State of Connecticut

Annual Report of Long-Term Care Facility
Cost Year 2016

Name of Facility (as licensed) Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center
Address (No. & Street, City, State, Zip Code) 205 Chestnut Hill Road, Stafford Springs, CT 06076
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Report for Year Beginning	Report for Year Ending
12/29/2015	9/30/2016

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2081C			07-5326

Medicaid Provider Numbers:	CCNH	RHNS	ICF-MR
	2081C		

For Department Use Only

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

MYERS AND STAUFFER LLC
CERTIFIED PUBLIC ACCOUNTANTS

December 11, 2013

Mr. Michael E. Mosier
Chief Financial Officer
Athena Health Care Systems
135 South Road
Farmington, CT 06032

Subject: Alternative Annual Report Approval

Dear Mr. Mosier:

This letter is a follow-up to your verbal approval regarding your request for alternative annual report utilization. We have reviewed your request for approval of the Athena Health Care Systems version of the 2013 Annual Report for the State of Connecticut. Based on our review, your version of the annual report has been approved.

It is not necessary to request approval on an annual basis. This approval will remain in effect until modifications have been made to the Annual Report by the Department of Social Services. The provider community will be notified should such changes occur. At that time, you will be required to submit a new request for approval based on the modified annual report.

Should you have any questions, please feel free to contact me at (860) 687-0790.

Sincerely,

Brittany L. Hester

Brittany L. Hester, Administrative Assistant

CC: Claudette B. Pickens, CPA
CC: Chris Lavigne

7 Waterside Crossing, Ste 202 | Windsor, CT 06095
PH 860.687.0790 | PH 855.716.9377 | FX 860.687.0810
www.mslc.com

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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 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 **Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center** [facility name] for the cost report period beginning **December 29, 2015** and ending **September 30, 2016**, 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 penalities 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
Christine M. McKinney	2/15/17		2/15/17
Printed Name (Administrator) **Christine M. McKinney**		Printed Name (Owner) **Lawrence Santilli**	
Subscribed and Sworn to before me: State of CONN	Date 2/15/17	Signed (Notary Public)	Comm. Expires 3/31/20
Address of Notary Public		41 Terrace Ln Bristol CT 06010	

(Notary Seal)

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State of Connecticut
Department of Social Services
25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility **Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center**	Period Covered:		From **12/29/2015**	To **9/30/2016**
Address of Facility **205 Chestnut Hill Road, Stafford Springs, CT 06076**				
Report Prepared By **Athena Health Care Associates, Inc**	Phone Number **(860) 751-3900**		Date **2/15/2017**	

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
860-684-6341	**09/30/16**	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**205 Chestnut Hill Road, Stafford Springs, CT 06076**

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2081C			**07-5326**

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.

Facility purchased on 12/29/2015

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Christine M McKinney	**001627**

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

Name	License No.:
Not Applicable	

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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
Stafford Springs CT SNF LLC	**205 Chestnut Hill Rd, Stafford Springs, CT**	**CT**

Name of Partners/Members	Business Address	Title	% Owned
Lawrence G Santilli	**135 South Rd Farmington, CT 06032**	**President**	**54.0000%**

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General Information and Questionnaire
Corporate Owners

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

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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Not Applicable			
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility

Not Applicable

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General Information and Questionnaire
Related Parties*

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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: Yes	No	%**	Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
Athena Stafford Springs Landlord LLC	**135 South Rd, Farmington, CT 06032**	☐	☑		**Lease of Property**	**Pg 22 L9**	**$685,108**	**$540,660**
Athena Health Care Assoc 401k Plan	**135 South Rd, Farmington, CT 06032**	☐	☑		**Facility participates in common 401k plan**			
Athena Health Care	**135 South Rd, Farmington, CT 06032**	☑	☐	**<50%**	**See Attached**			
Misc Facilities	**Various Addresses**	☑	☐	**>98%**	**Interfacility Loans**	**Pg 33 A2**		
Bayview Health Care Center	**301 Rope Ferry Rd Waterford, CT**	☑	☐	**>98%**	**JDR Software Settlement**	**Pg 16 Ln M13**	**$1,511**	**$1,511**
Procare Pharmacy	**111 Executive Blvd, Farmingdale, NY 11735**	☑	☐	**>98%**	**Pharmacy Services**	**pg 20 5a2, 5b,**	**$52,135**	**$52,135**
		☐	☐	**>98%**				
		☐	☐					
		☐	☐					

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

Evergreen Health Care
RELATED PARTIES QUESTIONNAIRE
PAGE 4

Report for FYE 9/30/2016

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No	%**				
Athena Health Care	135 South Rd Farmington, CT 06032	X		<50%	Management Fees, Marketing , Nursing Fill in Postage, Payroll, MIS , Gift Cards, Painters	Pg. 16 Ln 12, Pg 16 M3, Pg 13 Ln11a2 Pg 16 Ln M3, M13, M7, Pg 22 Ln 6a	$552,388	$227,431
Athena Health Care	135 South Rd Farmington, CT 06032		x		Health Insurance	PG 15 Ln 1a5	$897,352	$897,352

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General Information and Questionnaire
Basis for Allocation of Costs

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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

Not Applicable

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

Not Applicable

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Leaf Capital, PO Box 742647 Cincinnati, OH 45274	☐	☑	**Copier**	**12/30/15**	**48 Months**	**$10,809**	**$9,008**
Pitney Bowes, PO Box 371887, Pittsburgh, PA 15250	☐	☑	**Mail Machine**	**01/04/16**	**63 Months**	**$804**	**$601**
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
						Total ***	$9,609

Is a Mileage Log Book Maintained for All Leased Vehicles ? **Not Applicable - No 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.

LEAF

LEASE AGREEMENT

1720A Crete Street, Moberly, MO 65270
Phone: 800-662-3759, Fax: 800-426-2626

LESSEE LEGAL NAME:	Tax ID#:	Telephone No
Athena Health Care Associates, Inc.	999999999	8607513900

Billing Address:	Equipment Location (if other than Billing Address):
135 South Road, Farmington, CT 06032	135 South Road, Farmington, CT 06032

EQUIPMENT DESCRIPTION: (indicate quantity, new or used and include make, model, serial # and all attachments – see below and/or attached Schedule A)

Unit Quantity	Description of Equipment Leased	Make and Type	Model Number	Serial Number
1	See Sched. A			

BASE TERM IN MONTHS	TOTAL NUMBER OF LEASE PAYMENTS	END OF LEASE PURCHASE OPTION		
48	48 @ $847.00 (plus taxes)	✓ Fair market value, plus taxes ___ 10% of Equipment cost, plus taxes ___ $1.00, plus taxes (FMV unless another option is selected. You may not exercise a purchase option if you are in default. If you exercise a purchase option we will convey all of our right, title and interest in such Equipment to you on an AS-IS WHERE IS without warranty.)	(a) Advance Payment:	$0.00
			(b) Security Deposit:	$0.00
			(c) Documentation Fee:	$95.00
			Total due a + b + c =:	$95.00

**If more than one lease payment is required as an Advance Payment, the balance will be applied to lease payments in inverse order, starting with the last lease payment.
Your obligation to pay all amounts and perform all other obligations is non-cancellable, absolute, unconditional and not subject to abatement, set-off or defense.

