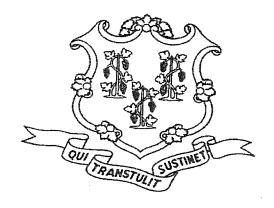
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2018

Name of Facility (as	•							
Stafford Springs CT	SNF LLC d/b/a	Evergreen He	ealth Care Cente	er				
Address (No. & Street	et, City, State, 2	Zip Code)						
205 Chestnut Hill Ro	oad, Stafford Sp	orings, CT 060	76					
Type of Facility								
Chronic and C	Convalescent		Rest Home wit	h Nursing				
☑ Nursing Home	e only		Supervision or	ıly		(Specify)		
(CCNH)			(RHNS)					
Report for Year Begi	nning		Report for Yea	r Ending				
10/1/2017			9/30/2018	_				
License Numbers:		CCNH	RHNS		(Specify)		Med	licare Provider
21001100110011000101		2081C			(-F))	07-5326		
								.,
Medicaid Provider N	umbers:	CC	NH	RE	INS		ICF	-IID
		2081C						
For Department Use	e Only				41			
Sequence Number	Signed and	Date	Sequence N	lumber	Signed a	nd Notarize	_d	Date Received
Assigned	Notarized	Received	Assign	ed	Digited a	ind ivolarized		Date Received
							\dashv	

Table of Contents

		4
Gene	eral Information - Administrator's/Owner's Certification	1
Gene	eral Information and Questionnaire - Data Required for Real Wage Adjustment	1A
Gene	eral Information and Questionnaire - Type of Facility - Organization Structure	2
	eral Information and Questionnaire - Partners/Members	3
	eral Information and Questionnaire - Corporate Owners	3A
Gene	eral Information and Questionnaire - Individual Proprietorship	3B
Gene	eral Information and Questionnaire - Related Parties	4
	eral Information and Questionnaire - Basis for Allocation of Costs	5
	eral Information and Questionnaire - Leases	6
	eral Information and Questionnaire - Accounting Basis	7
	edule of Resident Statistics	8
	edule of Resident Statistics (Cont'd)	9
A.	Report of Expenditures - Salaries & Wages	10
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives	11
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant	
	Administrators and Other Relatives (Cont'd)	12
B.	Report of Expenditures - Professional Fees	13
	Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee	
	for Service Basis	14
C.	Expenditures Other than Salaries - Administrative and General	15
C.	Expenditures Other than Salaries (Cont'd) - Administrative and General	16
	Schedule C-1 - Management Services	17
C.	Expenditures Other than Salaries (Cont'd) - Dietary	18
C.	Expenditures Other than Salaries (Cont'd) - Laundry	19
C.	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
	Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C.	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
	Depreciation Schedule	23
	Amortization Schedule	24
C.	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C.	Expenditures Other than Salaries (Cont'd) - Interest	26
C. C. D.	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D.	Adjustments to Statement of Expenditures	28
D.	Adjustments to Statement of Expenditures (Cont'd)	29
D. F.	Statement of Revenue	30
G.	Balance Sheet	31
G.	Balance Sheet (Cont'd)	32
G.	Balance Sheet (Cont'd)	33
G.	Balance Sheet (Cont'd)	34
G.	Balance Sheet (Cont'd) - Reserves and Net Worth	35
H.	Changes in Total Net Worth	36
Ī.	Preparer's/Reviewer's Certification	37
	•	

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

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health	2081C	9/30/2018	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Wwner)	Date
Christing M. MCK		2-15-19		2/15/19
Printed Name (Administrator)		2	Printed Name (Owner)	
Christine M. McKinney			Lawrence Santilli	
Subscribed and Sworn	State of	Date	Signed (Notary Public)	Comm. Expires
to before me:	CT	2/15/19	74	1/1/12020
Address of Notary Public				
484 Farmington Act	2 Hartford	CT O	6105	

(Notary Seal)

State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page 1A	of 37
Name of Facility		Period Cov	ered:	From	То
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Cent	er			10/1/2017	9/30/2018
Address of Facility					
205 Chestnut Hill Road, Stafford Springs, CT 06076			,	_	
Report Prepared By		Phone Nun		Date	
Athena Health Care Associates, Inc		(860) 751-3	3900	2/25/2019	
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 Fac	ility Report for Year I	Ended Page	of
	860-684-6341	9/30/2018	2	37
Name of Facility (as shown on license)	Address (No	o. & Street, City, State,	 Zip)	
Stafford Springs CT SNF LLC d/b/a Evergreen Health Ca	are C 205 Chestnu	it Hill Road, Stafford S	prings, CT 06076	
CCNH	RHNS	(Specify)	Medicare P	rovider No.
License Numbers: 2081C			07-5326	
Type of Facility (Check appropriate box(es))				
☐ Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Supervision only	1 1 1.51	ecify)	
Type of Ownership (Check appropriate box)				
O Proprietorship	O Profit Corp.	O Non-Profit Corp.	O Government	O Trust
		Date Opened Dar	te Closed	
If this facility opened or closed during report year provide	e:			
Has there been any change in ownership				
or operation during this report year?	O Yes	⊙ No If"	'Yes," explain fully	7.
Administrator				
Name of Administrator		Nursing Home		
Christine M McKinney		Administrator's	001627	
		License No.:		
Other Operators/Owners who are assistant administrators	(full or part time)		T	
Name Not Applicable		License No.:		
		· · · · · · · · · · · · · · · · · · ·		

General Information and Questionnaire Partners/Members

Name of Facility Stafford Springs CT SNF LLC	d/b/a Evergreen Health	License No. 2081C	Report for \ 9/30/2018	Year Ended	Page 3	of 37
Surfice opinings of order bloc				State(s) and		
Legal Name of Part	nership/LLC	Business	Address		Registered	
Stafford Springs CT SNF LLC		205 Chestnut H Stafford Spring		CT		
Name of Partners/Members	Business Ac	ldress		Title	% Ow	ned
Lawrence G Santilli	135 South Rd Farming	ton, CT 06032	Manager		0.60	34

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year En	ded	Page	of
Stafford Springs CT SNF LLC d/b/a Evergre	2081C	9/30/2018		3A	37
If this facility is owned or operated as a corpo	oration, provide the	following information	ion:		
Legal Name of Corporation		s Address	State(s) in Which	ch Incorp	orated
				N. C1	
Name of Directors, Officers	Busines	s Address	Title	No. Sh	
•				Held by	Each
		MANAGEMENT OF THE PROPERTY OF			
Names of Stockholders Owning at Least					
10% of Shares					
1070 01 5114103					
None other than listed above					
	·				

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

General Information and Questionnaire Individual Proprietorship

Name of Facility		Report for Year Ended	Page of
Stafford Springs CT SNF LLC d/b/a Evergreen Hea	2081C	9/30/2018	3B 37
If this facility is owned or operated as an individua	l proprietorship, pr	ovide the following informat	ion:
Owi	ner(s) of Facility		
		, , , , , , , , , , , , , , , , , , ,	

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

General Information and Questionnaire Related Parties*

Name of Facility Stafford Springs CT SNI	Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen Health	License No.	. No. 2081C	Report for 9/30/2018	Report for Year Ended 9/30/2018		Page 4	of 37
Are any individuals rece marriage, ability to conti	Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?	cility relass associ	ited throu	gh O Yes	o No	If "Yes," provide the Name/Address and complete the information on Page 11 of the report.	Name/Add ation on Pag	ress and ge 11 of the report.
Are any individuals or c including the rental of presented through femily as	Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility,	or servic	es, ility,	٥	o N			
association to any of the	association to any of the owners, operators, or officials of this facility?	of this fa	cility?	2		If "Yes," provide the following information:	e following i	nformation:
		Alsc	Also Provides			Indicate Where		
Name of Related	Business	Non-Rel	Goods/Services to Non-Related Parties		Description of Goods/Services	Costs are included in Annual Report	Cost	Actual Cost to the
Individual or Company		Yes	No %	T	Provided	Page # / Line #	Reported	Related Party
Athena Stafford Springs Landlord LLC	135 South Rd, Farmington, CT 06032	0	0	Lease		Pg 22 L9	813,906	747,006
Athena Health Care Assoc 401k Plan	135 South Rd, Farmington, CT 06032	0	•	Facili	Facility participates in common 401k plan			
Athena Health Care System	135 South Rd, Farmington, CT 06032	0	0 <50%		see attached			
Misc Facilities	Various Addresses	•	%86< O		Interfacility Loans	Pg 33 A2		
Athena Health Insurance	135 South Rd, Farmington, CT 06032	0	•	Healtl	Health Insurance	Pg 15, 1a5	1,338,532	1,338,532
Procare Pharmacy	111 Executive Blvd, Farmingdale, NY 11735	0	O >50%		Pharmacy Services	pg 20 5a2, 5b,	550,632	550,632
		0	•					
		0	•		,			
		0	•					

^{*} Use additional sheets if necessary.

