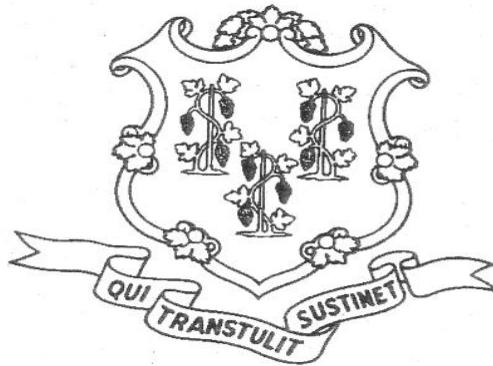


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2022

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 <input checked="" type="checkbox"/> Nursing Home only (CCNH)		Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Report for Year Beginning 10/1/2021		Report for Year Ending 9/30/2022			

License Numbers:	CCNH 2081C	RHNS	(Specify)	Medicare Provider 07-5326
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Medicaid Provider Numbers:	CCNH 2081C	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Stafford Springs CT SNF LLC d/b/a Evergreen Health	License No. 2081C	Report for Year Ended 9/30/2022	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)	Date	Signed (Owner)	Date
Printed Name (Administrator) Christine M. McKinney		Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)
Comm. Expires / /			
Address of Notary Public			

(Notary Seal)

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

Data Required for Real Wage Adjustment		Page 1A	of 37
Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	Period Covered:	From 10/1/2021	To 9/30/2022
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 2/8/2023	
Item	Total	CCNH	RHNS (Specify)
1. Dietary wages paid	\$		
2. Laundry wages paid	\$		
3. Housekeeping wages paid	\$		
4. Nursing wages paid	\$		
5. All other wages paid	\$		
6. Total Wages Paid	\$		
7. Total salaries paid	\$		
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$		

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-684-6341	Report for Year Ended 9/30/2022	Page 2	of 37
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Name of Facility (as shown on license) Stafford Springs CT SNF LLC d/b/a Evergreen Health Care C	Address (No. & Street, City, State, Zip) 205 Chestnut Hill Road, Stafford Springs, CT 06076		
License Numbers: CCNH 2081C	RHNS	(Specify)	Medicare Provider No. 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.

Administrator

Name of Administrator Christine M McKinney	Nursing Home Administrator's License No.: 001627
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Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name Not Applicable	License No.:

General Information and Questionnaire Partners/Members

General Information and Questionnaire

Corporate Owners

General Information and Questionnaire

Individual Proprietorship

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen Hea	License No. 2081C	Report for Year Ended 9/30/2022	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

General Information and Questionnaire

Related Parties*

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen Health		License No. 2081C	Report for Year Ended 9/30/2022			Page 4	of 37	
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes <input checked="" type="radio"/> 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?				<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the following information:				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Athena Stafford Springs Landlord LLC	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Lease of Property	Pg 22 L9	1,714,871	1,192,179
Athena Health Care Assoc 401k Plan	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Facility participates in common 401k plan	Pg 15 A7		
Athena Health Care System	135 South Rd, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	<50%	see attached			
Misc Facilities	Various Addresses	<input checked="" type="radio"/>	<input type="radio"/>	>98%	Interfacility Loans	Pg 33 A2		
Athena Health Insurance	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Health Insurance	Pg 15, 1a5	1,331,894	1,331,894
Procare Pharmacy	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Pharmacy Services	pg 20 5a2, 5b,	553,636	553,636
Procare LTC	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Pharmacy note payable		61,806	61,806
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen	License No. 2081C	Report for Year Ended 9/30/2022	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

General Information and Questionnaire Leases (Excluding Real Property)

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

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

⊕ No

Total ***

18,991

* 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 Stafford Springs CT SNF LLC d/b/a	License No. 2081C	Report for Year Ended 9/30/2022	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

⊕ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this

period the same as for the previous period?

Yes
 No

If "No," explain.