TERMS AND CONDITIONS

In this agreement ("Lease"), "we," "our," and "us" refers to **LEAF Capital Funding, LLC** as Lessor and "you" and "your" refer to the Lessee. You agree to lease the Equipment upon the following terms and conditions:

1. LEASE PAYMENTS AND TERM: The Lease is enforceable on you upon your execution. The term of the Lease shall commence on the date the Equipment is delivered to you ("Lease Commencement Date"). The first Lease Payment shall be due on the date we specify in the month following the Lease Commencement Date as set forth in our invoice, and the remaining Lease Payments will be due on the same day of each subsequent month (each, a "Payment Date") until paid in full. The Base Term shall commence on the date one month prior to the first Payment Date. We may charge you a portion of one Lease Payment for the period from the Lease Commencement Date until the first day of the Base Term ("Interim Rent"). The Interim Rent shall be due as invoiced. We may adjust the Lease Payments up to 15% if the actual costs are different than the estimate used to calculate the Lease Payments.

2. DELIVERY, ACCEPTANCE, USE AND REPAIR: You are responsible for Equipment delivery and installation. Unless you notify us otherwise in writing within 10 days of delivery, you unconditionally accept the Equipment. You authorize us to fill in the Lease Commencement Date, serial numbers and other information. **You will not move the Equipment from the above location without our written consent and are responsible for maintaining the Equipment in good repair.** We are not responsible for Equipment or vendor failures.

3. INDEMNIFICATION: You agree to indemnify, defend and hold us harmless from and against any losses, damages, penalties, claims and suits, including attorneys' fees and expenses related to the ordering, manufacture, installation, ownership, condition, use, lease, possession, delivery or return of Equipment.

4. LEASE EXPIRATION, RENEWAL: Unless you notify us at least 90 days prior to the expiration of the Lease of your election to return or purchase the Equipment, this Lease will renew on a month-to-month basis at the same monthly Lease Payment until you either exercise the purchase option or provide us with at least 90 days notice and return the Equipment. If you return the Equipment, (i) it must be to the location we designate and you are responsible for all return costs and we may charge a Restocking Fee equal to one Lease Payment, and (ii) you must securely remove all data from any and all disk drives or magnetic media prior to returning the Equipment (and you are solely responsible for selecting an appropriate removal standard that meets your business needs and complies with applicable laws). You will pay us for any loss in value resulting from failure to maintain the Equipment in accordance with this Lease or for damages incurred in shipping and handling. If you exercise a purchase option we will convey all of our interest in such Equipment to you on an AS-IS WHERE IS basis without representation or warranty.

5. LATE FEES AND CHARGES: If any amount is not paid within five (5) days of when due, you agree to pay us a late charge equal to the lesser of 10% of the amount past due or the maximum legal amount. Amounts which are not paid within 30 days of when due shall accrue interest at 1.5% per month (or if less, the maximum legal rate) until paid. You agree to pay $25 for each pay by phone and $35 for each returned payment.

6. NO WARRANTY: We do not manufacture the Equipment and you have selected the Equipment and the supplier. **WE MAKE NO EXPRESS OR IMPLIED WARRANTIES, INCLUDING THOSE OF MERCHANTABILITY OR FITNESS FOR A PURPOSE AND ARE NOT RESPONSIBLE FOR CONSEQUENTIAL OR INCIDENTAL DAMAGES.**

7. INSURANCE, RISK OF LOSS: You bear all risk of loss or damage to the Equipment from its order until it is returned in the required condition or purchased by you ("Risk Period"). During the Risk Period you will maintain property and liability insurance on the Equipment acceptable to us, naming us loss payee and additional insured. If you do not provide us with proof of such insurance, we may secure insurance on the Equipment to cover our interests (and only our interests). If we obtain such insurance, you will pay us an additional amount for the cost of such insurance and an administrative fee, the cost of which may be more than the cost to obtain your own insurance and on which we may make a profit.

8. OWNERSHIP AND TAXES: We own the Equipment (excluding licensed software). If you are deemed to own it, you grant us a security interest in the Equipment. You authorize us to file UCC financing statements to confirm our interest. You will pay, when due, all taxes, fines and penalties relating to the purchase, use, leasing and/or ownership of the Equipment. For administrative purposes, unless we otherwise direct in writing, you will list Lessee as the owner of the Equipment for property tax purposes and file and pay when due any property taxes relating to the Equipment directly to the taxing authority and provide us with evidence of compliance. If we pay any taxes, fees or penalties on your behalf, you will pay us the amount we paid plus an administrative fee. You agree to pay us the documentation fee specified above or if not so specified, the greater of either $125 or 0.5% of the Equipment cost. If we require an Equipment site inspection, or you request administrative services, you agree to reimburse our costs.

9. DEFAULT: If you or any guarantor do not pay us any amount within ten (10) days of its due date, or breach any terms of this Lease, any guaranty or any license relating to the Equipment, you will be in default. If you default, we may require you to do any combination of the following: (a) immediately pay all amounts then due, plus the present value of the remaining Lease Payments, Interim Rent and residual value of the Equipment, as determined by us, discounted at an annual rate of 3%; (b) return all of the Equipment; (c) allow us to repossess the Equipment; or (d) use any and all remedies available to us under applicable law. If you default, you agree to pay the cost of repossession and our attorney's fees and costs. In addition to all other charges and as reimbursement for expenses incurred and not as a penalty, we may require you to reimburse us for the phone calls, letters, and any additional expense incurred in the collection or servicing of this Lease for you. If we take possession of the Equipment, we may sell or otherwise dispose of it with or without notice, at a public or private sale, and apply the net proceeds (after we have deducted all costs related to the sale or disposition of the Equipment) to the amounts that you owe us. You agree that if notice of sale is required by law, 10 days' notice shall constitute reasonable notice. You remain responsible for any amounts that are due after we have applied such net proceeds. We may apply any security deposits to your obligations and if you do not default, the balance will be refunded without interest.