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

Report for FYE 9/30/2018 Evergreen Health Care RELATED PARTIES QUESTIONNAIRE

PAGE 4				-	indianta Whora		Actual
		Also Goods/	Also Provided Goods/Services to		Costs are Included	Costs	Cost to the Related
>F: = C 4 t		Non-Re	Non-Related Parties	Description	# dui / # duo0	Reported	Party
TANKT MANA	ADDRESS	Yes No	**% 0	Provided			
				1	Da 16 in 12 Pa 16 M3. Pa		
	135 South Rd	×	<50%	<50% Management Fees, Marketing, Nursing Fill in	13 Ln11a2 13 Ln11a2 Pn 16 In M3 M13, M7, Pq	\$1,258,945	\$628,420
Athena Health Care				1	201069		
1	Farmington, CT 06032			Postage, Payroll, MIS , Gift Cards, Painters	77 רון מס		

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No		Report for Year Ended	1 2 .	of	
Stafford Springs CT SNF LLC d/b/a Evergreen			9/30/2018		37	
If the facility is licensed as CDH and/or RCH or	r provides A	IDS or TBI	services with special Medicai	d rates, cost	S	
must be allocated to CCNH and RHNS as follow	ws:					
Item			Method of Allocation			
Dietary		Number of	meals served to residents			
Laundry		Number of	pounds processed			
Housekeeping			square feet serviced			
			hours of routine care provided			
Nursing			lassification, i.e., Director (or			
		Registered	Nurses, Licensed Practical Nu	rses, Aides a	and	
		Attendants			waara	
Direct Resident Care Consultants	4		hours of resident care provided	d by EACH		
			See listing page 13)			
Maintenance and operation of plant		Square feet				
Property costs (depreciation)		Square feet				
Employee health and welfare		Gross salar	····			
Management services			e cost center involved			
All other General Administrative expenses			rect 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 O Yes O No If "No," explain fully why such allocation			was			
costs allocated as required? O Yes O No not made.						
Not Applicable						
2. Explain the allocation of related company ex	penses and	attach copy	of appropriate supporting data	l.		
Not Applicable						
3. Did the Facility appropriately allocate and se	elf-disallow	direct and i	ndirect costs to non-nursing ho	me cost cen	ters?	
(e.g., Assisted Living, Home Health, Outpati	ent Services	s, Adult Day	y Care Services, etc.)			
	• Yes	O INO	If "No," explain fully why suc not made.	h allocation	was	

State of Connecticut Annual Report of Long-Term Care Facility CSP-6 Rev. 9/2002

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.

should not be included in these amounts.							
Name of Facility			License No.	Report for Year Ended	ear Ended		Page of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care	een Heal	th Care	2081C	9/30/2018			
	Related * to	d * to					\blacksquare
	Owners,	ers,					
	Operators,	itors,				Annual	
	Officers	cers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	ofLease	Claimed
Leaf Capital, PO Box 742647 Cincinnati, OH 45274	0	0	Copier	12/30/15	48 Months	10,809	10.809
Pitney Bowes, PO Box 371887, Pittsburgh, PA 15250	0	0	Mail Machine		63 Months	804	804
	0	•					
	0	•					
	0	•					
	0	0					
	0	•					
	0	0					
	0	0					
	0	0					
				1			

Is a Mileage Log Book Maintained for All Leased Vehicles?

11,613

Total ***

o N o

O Yes

^{*} 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	License No.	Report for Year Ended		Page	of
Stafford Springs CT SNF LLC d/b/	2081C	9/30/2018		7	37
The records of this facility for the p	period covered by this report	were maintained on the following basis:			
	Modified Cash				
Is the accounting basis for this					
Į ±	Yes	If "No," explain.			
previous period?	No				
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, C7	06511	
2					
3					
4					
Services Provided by This Firm (de.					
 Audit, Year End Financials, Tax Retu 	ırn and Medicare cost report		\$	27,125	
2 Medicare Cost Report			\$	2,700	
3			\$		
4			\$		
			Charge fo	r Services P	rovided
			\$	29,825	
Are These Charges Reflected in the Expend	diture Portion of This Report? If Y	es, Specify Expense Classification and Line No.	L		
	Pg 15, Line1d				
Legal Services Information					
Name of Legal Firm or Independent	t Attorney		Telephon	e Number	
1 Murtha Cullina	,		860-240-		
2 Goldman, Gruder & Woods, LI	LP		203-899-	8900	
3 State Marshall/probate					
4		· ·			
5					
Address (No. & Street, City, State, 2	Zip Code)				
1 185 Asylum St Hartford, CT 06	5103				
2 200 Connecticut Ave, Norwalk	, CT 06854				
3					
4					
5	·1. · C 11. · \				
Services Provided by This Firm (des					<u> </u>
1 Misc. Issues:Disallow (640): Audit Le	etter (570) Allow		\$	1,210	
2 A/R:disallow			\$	18,828	***************************************
3 conservatorship/probate fees/medicaic	d apps:disallow		\$	5,567	
4			\$		
5			\$	***************************************	
			Charge fo	r Services Pi	ovided
			\$	25,605	
Are These Charges Reflected in the Expend	diture Portion of This Report? If Y	es, Specify Expense Classification and Line No.			
-	Pg 15, Line1e				
O Yes O No					

State of Connecticut Annual Report of Long-Term Care Facility CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility			License No.	lo.			Report fo	Report for Year Ended	P		Page	of
Stationa Spinigs of Sint door a divisigned nearly care cerner	I Care Ce	iller	77	2081C			9/30/2018	3			χ	37
					-	Period 10/1 Thru 6/30	'1 Thru 6/.	30		Period 7/1 Thru 9/30	Thru 9/3	0
	Total All	Total CCNH	Total RHNS	Total								
	Levels	Level	Level	(Specify)	Total	CCNH	RHINS	(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			081	180			081	180		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	144	144			144	144			176	176		
B. As of midnight of THIS report period	173	173			176	176			173	173		
3. Total Number of Days Care Provided During Period												
Α. Medicare	10,153	10,153			7,778	7,778			2,375	2,375		
B. Medicaid (Conn.)	41,906	41,906			31,147	31,147			10,759	10,759		
C. Medicaid (other states)												
D. Private Pay	8,565	8,565			6,173	6,173			2,392	2,392		
E. State SSI for RCH												
F. Other (Specify)	924	924			745	745			179	179		
G. Total Care Days During Period (3A thru F)	61,548	61,548			45,843	45,843			15,705	15,705		
Total Number of Days Not Included in Figures in 3G												
Beds												
A. Medicaid Bed Reserve Days	82	82			34	34			48	48		
B. Other Bed Reserve Days	82	82			51	51			31	31		
5. Total Resident Days (3G + 4A + 4B)	61,712	61,712			45,928	45,928			15,784	15,784		

Schedule of Resident Statistics (Cont'd)

Name of Faci	lity			Lice	nse No.				Report	t for Year	Ended		Page	of
Stafford Sprin	ngs CT :	SNF LL	C d/b/a Evergree	2	081C					9/30/201	8		9	37
4. Were the	ere any	changes	in the certified l	ed ca	apacity du	ıring	the rep	ort yea	ar?	0	Yes	•	No	
11 1150	· · · · · · · · · · · · · · · · · · ·		f Change	1011.	Cł	onge	in Bed	c		Car	nacity Δ ff	er Change		
D . C						lange	1			Ca	pacity Air	T	1	
Date of	CCNH	RHNS	(Specify)		Lost		<u> </u>	Gaine	a					
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason f	or Change
	(1)	(2)	(3)	(1)	(2)	(3)	- (1)	(2)	(3)	CCIVII	IGINO	(Specify)	TCGSOII I	or change
							<u> </u>	 						
											·····			
}	•	_	in certified bed	-		g the r	report y	ear (a	s repor	ted in iter	n 4 above) provide the nu	ımber of	
RESIDI	ENT DA	YS for	90 days followin	g the	change.					·		T	Υ	
			Change in Re	esider	ıt Days					CC	NH	RHNS	(Spe	ecify)
1st chan														
2nd char											~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~			
3rd chan														·····
4th chan 6. Number		lents an	d Rates on Septe	mher	: 30 of Cc	st Ve	ar			l		L	<u> </u>	
O. INUITIDE	OI ICCSIC	ichts an	Medicare	JIIIOCI	Medic			Ι		Se	lf-Pay		Other Sta	te Assisted
														1
	Item		CCNH	C	CNH	RI	HNS	CC	CNH	RF	INS	(Specify)	R.C.H.	ICF-MR
No. of R	esidents	;	5		125				23			20		
Per Dien	n Rate							2						
a. One b			525.99		248.14				474.00			350.44		
b. Two	bed rms		525,99		248.14				464.00			350.44		
c. Three		e												
bed r	ms.							<u> </u>						
7 Total Nu	unhan af	Dhysio	al Therapy Treat	mont						TO	ΓAL	CCNH	RHNS	(Specify)
	Medica			mem.	•					10	7,306	7,306	IdiNo	(Specify)
			lusive of Part B)								7,500	7,		
			e Treatments								1,528	1,528		
	2. Rest	torative	Treatments											
	Other										23,015	23,015		
			Therapy Treatn								31,849	31,849		
			Therapy Treatm	ents										
	Medica										812	812		
В.		-	lusive of Part B) e Treatments								187	187		
			Treatments								107	107		
C.	Other	Oracivo	Ticuments								1,637	1,637		
		peech T	herapy Treatme	ents							2,636	2,636		
			tional Therapy		nents									
	Medica										3,486	3,486		
B.			usive of Part B)											
		·	e Treatments				·····				1,339	1,339		
		orative	Treatments								21.222	21.722		
	Other Total C)counati	onal Therapy T	route							21,720 26,545	21,720 26,545		`
D.	3 out O	ссирии	oran inciupy i	caun	ICIUS						د ۱۳۰۱ سر	20,545		

