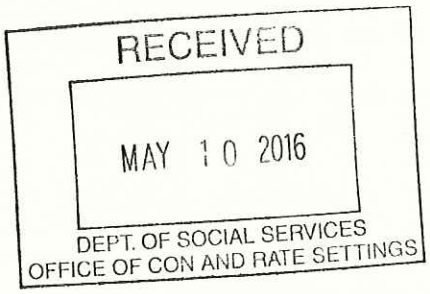
jmmc
Johnson Memorial Medical Center
Health care. The way it should be.



May 4, 2016

Department of Social Services
ATTN: Office of Reimbursement and CON
55 Farmington Avenue
Hartford, CT 06105

RE: Evergreen Health Care Center
FY – 9/30/2015 Annual Report

Dear Sirs,

Enclosed please find the FY 9/30/15 Annual Report for Evergreen Health Care Center. Included is the following item;

1 2 (two) Copies of the Annual Report signed and notarized

We have also submitted the annual report via Myers and Stauffer's web site.

If you should have any questions, or need information, please contact me (860)684-8133

Sincerely,

Thomas Blazejowski
Controller

Enclosures

Johnson Memorial Hospital
201 Chestnut Hill Road
Stafford Springs, CT 06076
860-684-4251/860-749-2201
TTY: 860-684-8441

Evergreen Health Care Center
205 Chestnut Hill Road
Stafford Springs, CT 06076
860-684-6341

Home & Community Health Services
101 Phoenix Avenue
P.O. Box 1199
Enfield, CT 06083
860-763-7600

State of Connecticut

15-102

Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed) Evergreen Health Care Center	
Address (No. & Street, City, State, Zip Code) 205 Chestnut Hill Road Stafford Springs, CT 06076	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/01/2014	Report for Year Ending 09/30/2015

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2081-C			07-5326

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	000020529		

For Department Use Only

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

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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
Evergreen Health Care Center	2081-C	09/30/2015	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 Evergreen Health Care Center [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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
		4/20/16		
Printed Name (Administrator) Staurt E. Rosenburg			Printed Name (Owner)	
Subscribed and Sworn to before me: Kristina L. Verny	State of CT	Date 1/26/16	Signed (Notary Public) Kristina L Verny	Comm. Expires 7/31/2019
Address of Notary Public 201 Chestnut Hill Rd Stafford Springs, CT 06076			Kristina L. Verny NOTARY PUBLIC My Commission Expires July 31, 2019	

(Notary Seal)

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CSP-1A Rev. 6/95

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 Evergreen Health Care Center	Period Covered:		From ########	To ########
Address of Facility 205 Chestnut Hill Road Stafford Springs, CT 06076				
Report Prepared By	Phone Number (860) 684-8133		Date 09/30/2015	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
(860) 684-8133	09/30/2015	2	37

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

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2081-C			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	Nursing Home Administrator's License No.:
Thomas Gutner	000750

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned
Not Applicable			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	3A	37

If this facility is owned or operated as a corporation, provide the following information:

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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
see attached listing			
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Johnson Health Care	155 Hazard Ave., Suite 5-6, Enfield CT 06082	⊙	○		drug testing		2,523	2,523
Johnson Memorial Hospital	201 Chestnut Hill Road, Stafford Springs, CT 06076	○	⊙		Water and Sewer		31,775	31,775
Johnson Memorial Hospital	201 Chestnut Hill Road, Stafford Springs, CT 06076	○	⊙		Cost Sharing arrangement		994,476	994,476
Johnson Memorial Hospital	201 Chestnut Hill Road, Stafford Springs, CT 06076	○	⊙		Land Rent		95,175	95,175
Johnson Memorial Hospital	201 Chestnut Hill Road, Stafford Springs, CT 06076	○	⊙		Insurance - Property		18,955	18,955
Johnson Memorial Hospital	201 Chestnut Hill Road, Stafford Springs, CT 06076	○	⊙		Insurance - Gen'l Liability/Malpractice, etc.		80,875	80,875
Johnson Memorial Hospital	201 Chestnut Hill Road, Stafford Springs, CT 06076	○	⊙		Workers Comp Insurance		770,215	770,215
Johnson Memorial Hospital	201 Chestnut Hill Road, Stafford Springs, CT 06076	○	⊙		Data Processing Fees		25,320	25,320
Johnson Memorial Hospital	201 Chestnut Hill Road, Stafford Springs, CT 06076	○	⊙		Lab/Xray/EKG PPS		101,516	101,516