10. ASSIGNMENT: You have no right to sell or assign the Equipment or Lease. We may sell or assign our rights in the Lease and/or Equipment and the new owner will have all our rights but will not be subject to any claim or defense you have against us.

11. ARTICLE 2A: You agree this Lease is a "finance lease" as defined in Article 2A of the Uniform Commercial Code. **You waive all rights and remedies conferred upon a lessee by Article 2A (508-522) of the UCC.** You have received a copy of the Supply Contract or been informed of the identity of the Supplier and you may have rights under the Supply Contract and may contact the Supplier for a description of those rights.

12. CREDIT INFORMATION: You authorize us or any of our affiliates to obtain credit bureau reports, and make other credit inquiries that we deem necessary.

13. CHOICE OF LAW: THIS LEASE WILL BE GOVERNED BY PENNSYLVANIA LAW. YOU CONSENT TO JURISDICTION IN THE STATE OR FEDERAL COURTS IN PENNSYLVANIA AND WAIVE ANY RIGHT TO A TRIAL BY JURY.

14. MISCELLANEOUS: This Lease is the parties' entire agreement and can be amended only in writing signed by both parties. A fax of the Lease with fax signatures may be treated as an original and will be admissible as evidence. You will use the Equipment only for business purposes and not for personal, family or household use.

ACCEPTED BY LESSEE: Athena Health Care Associates, Inc.

Print Name: X Christine M. McInerney Title: Administrator

X Christine M. McInerney
Lessee Authorized Signature

E-Mail Address: X Administrator@Eversrec Date: 12/30/15

PERSONAL GUARANTY: Undersigned guarantees that Lessee will make all payments and perform all other obligations under the Lease when due. Undersigned agrees that this is a guaranty of payment and not of collection, and that we can proceed directly against undersigned without first proceeding against Lessee or the Equipment. Undersigned also waives all suretyship defenses and notification if the Lessee is in default and consents to any extensions or modifications granted to Lessee. Undersigned will pay us all expenses (including attorneys' fees) we incur in enforcing our rights against undersigned or Lessee. If more than one person signs this guaranty, each agrees that his/her liability is joint and several. Undersigned authorizes us and our affiliates to obtain credit bureau reports and make inquiries regarding undersigned's personal credit. You consent to jurisdiction in the State or Federal courts in Pennsylvania and expressly waive any right to a trial by jury.

SIGNED X _____ Print Name: _____ E-Mail Address: _____

Accepted by:
LEAF Capital Funding, LLC By: _____ Title: Operations Manager Date: **12/31/2015**

pitney bowes

PITNEY BOWES LEASE AGREEMENT

Agreement Number

Your Business Information

EVERGREEN HEALTHCARE CENTER /ATHENA		942388882	
Full Legal Name of Lessee	DBA Name of Lessee	Tax ID # (FEIN/TIN)	
205 CHESTNUT HILL RD	STAFFORD SPRINGS	CT	06076-4005
Billing Address: Street	City	State	Zip+4
	( ) ext	22327908863	
Billing Contact Name	Billing Contact Phone #	Billing CAN #	
205 CHESTNUT HILL RD	STAFFORD SPRINGS	CT	06076-4005
Installation Address *(If different from billing address)* : Street	City	State	Zip+4
Todd Pandaitis	(203) 217 2650 ext	22327908863	
Installation Contact Name	Installation Contact Phone #	Installation CAN #	
Invoice Attention To	Lessee PO #		

Your Business Needs

Qty	Business Solution Description
	Mail Stream Solution - 1
1	DM125 Desktop Mailing System
1	IntelliLink Interface / PSD for DM125 / DM225
1	Basic Accounting (10 Dept)
1	5lb Integrated Weighing
1	Integrated Weighing Platform
1	Moistener for DM125
1	pbSmartPostage Free
1	Professional Installation for DM100/DM125
1	IntelliLink Subscription
1	Digital Access Connection Accepted

Check additional items to be included in client's payment

[X] **Service Level Agreement**
Standard - Provides maintenance and support for equipment

[ ] **Software Maintenance (additional terms apply)** - *Provides revision updates & technical assistance*

[X] **Meter Rental**
( ) **Value Based Services (not including USPS fees which will be charged separately)**

[X] **Purchase Power®** - *A line of credit providing a convenient way to mail now and pay later. Consolidate meter postage, permit postage and supplies under one account — see terms & conditions*

[ ] **Equipment Replacement Program** – *Protection in case of loss or damage to leased equipment*
( )Yes I want to enroll in the **ValueMAX®** equipment replacement program
(x) No Enrollment (I will provide proof of insurance within the next 30 days as noted in Section L9)

If green products are identified on your Order, the equipment covered by this Agreement includes remanufactured products that have gone through our factory certification testing process.

Your Payment Plan

Initial Term : 63 **months**

Number Of Months		Monthly Amount	Billed Quarterly At*
First	63	$63	$189

( ) Required advance check of $( ) received
( ) Tax Exempt Certificate Attached
( ) Tax Exempt Certificate Not Required

**Does not include any applicable sales, use, or property taxes which will be billed separately; payment plans begin after any applicable Interim Usage Period.*

Your Signature Below

By signing below, you agree to be bound by all the terms of this Agreement, including those located in the Pitney Bowes Terms (Version 10/15), which are available at www.pb.com/termsconditions and are incorporated by reference. **You acknowledge that you may not cancel the Lease (as defined in Section G1 of the Pitney Bowes Terms) for any reason and that all payment obligations are unconditional.** The Lease will be binding on us after we have completed our credit and documentation approval process and have signed below. The Lease requires you either to provide proof of insurance or participate in the ValueMAX equipment replacement program (see Section L9 of the Pitney Bowes Terms) for an additional fee.

E-Signed : 01/04/2016 01:05 PM CST
Patricia Scofield
pscofield@athenahealthcare.com
Title: Purchasing
IP: 50.202.223.126
Sertifi Electronic Signature
DocID: 20160104130022555

Print Name

Title

Date

Email Address

Pitney Bowes Signature

Print Name

Title

Date

Sales Information

James Burdacki	007
Account Rep Name	District Office

See Pitney Bowes Terms for additional terms and conditions

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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 **Marcum LLP**	**555 Long Wharf Drive, 12th Floor, New Haven, CT 06511**
2 **Dworkin, Hillman, Lamorte & Sterczala**	**4 Corporate Dr Shelton, CT 06484**
3	
4	

Services Provided by This Firm (*describe fully*)

1	**Audit, Year End Financials & Tax Return**	**$ 26,625**
2	**Tax Reporting (Disallow)**	**$ 2,100**
3		$ -
4		$ -