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Report of Ex		- Darari	·			
Name of Facility	License No.		Report for Year	Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care	2081C		9/30/2018		10	37
Are time records maintained by all individuals receiving con		0	Yes	0	No	
Are time records maintained by an individuals receiving our	mpenoanon.			- 1 11		
			Total Cost a	na Hours	I	
					(2 12)	
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
Operators/Owners (Complete also Sec. I						
of Schedule A1)						
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)	141,895	2,106				
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	248,275	12,959				
5. Dietary Service						
a. Head Dietitian	61,249	2,167				
b. Food Service Supervisor	54,678	2,282				
c. Dietary Workers	397,774	26,367				
6. Housekeeping Service		100				
a. Head Housekeeper						
b. Other Housekeeping Workers	142,618	11,243				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	85,930	2,201				
b. Other Maintenance Workers	128,526	5,572				
8. Laundry Service			a contract of			
a. Supervisor						
b. Other Laundry Workers	123,393	8,102				ļ
Barber and Beautician Services						<u> </u>
10. Protective Services						
11. Accounting Services						
a. Head Accountant				 	 	<u> </u>
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	224,049	4,417				
b. RN						
Direct Care	1,080,052				<u> </u>	<u> </u>
2. Administrative**	482,614	16,878				
c. LPN						
Direct Care	1,623,366	63,378	5	 		
2. Administrative**		1.54.500		 		
d. Aides and Attendants	2,559,253				 	
e. Physical Therapists	638,849					
f. Speech Therapists	90,963					
g. Occupational Therapists	419,912					
h. Recreation Workers	287,348	14,365				
i. Physicians						
1. Medical Director		 	 	<u> </u>	 	
2. Utilization Review			 			
3. Resident Care***						
4. Other (Specify)						
- Davids	-	 		 		
j. Dentists		 		<u> </u>		
k. Pharmacists		 	 	 	 	
Podiatrists Secial Workers/Case Management	223,995	8,880	1	<u> </u>		
m. Social Workers/Case Management	223,393	0,000				
n. Marketing o. Other (Specify)						
o. Other (Specify) See Attached Schedule						
A-13, Total Salary Expenditures	9,014,739	397,321	1			
A-15. 10iai Saiary Expenaitures	1 2,014,133	1 371,321	`1	1		·

^{*} 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.

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

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

		7	Assistan	t Administre	Assistant Administrators and Other Related Parties*	Kelate	d Parties	¥-		
Name of Facility			-	License No.		Report for	Report for Year Ended		Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	3/a Evergree	en Health C	are Center	2081C		9/30/2018) =	37
		Salary Paid	7							
				Fringe Benefits and/or Other Payments	Full Description of	Total Hours	Line Where Claimed on	Name and Address of All	Total Hours	Compensation
Name	CCNH	RHINS	(Specify)	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
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. He additional shoets if required	he consider	ill ssaluii pa	11 information	n is provided Hea	additional chapte if rea	lired				

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

^{**} Include all employment worked during the cost year.

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

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

•		Y	SSIStallt	Aummena	Assistant Auminishators and Other Refated Faines	Nelalen	ו מוווכט			
Name of Facility (as licensed)				License No.		Report for Year Ended	ear Ended		Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	/a Evergree	n Health Ca	ıre Center	2081C		9/30/2018			12	37
		Salary Paid		:						
				Fringe Benefits and/or Other		Total		440,440,000	Total	
Name	CCNH	RHNS	(Specify)	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section III - Administrators***										
				Health & Life	Day to day operations					
Christine M McKinney (10/1/17 - 9/30/18)	141,895			Insuracne, Payroll Taxes	if the nursing home facility	2,106				
Section IV - Assistant										
Administrators										
			`							
* The second sec	1 ha agaida	and unlock	informati	1 6	bearings to stoods lowerith to coll be birrows of	poning				

^{*}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

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

B. Report of E		CS - 1101			Dogo	of
Name of Facility	License No.	21.0	Report for Y 9/30/2018	ear Ended	Page 13	37
Stafford Springs CT SNF LLC d/b/a Evergreen Hea	208	ilC	L	1 7 7	13	3/
		·	Total Cost	and Hours		1
				-		
	COM		DIDIO	TT	(C:E)	T1
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary						4-1
(For all such services complete Schedule B1)						
1. Dietitian	20.704	00				
2. Dentist 3. Pharmacist	20,794	96 96				
	17,309 163	96				
	103	2				
5. Physical Therapy a. Resident Care						
b. Other 6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	18,337	596				
b. Utilization Review	10,337	390				
(Title 18 and 19 only) monthly meeting						
c. Resident Care**	1,482					
d. Administrative Services facility	1,482					
I Infection Control Committee						
(Quarterly meetings)						
2. Pharmaceutical Committee						
(Quarterly meetings) 3. Staff Development Committee						
(Once annually)						
e. Other (Specify)						
c. Guier (Speerly)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	erro Cisis Assistanti esperante esperante que esperante	EULEUCON CHANNESS DEL GARAGES DANS	BBC-637360-44074-441-38074-41034-401-001-001-001-001-001-001-001-001-00	- Columbia (Company) Columbia (C	200000000000000000000000000000000000000	604 (20.00000000000000000000000000000000000
2. Administrative***	8,959	144				
b. LPN						
1. Direct Care	The section of the se	A CONTRACTOR OF THE PROPERTY O) (A) (A) (A) (A) (A) (A) (A) (A) (A) (A	
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	#43.000000000000000000000000000000000000				The state of the s	
B-13 Total Fees Paid in Lieu of Salaries	67,044	934				
* Do not include in this section management consultants or services which	- must be reported a	n Dago 16 itam M	12 and cumported b	v required inform	ntion Days 17	

^{*} 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.

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

Name of Facility	License No.			Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Everg	reen Health C 2081C		9/30/2018		14	37
			to Owners,			
Name & Address of Individual	Full Explanation of Service		rs, Officers	Explai	nation of R	elationship
Y 117 2 200 Y/		Yes	No			
HealthDrive Dental Group, 888 Worcester St, Wellesley, MA 02482	Dentist	0	•			
ProCare LTC, 110 Bi-County Blvd. Suite 121, Farmingdale, NY 11735	Pharmacy Consulting/Nursing Consultants	0	0	Common Own	ers:Minority I	nterest
Bay State Family Podiatry, 74 Palomba Drive, Enfield, CT 06082	Podiatrist	0	0			
Athena Health Care 135 South Rd Farmington, CT 06032	MDS Fill-In	0	0	Common Owne	ers	
Dushyant Parikh, 146 Hazard Ave, Enfield CT 06082	Medical Director	0	0			
HealthDrive Audiology, 888 Worcester St, Wellesley, MA 02482	Audiology services	0	0			
HealthDrive Eye Care Group, 888 Worcester St, Wellesley, MA 02482	Eye Care Services	0	0			
HHC Physicians Care Inc, PO Box 417695, Boston, MA 02241-7695	Physician services	0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	•			
		0	0			
		0	0			
		0	0			
		0	•			
		0	0			
		0	•			
		0	•			
		0	•			
		0	•			

^{*} Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility License No.	 Report for Y	ear Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen H 2081C	9/30/2018		15	37
Item	 Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits		- 10 m		
Workmen's Compensation	\$ 419,658	419,658		
Disability Insurance	\$ 			
3. Unemployment Insurance	\$ 81,774	81,774		
4. Social Security (F.I.C.A.)	\$ 664,064	664,064		
5. Health Insurance	\$ 1,184,934	1,184,934		
6. Life Insurance (employees only)				
(not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory)	\$ 44,062	44,062		
(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*	\$ 102,430	102,430		
d. Accounting and Auditing	\$ 29,825	29,825		
e. Legal (Services should be fully described on Page 7)	\$ 25,605	25,605		
f. Insurance on Lives of Owners and	\$			
Operators (Specify)*		equal of the		
g. Office Supplies	\$ 71,491	71,491		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 30,500	30,500		
2. Cellular Phones	\$ 1,438	1,438		
i. Appraisal (Specify purpose and	\$			
attach copy)*				
		Table 1		
j. Corporation Business Taxes (franchise tax)	\$	2000		
k. Other Taxes (Not related to property - See Page 22)		-		
1. Income*	\$ neggyppines (f. 14) o the first of the first			one conversion to the transfer and the second of the secon
2. Other (<i>Specify</i>)	\$ ***************************************	····	· · · · · · · · · · · · · · · · · · ·	**************************************
See Attached Schedule				
3. Resident Day User Fee	\$ 1,083,119	1,083,119		
Subtotal	\$ 3,738,900	3,738,900		
		(Carry Subto	4.1.C 1.	4

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

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

Name of Facility License No.		Report for Y	ear Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health 2081C		9/30/2018		16	37
dation Springs C1 bitt BBC word 21 big					
Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forwa	ard:	3,738,900	3,738,900		
1. Travel and Entertainment					
Resident Travel and Entertainment	\$				
Holiday Parties for Staff	\$	5,539	5,539		
3. Gifts to Staff and Residents	\$	8,750	8,750		
4. Employee Travel	\$	1,416	1,416		
5. Education Expenses Related to Seminars and Conventions	\$	809	809		
6. Automobile Expense (not purchase or depreciation)	\$				
7. Other (Specify)	\$				
See Attached Schedule					
m. Other Administrative and General Expenses					
Advertising Help Wanted (all such expenses)	\$	3,010	3,010		
2. Advertising Telephone Directory (all such expenses)***	\$				
3. Advertising Other (Specify)***	\$	27,747	27,747		
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	\$		24,204		
* 8. Dues and Membership Fees to Professional	\$	13,079	13,079		
Associations (Specify)					
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	3			<u> </u>	
10. Contributions***	\$	4,200	4,200		
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**		607,118	607,118		
13. Other (Specify)	9	104,507	104,507		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	5	4,539,279	4,539,279	1	<u> </u>