Independent Accounting Firm

Name of Accounting Firm 1 Marcum LLP 2 3 CJLC 4	Address (No. & Street, City, State, Zip Code) 555 Long Wharf Drive, 12th Floor, New Haven, CT 06511 225 Pitkin St. East Hartford, CT 06108
---	--

Services Provided by This Firm (*describe fully*)

1	Tax Returns; medicare cost report	\$	15,253
2	Relief funds audit	\$	15,330
3	Audit	\$	15,000
4		\$	
		Charge for Services Provided	
		\$	45,583

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

Yes No Pg 15, Line 1d

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 State Marshall/Probate	
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	\$	10,225
2	A/R, Misc. issues: Disallow	\$	32,640
3	conservatorship/probate fees/medicaid apps:disallow	\$	1,225
4		\$	
5		\$	
		Charge for Services Provided	
		\$	44,090

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

Yes No

Schedule of Resident Statistics

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center			License No. 2081C			Report for Year Ended 9/30/2022				Page 8	of 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					180	180						
A. On last day of PREVIOUS report period	180	180										
B. On last day of THIS report period	180	180							180	180		
2. Number of Residents					149	149						
A. As of midnight of PREVIOUS report period	149	149										
B. As of midnight of THIS report period	140	140							140	140		
3. Total Number of Days Care Provided During Period					7,114	7,114						
A. Medicare	9,139	9,139							2,025	2,025		
B. Medicaid (Conn.)	37,890	37,890			28,521	28,521			9,369	9,369		
C. Medicaid (other states)												
D. Private Pay	6,499	6,499			5,273	5,273			1,226	1,226		
E. State SSI for RCH												
F. Other (Specify) Managed Care	524	524			286	286			238	238		
G. Total Care Days During Period (3A thru F)	54,052	54,052			41,194	41,194			12,858	12,858		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	5	5			5	5						
5. Total Resident Days (3G + 4A + 4B)	54,057	54,057			41,199	41,199			12,858	12,858		

Schedule of Resident Statistics (Cont'd)

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen	License No. 2081C	Report for Year Ended 9/30/2022	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No

If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	9	102		14			15	
Per Diem Rate								
a. One bed rm.	624.69	292.00		564.00			388.29	
b. Two bed rms.	624.69	292.00		554.00			388.29	
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		4,878	4,878		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		1,660	1,660		
2. Restorative Treatments					
C. Other		14,499	14,499		
D. Total Physical Therapy Treatments		21,037	21,037		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		818	818		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		125	125		
2. Restorative Treatments					
C. Other		2,185	2,185		
D. Total Speech Therapy Treatments		3,128	3,128		

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		3,296	3,296		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		1,374	1,374		
2. Restorative Treatments					
C. Other		13,431	13,431		
D. Total Occupational Therapy Treatments		18,101	18,101		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		2081C	9/30/2022	10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes		<input type="radio"/> No	
		Total Cost and Hours			
Item		CCNH	Hours	RHNS	Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	178,197	2,115			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	251,319	11,165			
5. Dietary Service					
a. Head Dietitian	66,236	2,109			
b. Food Service Supervisor	55,297	2,012			
c. Dietary Workers	466,569	24,780			
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers	244,726	12,159			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	103,778	2,394			
b. Other Maintenance Workers	112,868	3,939			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	116,460	7,298			
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	141,583	1,768			
b. RN					
1. Direct Care	989,723	4,958			
2. Administrative**	556,781	23,119			
c. LPN					
1. Direct Care	2,313,594	54,880			
2. Administrative**					
d. Aides and Attendants	2,359,860	91,684			
e. Physical Therapists	434,061	10,016			
f. Speech Therapists	101,731	2,227			
g. Occupational Therapists	341,982	8,148			
h. Recreation Workers	313,128	13,132			
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	276,463	7,909			
n. Marketing					
o. Other (Specify) See Attached Schedule					
<i>A-13. Total Salary Expenditures</i>	9,424,356	285,812			

* 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)

Schedule of Other Fees (Page 13)

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***

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center				License No. 2081C		Report for Year Ended 9/30/2022			Page 11	of 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.

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***

Name of Facility (as licensed)				License No.		Report for Year Ended			Page 12 of 37	
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center				2081C		9/30/2022				
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 (10/1/21-9/30/22)	178,197			Health & Life Insurance, Payroll Taxes	Day to day operations of the nursing home facility	2,115	A2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended		Page	of
	2081C	9/30/2022		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					
3. Pharmacist	18,186	100			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	57,329	1,380			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**					
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
9. Speech Therapist					
a. Resident Care					
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care					
2. Administrative***					
b. LPN					
1. Direct Care					
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify)					
See Attached Schedule					
B-13 Total Fees Paid in Lieu of Salaries	75,515	1,480			