Charge for Services Provided **$28,725**

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

☑ Yes ☐ No **Pg 15, Line1d**

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 **Murtha Cullina**	**860-240-6000**
2 **Goldman, Gruder & Woods, LLP**	**203-899-8900**
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 **185 Asylum St Hartford, CT 06103**
2 **200 Connecticut Ave, Norwalk, CT 06854**
3
4
5

Services Provided by This Firm (*describe fully*)

1	**Misc Issues: (Disallow)**	**$ 4,163**
2	**A/R (disallow)**	**$ 4,196**
3		$ -
4		$ -
5		$ -

Charge for Services Provided **$8,359**

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

☑ Yes ☐ No **Pg 15, Line1e**

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**09/30/16**	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.....	**180**	**180**			**180**	**180**			**180**	**180**		
B. On last day of THIS report period.....	**180**	**180**			**180**	**180**			**180**	**180**		
2. Number of Residents												
A. As of midnight of PREVIOUS report period.....												
B. As of midnight of THIS report period.....	**149**	**149**			**141**	**141**			**149**	**149**		
3. Total Number of Days Care Provided During Period												
A. Medicare.....	**8,054**	**8,054**			**5,780**	**5,780**			**2,274**	**2,274**		
B. Medicaid (Conn.).....	**26,108**	**26,108**			**17,468**	**17,468**			**8,640**	**8,640**		
C. Medicaid (other states).....												
D. Private Pay.....	**4,773**	**4,773**			**2,960**	**2,960**			**1,813**	**1,813**		
E. State SSI for RCH.....												
F. Other (Specify) Managed Care	**1,032**	**1,032**			**559**	**559**			**473**	**473**		
G. Total Care Days During Period (3A thru F).....	**39,967**	**39,967**			**26,767**	**26,767**			**13,200**	**13,200**		
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.....	**57**	**57**			**42**	**42**			**15**	**15**		
5. ***Total Resident Days*** **(3G + 4A + 4B).....**	**40,024**	**40,024**			**26,809**	**26,809**			**13,215**	**13,215**		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	9	37

4. Were there any changes in the certified bed capacity during the report year? ☐ YES ☑ NO
If "YES", provide the following information:

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

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 CCNH	Medicaid CCNH	Medicaid RHNS	Self-Pay CCNH	Self-Pay RHNS	Self-Pay (Specify)	Other State Assisted R.C.H.	Other State Assisted ICF-MR
No. of Residents	18	96		20		15		
Per Diem Rate								
a. One bed rm.	523.81	249.57		424.00		428.93		
b. Two bed rms.	523.81	249.57		402.00		428.93		
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	4,561	4,561		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	482	482		
2. Restorative Treatments				
C. Other	21,164	21,164		
D. ***Total Physical Therapy Treatments***	26,207	26,207		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	392	392		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	35	35		
2. Restorative Treatments				
C. Other	1,387	1,387		
D. ***Total Speech Therapy Treatments***	1,814	1,814		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,345	3,345		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	411	411		
2. Restorative Treatments				
C. Other	35,994	35,994		
D. ***Total Occupational Therapy Treatments***	39,750	39,750		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	10	37

Are time records maintained by all individuals receiving compensation? ☑ Yes ☐ No

Item	Total Cost and Hours					
	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)	113,701	1,688				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	174,384	8,010				
5. Dietary Service						
a. Head Dietitian	49,119	1,734				
b. Food Service Supervisor	50,630	1,734				
c. Dietary Workers	307,708	20,065				
6. Housekeeping Service						
a. Head Housekeeper	15,201	712				
b. Other Housekeeping Workers	134,963	10,189				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	64,931	1,746				
b. Other Maintenance Workers	80,836	3,604				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	71,559	5,613				
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	129,487	2,582				
b. RN						
1. Direct Care	841,979	23,116				
2. Administrative**	384,853	14,823				
c. LPN						
1. Direct Care	1,065,344	41,064				
2. Administrative**						
d. Aides and Attendants	1,905,964	119,806				
e. Physical Therapists	527,625	14,278				
f. Speech Therapists	69,419	1,760				
g. Occupational Therapists	369,330	11,341				
h. Recreation Workers	170,628	9,270				
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	178,328	7,264				
n. Marketing						
o. Other (Specify)						
A-13. Total Salary Expenditures	6,705,989	300,399				

* 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)

Position	$ CCNH	Hours CCNH	$ RHNS	Hours RHNS	$ (Specify)	Hours (Specify)
Total	$ -	-	$ -	-	$ -	-

Schedule of Physician: Other Fees (Page 13)

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

Schedule of Other Fees (Page 13)

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

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CSP-11 Rev. 10/2005

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

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	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										
Not Applicable										
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).										
Not Applicable										

* 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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CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	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* **										
Christine M McKinney (12/29/15 - 9/30/16)	113,701			Health & Life Insuracne, Payroll Taxes	Day to day operations if the nursing home facility	1,688	A2	Meadowbrook Of Granby 350 Salmon Brook St Granby, CT 06035	455	27,232
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
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	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						
2. Dentist	10,260	72				
3. Pharmacist	1,250	16				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	17,782	320				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	15,003	200				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	559					
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						
b. Other						
10. Occupational Therapist						
a. Resident Care	15,042	272				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	31,348	147				
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	91,244	1,027				

* 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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B. Report of Expenditures - Professional Fees (Medical Director Detail)

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	13 a	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
a. Medical Director Detail	0	200		0	0	0

Dr Dushyant Parikh $15,003 200 hours

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CSP-14 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
HealthDrive Dental Group, 888 Worcester St, Wellesley, MA 02482	Dentist	☐	☑	
Partners Pharmacy, PO Box 9689 Union, NY 11555	Pharmacy Consulting	☐	☑	
Janet Williams, 100 Bull Hill Rd Colchester, CT 06415	Nurse Consultant	☐	☑	
Athena Health Care 135 South Rd Farmington, CT 06032	Nursing Fill-In	☑	☐	Common Owners
Access Therapies, PO Box 823461, Philadelphia, PA 19182	Physical and Occupational Therapy	☐	☑	
Dushyant Parikh, 146 Hazard Ave, Enfield CT 06082	Medical Director	☐	☑	
Bay State Family Podiatry, 74 Palomba Drive, Enfield, CT 06082	Physician	☐	☑	
Greater Hartford Orthoped, 1000 Aslyum Ave, Hartford, Ct 06105	Physician	☐	☑	
HealthDrive Audiology Group, 888 Worcester St Wellesley, MA 02482	Physician	☐	☑	
		☐	☐	
		☐	☐	
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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