^{*} 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)
			T C
		30.00	
Total Other Travel and Entertainment	S -	s -	2 - 2

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	S 27,747		The Carlo
		4.000	
Total Other Advertising	\$ 27,747	\$ -	s -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF Dues	\$ 13,079		1
		14 C C C C C C C C C C C C C C C C C C C	15 15 15 15 15 15 15
		- C.	
		31 (5.00)	
	100000		
	74485		
Total Dues	\$ 13,079	5 -	s -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Miscellaneous	\$ 4,200		le de la companya de
	100000000000000000000000000000000000000	100	
Total Contributions	\$ 4,200	S -	\$ -

Schedule of Other Administrative and General

Description		CCNH	RHNS	(Specify)
Licenses	S	900		
Bank Charges	\$	14,188		
Payroll Processing Fees	S	17,493		
Employee Physicals/Background Checks	S	16,667		
Data Processing/ Software Maint. Fees	S	46,340		
Cleary energy Audit	S	4,694	State of the state	
Citation 2017-01-LTC-246	S	4,225	•	
	35525		1000	
				The state of the s
	SAGA	480 700		
Total Other Administrative and General	S	104,507	\$	S

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Stafford Springs CT SNF LLC d/b/a Ever	2081C	9/30/2018	17 37
Name & Address of Individual or Company Supplying Service Athena Health Care Assoc., Inc 135	Cost of Management Service 861,185	Full Description of Mgmt. Service Provided Contract Attached to a Prior	Indicate Where Costs are Included in Annual Report Page #/Line # See Below
South Road Farmington, CT 06032		Year	D 16 Line 12
Allocation of the Above	568,382	Admin/Gen 66%	Pg 16, Line 12
	137,790	Indirect 16%	Pg 20, Line 5k
	155,013	Direct 18%	Pg 20, Line 5J
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	38,736	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.

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

				Page 5)				Υ	
Nam	ne of Facility		License	No.		oort for Ye	ear Ended	Page	of
	ford Springs CT SNF LLC d/b/a Evergreen Hea	lth		2081C	9	9/30/2018		18	37
	Item			Total	(CCNH	RHNS	(Sp	ecify)
2.	Dietary								
	a. In-House Preparation & Service								
	1. Raw Food		\$	455,489	ļ	455,489		<u> </u>	
	Non-Food Supplies		\$	34,200		34,200			
	3. Other (Specify)		\$	2,182		2,182			
	Dishes=\$2,182								
	b. Purchased Services (by contract other		\$						
	than through Management Services)								
	(Complete Schedule C-2 att. Page 21)		0	127 700		127 700			
	c. Other (Specify)		\$	137,790		137,790			
	Management Services								
	T (1) $T (1)$ $T (1$		\$	629,661		629,661			
2D.	Total Dietary Expenditures $(2a + b + c + d)$		Φ	029,001	\vdash	027,001		 	
						COM	DIDIC	(0.	anifu)
2F.	Dietary Questionnaire			Total	-	CCNH	RHNS	(9)	pecify)
G.	Resident Meals: Total no. of meals served per	day	y:*	506	<u> </u>	506	<u> </u>	<u> </u>	
H.	Is cost of employee meals included in 2E?	•	Yes	0	No)			
T	Did you receive revenue from employees?	0	Yes	•	No	•	If yes, specify		
I.							amt.		
J.	Where is the revenue received reported in the	Cos	st Repor	t? (Page/Line	Iten	n)		************	
	Is cost of meals provided to persons other						If yes, specify		
K.	than employees or residents (i.e., Board	•	Yes	0	No)	cost.		01.15 6
	Members, Guests) included in 2E?								\$1,156
,	Is any revenue collected from these people?	\circ	Ves	•	No)	If yes, specify		
L.	is any revenue confected from these people:		103				amt.		
M.	Where is the revenue received reported in the	Co	st Repo	t? (Page/Line	Iten	n)			
	Is cost of food (other than meals, e.g.,								
	snacks at monthly staff meetings, board	\cap	Yes	•	No)	If yes, specify		
N.	meetings) provided to employees included		1 03	O		•	cost.		
	in 2E?								
	**************************************	\circ	Yes	•	No)	If yes, specify		
Ю.	Is any revenue collected from employees?	U	168		110		amt.		
P.	Where is the revenue received reported in the	Со	st Repo	rt? (Page/Line	Iter	n)			
1~ '									

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

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

1	ne of Facility	License		Report for Y		Page	of
Stat	ford Springs CT SNF LLC d/b/a Evergreen Health C	1	2081C	9/30/2018	1	19	37
	Ītem		Total	CCNH	RHNS	(Spec	cify)
3.	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.					
	Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.					
	processed.***	Amt. \$					
	3. Personal clothing of residents	Lbs.					
	washed, ironed, and/or processed.***	Amt. \$					
	4. Repair and/or purchase of linens.***	Lbs.					
ļ		Amt. \$	162,044	162,044			
	b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$					
	c. Other (Specify) Supplies=\$5,032	\$	5,032	5,032			
3D.	Total Laundry Expenditures (3a + b + c)	\$	167,076	167,076			
3F. G.	Laundry Questionnaire Is cost of employee laundry included in 3E? O	Yes	•	No	If yes, specify cost.		
H.	Did you receive revenue from employees?	Yes	0	No	If yes, specify amt.		
I.	Where is the revenue received reported in the Cost	Report?		(Page/Line			
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? O	Yes	•	No	If yes, specify amt.		
L.	Where is the revenue received reported in the Cost	Report?		(Page/Line	Item)		

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

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

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

	ne of Facility	License No.	Rep	ort for Year E	Ended	Page	of
Sta	fford Springs CT SNF LLC d/b/a Evergreen	2081C		9/30/2018		20	37
	Item	_		Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced					
	a. In-House Care	by Personnel					
	1. Supplies - Cleaning (<i>Mops</i> ,	Amt.	\$	46,805	46,805		
	pails, brooms, etc.)						
	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att.	Amt.	\$				
	Page 21)						
	C. Other (<i>Specify</i>)		\$				
4D.	Total Housekeeping Expenditures (4a +	b+c)	\$	46,805	46,805		
5.	Resident Care (Supplies)**						
	a. Prescription Drugs***						
	1. Own Pharmacy		\$				
	2. Purchased from		\$	467,114	467,114		
	Partners Pharmacy and Procare Pharmacy						
	b. Medicine Cabinet Drugs		\$	22,394	22,394		
	c. Medical and Therapeutic Supplies		\$	302,649	302,649		
	d. Ambulance/Limousine***		\$	4,375	4,375		***************************************
	e. Oxygen						
	1. For Emergency Use		\$				
	2. Other***		\$	45,650	45,650		
	f. X-rays and Related Radiological		\$	29,396	29,396		
	Procedures***						
	g. Dental (Not dentists who should be incl	uded under	\$				
*****	salaries or fees)						
	h. Laboratory***		\$	39,804	39,804		
	i. Recreation		\$	12,708	12,708		
	j. Direct Management Services*		\$				
	k. Indirect Management Services*		\$				
	l. Other (Specify)****	**************************************	\$	281,753	281,753		
	See Attached Schedule			,,,,	,,,,,		
M.	Total Resident Care Expenditures (5a - 5j)	\$	1,205,843	1,205,843		
	Schedule C-1 Page 17 must be fully completed on t			7 7-1-	-,,,		·····

^{*} 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

		(CCNH	RF	INS	(Spe	ecify)
<u>Jescription</u>	0	\$.	\$		\$	
		\$	155,013	\$		\$	3
Management Fee Direct		\$		\$	-	\$	
		\$	29,327	\$		\$	
Cable TV		\$	25,574	\$		\$	(1) m (1) -
Medical Equip Rentals-Medicaid		\$	22,035	\$		\$	
Physical Therapy Supplies		\$	2,660	\$		\$	-
Occupational Therapy Supplies		\$	6,379	\$		\$	- -
Oxygen Equipment Rentals		\$	40,765	\$		\$	
Medical Equip Rentals-Other		\$.,,,,,,,	\$	12.5	\$	
		\$		\$		\$	
		\$		S		\$	
	Ö	- Conference		\$		\$	
	Ô	n sámki Vo		\$	- 0	\$	
	C	0 000 000		\$		S	
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	(5 - 1507 C	ligija s t alija Rojeka se	\$	-	\$	
		8 3.008.0		\$		\$	
	<u>(</u>	A 34000 NA		\$		s	
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		-	<u>.</u>	\$		\$	
	(\$		Ŝ	
		0 \$		\$		\$	
	<u> </u>	0 \$	201.752			S	
Total Other Resident Care	Service Commence	\$	281,753	1 0		.es. [-0, Ψ ,28'9'2'	gar, esta en el cità

State of Connecticut Annual Report of Long-Term Care Facility CSP-21 Rev. 10/2001

