State of Connecticut

15-48

Annual Report of Long-Term Care Facility

Cost Year 2015

RECEIVED
FEB 17 2016
DEPT. OF SOCIAL SERVICES
OFFICE OF CON AND RATE SETTINGS

Name of Facility (as licensed) Greensprings Healthcare and Rehabilitation Center, LLC	
Address (No. & Street, City, State, Zip Code) 51 Applegate Lane, East Hartford, CT 06118	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2392			07-5206

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	000010082		

For Department Use Only

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

RECEIVED

FEB 23 2016

MYERS & STAUFFER LC

Table of Contents

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

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

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center, LL	2392	9/30/2015	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 Greensprings Healthcare and Rehabilitation Center, LLC [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. {a}

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.

{a} Subject to Desk Audit Review

Signed (Administrator)	Date	Signed (Owner)	Date
	2/9/16		
Printed Name (Administrator) Marc Lei		Printed Name (Owner) David Blumenkrantz	

Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires
Scott Chapalis	CT	2/9/16		07/31/2019

Address of Notary Public
934 Silver Lane East Hartford, CT 06118

SCOTT CHAPALIS NOTARY PUBLIC (Notary Seal) COMMISSION EXPIRES JULY 31, 2019 CONNECTICUT

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

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center, LL	2392	9/30/2015	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 Greensprings Healthcare and Rehabilitation Center, LLC [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. {a}

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.

{a} Subject to Desk Audit Review

Signed (Administrator)		Date	Signed (Owner)	Date
				2/8/16
Printed Name (Administrator) Marc Lei			Printed Name (Owner) David Blumenkrantz	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

State of Connecticut
Annual Report of Long-Term Care Facility
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 Greensprings Healthcare and Rehabilitation Center, LLC	Period Covered:		From 10/1/2014	To 9/30/2015
Address of Facility 51 Applegate Lane, East Hartford, CT 06118				
Report Prepared By Marcum LLP	Phone Number 203-781-9600		Date 12/8/2015	

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 10/2005

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-568-7520	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Greensprings Healthcare and Rehabilitation Center, LLC	51 Applegate Lane, East Hartford, CT 06118

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2392			07-5206

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.

Acquired from Aurora Senior Living as of 10/1/2014.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Marc Lei	001967

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

Name	License No.:
Jason Mervin	

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

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center, LL	2392	9/30/2015	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Greenspring Healthcare and Rehabilitation Center, LLC	51 Applegate Lane, East Hartford, CT 06118	CT

Name of Partners/Members	Business Address	Title	% Owned
David Blumenkrantz	51 Applegate Lane, East Hartford, CT 06118	Owner	1

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

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation C	2392	9/30/2015	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
N/A		

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

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

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Cente	2392	9/30/2015	3B	37

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

Owner(s) of Facility
N/A

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

General Information and Questionnaire

Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center, LL	2392	9/30/2015	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	%**				
Applegate Realty LLC	51 Applegate Lane, East Hartford, CT 06118	○	⊙		Related Party Rent	Pg. 22 / Line 9	300,000	273,508
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Cen	2392	9/30/2015	5	37

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.

N/A

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

N/A

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.

N/A

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

General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center, LLC	2392	9/30/2015	6	37

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
Ecolab Institutional, 370 Wabasha St N, St Paul, MN 55102	O	⊙	Dish Machine	06/01/13	Open Ended	2,856	2,856
Hewlett-Packard Financial Services Co., 200 Connell Dr, Berkeley Heights, NJ 07922	O	⊙	Printer	09/19/14	Open Ended	1,842	1,842
Xerox Corporation, 155 Pinelawn Rd, Melville, NY 11747	O	⊙	Copier	03/10/14	Open Ended	998	998
Ryan Motors Corp, 352 Rt. 18, East Brunswick, NJ 08816	O	⊙	Owner's Vehicle Lease (See Attached)	12/15/14	39 Months	7,308	7,308
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					

Is a Mileage Log Book Maintained for All Leased Vehicles ? O Yes O No **Total** *** 13,004

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehal	2392	9/30/2015	7	37

The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual O Cash O Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Craig J. Lubitski Consulting LLC	225 Pitkin Street, East Hartford, CT 06108
2 Solomon Hirsch, CPA P.C.	14 Joan Lane, Monsey, NY 10952
3 Moore Stephens Lovelace CPAs & Advisors	701 Brickell Ave Suite 550, Miami, FL 33131
4 Marcum LLP	555 Long Wharf Drive, New Haven, CT 06511

Services Provided by This Firm (*describe fully*)

1	Reimbursement consulting	$ 1,200
2	Preparation of LLC Tax Return	$ 2,000
3	Preparation Medicare cost report	$ 2,500
4	Reimbursement consulting, Prepare Medicaid cost report, Financial Review	$ 12,226
		Charge for Services Provided $ 17,926

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

⊙ Yes O No Page 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Schutler Bogar LLC	717-585-7186
2 Capozzi Adler, P.C.	717-233-4103
3 Mutha Cullina LLP	860-240-6000
4 Reed Smith	215-851-8100
5 Various	Various

