			
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$	51	51			
b. Building & Building Improvements	\$	144,613	144,613			
c. Non-Movable Equipment	\$	6,806	6,806			
d. Movable Equipment	\$	38,497	38,497			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	189,966	189,966			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$	27,779	27,779			
c. Leasehold Improvements	\$	9,621	9,621			
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$	37,400	37,400			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	688,100	688,100			
10. Property Taxes						
a. Real estate taxes paid by owner	\$	74,693	74,693			
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$	7,471	7,471			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	997,630	997,630			

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

Cook Willow Convalescent Hospital, Inc.
9/30/2017

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:				
12/1/2016	Booster Heater	\$ 1,579	10	\$ 158
Total additions for Non-Movable Equipment		\$ 1,579		\$ 158 *
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:				
7/10/2017	Resident Furniture	\$ 2,849	5	\$ 142
9/12/2017	Resident Furniture	\$ 59,988	5	\$ 1,000
Total additions for Movable Equipment		\$ 62,837		\$ 1,142 *
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:				
12/1/2016	Cabinets	\$ 5,146	20	\$ 193
1/1/2017	Countertops	\$ 7,843	20	\$ 294
4/28/2017	Water Heater	\$ 1,171	10	\$ 59
9/1/2017	Water Heater	\$ 1,165	10	\$ 58
Total additions for Leasehold Improvement		\$ 15,325		\$ 604 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
Cook Willow Convalescent Hospital, Inc.			932-C		9/30/2017			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. HUD Mortgage Aq Fees - New	9	2001	30 yrs	329,805	165,818			10,994	
2. HUD Mortgage Aq Fees - Extension	9	2001	30 yrs	453,482	228,000			15,116	
3. Extension Fees	12	2002	30 yrs	50,070	24,617			1,669	
B-4. Subtotal									27,779
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	Var	Var	Var	192,410	101,960	SL		9,017	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				15,325				604	
C-4. Subtotal									9,621
D. Total Amortization									37,400

* 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 Cook Willow Convalescent Hospital,	License No. 932-C	Report for Year Ended 9/30/2017	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?*

Yes No

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

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

Description	Total
1. Date Land Purchased	7/30/1974
2. Date Structure Completed	7/30/1974
3. If NOT Original Owner, Date of Purchase	
4. Date of Initial Licensure	7/30/1974
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 9/30/16	3,576,621			
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	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital	932-C	9/30/2017	26	37
Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
2. Second Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
3. Third Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
4. Fourth Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount	\$			
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Cook Willow Convalescent Hospit		932-C		9/30/2017		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$ 2,364	2,364		
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)				\$ 2,364	2,364		
12. D. Other Interest Expense (Specify) REAL ESTATE TAXES				\$ 12,404	12,404		
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 14,768	14,768		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 93,224	93,224		
b. Insurance on Automobiles				\$ 3,959	3,959		
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)				\$ 97,184	97,184		
15. Total All Expenditures (A-13 thru C-14)				\$ 5,697,084	5,697,084		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.				932-C	9/30/2017	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	\$ 112,277	112,277		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.	15	1e	Accounting & Legal	\$ 12,885	12,885		
11.			Telephone	\$			
12.	15	1h.2	Cellular Telephone	\$ 3,298	3,298		
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators	\$ 37,109	37,109		
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	16.1	Automobile Expense (e.g. personal use)	\$ 1,263	1,263		
18.	16	m2/m	Unallowable Advertising *	\$ 2,851	2,851		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$ 1,175	1,175		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 5,890	5,890		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$ 61,167	61,167		
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)				\$ 237,915	237,915		

* 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	FINES AND PENALTIES	\$ 4,966		
16	m13	CREDIT CARD FEES	\$ 544		
16	m13	OTHER ADMINISTRATIVE EXPENSE	\$ 380		
Total Other A&G Adjustments			\$ 5,890	\$ -	\$ -

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	9/30/2017	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 237,915	237,915		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 61,306	61,306		
28.	20	5d	Ambulance/Limousine	\$ 5,037	5,037		
29.			X-rays, etc	\$			
30.	20	5f	Laboratory	\$ 2,981	2,981		
31.			Medical Supplies	\$			
32.	20	5e.2	Oxygen (non emergency)	\$ 6,885	6,885		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 14,844	14,844		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 13,862	13,862		
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$ 5,412	5,412		
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 4,165	4,165		
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.	27	14b	Property Insurance	\$ 2,071	2,071		
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 354,478	354,478		

*** 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.

Cook Willow Convalescent Hospital, Inc.
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV CONSULT MED A	\$ 1,350		
20	5j	IV THERAPY EXPENSE	\$ 8,182		
20	5j	OUTSIDE MED SERVICES MED A	\$ 5,312		
Total Other Ancillary Costs			\$ 14,844	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		Motor Vehicle Depreciation	\$ 13,862		
Total Excess Movable Equipment Depreciation			\$ 13,862	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		Apartment Allocation	\$ 3,492		
		Meals on Wheels Allocatoin	\$ 673		
Total Other Property Adjustments			\$ 4,165	\$ -	\$ -