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

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	C d/b/a Evergreen Heal	th Care Cent	er	License No. 2081C	Report for Year Ended 9/30/2018				Page 21	of 37
		Related ** to Owners,	o Owners,	•						
		Operators, Officers	Officers				otal Cost/	Total Cost/Page Ref.***	*	
Name of Individual or				Explanation of	Full Explanation of					
Company	Address	Yes	No	Relationship	Service Provided*	CCNH	RHNS	(Specify)	Pg	Line
Procare LTC Pharmacy	111 Excutive Blvd Farmingdale NY 11735	0	0	Common Owners:Minority Interest	Pharmacy Services	550,632			20	5A2 &
ADP	PO Box 842875, Boston, MA 02284-2875	0	•		Payroll Processing	12.228				m13
Vasseur Landscaping	156 Broad Brook Rd Enfield, CT 06082	0	0		Landscaping and Snow Removal Services	63.147				į,
USA Hauling & Recycling	PO Box 808 East Windsor, CT 06088	0	•		Rubbish Removal	34 145			22	j.
Unitex Textile Services	Pwy, Mt Vernon, NY 10550	0			Laundry Services	157,158				3A4
		0	0							
·		0	0							
		0	•							
		0	•							
		0	0							
		0	•							
		0	•					٠		
		0	0							
		0	0							

^{*} 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 Licens		Report for Y	ear Ended		Page	of
Stafford Springs CT SNF LLC d/b/a Evergree 2	081C	9/30/2018			22	37
Item		Total	CCNH	RHNS	(Sp	ecify)
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	157,154	157,154			
b. Heat	\$	152,159	152,159			
c. Light & Power	\$	191,778	191,778			
d. Water	\$	339,441	339,441			
e. Equipment Lease (Provide detail on page 6)	\$	11,613	11,613			
f. Other (itemize)	\$	171,482	171,482			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	1,023,627	1,023,627			
7. Depreciation (complete schedule page 23*)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$	152,041	152,041			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	152,041	152,041			
8. Amortization (Complete att. Schedule Page 24*))					
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	62,981	62,981			
d. Other (Specify)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$	62,981	62,981			
9. Rental payments on leased real property less						
real estate taxes included in item 10b	\$	813,906	813,906			
10. Property Taxes						
a. Real estate taxes paid by owner	\$	196,588	196,588			
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$	13,618	13,618			
11. <i>Total Property Expenses</i> (7e + 8e + 9 + 10)	\$	1,239,134	1,239,134			

^{*} 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

	CCNH	RHNS	(Specify)
Description	\$ -	\$ -	\$ -
	\$ 52,329	\$ -	\$ -
Groundskeeping	\$ 41,803	\$ -	\$ -
Rubbish Removal	\$ 27,345	S -	\$ -
Snow Removal	\$ 48,514	\$ -	\$ -
Supplies	\$ 1,491	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ =
		\$ -	\$ -
	\$	\$ -	<u> </u>
	\$ -	\$ -	\$
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	<u> </u>
	\$ =	\$ =	\$ -
	S =:	S -	<u> </u>
	S 7	\$ -	<u> </u>
	\$:	\$ -	The Alexander of the Auditor Physic
	\$ 5	\$ -	100000000000000000000000000000000000000
	\$ -	\$ -	THE RESERVE OF STREET
Total Other Repairs and Maintenance	\$ 171,482	2 \$ -	\$

State of Connecticut Annual Report of Long-Term Care Facility CSP-23 Rev. 10/2006 Depreciation Schedule

				ンソルロング	Dept ectation Schedine	ampan					
Name of Facility	<u> </u>	(License No.	ŧ		Report for Year Ended	Snded		Page	Jo
Stationa Springs C1 SNF LLC d/b/a Evergreen Health Care Center	en Health C	are Cen	er	2081C	C		9/30/2018			23	37
				Historical			Accumulated				
				Cost	Less		Depreciation to	Method of			
				Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	
Property Item				Land	Value	Depreciated	Year's Operations		Life	for This Year	Totals
A. Land Improvements											
1. Acquired prior to this report period											
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	ch schedule)										
A-4. Subtotal											
B. Building and Building Improvements											
1. Acquired prior to this report period											
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	ch schedule)										
B-4. Subtotal											
C. Non-Movable Equipment											
1. Acquired prior to this report period											
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	ch schedule)										
C-4. Subtotal											
	Is a mileage logbook	Date of		Historical			Accumulated				
	maintained?	Acquisition	trion	Cost	Less		Depreciation to	Method of			
	Ves	Month	V	Exclusive of	Salvage	Cost to Be	Beginning of			Depreciation	
D Moveble Equipment	1000		rear	Laliu	value	Deprecialed	rear's Operations	Depreciation	Life	for This Year	Totals
b.											
C.											
d.											Tr.
2. Movable Equipment								H			
a. Acquired prior to this report period		6	2017	630,812		630,812	185,377	S/L	Various	127.933	
b. Disposals (attach schedule)											
c. Acquired during this report period											
(attach schedule)		6	2018	441,853		441,853		S/L	Varions	24.108	
rj											152.041
E. Total Depreciation											152 041
											172,071

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

Amortization Schedule*

Nan	Name of Facility		License No.		Report for Year Ended	r Ended		Page	Jo
Staf	Stafford Springs CT SNF LLC d/b/a Evergreen Health Care	Health Care	q 2081C	1C	9/30/2018			24	37
		Andrews of the Control of the Contro			Accumulated				
		Date of		49	Amort. to				
		Acquisition			Beginning of	Basis for	4		
			Length of	Cost to Be	Year's	Computing	Rate	Amortization	
	Item	Month Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
Α.	Organization Expense	-							
	, [
	2.								
	3.								
A-4	A-4. Subtotal								
В.	Mortgage Expense								
	1. Finance Fees	12 15	10 years	51,000	8,925				
	2.								
	3.								
B-4	B-4. Subtotal								
ن	Leasehold Improvements and Other								
	1. Acquired prior to this report period	9 201	2017 Various	345,051	37,600			34,415	
	2. Disposals (attach schedule)								
	3. Acquired during this report period								
	(attach schedule)	9 201	8 Various	800,257		SL	Varior	28,566	
C-4	C-4. Subtotal								62,981
0.	Total Amortization								62,981

* 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; ORC. Remaining Life of Lease; ORD. Actual Life if owned by Related Party.

Schedule of Movable Equipment Acquired during this report period

cquisition Date	Description of Item	Cost	Life I	Depreciation
dditions:			15	\$ 38
ct-17	Burnisher	\$ 1,149		s 104
ct-17	Mitel phone	\$ 1,041	5	
ov-17	Medical equipment	\$ 1,514		
The second secon	Nursing station krosk	\$ 7,231	- 15	\$ 241
lov-17	patient furniture	\$ 70,361	15	\$ 2,345
lov-17	piano/accessories	\$ 17,133	10	S 857
lov-17		\$ 14,026	15	\$ 468
lov-17	patient furniture	\$ 5,562	20	\$ 139
lov-17	fish tank	\$ 17,783	15	\$ 593
Nov-17	patient furniture	\$ 10,304	5	\$ 1,030
Nov-17	artwork	\$ 24,444	5	\$ 2,444
Vov-17	supplies	And the second s	-15	\$ 53
Nov-17	patient furniture	\$ 1,581	Charlett Water	s 3,691
Vov-17	Medical equipment	\$ 73,829	10.	
Nov-17	patient furniture	\$ 25,467	15	
The second secon	Medical equipment	\$ 9,537	10	s 477
Vov-17	patient furniture	\$ 3,303	15	\$ 110
Nov-17	patient furniture	\$ 8,883	15	\$ 296
Nov-17		\$ 1.027	5	\$ 103
Nov-17	recreation supplies	\$ 6,915	15	\$ 231
Nov-17	patient firmiture	\$ 3,134	- 10	\$ 157
Nov-17	food warmers	\$ 1,224	5	\$ 122
May-18	Devixe Measurement Bedsystem	\$ 4,088	10	\$ 204
May-18	diathermy	and the state of t	5	\$ 489
May-18	resident room TV's	\$ 4,885	5	\$ 422
Jun-18	resident room TV's	\$ 4,224	5	\$ 197
Jun-18	resident room TV's	\$ 1,965	Tarable party of the second	
The state of the s	bed rails	S 1,608	5	\$ 161
Aug-18	resident room TV's	\$ 10,154	5	\$ 1,015
Aug-18	resident room TV's	\$ 2,702	5	\$ 270
Aug-18	resident room TV's	\$ 19,542	5	\$ 1,954
Sep-18		\$ 1,975	15	\$ 66
Sep-18	ultracare bed	\$ 72,403	10	\$ 3,620
Sep-18	hoyer lift	\$ 12,859	5	\$ 1,286
Sep-18	resident room TV's		275000000000000000000000000000000000000	
				4 (2 (4)
				10.50
			100000000000000000000000000000000000000	200000000000000000000000000000000000000
				250000000000000000000000000000000000000
			200000000000000000000000000000000000000	
			1000	
			100000	
	see attached		various	100000
yarious	See attacked	13 - 1 2 3 3 4 5 5	Hinnell	
		\$ 441,853		\$ 24,108
Total additions for M	ovable Equipment	0		
Deletions:			340000	30 100 100 1
Various			150.00	1200000
			0.00	
			1 PORT (12 CA)	
inchiga paralla del Tito			22222	
			2000000	101000000000000000000000000000000000000
			1002200	383 (888)
	oyable Equipment	S		S -
Tatal deletions for M	BYSHIC EUBIUHEHU			