* 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*

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	366,073	366,073		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	64,438	64,438		
4. Social Security (F.I.C.A.)	\$	664,173	664,173		
5. Health Insurance	\$	1,093,043	1,093,043		
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	44,340	44,340		
8. Uniform Allowance	\$	38,696	38,696		
9. Other (<i>Specify</i>) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$	115,565	115,565		
d. Accounting and Auditing	\$	45,583	45,583		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$	44,090	44,090		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$	58,728	58,728		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	26,414	26,414		
2. Cellular Phones	\$	1,538	1,538		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$	944,176	944,176		
Subtotal	\$	3,506,857	3,506,857		

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen Health	License No. 2081C	Report for Year Ended 9/30/2022		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
	<i>Subtotals Brought Forward:</i>	3,506,857	3,506,857		
I. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	3,640	3,640		
3. Gifts to Staff and Residents	\$	14,037	14,037		
4. Employee Travel	\$	5,412	5,412		
5. Education Expenses Related to Seminars and Conventions	\$	5,465	5,465		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	9,685	9,685		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)**** See Attached Schedule	\$	5,347	5,347		
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	\$	6,469	6,469		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	12,509	12,509		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$	610,116	610,116		
13. Other (<i>Specify</i>) See Attached Schedule	\$	130,279	130,279		
C-14 Total Administrative & General Expenditures	\$	4,309,816	4,309,816		

* 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	\$ 5,347		
Total Other Advertising	\$ 5,347	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF Dues	\$ 12,509		
Total Dues	\$ 12,509	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Licenses	\$ 1,995		
Bank Charges	\$ 19,596		
Payroll Processing Fees	\$ 22,323		
Employee Physicals/Background Checks	\$ 6,383		
Data Processing/Software Maint. Fees	\$ 68,168		
Medicare Assess, Medicaid app.	\$ 11,814		
Total Other Administrative and General	\$ 130,279	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Stafford Springs CT SNF LLC d/b/a Ever	License No. 2081C	Report for Year Ended 9/30/2022	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	904,463	Contract Attached to a Prior Year	See Below
Allocation of the above	144,714; \$162,803	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032		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)

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen Health	License No. 2081C	Report for Year Ended 9/30/2022		Page 18 of 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 562,195	562,195		
2. Non-Food Supplies	\$ 46,608	46,608		
3. Other (Specify) _____ Dishes=\$5,402	\$ 5,402	5,402		
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$			
c. Other (Specify) _____ Management Services	\$ 138,516	138,516		
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 752,721	752,721		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No				If yes, specify cost. \$663
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

C. Expenditures Other Than Salaries (cont'd) - Laundry Basis for Allocation of Costs

(See Note on Page 5)

Name of Facility	License No.	Report for Year Ended		Page	of
	2081C	9/30/2022		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. \$	177,040	177,040		
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$				
c. Other (<i>Specify</i>) Supplies=\$7,129	\$	7,129	7,129		
3D. Total Laundry Expenditures (3a + b + c)	\$	184,169	184,169		
3E. Laundry Questionnaire					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 37,682	37,682		
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel				
	Amt.	\$			
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	37,682	37,682		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Procare	\$	384,534	384,534		
b. Medicine Cabinet Drugs	\$	12,371	12,371		
c. Medical and Therapeutic Supplies	\$	448,958	448,958		
d. Ambulance/Limousine***	\$	2,731	2,731		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	64,457	64,457		
f. X-rays and Related Radiological Procedures***	\$	15,569	15,569		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	48,466	48,466		
i. Recreation	\$	23,099	23,099		
j. Direct Management Services*	\$	92,105	92,105		
k. Indirect Management Services*	\$	81,871	81,871		
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	224,604	224,604		
5M. Total Resident Care Expenditures (5a - 5j)	\$	1,398,765	1,398,765		

* 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

Report of Expenditures

* 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 Stafford Springs CT SNF LLC d/b/a Evergreen	License No. 2081C	Report for Year Ended 9/30/2022			Page 22 37
Item	Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 132,273	132,273			
b. Heat	\$ 170,244	170,244			
c. Light & Power	\$ 169,769	169,769			
d. Water	\$ 113,802	113,802			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 18,991	18,991			
f. Other (<i>itemize</i>)	\$ 169,685	169,685			
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 774,764	774,764			
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$ 19,207	19,207			
b. Building & Building Improvements	\$				
c. Non-Movable Equipment	\$				
d. Movable Equipment	\$ 88,411	88,411			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 107,618	107,618			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$ 51,558	51,558			
d. Other (<i>Specify</i>)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$ 51,558	51,558			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,788,461	1,788,461			
10. Property Taxes					
a. Real estate taxes paid by owner	\$ 209,365	209,365			
b. Real estate taxes paid by lessor	\$				
c. Personal property taxes	\$ 15,339	15,339			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 2,172,341	2,172,341			