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation.....	$	259,041	259,041		
2. Disability Insurance.....	$				
3. Unemployment Insurance.....	$	160,426	160,426		
4. Social Security (F.I.C.A.).....	$	500,827	500,827		
5. Health Insurance.....	$	897,352	897,352		
6. Life Insurance (employees only)					
(not-owners and not-operators).....	$				
7. Pensions (Non-Discriminatory)	$	40,272	40,272		
(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.....	$	28,725	28,725		
e. Legal (*Services should be fully described on Page 7*)	$	8,359	8,359		
f. Insurance on Lives of Owners and	$				
Operators (*Specify*)*.....					
g. Office Supplies.....	$	54,602	54,602		
h. Telephone and Cellular Phones.....					
1. Telephone & Pagers.....	$	11,120	11,120		
2. Cellular Phones.....	$	360	360		
i. Appraisal (*Specify purpose and*	$				
attach copy)*.....					
j. Corporation Business Taxes (*franchise tax*).	$				
k. Other Taxes (*Not related to property - See Page 22*)					
1. Income*.....	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	672,009	672,009		
Subtotal	$	2,633,093	2,633,093		

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

(Carry Subtotals forward to next page)

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
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,633,093	2,633,093		
l. Travel and Entertainment					
1. Resident Travel and Entertainment.....	$				
2. Holiday Parties for Staff.....	$				
3. Gifts to Staff and Residents.....	$	7,136	7,136		
4. Employee Travel.....	$	2,585	2,585		
5. Education Expenses Related to Seminars and Conventions	$	1,778	1,778		
6. Automobile Expense (*not purchase or depreciation*).....	$	2,246	2,246		
7. Other (*Specify*).....	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*).....	$	4,624	4,624		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***.....	$	7,730	7,730		
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.....	$	6,543	6,543		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	7,443	7,443		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions.....	$	13	13		
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual*)	$				
12. Administrative Management Services**.....	$	354,545	354,545		
13. Other (*Specify*) See Attached Schedule	$	79,528	79,528		
C-14 Total Administrative & General Expenditures	$	3,107,264	3,107,264		

* 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)
Promotional	$ 7,730		
Total Other Advertising	$ 7,730	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF - Mutual Aid	$ 350		
CAHCF Dues	$ 7,093		
Total Dues	$ 7,443	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Charges	$ 6,910		
Payroll Processing Fees	$ 13,524		
Employee Physicals/Background Checks	$ 14,143		
Data Processing/ Software Maint. Fees	$ 41,061		
Sate of CT- Citation No 2016-50	$ 2,360		
State of CT - Citation No 2016-51	$ 1,530		
Total Other Administrative and General	$ 79,528	$ -	$ -

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CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility **Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center**	License No. **2081C**	Report for Year Ended **9/30/2016**	Page 17 of 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 #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	$493,116	Contract Attached to a Prior Year	See Below
Allocation of the Above	$325,457 $78,899 $88,760	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 18, Line 2C Pg 20, Line 5J
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	$29,088	Admin/Gen- Other Exp	Pg 16, Line 12

*** 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
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food.....	$	230,545	230,545		
2. Non-Food Supplies.....	$	34,191	34,191		
3. Other (*Specify*)_____	$	753	753		
Dishes = $753					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**.....	$	78,899	78,899		
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	344,388	344,388		
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*		433	433		

H.	Is cost of employee meals included in 2E?	☑ Yes	☐ No	
I.	Did you receive revenue from employees?	☐ Yes	☑ No	If yes, specify amount.
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. = $713
L.	Is any revenue collected from these people?	☐ Yes	☑ No	If yes, specify amount.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	☐ Yes	☑ No	If yes, specify cost.
O.	Is any revenue collected from employees?	☐ Yes	☑ No	If yes, specify amount.
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.

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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 **Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center**	License No. **2081C**	Report for Year Ended **9/30/2016**	Page of 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. $	129,706	129,706		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**.....	$				
d. Other (*Specify*) **Supplies = $7,263**	$	7,263	7,263		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	136,969	136,969		

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 amount.
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 amount.
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.

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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
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	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.	$	24,370	24,370		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*.....		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)....		$	24,370	24,370		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy.....		$				
2. Purchased from **Partners Pharmacy and Procare Pharmacy**		$	388,887	388,887		
b. Medicine Cabinet Drugs.....		$	51,784	51,784		
c. Medical and Therapeutic Supplies.....		$	259,417	259,417		
d. Ambulance/Limousine***.....		$	1,154	1,154		
e. Oxygen						
1. For Emergency Use.....		$				
2. Other***.....		$	23,966	23,966		
f. X-rays and Related Radiological Procedures***.....		$	32,805	32,805		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***.....		$	31,253	31,253		
i. Recreation.....		$	8,365	8,365		
j. Other (Specify)**** See Attached Schedule		$	173,679	173,679		
5K. ***Total Resident Care Expenditures*** (5a - 5j).....		$	971,310	971,310		

* 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)
Management Fee Direct	$ 88,760		
Cable TV	$ 20,444		
Medical Equip Rentals-Medicaid	$ 18,534		
Physical Therapy Supplies	$ 22,664		
Occupational Therapy Supplies	$ 2,697		
Oxygen Equipment Rentals	$ 5,363		
Medical Equip Rentals-Other	$ 15,217		
Total Other Resident Care	$ 173,679	$ -	$ -

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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
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	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
Parnters Pharmacy Of CT	PO Box 9689 Uniondale, NY 11555	☐	☑		Pharmacy Services	475,093			20 & 13	5b and B3
Procare LTC Pharmacy	111 Excutive Blvd Farmingdale NY 11735	☑	☐	Common Owners	Pharmacy Services	52,135			20	5b and B3
Total Laundry	114 Woodland St Hartford, CT 06105	☐	☑		Laundry Services	142,726			19	3a4
Vasseur Landscaping	156 Broad Brook Rd Enfield, CT 06082	☐	☑		Landscaping and Snow Removal Services	22,294			22	6f
USA Hauling & Recycling	PO Box 808 East Windsor, CT 06088	☐	☑		Rubbish Removal	28,398			22	6f
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							

* 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
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	22 | 37