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Xerox Financial Servies, P.O. Box 207882, Dallas, TX 75320	○	◉	Copiers and printers sublet through affiliated corp. Johnson Memorial Hospital				19,743
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total ***	19,743

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

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Marcum LLP	555 Long Wharf Dr., New Haven, CT 06511
2 Whittlesey & Hadley	280 Trumbull St., 24th Fl, Hartford, CT 06103
3	
4	

Services Provided by This Firm (*describe fully*)

1	Annual financials statement audit	$ 35,000
2	Audit of 403B Pan	$ 4,000
3		$
4		$
		Charge for Services Provided $ 39,000

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

⊙ Yes ○ No

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Michalik, Bauer, Sivla, & Ciccarillo	860-225-8403
2 Reid and Reige, P.C.	860-240-1002
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)

1 35 Pearl St., New Britian, CT
2 1 Financial Plaza, Hartford, CT 06103
3
4
5

Services Provided by This Firm (*describe fully*)

1	collection services	$ 2,409
2	Legal services associated with bankruptcy filing	$ 211,125
3		$
4		$
5		$
		Charge for Services Provided $ 213,534

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

⊙ Yes ○ No

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	180	180			180	180			180	180		
B. On last day of THIS report period	180	180			180	180			180	180		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	146	146			146	146			143	143		
B. As of midnight of THIS report period	140	140			141	141			140	140		
3. Total Number of Days Care Provided During Period												
A. Medicare	10,058	10,058			7,446	7,446			2,612	2,612		
B. Medicaid (Conn.)	34,661	34,661			26,224	26,224			8,437	8,437		
C. Medicaid (other states)												
D. Private Pay	6,527	6,527			4,797	4,797			1,730	1,730		
E. State SSI for RCH												
F. Other (Specify)	635	635			430	430			205	205		
G. Total Care Days During Period (3A thru F)	51,881	51,881			38,897	38,897			12,984	12,984		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	51,881	51,881			38,897	38,897			12,984	12,984		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	9	37

4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	28	93		21				
Per Diem Rate								
a. One bed rm.	539.00	243.00		424-452				
b. Two bed rms.	539.00	243.00		414-434				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	408	408		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	6,819	6,819		
D. ***Total Physical Therapy Treatments***	7,227	7,227		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	50	50		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	389	389		
D. ***Total Speech Therapy Treatments***	439	439		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	181	181		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	6,165	6,165		
D. ***Total Occupational Therapy Treatments***	6,346	6,346		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	589,363	27,485	.			
5. Dietary Service						
a. Head Dietitian	60,571	2,080				
b. Food Service Supervisor						
c. Dietary Workers	479,884	29,316				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	265,325	19,742				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	83,387	2,080				
b. Other Maintenance Workers	94,582	4,302				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	76,287	6,229				
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	192,536	4,072				
b. RN						
1. Direct Care	1,261,386	33,138				
2. Administrative**	471,525	12,964				
c. LPN						
1. Direct Care	1,481,416	55,034				
2. Administrative**						
d. Aides and Attendants	2,819,006	177,790				
e. Physical Therapists	547,942	13,842				
f. Speech Therapists	85,104	2,098				
g. Occupational Therapists	350,887	10,673				
h. Recreation Workers	249,343	13,355				
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	212,978	7,829				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	9,321,522	422,029				