* 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

Depreciation Schedule

Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Useful Life		
		Movable Category	Cost	Life	Depreciation
Additions:					
1/31/2022	Nurse call console	Administrative	\$ 4,148	5	\$ 415
3/31/2022	Press tool kit	Administrative	\$ 2,411	5	\$ 241
6/30/2022	6 mattresses	Standard Resident	\$ 3,332	5	\$ 333
6/30/2022	20 wandering tags	Administrative	\$ 4,072	5	\$ 407
7/31/2022	Leg actuator and 12 portable a/c	Administrative	\$ 10,177	5	\$ 1,018
9/30/2022	2 a/c units	Administrative	\$ 1,959	10	\$ 98
Total additions for Movable Equipment			\$ 26,099		\$ 2,512
Deletions:					
Total deletions for Movable Equipment			\$ -		\$ -

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
3/31/2022	1st fl shower room tile	\$ 6,103	10	\$ 305
4/30/2022	Hot water pump	\$ 2,452	5	\$ 245
Total additions for Leasehold Improvement		\$ 8,555		\$ 550
Deletions:				
12/28/2021	See attached	\$ (2,872,853)		
Total deletions for Leasehold Improvement		\$ (2,872,853)		\$ -

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen Health Care C			License No. 2081C		Report for Year Ended 9/30/2022			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1. Finance Fees	12	15	10 Years	51,000	8,925				
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	9	21	Various	2,872,853			Var		
2. Disposals (attach schedule)	12	21	Various	(2,872,853)					
3. Acquired during this report period (attach schedule)									
	9	22	Various	8,555		SL	Var	550	
C-4. Subtotal									550
D. Total Amortization									550

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Stafford Springs CT SNF LLC d/b/a E	License No. 2081C	Report for Year Ended 9/30/2022	Page 25	of 37
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11. Property Questionnaire

Part A

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

Yes

No

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

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

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase	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				
a. Type of Financing (e.g., fixed, variable)	Conventional			
b. Date Mortgage Obtained	12/19/15			
c. Interest Rate for the Cost Year	6.18%			
d. Term of Mortgage (number of years)	4			
e. Amount of Principal Borrowed	15,750,000			
f. Principal balance outstanding as of				

Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)	Sale leaseback			
h. Date of Refinancing	12/28/21			
i. New Interest Rate	Lease			
j. Term of Mortgage (number of years)	5			
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off	14,904,540			

Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			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)

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/	2081C	9/30/2022			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)	\$	94,059	94,059			
Vender Interest=\$19,090 Water Treatment Note Interest=\$						
13. Total All Interest Expense (12B7 + 12C3 + 12D)	\$	94,059	94,059			
14. Insurance						
a. Insurance on Property (buildings only)	\$	166,710	166,710			
b. Insurance on Automobiles	\$					
c. Insurance other than Property (as specified above)						
1. Umbrella (<i>Blanket Coverage</i>)	\$					
2. Fire and Extended Coverage	\$					
3. Other (Specify)	\$					
14d. Total Insurance Expenditures (14a + b + c)	\$	166,710	166,710			
15. Total All Expenditures (A-13 thru C-14)	\$	19,390,898	19,390,898			

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		2081C	9/30/2022	28 37	
			Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$ 341,982	341,982		
4.			Other - See attached Schedule	\$ 8,054	8,054		
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$ 115,565	115,565		
10.			Accounting	\$			
10a.			Legal	\$ 44,090	44,090		
11.			Telephone	\$			
12.			Cellular Telephone	\$ 1,178	1,178		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$ 14,037	14,037		
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.			Unallowable Advertising *	\$ 5,347	5,347		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$ 337,720	337,720		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 31,410	31,410		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$ 663	663		
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 900,046	\$ 900,046			

* 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)
pg10	12m	Marketing Activities	\$ 8,054		
Total Other Salaries Adjustment			\$ 8,054	\$ -	\$ -

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	\$ 19,596		
16	m13	Medicare Assess	\$ 11,814		
Total Other A&G Adjustments			\$ 31,410	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-29 Rev. 9/2018