Item	Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance..... $	151,559	151,559		
b. Heat..... $	57,928	57,928		
c. Light & Power..... $	127,863	127,863		
d. Water..... $				
e. Equipment Lease (*Provide detail on page 6*)..... $	9,609	9,609		
f. Other (*itemize*)..... $	79,873	79,873		
See Attached Schedule				
6g. ***Total Maint. & Operating Expense*** (6a - 6f)..... $	426,832	426,832		
7. Depreciation (*complete schedule page 23**)				
a. Land Improvements..... $				
b. Building & Building Improvements..... $				
c. Non-Movable Equipment..... $				
d. Movable Equipment..... $	60,605	60,605		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)..... $	60,605	60,605		
8. Amortization (*Complete att. Schedule Page 24**)				
a. Organization Expense..... $				
b. Mortgage Expense..... $	3,825	3,825		
c. Leasehold Improvements..... $	9,200	9,200		
d. Other (*Specify*)..... $				
*8e. ***Total Amortization Costs*** (8a + b + c + d)..... $	13,025	13,025		
9. Rental payments on leased real property less real estate taxes included in item 10b..... $	540,660	540,660		
10. Property Taxes				
a. Real estate taxes paid by owner..... $	132,035	132,035		
b. Real estate taxes paid by lessor..... $				
c. Personal property taxes..... $				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)..... $	746,325	746,325		

* 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)**
Groundskeeping	$ 10,331		
Rubbish Removal	$ 27,366		
Snow Removal	$ 5,371		
Supplies	$ 36,805		
Total Other Repairs and Maintenance	$ 79,873	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	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					S/L	Various		
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period					S/L	Various		
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					S/L	Various		
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period					SL	Various		
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)					SL	Various		
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period									S/L	Various		
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2016	595,139		595,139		S/L	Various	60,605	
D-3. Subtotal												60,605
E. ***Total Depreciation***												60,605

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Dec-15	Closing Entry - Various Equipment	$ 500,000	5	$ 50,000	
Dec-15	CDW - Computers	$ 762	5	$ 76	
Dec-15	CDW- Laptops	$ 21,158	3	$ 3,526	
Dec-15	CDW - Various Computer Equipment	$ 5,120	5	$ 512	
Dec-15	CDW- Software	$ 4,489	3	$ 748	
Dec-15	CDW- Desktop Computer	$ 7,111	5	$ 711	
Dec-15	CDW- Various Computer Equipment	$ 1,190	5	$ 119	
Jan-16	CDW- Monitors & Laptops	$ 512	3	$ 85	
Jan-16	Med-Pat- Resident Phones	$ 2,022	5	$ 202	
Jan-16	Proline- Diswashing Element	$ 1,192	5	$ 119	
Mar-16	Direct Supply- Mattress	$ 1,370	5	$ 137	
Apr-16	Wescom- PCC Software	$ 5,277	3	$ 880	
Apr-16	Ritcher Healthcare- PCC Software	$ 4,925	3	$ 821	
Apr-16	Kittredge - Steamer	$ 15,184	10	$ 759	
Jun-16	Direct Supply - 5 resident TV's	$ 2,182	5	$ 218	
Jun-16	Direct Supply- Utility Cart	$ 1,061	10	$ 53	
Jun-16	Direct Supply- Mattress	$ 1,178	15	$ 39	
Jul-16	Romax- 4 resident TV's	$ 957	5	$ 96	
Sep-16	Relay- PCC Software	$ 4,545	3	$ 758	
Sep-16	HD Supply- 98 Mirrors	$ 14,904	10	$ 745	
Total additions for Movable Equipment		$ 595,139		$ 60,605	*
Deletions:					
Various					
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:					
Various	See Attached 5 Year	$ 16,424	5	$ 1,642	
Various	See Attached 10 year	$ 137,275	10	$ 6,864	
Various	See Attached 15 Year	$ 651	15	$ 22	
Various	See Attached 20 year	$ 26,898	20	$ 672	
Total additions for Leasehold Improvements		$ 181,248		$ 9,200	*
Deletions:					
Total deletions for Leasehold Improvements		$ -		$ -	**

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

Evergreen Health Care Center
Leasehold Improvements
9/30/2016

DATE	VENDOR	DESCRIPTION	YEARS	AMOUNT	
3/31/2016	Barts Electrical	Magnasium Probe	5	$4,064.49	
5/31/2016	Sherwin Williams	Wall Paper - Lobby/ Nursing	5	$5,446.46	
7/31/2016	Vasseur Landscaping	Landscaping	5	$6,912.75	$16,423.70
12/31/2015	Raintech	Maglock	10	$626.25	
3/31/2016	State-wide Electrical	Electrical work & Outlets	10	$16,040.00	
3/31/2016	State-wide Electrical	Electrical work Circuts & panels	10	$10,286.32	
4/30/2016	Precision Mechanical	Motor & Recirculator Pump	10	$1,675.27	
5/31/2016	State-wide Electrical	Light fixtures	10	$2,443.39	
7/31/2016	Write Way Sign	Sign	10	$1,781.36	
8/31/2016	All Trade Industires	Shower Stall	10	$15,055.44	
9/30/2016	Total Communication	Phone System	10	$1,019.30	
9/30/2016	Total Communication	Phone System	10	$1,122.72	
9/30/2016	HD Supply	Faucet	10	$1,011.96	
9/30/2016	Kidd-Luukko	Roof	10	$9,250.00	
9/30/2016	Total Communication	Phone System	10	$76,962.60	$137,274.61
12/31/2015	CDW	Wallmount Cabinet	15	$651.31	$651.31
6/30/2016	Precision Mechanical	Exhaust Fans	20	$17,206.37	
7/31/2016	Procision Mechanical	Service Sink	20	$1,716.38	
9/30/2016	Simplex	Sprinkler pipe replaced	20	$7,975.17	$26,897.92
TOTAL ACQUISITIONS FOR 2016				$181,247.54	$181,247.54

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	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. **Finance Fees**	12	15	10 years	51,000				3,825	
2.									
3.									
B-4. Subtotal									3,825
C. **Leasehold Improvements and Other** (Specify)									
1. Acquired prior to this report period		2015	Various				Var		
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2016	Various	181,248		SL	Var	9,200	
C-4. Subtotal									9,200
D. ***Total Amortization***									13,025

* 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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Supplemental Page

Amortization Schedule - Detail of Leasehold Improvements & Other

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	24A	37

C. **Leasehold Improvements** (Specify)										
1. Acquired prior to this report period		2015								
2. Disposals (attach schedule)										
3. Acquired during this report period	9	2016	Varies	181,248		SL	Variou	9,200		
C-4. Subtotal.....										9,200
C. **Other** (Specify)										
1.										
2.										
C-4. Subtotal.....										
Total Acquired prior to this report period		2015	Various				Var			
Total Disposals										
Total Acquired during this report period	9	2016	Various	181,248		SL	Var	9,200		