^{**}Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

chedule of Leasenoid	Improvements Acquired during this report per		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:			rn.	5 188
Nov-17	bubbling boulder	\$ 3,751	20	
Nov-17	oxygen system	\$ 42,785	10	
Nov-17	fence	\$ 1,986	SAN TANKE OF SERVICE STREET, SEC. 10.	\$ 97
Nov-17	lamps & timeclock	\$ 1,949	- CE - Creative and Contract of the	\$ 225
Nov-17	lighting	\$ 4,498		\$ 1,037
Nov-17	Architectural design	\$ 31,102	and the state of t	\$ 679
Nov-17	sound system	\$ 6,785	Committee of the Commit	\$ 480
Nov-17	Architectural design	\$ 9,600	STORES AND ASSESSMENT OF THE PARTY OF THE PA	\$ 19,951
Nov-17	30 bed renovation	\$ 598,537		\$ 881
Nov-17	window treatments	\$ 35,239	Charlest Annual Control of the Contr	\$ 431
Nov-17	signage	\$ 4,309	-5	100
Nov-17	traveling cable	\$ 21,540	20	
Dec-17	acrylic logo	\$ 2,475		2 2 - 30 F 2 F 2 F 2 F 2 F 2 F 2 F 2 F 2 F 2 F
Mar-18	flag pole	\$ 3,271	And the second second	\$ 586
Int-18	compressors	\$ 23,450		
Aug-18	compressor	\$ 8,980	10	ررع وا
Aug-10		- 000 0E2		\$ 28,566
Total additions for Le	asehold Improvements	\$ 800,257		1 20000
Deletions:		Caracian Service Advantage Conference	O Amazonia Salakaria	
DCICIIO				
	Control of the Contro			
			2000 BERNES	
	The state of the s			S -
Total deletions for Le	aschold Improvements	\$ -	30 (12 22 24	Of the Control of the Control

^{*}Ties to Page 24, Line C3
**Ties to Page 24, Line C2

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

Name of Facility License No.		Report for Year E	nded		Page of
Stafford Springs CT SNF LLC d/b/a E 20	81C	9/30/2018			25 37
11. Property Questionnaire					
Part A	***************************************				Samuel Samuel Control of the Control
Is the property either owned by the Facility	0	Yes	0	N-	If "Yes," complete Part B.
or leased from a Related Party?*	©	ies	O	No	If "No," complete Part C.
*If any owner or operator of this facility is relate					
business association to any person or organization a related party transaction.	on from whom	buildings are leased, th	nen it is considered		
Description		Total			
Date Land Purchased		1000			
Date Structure Completed					
3. If NOT Original Owner, Date of Purchas	se	12/29/15			
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		13t Wiortgage	Ziid Wortgage	31d Wortgage	4th Wortgage
a. Type of Financing (e.g., fixed, variab	le)	Conventional			
b. Date Mortgage Obtained		12/29/15			
c. Interest Rate for the Cost Year		6.18%			
d. Term of Mortgage (number of years)		4			
e. Amount of Principal Borrowed	0/20/2010	15,750,000			
f. Principal balance outstanding as of	9/30/2018	15,750,000			
Complete if Mortgage was Refinanced					
During Current Cost Year g. Type of Financing (e.g., fixed, variab	10)				
h. Date of Refinancing	16)	i			
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
 Principal Outstanding on Note Paid-C 	Off				
Part C - Arms-Length Leases for Real					
Name and Address of Lessor	Prop	erty Leased	Date of Lease	Term of Lease	Annual Amount of Lease
		<u> </u>			

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 Ye	Report for Year Ended		
Stafford Springs CT SNF LLC d/b/a 2081C		9/30/2018			Page of 26 37
Item		Total	CCNH	RHNS	(Specify)
12. Interest					1
A. Building, Land Improvement & Non-Moval	ble				
Equipment	4				
First Mortgage Name of Lender	Rate)]			
Name of Lender	Rate				
Address of Lender					
Second Mortgage	\$				
Name of Lender	Rate			Territoria	
Address of Lender					
Address of Lender					
3. Third Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
D. OVERTAL X. A. C.					
B. CHEFA Loan Information	\$				
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) \$				
		(Camp	Subtotals fo	anuand to m	t naca)

(Carry Subtotals forward to next page)

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

Name of Facility Stafford Springs CT SNF LLC d/b/ 20	No. 81C		Report for Y	Year Ended		Page of
Stanford Springs CT SINF LLC d/b/j 20	010		9/30/2018		T	27 37
Item			Total	CCNH	RHNS	(Specify)
	totals Bro	ught Forward:				
12. C. Movable Equipment						
1. Automotive Equipment	г	\$				
A. Item	Rate	Amount				The state of the s
Lender		<u> </u>				
					10 mg 1 mg	120
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender	······································					
B. Item	Rate	Amount				
Lender						
Address of Lender	· vii					
12. C. 3. Total Movable Equipment Inter-	act					
Expense (C1 + 2)	ost	\$				
12. D. Other Interest Expense (Specify)		\$	2,488	2,488		
Vender Interest = \$2,488		-		2,100		
13. Total All Interest Expense (12B7 + 120	$^{3} + 12D$	\$	2.499	2 400		
14. Insurance	22 (1212)	Φ	2,488	2,488		
a. Insurance on Property (buildings or	ıly)	\$	100,536	100,536		
b. Insurance on Automobiles		\$	154	154		
c. Insurance other than Property (as sp	pecified at	oove)				
1. Umbrella (Blanket Coverage)						
2. Fire and Extended Coverage		\$				
3. Other (<i>Specify</i>)		\$				
4d. Total Insurance Expenditures (14a + b	+ a)	.	100 600	100 000		
5. Total All Expenditures (A-13 thru C-14		\$ \$	100,690	100,690		
20 Zour zur Espenanties (22-13 infu C-15	7	ا م	10,000,000	18,036,386		

D. Adjustments to Statement of Expenditures

ı	e of F			1	icense No.	Report for Ye	ear Ended	Page		of
Staff	ord Sp	orings	CT SNF LLC d/b/a Evergreen Health Care Cer	<u> </u>	2081C	9/30/2018		28] 3	37
					Total					
Item	Page	Line			Amount of	-				
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	(S ₁	pecify)
Page	10 - 5	Salari	es and Wages			2.00				
1.			Outpatient Service Costs	\$	S					
2.			Salaries not related to Resident Care	\$						
3.	10	A12g	Occupational Therapy	\$	419,912	419,912				
4.			Other - See attached Schedule	\$						
Page	13 - I	Profes	sional Fees							
5.	13	B8c	Resident Care Physicians **	\$	1,482	1,482				
6.			Occupational Therapy	\$						
7.			Other - See attached Schedule	\$						
Pages	s 15 &	16 -	Administrative and General							
8.	15	1a9	Discriminatory Benefits	\$						
9.	15	1c	Bad Debts	\$		102,430				
10.	15	1d&e	Accounting	\$						
10a.			Legal	\$		25,035				
11.			Telephone	\$	·					
12.	15	1h2	Cellular Telephone	\$	4	393				
13.			Life insurance premiums on the life							
			of Owners, Partners, Operators	\$						
14.	16	1 3	Gifts, flowers and coffee shops	\$	4	8,750			······································	
15.			Education expenditures to colleges or		-,1					
			universities for tuition and related costs				2			
l			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&1	Unallowable Advertising *	\$	27,747	27,747	···			
19.			Income Tax / Corporate Business Tax	\$	(250)	(250)				
20.			Fund Raising / Contributions	\$		4,200				
21.			Unallowable Management Fees	\$	416,146	416,146				
22.	10		Barber and Beauty	\$	710,170	710,170				
23.			Other - See attached Schedule	\$	18,413	18,413				
	18 - D	ietar	Expenditures	Ψ	10,413	10,413				
24.	18		Meals to employees, guests and others							
ا. ت	10		who are not residents	\$	1,156	1,156				
Paga	19 _ T		ry Expenditures	Φ	1,150	1,130				
25.	17-1		Laundry services to employees, guests	\dashv						
۵۵.			and others who are not residents	e						
Page	20 13		keeping Expenditures	\$						
26.	20 - M		Housekeeping services to employees, guests	-						
∠0.			and others who are not residents					3.00		
L		1		\$	1.025.414	1.005.414				
			Subtotal (Items 1 - 26)	Þ	1,025,414	1,025,414				

^{*} 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

_ ~ .	y : n.c	Description	CCNH	RHNS	(Specify)
Page Ref	Line Kei	Description [S -	S -	\$ -
			S -	S -	\$ -
			\$ -	\$ -	\$ -
			S -	S -	\$ -
	200		\$ -	\$ -	S
			\$ -	S -	S -
			\$ -	s -	\$ -
			s -	S -	\$ -
Total Other	er Salaries	Adjustment			

Schedule of Fees Adjustments

			CCNH	RHNS	(Specify)
Page Ref	Line Ref	Description	S -	s -	\$ -
			\$ -	s -	\$ -
			\$ -	S -	\$ -
			\$ -	\$ -	S -
			S -	s -	\$ -
	65.5		\$ -	S -	S -
			s -	\$ -	\$ -
			S -	s -	\$ -
			S -	\$ -	\$ -
Total Other	er Fees Ad	ustments			

Schedule of Other A&G Adjustments

		ann tuta	CCNH	RHNS	(Specify)
Page Ref		Description	\$ 14,188	\$	\$ -
16	M13	Bank Charges	S -	\$ -	s -
	5.75	Fine: Citation No. 2017-01-LTC 246	\$ 4,225	\$ -	\$ -
16	M13	Fine: Citation No. 2017-01-DTC 240	\$ -	\$ -	\$ -
			S -	\$ -	\$
			S -	S -	\$
			18,413	\$	\$
Total Othe	r A&G A	djustments	J		