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			2081C	9/30/2022		29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 900,046	900,046		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$ 384,534	384,534		
28.			Ambulance/Limousine	\$ 2,731	2,731		
29.			X-rays, etc	\$ 15,569	15,569		
30.			Laboratory	\$ 48,466	48,466		
31.			Medical Supplies	\$ 25,142	25,142		
32.			Oxygen (non emergency)	\$ 64,457	64,457		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 11,958	11,958		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 15,671	15,671		
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.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$ 92,105	92,105		
46.			Management Fees Indirect	\$ 81,871	81,871		
47.			Other - Direct	\$ 41,208	41,208		
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 1,683,758	1,683,758		

*** 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

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 30 37
Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 21,022,562	21,022,562			
b. Medicaid Room and Board Contractual Allowance **	\$ (9,757,971)	(9,757,971)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,129,616	2,129,616			
b. Medicare Room and Board Contractual Allowance **	\$ 254,202	254,202			
4. a. Private-Pay Residents and Other	\$ 7,144,325	7,144,325			
b. Private-Pay Room and Board Contractual Allowance **	\$ (821,072)	(821,072)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 151,956	151,956			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (151,956)	(151,956)			
c. Prescription Drugs - Non-Medicare	\$ 301,182	301,182			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (301,182)	(301,182)			
2. a. Medical Supplies - Medicare	\$ 10,107	10,107			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (420)	(420)			
c. Medical Supplies - Non-Medicare	\$ 240	240			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (240)	(240)			
3. a. Physical Therapy - Medicare	\$ 605,992	605,992			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (509,503)	(509,503)			
c. Physical Therapy - Non-Medicare	\$ 527,984	527,984			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (527,984)	(527,984)			
4. a. Speech Therapy - Medicare	\$ 162,535	162,535			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (138,136)	(138,136)			
c. Speech Therapy - Non-Medicare	\$ 114,325	114,325			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (114,325)	(114,325)			
5. a. Occupational Therapy - Medicare	\$ 478,530	478,530			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (417,334)	(417,334)			
c. Occupational Therapy - Non-Medicare	\$ 491,100	491,100			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (491,100)	(491,100)			
6. a. Other (<i>Specify</i>) - Medicare	\$				
b. Other (<i>Specify</i>) - Non-Medicare	\$ (44,644)	(44,644)			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 20,118,789	20,118,789			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 410	410			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 38,782	38,782			
V. Total Other Revenue (1 thru 8)	\$ 39,192	39,192			
VI. Total All Revenue (III +V)	\$ 20,157,981	20,157,981			

* 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)
	Total Other Resident Revenue - Medicare	\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
n/a	HHS funding	\$ 290,359		
	Medicaid funds carryover	\$ (91,000)		
	Medicaid rate adj and recoupments	\$ (244,003)		
	Total Other Resident Revenue	\$ (44,644)	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
31,A8	Interest on renovation account	3,257,966	\$ 410		
	Total Interest Income		\$ 410	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Bad debt recoveries	\$ 38,782		
	Total Other Revenue	\$ 38,782	\$ -	\$ -

G. Balance Sheet

Name of Facility Stafford Springs CT SNF LLC d/b/a Ev	License No. 2081C	Report for Year Ended 9/30/2022	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$ 91,401	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 2,517,788	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$ 33,448	
5. Prepaid Expenses			\$ 205,821	
a. Prepaid Insurance 175,746				
b. ERC Deposit 25,000				
c. Prepaid Health Insurance 5,075				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$ (179,000)	
Medicaid carry over funds (179,000)				
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$ 2,669,458	
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 8,555			\$ 8,005	
Accum. Depreciation 550 Net				
5. Non-Movable Equipment *Historical Cost			\$	
Accum. Depreciation _____ Net				
6. Movable Equipment *Historical Cost 1,464,356			\$ 528,202	
Accum. Depreciation 936,154 Net				
7. Motor Vehicles *Historical Cost			\$	
Accum. Depreciation _____ Net				
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$ (39,142)	
See Schedule (39,142)				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$ 497,065	

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref Line Ref Description

Total Prepaid Expenses		\$ -

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

Page Ref Line Ref Description

Total Other Current Assets (Itemize)		\$ -

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

Page Ref Line Ref Description

	Moveable Equipment Carryforward	\$ (71,273)
	Project Development	\$ 32,131
Total Other Other Fixed Assets (Itemize)		\$ (39,142)

Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

	Deposit-taxes, utilities	\$ 917,867
	Goodwill	\$ 1,954,600
	Finance Fees	\$ 126,030
Total Other Assets		\$ 2,998,497