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	$	Hours	$	Hours	$	Hours
Dietician	$ 1,242	47				
Housekeeper	$ 1,830	94				
Rehab services	$ 1,504	28				
Receptionist	$ 1,775	124				
Total	$ 6,351	293	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Not applicable										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
Not applicable										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	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	12,788	11				
3. Pharmacist	16,420	360				
4. Podiatrist	408	30				
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	20,000	101				
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	5,578	155				
2. Administrative***	123,702	1,079				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	6,351	293				
B-13 Total Fees Paid in Lieu of Salaries	185,247	2,029				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Gordon O. Holder, 971 Marshall Phelps Rd.,Windsor, CT 06095	Dental Service to Residents	○	◉	
Partners Pharmacy, P.O. Box 9669, Uniondale, NY 11555	Pharmacy Consultant	○	◉	
Dushyant Parikh, 30 W. Stafford Rd., Stafford Springs, CT 06076	Medical Director	○	◉	
Robert Tatoian, 74 Palomba Drive, Enfield, CT 06082	Podiatry	○	◉	
360 Healthcare Staffing, P.O. Box 8092, Fort Smith, Arkansas, 72902	Temp Help Agency	○	◉	
Johnson Memorial Hospital, 201 Chestnut Hill Rd., Stafford Springs, CT 06076	Provide nursing staff, pharmacy, technician services	◉	○	related party
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	770,215	770,215		
2. Disability Insurance	$	34,932	34,932		
3. Unemployment Insurance	$	46,865	46,865		
4. Social Security (F.I.C.A.)	$	680,633	680,633		
5. Health Insurance	$	1,274,401	1,274,401		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	5,222	5,222		
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	17,946	17,946		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	(25,876)	(25,876)		
d. Accounting and Auditing	$	35,000	35,000		
e. Legal (*Services should be fully described on Page 7*)	$	2,409	2,409		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	12,071	12,071		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	31,885	31,885		
2. Cellular Phones	$	6,407	6,407		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22*)					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	896,980	896,980		
Subtotal	$	3,789,090	3,789,090		

* 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

Evergreen Health Care Center
09/30/2015

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Employee preemployment physicals	$ 7,819		
Tuition Reimbursement	$ 6,815		
Health Equity Fees	$ 1,190		
Other Benefits	$ 2,122		
Total	$ 17,946	$ -	$ -

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	########	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,789,090	3,789,090		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	8,930	8,930		
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	4,905	4,905		
5. Education Expenses Related to Seminars and Conventions	$	2,512	2,512		
6. Automobile Expense (*not purchase or depreciation*)	$	92	92		
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	641	641		
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	$	8,435	8,435		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	30	30		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual*)	$	51,337	51,337		
12. Administrative Management Services**	$	1,229,376	1,229,376		
13. Other (*Specify*) See Attached Schedule	$	148,045	148,045		
C-14 Total Administrative & General Expenditures	$	5,243,393	5,243,393		

* 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)
Marketing	$ 641		
Total Other Advertising	$ 641	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CATRD	$ 30		
Total Dues	$ 30	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Licenses	$ 500		
Seminars	$ 3,685		
Bank Fees	$ 2,134		
Minor equipment and furniture	$ 2,613		
water cooler supplies	$ 4,408		
cleaning fish tanks	$ 200		
other miscellaneous administrative expenses	$ 9,805		
drug testing	$ 4,214		
physicals	$ 7,819		
Consulting services for msu wing	$ 12,800		
U.S. Trustee Fees	$ 21,867		
Deloitte Consulting	$ 78,000		
Total Other Administrative and General	$ 148,045	$ -	$ -

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CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Evergreen Health Care Center	License No. 2081-C	Report for Year Ended 09/30/2015	Page 17 of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Johnson Memorial Hospital,201 Chestnut Hill Road, Stafford Springs, CT 06076	994,476	Operational $ Financial Management	Page 16, line m 12
Masonicare, 22 Masonic Ave, Waalingford, CT 06492	234,900	Interim Administrator	Page 16, line m 12

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

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CSP-18 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page of
Evergreen Health Care Center	2081-C	09/30/2015	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	363,627	363,627		
2. Non-Food Supplies	$	57,712	57,712		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	421,339	421,339		
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*					
H. Is cost of employee meals included in 2E?		○ Yes	◉ No		
I. Did you receive revenue from employees?		○ Yes	◉ No	If yes, specify amt.	
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?		◉ Yes	○ No	If yes, specify cost.	
L. Is any revenue collected from these people?		◉ Yes	○ No	If yes, specify amt.	$2,085
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					Page 30, IV 1
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?		○ Yes	◉ No	If yes, specify cost.	
O. Is any revenue collected from employees?		○ Yes	◉ No	If yes, specify amt.	
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