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

D. T.	Name of Facility License No. Report for Year Ended Page of									
		-	· · · · · · · · · · · · · · · · · · ·			ear Ended	Page			
Staff	ord Sp	orings	CT SNF LLC d/b/a Evergreen Health Care	2081C	9/30/2018	,	29	37		
				Total						
	Page			Amount of						
No.	No.	No.	Item Description	Decrease	CCNH	RHNS	(Spe	cify)		
			Subtotals Brought Forward \$	1,025,414	1,025,414					
			nt Care Supplies***							
27.	20	5a1&	Prescription Drugs \$	<u> </u>	467,114					
28.	20	5d	Ambulance/Limousine \$	<u> </u>	4,375					
29.	20	5f	X-rays, etc \$	<u> </u>	29,396					
30.	20	5h	Laboratory \$	39,804	39,804					
31.	20	5c	Medical Supplies \$	24,200	24,200					
32.	20	5e2	Oxygen (non emergency) \$	45,650	45,650					
33.	20	5j	Occupational Therapy \$	2,660	2,660					
34.			Other - See Attached Schedule \$	88,687	88,687					
Page	22 - N	Mainte	enance and Property							
35.			Excess Movable Equipment Depreciation							
			See Attached Schedule \$	106,261	106,261					
36.			Depreciation on Unallowable							
			Motor Vehicles \$		A CELEGO VIDA VIDA DE DE DES PER CONTROL DE					
37.			Unallowable Property and Real							
			Estate Taxes \$			A CANADA MANAGAMAN AND AND AND AND AND AND AND AND AND A				
38.			Rental of Building Space or Rooms \$							
39.			Other - See Attached Schedule \$							
Page	27 - I	nsura	<u></u>							
40.			Mortgage Insurance \$							
41.			Property Insurance \$			***************************************				
Othe	r - Mis		<u> </u>							
42.			Other - Indirect \$							
43.			Interest Income on Account Rec. \$	32	32					
44.			Other - Miscellaneous Administrative \$							
45.			Management Fees Direct \$	113,494	113,494					
46.			Management Fees Indirect \$	100,884	100,884					
47.			Other - Direct \$							
	For Pr	ofit P	roviders Only							
48.	- 1 ·		Building/Non Movable Eq. Depreciation				40.00			
.5.			Unallowable Building Interest -							
			See Attached Schedule \$							
49	Total	Amo	unt of Decrease (Items 1 - 48)	2,047,971	2,047,971					
47.	1 Olul	ZIIIUL	ani oj Decreuse (menis 1 - 70)	1 2,037,271	1 2,0 1,7 1		L			

^{***} 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		Medical Equipment Rental - Other	\$ 40,765		
20	AND RESIDENCE OF STREET	Ebox	\$ 22,195		
		Radio & Television	\$ 25,727		
	er Ancillar	<u> </u>	\$ 88,687	s -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	ANY TWO CLUSTER SET SHOULD BE		\$ 106,261		
1.00					
	1000				1
otal Eyes	se Movahl	e Equipment Depreciation	\$ 106,261	\$ -	\$ <u>-</u>

Schedule of Other Property Adjustments

Page Ref	I ina Ref	Description	CCNH	RHNS	(Specify)
rage Nei	Line Rei	Vescription.			
				100	
m 101		Adjustments	s -	s -	\$ -
I otal Otne	rroperty	Adjustments			

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
				10.00	
				2.00	
10 - 19					
6.6					
Total Other	r Adjustme	ents	\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
					100
				100 T	
Total Unall	owable Bu	ilding Interest	S -	\$ -	\$ -

F. Statement of Revenue

Name of Facility License No.	 Report for Y	ear Ended		Page of
Stafford Springs CT SNF LLC d/b/a Ever 2081C	 9/30/2018	30 37		
Item	 Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue				
1. a. Medicaid Residents (CT only)	\$ 19,544,086	19,544,086		
b. Medicaid Room and Board Contractual Allowance **	\$ (9,120,711)	(9,120,711)		
2. a. Medicaid (All other states)	\$ 			
b. Other States Room and Board Contractual Allowance **	\$ 			
3. a. Medicare Residents (all inclusive)	\$ 2,184,710	2,184,710		
b. Medicare Room and Board Contractual Allowance **	\$ 591,661	591,661		
4. a. Private-Pay Residents and Other	\$ 7,294,422	7,294,422		
b. Private-Pay Room and Board Contractual Allowance **	\$ (404,755)	(404,755)		
II. Other Resident Revenue	14.75			
a. Prescription Drugs - Medicare	\$ 253,557	253,557		
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (253,557)	(253,557)		
c. Prescription Drugs - Non-Medicare	\$ 401,417	401,417		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (401,417)	(401,417)		
2. a. Medical Supplies - Medicare	\$ 6,200	6,200		
b. Medical Supplies - Medicare Contractual Allowance **	\$			
c. Medical Supplies - Non-Medicare	\$ 1,955	1,955		
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (1,955)	(1,955)		
3. a. Physical Therapy - Medicare	\$ 989,510	989,510		
b. Physical Therapy - Medicare Contractual Allowance **	\$ (818,255)	(818,255)		
c. Physical Therapy - Non-Medicare	\$ 835,250	835,250		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (835,250)	(835,250)		
4. a. Speech Therapy - Medicare	\$ 148,655	148,655		
b. Speech Therapy - Medicare Contractual Allowance **	\$ (119,567)	(119,567)		
c. Speech Therapy - Non-Medicare	\$ 159,730	159,730		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (159,730)	(159,730)		
5. a. Occupational Therapy - Medicare	\$ 796,865	796,865		
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (711,505)	(711,505)		
c. Occupational Therapy - Non-Medicare	\$ 701,150	701,150		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (701,150)	(701,150)		
6. a. Other (Specify) - Medicare	\$			
b. Other (Specify) - Non-Medicare	\$ (57,265)	(57,265)		
III. Total Resident Revenue (Section I. thru Section II.)	\$ 20,324,051	20,324,051		
IV. Other Revenue*				
1. Meals sold to guests, employees & others	\$ TO THE REAL PROPERTY OF THE PR	and the second s	PRODUCTION TO A STATE OF THE PROPERTY OF THE P	And the second of the second s
2. Rental of rooms to non-residents	\$			
3. Telephone	\$ 			
Rental of Television and Cable Services	\$			
5. Interest Income (Specify)	\$ 2,754	2,754		
6. Private Duty Nurses' Fees	\$			
7. Barber, Coffee, Beauty and Gift shops	\$			
8. Other (Specify)	\$ 15,583	15,583		
V. Total Other Revenue (1 thru 8)	\$ 18,337	18,337		
VI. Total All Revenue (III +V)	\$ 			
71. Total All Revenue (III + v)	 20,342,388	20,342,388		

^{*} 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)
0.50.20.50		S -	S -	s -
		S -	\$ -	S -
2.4		s -	S -	S -
		\$	S -	\$ -
ALMAN.		S -	S -	S -
		S -	S -	S -
Total Othe	r Resident Revenue - Medicare	s -	S -	\$ -

and the same at the Property of the same at the same a

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Retroactives	\$ (57,265)	S -	S -
(3) 3313		s -	s -	S -
45.54.75		S	S -	S -
		S -	S -	\$
		s -	S -	S .
		S -	s -	S
Total Othe	er Resident Revenue	\$ (57,265)	S -	S -

Interest Income

Account

Page Ref Account	Balance	CCNH	RHNS	(Specify)
30/IV5 Interest on A/R		\$ 32	\$ -	S -
31,A8 Interest on Renovation Account	3,257,966	\$ 2,722	\$ -	S S
		S -	S -	S -
		S	<u> </u>	S -
Total Interest Income		\$ 2,754	S -	S -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
		S :	S -	S -
	Bad Debt Recoveries	\$ 15,583	S -	S
		S	S -	S -
er Vice		\$ -	S -	S -
2000		S	\$ -	S -
0.235.488		s -	S -	S -
		s -	S -	S -
		\$	S -	S
		S -	s -	S
		\$ -	S -	S -
		s -	S -	S
and the		S	S -	S -
otal Oth	er Revenue	15,583	S	S

G. Balance Sheet

Name of Facility	1	License No.	Report for Year	Ended	Page	of
Stafford Springs CT SNF L	LC d/b/a Ev	2081C	9/30/2018		31	37
	,	Account			Ar	nount
Assets						
A. Current Assets						
1. Cash (on hand an	d in banks)			\$	3	385,854
Resident Account		<u> </u>		\$		1,754,799
3. Other Accounts R	eceivable (Ex	cluding Owners or R	elated Parties)	\$		
4 Inventories	***************************************			\$		26,168
Prepaid Expenses				\$		379,691
a. Prepaid Insura			378,228			
b. Health Insuran	ce (Wellness)		1,463			
c		···········	····			
d. See Schedule						
6. Interest Receivabl				\$		
7. Medicare Final Se		eivable		\$		
8. Other Current Ass			2.057.066	\$		3,257,966
Working Capital I	eserve		3,257,966			
***************************************	,					
See Schedule						
A-9. Total Current Assets	(Lines A1 thr	ru 8)		\$	 	5,804,478
B. Fixed Assets						
1. Land				\$		
2. Land Improvement		Historical Cost		\$		
		Accum. Depreciation		Net		
3. Buildings		Historical Cost		\$		
4 1 2		ccum. Depreciation	1 1 1 5 0 0 0	Net		
4. Leasehold Improv		Historical Cost	1,145,308	. \$		1,044,727
		ccum. Depreciation	100,581			
5. Non-Movable Equ	1	Historical Cost				
		ccum. Depreciation	### A A A ##	Net		400.001
6. Movable Equipme		Historical Cost	770,397	\$		432,901
		ccum. Depreciation	337,496			
7. Motor Vehicles		Historical Cost		\$		
		ccum. Depreciation		Net	·····	
8. Minor Equipment-	Not Deprecia	bie		\$		
9. Other Fixed Asset	s (itemize)			\$		710,698
See Schedule	***************************************		710,698			
B-10. Total Fixed Assets	(Lines B1 th	ıru 9)		\$		2,188,326