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			\$ -	\$ -	\$ -

Annual Report of Long-Term Care Facility

CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2017		30	37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 4,138,640	4,138,640			
b. Medicaid Room and Board Contractual Allowance **	\$ (876,101)	(876,101)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 634,940	634,940			
b. Medicare Room and Board Contractual Allowance **	\$ 17,106	17,106			
4. a. Private-Pay Residents and Other	\$ 753,645	753,645			
b. Private-Pay Room and Board Contractual Allowance **	\$ 17,356	17,356			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 52,163	52,163			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$ 4,146	4,146			
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	\$ 89,154	89,154			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 106,963	106,963			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 37,833	37,833			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 20,130	20,130			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 144,105	144,105			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 45,799	45,799			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (<i>Specify</i>) - Medicare	\$ (266,814)	(266,814)			
b. Other (<i>Specify</i>) - Non-Medicare	\$ (28,944)	(28,944)			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 4,890,122	4,890,122			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$ 100,045	100,045			
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 674	674			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 410	410			
V. Total Other Revenue (1 thru 8)	\$ 101,129	101,129			
VI. Total All Revenue (III +V)	\$ 4,991,251	4,991,251			

* 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	\$ 1,307		
	LAB - MEDICARE A	\$ 4,173		
	CONT ALW MEDICARE A	\$ (251,796)		
	CONT ALW ANCILL MEDICARE B	\$ (20,498)		
Total Other Resident Revenue - Medicare		\$ (266,814)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	X-RAY - INSURANCE	\$ 67		
	LAB - INSURANCE	\$ 2,575		
	LAB -EVERCARE	\$ 11,934		
	CONT ALW ANCILLARIES	\$ 704		
	CONT ALW ANCILL INSURANCE	\$ (47,249)		
	CONT ALW ANCILL EVERCARE	\$ (10,234)		
	EVERCARE DIVIDENDS	\$ 13,260		
Total Other Resident Revenue		\$ (28,944)	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	INTEREST INCOME		\$ 674		
Total Interest Income			\$ 674	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	MISC. REVENUE	\$ 410		
Total Other Revenue		\$ 410	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	114,875
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,047,282
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	4,807
5. Prepaid Expenses			\$	25,589
a. PREPAID INSURANCE	39,432			
b. PREPAID INTEREST	174			
c. PREPAID PERSONAL PROP TAXES	5,050			
d. PREPAID WATER & SEWER	(19,067)			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	71,510
DUE FROM EMPLOYEES	100			
WEBSTER RECEIVABLE	71,410			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,264,062
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	3,509	\$	242
	Accum. Depreciation	3,267		Net
3. Buildings	*Historical Cost		\$	
	Accum. Depreciation			Net
4. Leasehold Improvements	*Historical Cost	207,734	\$	96,153
	Accum. Depreciation	111,581		Net
5. Non-Movable Equipment	*Historical Cost	76,600	\$	19,652
	Accum. Depreciation	56,948		Net
6. Movable Equipment	*Historical Cost	685,637	\$	130,599
	Accum. Depreciation	555,038		Net
7. Motor Vehicles	*Historical Cost	128,377	\$	61,738
	Accum. Depreciation	66,639		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	(7,854)
Book Vs Cost Report		(7,854)		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	300,530

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.	932-C	9/30/2017	32	37
Account			Amount	
Total Brought Forward:			\$	1,564,592
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	4,065,477	Net	\$
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)			\$	1,444,518
D. Investment and Other Assets				
1. Deferred Deposits			\$	387,143
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>)			\$	1,097,803
Name and Address	Amount	Loan Date		
Various	1,097,803	Various		
7. Other Assets (<i>itemize</i>)			\$	

D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	1,484,946
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	4,494,056

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Cook Willow Convalescent Hospital, Inc.		932-C	9/30/2017	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	1,309,873
2. Notes Payable (itemize)				\$	64,409
NOTE PAYABLE UNITED BANK				(1,617)	
NOTE PAYABLE VALUE HEALTH				4,934	
NOTE PAYABLE - HUNTINGTON N.B.				25,926	
Note Payable - Citizens				35,167	
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)				\$	187,888
5. Accrued Payroll (Owners and/or Stockholders only)				\$	
6. Accrued Payroll Taxes Payable				\$	21,049
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)				\$	129,304
P/R 401-K		4,150 ACCRUED INTEREST	(2,421)		
P/R DISABILITY INSURANCE		(2,050) ACCRUED EXPENSE C	2,371		
P/R LIFE INSURANCE		2,444 DUE TO RESIDENT TF	13,575		
P/R GARNISHMENT		3,899 DUE TO MEDICAID U:	107,337		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,712,523

* 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 Cook Willow Convalescent Hospital, Inc.	License No. 932-C	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount
Total Brought Forward:				1,712,523
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>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$

B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$
C. Total All Liabilities (Lines A-13 + B-5)				\$ 1,712,523

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	9/30/2017	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			\$	1,492,850
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			\$	
5. Reserve for funds set aside as donor restricted			\$	414,922
6. Total Reserves			\$	2,004,053
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			\$	956,231
6. Gain or Loss for Period			\$	(705,833)
	10/1/2016	thru	9/30/2017	
7. Total Net Worth			\$	777,481
C. Total Reserves and Net Worth			\$	2,781,534
D. Total Liabilities, Reserves, and Net Worth			\$	4,494,056

H. Changes in Total Net Worth

Name of Facility Cook Willow Convalescent Hospital, Inc.	License No. 932-C	Report for Year Ended 9/30/2017	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	1,463,723
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	4,991,251
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	5,697,084
D. Net Income or Deficit			\$	(705,833)
E. Balance			\$	757,890
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			\$	757,890
				09/30/17

I. Preparer's/Reviewer's Certification

Name of Facility Cook Willow Convalescent Hospital, Inc.		License No. 932-C	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Preparer/Reviewer Certification					
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>					
Signature of Preparer 		Title CPA	Date Signed 3/5/18		
Printed Name of Preparer CJLC LLC					
Address 225 Pitkin Street, East Hartford, CT 06108			Phone Number 860-610-9009		