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

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

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CSP-19 Rev. 9/2002

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

Name of Facility Evergreen Health Care Center	License No. 2081-C	Report for Year Ended 09/30/2015	Page 19 of 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. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	163,748	163,748		
c. Management Services**	$				
d. Other (*Specify*) Laundry Supplies	$	12,410	12,410		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	176,158	176,158		

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

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	26,403	26,403		
b. Purchased Services (*by contract other than through Management Services*) (*Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	26,403	26,403		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	414,357	414,357		
b. Medicine Cabinet Drugs		$	55,344	55,344		
c. Medical and Therapeutic Supplies		$				
d. Ambulance/Limousine***		$	3,815	3,815		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	25,618	25,618		
f. X-rays and Related Radiological Procedures***		$	51,741	51,741		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	76,196	76,196		
i. Recreation		$	6,793	6,793		
j. Other (Specify)**** See Attached Schedule		$	368,136	368,136		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,002,000	1,002,000		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Vaccines	$ 26,525		
Durable Medical Equipment	$ 36,524		
IV Therapy supplies	$ 18,673		
Nursing Supplies	$ 270,270		
OBRA related supplies	$ 11,788		
physical therapy supplies	$ 4,238		
audiology	$ 118		
Total Other Resident Care	$ 368,136	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
USA Hauling & Recycling	P.O. Box 808, East Windsor, CT 06088	○	⊙		Rubbish Removal	25,446			22	6f
Masonicare	22 Masonicare Ave., Wallingford, CT 06492	○	⊙		Provides Interim Administrator	234,900			16	m12
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	22	37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	54,489	54,489		
b. Heat	$	136,002	136,002		
c. Light & Power	$	166,762	166,762		
d. Water	$	31,775	31,775		
e. Equipment Lease (*Provide detail on page 6*)	$	19,743	19,743		
f. Other (*itemize*)	$	143,579	143,579		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	552,350	552,350		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	68,474	68,474		
b. Building & Building Improvements	$	190,596	190,596		
c. Non-Movable Equipment	$	34,524	34,524		
d. Movable Equipment	$				
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	293,594	293,594		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	2,910	2,910		
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	2,910	2,910		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	95,175	95,175		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	391,679	391,679		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Cable TV (Cox)	$ 20,781		
Rubbish Removal	$ 25,446		
Other Maintenance contracted services	$ 28,713		
Maintenance Supplies	$ 46,919		
Medwaste pick up	$ 14,936		
Storage Rental	$ 6,784		
Total Other Repairs and Maintenance	$ 143,579	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	1,424,027		1,424,027	687,680	SL	various	68,474	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								68,474
B. **Building and Building Improvements**								
1. Acquired prior to this report period	16,126,894		16,126,894	9,036,349			189,500	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	13,850		13,850				1,024	
B-4. Subtotal								190,524
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	54,743		54,743	54,743	SL	various		
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					2,180,086		2,180,086	2,178,045	SL	various	2,041	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					66,602		66,602			4	8,325	
D-3. Subtotal												10,366
E. ***Total Depreciation***												269,364

Evergreen Health Care Center
09/30/2015

Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Carpeting	flooring for 2nd floor	$ 6,629	5	$ 663	
transformer	kitchen panel power	$ 7,221	10	$ 361	
Total additions for Building Improvements		$ 13,850		$ 1,024	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
truck	2015 GMC Sierra Truck	$ 66,602	4	$ 8,325	
Total additions for Movable Equipment		$ 66,602		$ 8,325	*
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:					
Total additions for Leasehold Improvement		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1. Refinancing = 30 bed Alzheimer's ur		2008	454 months	146,625	23,578	SL		2,909	
2.									
3.									
B-4. Subtotal									2,909
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									2,909

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* O Yes O 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	Leased
2. Date Structure Completed	10/01/89
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	10/01/89
5. Total Licensed Bed Capacity	180
6. Square Footage	66,500
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)	fixed			
b. Date Mortgage Obtained	08/27/07			
c. Interest Rate for the Cost Year	variable			
d. Term of Mortgage (number of years)	40			
e. Amount of Principal Borrowed	15,199,990			
f. Principal balance outstanding as of _____	14,213,697			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	26	37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	477,492	477,492		
Name of Lender: People's United Bank	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)	$	477,492	477,492		