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

Evergreen Moveable Equipment Carryforward Schedule

Cost Year	Original	TVs Patient Rooms 2016	Purchase rice adjmt 2016	-	Vs Patient ooms 2018			Totals
	Disallow Adjustme nt Cost Term	\$ 3,139 5	\$ 500,000 5	\$	56,332 5			
2016	Deprec	\$ 314	\$ 50,000				\$	50,314
2016	Book Value	 2,825	\$ 450,000	•			\$4	452,825
2017	Deprec	\$ 628	\$ 100,000					100,628
2017	Book Value	 2,197	\$ 350,000	•				352,197
2018	Deprec	\$ 628	\$ 100,000	\$	5,633		\$ -	106,261
2018	Book Value	 1,569	\$ 250,000	\$	50,699	•	\$:	302,268
2019	Deprec	\$ 628	\$ 100,000	\$	11,266		\$ 1	111,894
2019	Book Value	\$ 941	\$ 150,000	\$	39,433	•	\$ '	190,374
		\$ 628	\$ 100,000	\$	11,266		\$	111,894
	-	\$ 313	\$ 50,000	\$	28,167		\$	78,480
		\$ 313.00	\$ 50,000.00	\$	11,266		\$	61,579
	-	\$ -	\$ -	\$	16,901		\$	16,901
				\$	11,266		\$	11,266
				\$	5,635		\$	5,635
				\$	5,635.00			

G. Balance Sheet (cont'd)

Nam	ie of	f Facility	License No.	Report for Year Ended		Page		of
Staff	ford	Springs CT SNF LLC d/b/a Ev	2081C	9/30/2018		32		37
			Account			Am	ount	
				Total Brought Forward:	\$		7,99	2,804
C.	Le	asehold or like property record	ed for Equity Purpose	es.				
İ	1.	Land			\$			
	2.	Land Improvements	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	3.	Buildings	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	4.	Non-Movable Equipment	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	5.	Movable Equipment	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	6.	Motor Vehicles	*Historical Cost					
			Accum. Depreciation	n Net	\$			
		Minor Equipment-Not Deprec			\$			
C-8		tal Leasehold or Like Properti	ies (C1 thru 7)		\$			
D.	Inv	vestment and Other Assets						
	1.	Deferred Deposits			\$			
		Escrow Deposits			\$			
	3.	Organization Expense	*Historical Cost					
			Accum. Depreciation	n Net	\$	····		
		Goodwill (Purchased Only)			\$		26	2,123
	5.	Investments Related to Reside	ent Care (itemize)		\$			
	6.	Loans to Owners or Related P	·		\$			
		Name and Address	Amount	Loan Date				
<u> </u>					<u>-</u>		2.04	7 0 4 5
	7.	Other Assets (itemize)			\$		2,05	7,845
						5 55		
				2.057.945				
-	/r	See Schedule	-4- (T: D1 41 T)	2,057,845	<u> </u>		2.21	0.060
		tal Investments and Other Asso			\$			9,968
D-9.	10	tal All Assets (Lines A9 + B10	T (0 T D8)		\$		10,31	<u> </u>

^{*} 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 Fac	cility		License No.	Report for Year I	Ended	Page	of
Stafford Spr	inos (CT SNF LLC d/b/a Evergree	2081C	9/30/2018		33	37
Starrora Spr	11150		Account			Ar	nount
Liabilities							
A.	Cu	rrent Liabilities				_	0.077.040
	1.	Trade Accounts Payable				\$	2,877,249
	2.	Notes Payable (itemize)			la la	\$	(4,637,000)
		Due From related party		(4,637,000	0)		
							Aller Committee
		See Schedule				<u> </u>	
	3.	Loans Payable for Equipn		n)(itemize)	Date Due	D	
		Name of Lender	Purpose	Amount	Date Due		
			*				
		Accrued Payroll (Exclusive	of Owners and/or	Stockholders only)	1	\$	209,290
	<u>4.</u>	Accrued Payroll (Exclusive Accrued Payroll (Owners	and/or Stockholder	s only)		\$	
	5.			3 Only)		\$	13,256
	6.	Accrued Payroll Taxes Pa				\$	
	7.	Medicare Final Settlemen				\$	
	8.					\$	
	9.	Mortgage Payable (<i>Curre</i>). Interest Payable (<i>Exclusiv</i>	of Owner and/or	Related Parties)		\$	
			e of Owner anaror s	Retaled 1 di tico)		\$	
		Accrued Income Taxes*	(itawiga)			\$	446,375
	12	2. Other Current Liabilities		2.061			
		Acc'd Operating Expenses	10.	2,961			
		Acc'd Expense - Sales Tax	26	1,857			
		Provider Taxes Due		1,556 See Schedule			
	2 70	Accd Health insurance total Current Liabilities (Li		1,550 See Selfeddie		\$	(1,090,830
A-1	3. I	om Carrent Labounes (E)	1100 1 1 1 1 1 1 1 1 1 1 1 1 1 1			<u> </u>	

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

(Carry Total forward to next page)

EVERGREEN ACCRUED EXPENSES-OPERATIONS September 30, 2018

September 30, 2	ACCT. # 2170
2017	
Health Insurance	(63,073.60)
Insurance Doouble booked Invoice	9,208.98
IBNR-Insurance	(18,216.40)
Beginning Balance	(72,081.02)
2018	
Accounting	-\$22,500.00
Management Fee	-\$68,380.46
Balance 9/30/17	(\$162,961.48)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year	Ended	Page	01
Stafford Springs CT SNF LLC d/b/a Evergi	2081C			34	37
F	Account			Amo	ount
		Total Brough	nt Forward:		(1,090,830)
Liabilities (cont'd)					
B. Long-Term Liabilities					
 Loans Payable-Equipment 	(itemize)		\$		
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable			\$		
3. Loans from Owners or Rel	ated Parties (itemize	e)	\$		
Name and Address of Lender	Amount	Loan D	ate		
				8.3	
Working Capital Reserve					
,					
4. Other Long-Term Liabilitie	es (itemize)	1	\$		8,524,242
Notes Payable Related Lan		8,524,242			
		AND			
	A CONTRACTOR OF THE CONTRACTOR			100	
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)		\$		8,524,242
C. Total All Liabilities (Lines A-	13 + B-5)		\$		7,433,412

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

	ne of Facility	License No.	Report for Y	ear Ended	Page	
Staf	fford Springs CT SNF LLC d/b/a	E 2081C Account	9/30/2018		35	37
-	Reserves		Amount			
A.						
	1. Reserve for value of leased				\$	
	2. Reserve for depreciation va	lue of leased buildi	ngs and appurte	enances		
	to be amortized				\$	
	3. Reserve for depreciation va	lue of leased perso	nal property (Ed	quity)	\$	
	4. Reserve for leasehold real p	properties on which	fair rental valu	e 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				\$	
	5. Cumulated Earnings				\$	573,318
	6. Gain or Loss for Period	10/1/20	17 thru	9/30/2018	\$	2,306,042
	7. Total Net Worth				\$	2,879,360
C.	Total Reserves and Net Worth				\$	2,879,360
D.	Total Liabilities, Reserves, and	! Net Worth			\$	10,312,772

H. Changes in Total Net Worth

Nam	e of Facility	License No.	Report for Year	Ended	Page	of
Staff	ford Springs CT SNF LLC d/b/a Eve	2081C	9/30/2018		36	37
			Amount			
A.	Balance at End of Prior Period as s		<u> </u>	2,005,739		
B.	Total Revenue (From Statement of		<u> </u>	20,342,388		
C.	Total Expenditures (From Stateme		<u> </u>	18,036,346		
D.	Net Income or Deficit				B	2,306,042
E.	Balance				5	4,311,781
F.	Additions					
	1. Additional Capital Contributed	(itemize)				
	2017 AJE - expense adjust	2017 AJE - expense adjustments 1,474				
	2017 AJE - Health Insuran	ce	59,081		f 1 126 14	
	2017 AJE - loss on extingu	ished debt	(95,575)			
	Inter Company Loan Adjus	tment	(1,550,000)			
	2. Other (itemize)					
	preferred equity payments	preferred equity payments 152,599				
						100
F-3.	Total Additions				<u> </u>	(1,432,421)
G.	Deductions					
	1. Drawings of Owners/Operators		\$			
	Name and Address (No., City,	State, Zip)	Title	Amount		
					7	
	2. Other Withdrawings (Specify)		\$			
	Purpose Am		ınt			
-	3. Total Deductions				<u> </u>	F
H. Balance at End of Period 09/30/18						2,879,360
П.	Durance at Dine of a crion	07130	7.10	1	<u> </u>	

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		2081C		9/30/2018	37	<u> </u>	37							
Check appropriate category														
Ø	Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)			☐ (Specify)									
Preparer/Reviewer Certification														
	I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.													
Signat	ure of Preparer		Title <i>CAO</i>		Date Signed	9								
Printed Name of Preparer														
Athena Health Care Associates, Inc					Phone Number									
Address				LHOUG MAINING										
135 South Road Farmington, CT 06032				(860) 751-3900										