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

Name of Facility	License No.	Report for Year Ended	Page of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	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	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	180
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Conventional			
b. Date Mortgage Obtained	12/29/15			
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)	25			
e. Amount of Principal Borrowed	9,400,000			
f. Principal balance outstanding as of 9/30/2016	9,229,000			
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 **Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center**	License No. **2081C**	Report for Year Ended **9/30/2016**			Page 26 of 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
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	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*)..... $	5,320	5,320		
Vender Interest = $2,543; Bond Fees = $2,777				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D).....$	5,320	5,320		
14. Insurance				
a. Insurance on Property (buildings only)..... $	62,588	62,588		
b. Insurance on Automobiles..... $	995	995		
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)... $	63,583	63,583		
15. ***Total All Expenditures (A-13 thru C-14)*****.....** $	12,623,594	12,623,594		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	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.	10	A12g	Occupational Therapy..... $	369,330	369,330		
4.	Var	Var	Other - See attached Schedule..... $	51,649	51,649		
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **..... $	559	559		
6.	13	B10a	Occupational Therapy..... $	15,042	15,042		
7.			Other - See attached Schedule..... $				
Pages 15 & 16 - Administrative and General							
8.	15	1a9	Discriminatory Benefits..... $				
9.			Bad Debts..... $				
10.	15	1d&e	Accounting & Legal..... $	10,459	10,459		
11.	30	IV3	Telephone..... $				
12.			Cellular Telephone..... $				
13.			Life insurance premiums on the life of Owners, Partners, Operators..... $				
14.	16	1 3	Gifts, flowers and coffee shops..... $	7,136	7,136		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees..... $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative.... $				
17.			Automobile Expense (e.g. personal use). $				
18.	16	m2&3	Unallowable Advertising *..... $	7,730	7,730		
19.			Income Tax / Corporate Business Tax... $				
20.			Fund Raising / Contributions..... $				
21.	16	m12	Unallowable Management Fees..... $	214,471	214,471		
	18	2c	$	51,993	51,993		
	20	5j	$	58,492	58,492		
22.			Barber and Beauty..... $				
23.	Var	Var	Other - See attached Schedule..... $	12,311	12,311		
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents..... $	713	713		
Page 19 - Laundry Expenditures							
25.	19	3d	Laundry services to employees, guests and others who are not residents..... $				
Page 20 - Housekeeping Expenditures							
26.	20	4d	Housekeeping services to employees and others who are not residents..... $				
			Subtotal (Items 1 - 26) $	799,885	799,885		

* 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)
10	12M	Marketing Salaries & Fringe Benefits	51,649		
Total Other Salaries Adjustment			$ 51,649	$ -	$ -

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	Bank Charges	6,910		
16	M13	Bayview - JDR Software Settlement	1,511		
16	M13	Fine: Citation No. 2016-50	2,360		
16	M13	Fine: Citation No. 2016-51	1,530		
Total Other A&G Adjustments			$ 12,311	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	799,885	799,885		
Page 20 - Resident Care Supplies***							
27.	20	5a1&2	Prescription Drugs..... $	388,887	388,887		
28.	20	5d	Ambulance/Limousine..... $	1,154	1,154		
29.	20	5f	X-rays, etc..... $	32,805	32,805		
30.	20	5h	Laboratory..... $	31,253	31,253		
31.	20	5c	Medical Supplies..... $	34,395	34,395		
32.	20	5e2	Oxygen (non emergency)..... $	23,966	23,966		
33.	20	5j	Occupational Therapy..... $	2,697	2,697		
34.	Var	Var	Other - See Attached Schedule..... $	15,217	15,217		
Page 22 - Maintenance and Property							
35.	Var	Var	Excess Movable Equipment Depreciation See Attached Schedule..... $	50,314	50,314		
36.			Depreciation on Unallowable Motor Vehicles..... $				
37.			Unallowable Property and Real Estate Taxes..... $				
38.			Rental of Building Space or Rooms..... $				
39.			Other - See Attached Schedule..... $				
Page 27 - Insurance							
40.			Mortgage Insurance..... $				
41.			Property Insurance..... $				
Other - Miscellaneous							
42.			Research or Experimental Activities..... $				
43.	20	5j	Radio and Television Revenue..... $	16,844	16,844		
44.	30	IV5	Vending Machine Revenue..... $	50	50		
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.	30	IV5	Interest Income on Accounts Rec..... $	115	115		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule..... $				
Not For Profit Providers Only							
50.	Var	Var	Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule..... $				
51.	***Total Amount of Decrease (Items 1 - 50)*** ..... $			1,397,582	1,397,582		

*** 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.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental - Other	15,217		
Total Other Ancillary Costs			$ 15,217	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Movable Equipment Carryforward AJE	50,314		
Total Excess Movable Equipment Depreciation			50,314		

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

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

Evergreen Moveable Equipment Carryforward Schedule

Cost Year		TVs Patient Rooms 2016	Purchase Price adjmt 2016	Totals
	Original Disallow Adjustment			
	Cost	$ 3,139	$ 500,000	
	Term	5	5	
2016	Deprec	$ 314	$ 50,000	$ 50,314
2016	Book Value	$ 2,825	$ 450,000	$ 452,825
2017	Deprec	$ 628	$ 100,000	$ 100,628
2017	Book Value	$ 2,197	$ 350,000	$ 352,197
2018	Deprec	$ 628	$ 100,000	$ 100,628
2018	Book Value	$ 1,569	$ 250,000	$ 251,569
2019	Deprec	$ 628	$ 100,000	$ 100,628
2019	Book Value	$ 941	$ 150,000	$ 150,941
		$ 628	$ 100,000	$ 100,628
		$ 313	$ 50,000	$ 50,313
		$ 313.00	$ 50,000.00	$ 50,313
		$ -	$ -	$ -

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
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	10,934,815	10,934,815		
b. Medicaid Room and Board Contractual Allowance **	$	(4,561,692)	(4,561,692)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents (*all inclusive*)	$	2,421,468	2,421,468		
b. Medicare Room and Board Contractual Allowance **	$	824,803	824,803		
4. a. Private-Pay Residents and Other	$	3,479,001	3,479,001		
b. Private-Pay Room and Board Contractual Allowance **	$	(45,731)	(45,731)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	261,074	261,074		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(261,074)	(261,074)		
c. Prescription Drugs - Non-Medicare	$	221,236	221,236		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(182,306)	(182,306)		
2. a. Medical Supplies - Medicare	$	16,395	16,395		
b. Medical Supplies - Medicare Contractual Allowance **	$	(8,860)	(8,860)		
c. Medical Supplies - Non-Medicare	$	1,717	1,717		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(1,717)	(1,717)		
3. a. Physical Therapy - Medicare	$	1,042,739	1,042,739		
b. Physical Therapy - Medicare Contractual Allowance **	$	(887,220)	(887,220)		
c. Physical Therapy - Non-Medicare	$	381,475	381,475		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(379,035)	(379,035)		
4. a. Speech Therapy - Medicare	$	153,125	153,125		
b. Speech Therapy - Medicare Contractual Allowance **	$	(127,328)	(127,328)		
c. Speech Therapy - Non-Medicare	$	51,330	51,330		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(48,680)	(48,680)		
5. a. Occupational Therapy - Medicare	$	987,969	987,969		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(864,956)	(864,956)		
c. Occupational Therapy - Non-Medicare	$	351,110	351,110		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(349,110)	(349,110)		
6. a. Other (*Specify*) - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	43,572	43,572		
III *Total Resident Revenue* (Section I.thru Section II.)	$	13,454,120	13,454,120		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	2,652	2,652		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	1,757	1,757		
V. Total Other Revenue (1 thru 8)	$	4,409	4,409		
VI. Total All Revenue (III + V)	$	13,458,529	13,458,529		