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

1 1426 N. 3rd St. Suite 200 PO Box 5400
2 P.O. Box 5866
3 185 Asylum Street, Hartford, CT 06103
4 1717 Arch St, Suite 3100, Philadelphia, PA 19103
5 Various

Services Provided by This Firm (*describe fully*)

1	Project fee, Deed search (Disallowed on Pg. 28)	$ 508
2	Collections (Disallowed on Pg. 28)	$ 305
3	Purchase of Facility (Disallowed $3,238 on Pg. 28), General Representation	$ 17,358
4	General labor matters	$ 1,160
5	Conservatorship / Probate Court (Disallowed on Pg. 28)	$ 412
		Charge for Services Provided $ 19,743

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

⊙ Yes O No Page 15, Line 1e

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

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center, LLC	2392	9/30/2015	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	145	145			145	145			145	145		
B. On last day of THIS report period	145	145			145	145			145	145		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	93	93			93	93			76	76		
B. As of midnight of THIS report period	89	89			76	76			89	89		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,825	1,825			1,311	1,311			514	514		
B. Medicaid (Conn.)	28,874	28,874			21,062	21,062			7,812	7,812		
C. Medicaid (other states)												
D. Private Pay	1,012	1,012			994	994			18	18		
E. State SSI for RCH												
F. Other (Specify) Hospice & Other Insurance	475	475			328	328			147	147		
G. Total Care Days During Period (3A thru F)	32,186	32,186			23,695	23,695			8,491	8,491		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	3	3							3	3		
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	32,189	32,189			23,695	23,695			8,494	8,494		

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

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation C	2392	9/30/2015	9	37

4. Were there any changes in the certified bed capacity during the report year? O 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	4	82		3				
Per Diem Rate								
a. One bed rm.	Various	231.70		405.00				
b. Two bed rms.	Various	231.70		381.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	267	267		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	209	209		
C. Other	273	273		
D. ***Total Physical Therapy Treatments***	749	749		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	27	27		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	15	15		
D. ***Total Speech Therapy Treatments***	42	42		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	269	269		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	127	127		
C. Other	274	274		
D. ***Total Occupational Therapy Treatments***	670	670		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center, LLC	2392	9/30/2015	10	37

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

Item	Total Cost and Hours					
	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)	187,500	2,340				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	117,652	2,223				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	24,017	1,109				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	97,403	5,753				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	438,795	22,584				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	46,785	2,096				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	48,123	2,345				
b. Other Maintenance Workers	56,109	3,277				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
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	208,101	4,164				
b. RN						
1. Direct Care	456,657	11,636				
2. Administrative**	142,705	4,348				
c. LPN						
1. Direct Care	1,069,889	35,881				
2. Administrative**						
d. Aides and Attendants	1,635,634	84,821				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	98,928	6,690				
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	113,892	3,960				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	40,888	2,032				
A-13. Total Salary Expenditures	4,783,078	195,259				

* 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 $	CCNH Hours	RHNS $	RHNS Hours	(Specify) $	(Specify) Hours
	-					
Medical Records	$ 40,888	2,032				
Total	$ 40,888	2,032	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH $	CCNH Hours	RHNS $	RHNS Hours	(Specify) $	(Specify) Hours
	-					
Respiratory Therapist	$ 1,750	29				
MDS Consultant	$ 412	N/A				
Total	$ 2,162	29	$ -	-	$ -	-

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	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center, LLC	2392	9/30/2015	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
David Blumenkrantz	187,500			Non Discrim	Owner	2,340	A1			
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).										

* 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	of
Greensprings Healthcare and Rehabilitation Center, LLC	2392	9/30/2015	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* **										
Marc Lei	117,652			Non Discrim	Administrator	2,223	A2			
Section IV - Assistant Administrators										
Jason Mervin	24,017			Non Discrim	Assistant Administrator	1,109	A3			

*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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center,	2392	9/30/2015	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						
3. Pharmacist	6,302	967				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	168,248	2,200				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	30,000	192				
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	48,574	508				
b. Other						
10. Occupational Therapist						
a. Resident Care	145,021	1,864				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	83,625	695				
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	2,162	29				
B-13 Total Fees Paid in Lieu of Salaries	483,932	6,455				