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	27	37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	477,492	477,492		
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*) $				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	477,492	477,492		
14. Insurance				
a. Insurance on Property (buildings only) $	18,955	18,955		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	80,875	80,875		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	99,830	99,830		
15. ***Total All Expenditures (A-13 thru C-14)*** $	17,897,413	17,897,413		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	28	37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $	342,515	342,515		
4.			Other - See attached Schedule $				
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 $	(25,876)	(25,876)		
10.			Accounting & Legal $	2,270	2,270		
11.			Telephone $				
12.			Cellular Telephone $	6,407	6,407		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.			Unallowable Advertising * $	641	641		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	2,463	2,463		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
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) $	328,420	328,420		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Bank fees	$ 2,134		
16	m13	credentialing renewal for S Boucher	$ 329		
Total Other A&G Adjustments			$ 2,463	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Evergreen Health Care Center	2081-C	09/30/2015	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	328,420	328,420		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $	414,357	414,357		
28.			Ambulance/Limousine $	3,815	3,815		
29.			X-rays, etc $	107,373	107,373		
30.			Laboratory $	20,570	20,570		
31.			Medical Supplies $				
32.			Oxygen (non emergency) $	25,618	25,618		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	70,014	70,014		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.			Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $				
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $	14,836	14,836		
51.			***Total Amount of Decrease (Items 1 - 50)*** $	985,003	985,003		

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

Attachment Page 29

Evergreen Health Care Center
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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		Durable Medical Equipment	$ 36,524		
		IV Therapy	$ 18,673		
		OBRA related nursing supplies	$ 11,788		
		Physical Therapy supplies	$ 3,029		
Total Other Ancillary Costs			$ 70,014	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12D	Imputed interest	$ 14,836		
Total Unallowable Building Interest			$ 14,836	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	12,995,538	12,995,538		
b. Medicaid Room and Board Contractual Allowance **	$	(5,387,617)	(5,387,617)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	5,177,946	5,177,946		
b. Medicare Room and Board Contractual Allowance **	$	(2,533,012)	(2,533,012)		
4. a. Private-Pay Residents and Other	$	3,057,798	3,057,798		
b. Private-Pay Room and Board Contractual Allowance **	$	(208,785)	(208,785)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	348,758	348,758		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	35,979	35,979		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$	5,535	5,535		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	8,024	8,024		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	1,214,352	1,214,352		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	98,090	98,090		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	99,940	99,940		
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	3,840	3,840		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	1,088,761	1,088,761		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	67,695	67,695		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	255,609	255,609		
b. Other *(Specify)* - Non-Medicare	$	127,182	127,182		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	16,455,633	16,455,633		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	2,085	2,085		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	3,360	3,360		
8. Other (*Specify*)	$	54,936	54,936		
V. Total Other Revenue (1 thru 8)	$	60,381	60,381		
VI. Total All Revenue (III +V)	$	16,516,014	16,516,014		

* *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)
30	IV Therapy	$ 30,152		
30	Lab	$ 98,866		
30	Oxygen	$ 61,862		
30	Xray	$ 45,882		
30	Vaccines	$ 11,527		
30	Enteral	$ 7,320		
Total Other Resident Revenue - Medicare		$ 255,609	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30	IV Therapy	$ 4,313		
30	Lab	$ 4,753		
30	Oxygen	$ 114,422		
30	Xray	$ 3,334		
30	Vaccines	$ 360		
Total Other Resident Revenue		$ 127,182	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Total Interest Income			$ -	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30	Donations	$ 3,551		
30	Medicaid application fees	$ 5,000		
30	Other revenue	$ 100		
30	Optum QM Incentive	$ 26,065		
30	Physical Therapist	$ 20,220		
Total Other Revenue		$ 54,936	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	31	37