* *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

Page Ref	Related Exp Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Page Ref	Related Exp Description	CCNH	RHNS	(Specify)
N/A	Retroactives	$ 43,572		
Total Other Resident Revenue		$ 43,572	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
30/IV5	Interest on A/R	$ 115	$ 115		
30/IV5	Interest on Renovation Account	$ 2,537	$ 2,537		
Total Interest Income			$ 2,652	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
na	Vending Machine Income	$ 50		
na	Donation : Non-Specific	$ 1,707		
Total Other Revenue		$ 1,757	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	31	37

Account			Amount
Assets			
A. Current Assets			
1. Cash (*on hand and in banks*)			$ 648,124
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			$ 1,244,003
3. Other Accounts Receivable (Excluding Owners or Related Parties)			$
4 Inventories			$ 29,224
5. Prepaid Expenses			$ 136,239
a. Prepaid Insurance		136,239	
b.			
c.			
d.			
6. Interest Receivable			$
7. Medicare Final Settlement Receivable			$ (2,457)
8. Other Current Assets (*itemize*)			$ 1,611,703
Wage Enhancement		(80,824)	
Working Capital Reserve		1,647,527	
Renewal & Replacement Fund		45,000	
A-9. ***Total Current Assets*** (Lines A1 thru 8)			$ 3,666,836
B. Fixed Assets			
1. Land			$
2. Land Improvements	*Historical Cost		$
	Accum. Depreciation	Net	
3. Buildings	*Historical Cost		$
	Accum. Depreciation	Net	
4. Leasehold Improvements	*Historical Cost	181,248	$ 172,048
	Accum. Depreciation	(9,200) Net	
5. Non-Movable Equipment	*Historical Cost		$
	Accum. Depreciation	Net	
6. Movable Equipment	*Historical Cost	142,313	$ 81,708
	Accum. Depreciation	(60,605) Net	
7. Motor Vehicles	*Historical Cost		$
	Accum. Depreciation	Net	
8. Minor Equipment-Not Depreciable			$
9. Other Fixed Assets (*itemize*)			$ 574,198
Moveable Equipment Carryforward		452,825	
Project Development - See Attached		121,373	
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)			$ 827,954

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

(Carry Total forward to next page)

Evergreen Health Care Center
Project Development
FYE 9/30/16

Date	Vendor	Description	Amount
4/30/2016	ROSE-TISO & CO., LLC	ev-schematic design contract	$2,600.00
5/31/2016	ROSE-TISO & CO., LLC	ev-construction documents	$2,900.00
6/30/2016	SHERWIN-WILLIAMS: EVERGREEN	EV-INSTALL FLOORING	$95,960.67
8/31/2016	Sherwin williams	Flooring	$11,778.14
8/31/2016	Sherwin williams	Flooring	$6,444.70
8/31/2016	Sherwin williams	Flooring	$1,049.36
8/31/2016	Sherwin williams	Flooring	$640.57
	Balance @ 9/30/16		$121,373.44

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	32	37

Account			Amount
		Total Brought Forward:	$ 4,494,790
C. Leasehold or like property recorded for Equity Purposes.			
1. Land			$
2. Land Improvements	*Historical Cost.....		
	Accum. Depreciation	Net.....	$
3. Buildings	*Historical Cost.....		
	Accum. Depreciation	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)			$
D. Investment and Other Assets			
1. Deferred Deposits			$
2. Escrow Deposits			$
3. Organization Expense	*Historical Cost.....		
	Accum. Depreciation	Net.....	$
4. Goodwill (Purchased Only)			$ 269,395
5. Investments Related to Resident Care (*itemize*)			$
6. Loans to Owners or Related Parties (*itemize*)			$
Name and Address	Amount	Loan Date	
7. Other Assets (*itemize*)			$ 2,001,775
Defered Finance Fees		47,175	
Goodwill		1,954,600	
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$ 2,271,170
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ 6,765,960

* 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
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 1,007,687
2. Notes Payable (*itemize*)					$ (1,282,000)
Due From Related Party				(1,282,000)	
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*)					$ 484,436
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 23,479
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*)					$ 284,975
Acc'd Operating Expenses				50,938	
Acc'd Expense - Sales Tax				4,057	
Provider Taxes Due				229,980	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 518,577

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

(Carry Total forward to next page)

** Interest Bearing - Do Not Include in Return on Equity Calculation.

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	34	37

Account	Amount
Total Brought Forward:	518,577
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*)	$	4,894,514
Notes Payable Related Landlord **4,894,514**		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$	4,894,514
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$	5,413,091

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

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity*)	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$ 657,292
	5. Cumulated Earnings	$ (139,358)
	6. Gain or Loss for Period 12/29/2015 thru 9/30/2016	$ 834,935
	7. Total Net Worth	$ 1,352,869
C.	***Total Reserves and Net Worth***	$ 1,352,869
D.	***Total Liabilities, Reserves, and Net Worth***	$ 6,765,960

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	36	37

	Account	Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015	$
B.	Total Revenue (*From Statement of Revenue Page 30*)	$ 13,458,529
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$ 12,623,594
D.	Net Income or Deficit	$ 834,935
E.	Balance	$ 834,935
F.	Additions	
	1. Additional Capital Contributed (*itemize*)	
	Preferred Equity Payments **(139,358)**	
	Treasury Stock **657,292**	
	2. Other (*itemize*)	
F-3.	Total Additions	$ 517,934
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***	09/30/16	$ 1,352,869

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	**2081C**	**9/30/2016**	37	37

Check appropriate category		
CCNH	RHNS	Other (*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 appplicable 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
	CFO	2-15-17

Printed Name of Preparer

Athena Health Care Associates, Inc

Address	Phone Number
135 South Road Farmington, CT 06032	(860) 751-3900

Cost report forms generated by Athena Health Care Associates, Inc as approved in letter dated 12/11/13.