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref Line Ref Description

Total Notes Payable		\$ -

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

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)		\$ -

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

Page Ref Line Ref Description

Total Other Current Liabilities (Itemize)		\$ -

G. Balance Sheet (cont'd)

Name of Facility Stafford Springs CT SNF LLC d/b/a Ev	License No. 2081C	Report for Year Ended 9/30/2022	Page 32 37
Account		Amount	
Total Brought Forward:		\$ 3,166,523	
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)		\$	261,774
5. Investments Related to Resident Care (<i>itemize</i>)		\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)		\$	
Name and Address	Amount	Loan Date	
7. Other Assets (<i>itemize</i>)		\$	2,998,497
See Schedule	2,998,497		
D-8. Total Investments and Other Assets (Lines D1 thru 7)		\$	3,260,271
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)		\$	6,426,794

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of								
Stafford Springs CT SNF LLC d/b/a Evergreen	2081C	9/30/2022	33 37								
Account			Amount								
Liabilities											
A. Current Liabilities											
1. Trade Accounts Payable			\$ 2,784,330								
2. Notes Payable (<i>itemize</i>) Water treatment note			\$ 1,167,325								
See Schedule											
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)			\$								
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Name of Lender</th> <th style="text-align: left;">Purpose</th> <th style="text-align: left;">Amount</th> <th style="text-align: left;">Date Due</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				Name of Lender	Purpose	Amount	Date Due				
Name of Lender	Purpose	Amount	Date Due								
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)			\$ 366,939								
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$								
6. Accrued Payroll Taxes Payable			\$ 432,606								
7. Medicare Final Settlement Payable			\$								
8. Medicare Current Financing Payable			\$								
9. Mortgage Payable (<i>Current Portion</i>)			\$								
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$								
11. Accrued Income Taxes*			\$								
12. Other Current Liabilities (<i>itemize</i>)			\$ 2,930,944								
Acc'd Operating Expenses											
Provider Taxes Due			2,633,218								
Acc'd Health insurance			5,787								
See Schedule											
A-13. Total Current Liabilities (Lines A1 thru 12)			\$ 7,682,144								

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen	License No. 2081C	Report for Year Ended 9/30/2022	Page 34	of 37
Account			Amount	
Total Brought Forward:			\$ 7,682,144	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$ 347,396
Name and Address of Lender	Amount	Loan Date		
Procare Investment	347,396	n/a		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ (10,877,427)
Notes payable related landlord/facilities				\$ (10,983,140)
Note procare CT				\$ 103,097
Note procare MA				\$ 2,616
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ (10,530,031)
C. Total All Liabilities (Lines A-13 + B-5)				\$ (2,847,887)

G. Balance Sheet (cont'd)

Reserves and Net Worth

Name of Facility Stafford Springs CT SNF LLC d/b/a E	License No. 2081C	Report for Year Ended 9/30/2022	Page 35	of 37
Account				Amount
A. Reserves				
1. Reserve for value of leased land				\$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				\$
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)				\$
4. Reserve for leasehold real properties on which fair rental value is based				\$
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				\$ 8,333,622
6. Gain or Loss for Period	10/1/2021	thru	9/30/2022	\$ 941,059
7. Total Net Worth				\$ 9,274,681
C. Total Reserves and Net Worth				\$ 9,274,681
D. Total Liabilities, Reserves, and Net Worth				\$ 6,426,794

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 Eve	2081C	9/30/2022	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ 8,333,621		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 20,157,981		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 19,216,922		
D. Net Income or Deficit				\$ 941,059		
E. Balance				\$ 9,274,680		
F. Additions						
1. Additional Capital Contributed (<i>itemize</i>)						
2. Other (<i>itemize</i>)						
F-3. Total Additions				\$		
G. Deductions						
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$		
Name and Address (No., City, State, Zip)		Title	Amount			
2. Other Withdrawings (<i>Specify</i>)				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. Balance at End of Period				\$ 9,274,680		

I. Preparer's/Reviewer's Certification

Name of Facility Stafford Springs CT SNF LLC d/b/a	License No. 2081C	Report for Year Ended 9/30/2022	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer Athena Health Care Associates, Inc		
Address Address 135 South Road, Farmington CT 06032		Phone Number (860) 751-3900
Contacted Person Regarding Additional Information Needed Regarding This Report Lynn Rinaldi		Phone Number (860) 751-3900
Contact Email Address lrinadli@athenahealthcare.com		