Account			Amount
Assets			
A. Current Assets			
1. Cash (*on hand and in banks*)			$ 67,163
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			$ 1,580,143
3. Other Accounts Receivable (Excluding Owners or Related Parties)			$ 14,363
4 Inventories			$ 26,625
5. Prepaid Expenses			$ 236,584
a. Prepaid Insurance		206,246	
b. Prepaid Expenses		28,338	
c. Retainers		2,000	
d.			
6. Interest Receivable			$
7. Medicare Final Settlement Receivable			$
8. Other Current Assets (*itemize*)			$ 134,451
Due from Workers Comp Insurance		134,451	
A-9. ***Total Current Assets*** (Lines A1 thru 8)			$ 2,059,329
B. Fixed Assets			
1. Land			$
2. Land Improvements	*Historical Cost	1,424,027	$ 667,873
	Accum. Depreciation	756,154 Net	
3. Buildings	*Historical Cost	16,126,894	$ 6,901,045
	Accum. Depreciation	9,225,849 Net	
4. Leasehold Improvements	*Historical Cost		$
	Accum. Depreciation	Net	
5. Non-Movable Equipment	*Historical Cost	54,743	$
	Accum. Depreciation	54,743 Net	
6. Movable Equipment	*Historical Cost	2,180,086	$
	Accum. Depreciation	2,180,086 Net	
7. Motor Vehicles	*Historical Cost	66,602	$ 58,277
	Accum. Depreciation	8,325 Net	
8. Minor Equipment-Not Depreciable			$
9. Other Fixed Assets (*itemize*)			$ (4,687,820)
People's Bank-Mortgage Financing Costs		120,138	
Impairment Loss on Long Lived Assets		(4,807,958)	
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)			$ 2,939,375

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	32	37

Account			Amount
		Total Brought Forward:	$ 4,998,704
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)			$
5. Investments Related to Resident Care (*itemize*)			$
6. Loans to Owners or Related Parties (*itemize*)			$
Name and Address	Amount	Loan Date	
7. Other Assets (*itemize*)			$
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ 4,998,704

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 678,992
2. Notes Payable (*itemize*)					$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 497,435
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$ 14,213,697
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$ 1,271,172
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 939,502
Accrued Accounting Fees	31,000	Other Accrued Payables	50,269		
AR Credit Balances	174,580	Accrued Bankruptcy Fee	355,307		
Due to Affiliates	(170,998)				
Accrued Provider Tax	499,344				
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 17,600,798

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	34	37

Account	Amount
Total Brought Forward:	17,600,798
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 762,512
Workers Compensation Liability	642,296	
Self Insurance Trust Liability	53,353	
Patient Trust	66,863	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 762,512
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 18,363,310

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

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	35	37

Account		Amount
A. **Reserves**		
1. Reserve for value of leased land		$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized		$
3. Reserve for depreciation value of leased personal property *(Equity)*		$
4. Reserve for leasehold real properties on which fair rental value is based		$
5. Reserve for funds set aside as donor restricted		$
6. Total Reserves		$
B. **Net Worth**		
1. Owner's Capital		$
2. Capital Stock		$
3. Paid-in Surplus		$
4. Treasury Stock		$
5. Cumulated Earnings		$ (11,766,376)
6. Gain or Loss for Period	10/01/2014 thru 09/30/2015	$ (1,598,230)
7. Total Net Worth		$ (13,364,606)
C. ***Total Reserves and Net Worth***		$ (13,364,606)
D. ***Total Liabilities, Reserves, and Net Worth***		$ 4,998,704

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	36	37

Account			Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2014			$ (9,332,404)
B. Total Revenue (*From Statement of Revenue Page 30*)			$ 16,516,014
C. Total Expenditures (*From Statement of Expenditures Page 27*)			$ 17,897,295
D. Net Income or Deficit			$ (1,598,230)
E. Balance			$ (10,930,634)
F. Additions			
1. Additional Capital Contributed (*itemize*)			
2. Other (*itemize*)			
other adjustments	52,636		
F-3. Total Additions			$ 52,636
G. Deductions			
1. Drawings of Owners/Operators/Partners (*Specify*)			$
Name and Address (*No., City, State, Zip*)	Title	Amount	
2. Other Withdrawings *(Specify)*			$
Purpose		Amount	
3. Total Deductions			$
H. ***Balance at End of Period***	09/30/15		$ (10,877,998)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Evergreen Health Care Center	2081-C	09/30/2015	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Thomas Blazejowski	Controller	4/22/16

Printed Name of Preparer	
Thomas Blazejowski	

Addres Address	Phone Number
201 Chestnut Hill Rd, Stafford Springs, CT	860-684-8133

Level	Item	Reported as