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center, LLC	2392	9/30/2015	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Omnicare, 525 Knotter Drive, Cheshire, CT 06410	Pharmacist	○	⊙	N/A
Marc N. Raad, 464 Wolcott Road, Wolcott, CT 06716	Medical Director	○	⊙	N/A
HealthPro Therapy Services LLC, 10600 York Rd Suite 105, Cockysville, MD 21030	Physical, Occupational and Speech Therapy	○	⊙	N/A
Genter Healthcare Inc, PO Box 478, New London, NH 03257	Inhalation Therapy	○	⊙	N/A
Nancy K. Gillies	RN Infection Control Consultant	○	⊙	N/A
Anne Cahill	RN Consultant	○	⊙	N/A
E2XPonential Healthcare Consulting Group, 10600 York Rd Suite #105, Cockeysville,MD	MDS Consultant	○	⊙	N/A
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Greensprings Healthcare and Rehabilitation Cente	2392	9/30/2015		15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	369,063	369,063		
2. Disability Insurance	$	29,192	29,192		
3. Unemployment Insurance	$	135,480	135,480		
4. Social Security (F.I.C.A.)	$	336,793	336,793		
5. Health Insurance	$	866,131	866,131		
6. Life Insurance (employees only) (not-owners and not-operators)	$	16,140	16,140		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	218,250	218,250		
8. Uniform Allowance	$	385	385		
9. Other (*Specify*) See Attached Schedule	$	31,489	31,489		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	82,619	82,619		
d. Accounting and Auditing	$	17,926	17,926		
e. Legal (*Services should be fully described on Page 7*)	$	19,743	19,743		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	44,360	44,360		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	29,507	29,507		
2. Cellular Phones	$	3,172	3,172		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	250	250		
k. Other Taxes (*Not related to property - See Page 22*)					
1. Income*	$				
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	645,445	645,445		
Subtotal	$	2,845,945	2,845,945		

* 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

Greensprings Healthcare and Rehabilitation Center, LLC
9/30/2015

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
	-		
Union Dues	$ 31,489		
Total	$ 31,489	$ -	$ -

Schedule of Other Taxes

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

State of Connecticut
Annual Report of Long-Term Care Facility
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
Greensprings Healthcare and Rehabilitation Center, Ll	2392	9/30/2015	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,845,945	2,845,945		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	1,915	1,915		
2. Holiday Parties for Staff	$	2,026	2,026		
3. Gifts to Staff and Residents	$	458	458		
4. Employee Travel	$	26,499	26,499		
5. Education Expenses Related to Seminars and Conventions	$	940	940		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	5,121	5,121		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	10,163	10,163		
4. Fund-Raising***	$				
5. Medical Records	$	7,681	7,681		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$	25	25		
7. Postage	$	2,650	2,650		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	725	725		
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*)	$	270,928	270,928		
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	27,820	27,820		
C-14 Total Administrative & General Expenditures	$	3,202,896	3,202,896		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
	-		
Advertising Expense	$ 10,163		
Total Other Advertising	$ 10,163	$ -	$ -

Schedule of Dues

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

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	-		
Licenses	$ 333		
Miscellaneous - Laptop/Computer Charges	$ 1,332		
Miscellaneous - Fraud	$ 55		
Meals	$ 6,241		
Criminal Checks	$ 531		
Licenses	$ 809		
Bank Fees	$ 5,654		
Employee Meals/Food	$ 798		
Translation Services	$ 866		
Monthly Compliance Program Fees	$ 11,201		
Total Other Administrative and General	$ 27,820	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Greensprings Healthcare and Rehabilitatio	License No. 2392	Report for Year Ended 9/30/2015	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 #
N/A			

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

State of Connecticut
Annual Report of Long-Term Care Facility
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
Greensprings Healthcare and Rehabilitation Center, LL	2392	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	310,064	310,064		
2. Non-Food Supplies	$	19,137	19,137		
3. Other (*Specify*) Equipment	$	1,848	1,848		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	150,910	150,910		
c. Management Services**	$				
d. Other (*Specify*)	$				
2E. *Total Dietary Expenditures* (2a + b + c + d)	$	481,959	481,959		

		Total	CCNH	RHNS	(Specify)
2F.	Dietary Questionnaire				
G.	Resident Meals: Total no. of meals served per day:*				

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

State of Connecticut
Annual Report of Long-Term Care Facility
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	License No.	Report for Year Ended	Page of
Greensprings Healthcare and Rehabilitation Center, LLC	2392	9/30/2015	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. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	313,386	313,386		
c. Management Services**	$				
d. Other (*Specify*) Equipment	$	1,032	1,032		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	314,418	314,418		

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

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

** 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 9/2002

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
Greensprings Healthcare and Rehabilitation Cen	2392	9/30/2015	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.	$				
b. Purchased Services (*by contract other than through Management Services*) (*Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	391,125	391,125		
c. Management Services*		$				
d. Other (*Specify*) Supplies		$	33,764	33,764		
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	424,889	424,889		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Omnicare		$	79,843	79,843		
b. Medicine Cabinet Drugs		$	29,809	29,809		
c. Medical and Therapeutic Supplies		$				
d. Ambulance/Limousine***		$	3,821	3,821		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	8,717	8,717		
f. X-rays and Related Radiological Procedures***		$	2,230	2,230		
g. Dental (*Not dentists who should be included under salaries or fees*)		$	10,152	10,152		
h. Laboratory***		$	4,381	4,381		
i. Recreation		$	38,432	38,432		
j. Other (Specify)**** See Attached Schedule		$	228,972	228,972		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	406,357	406,357		

* 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)
	-		
Nursing Supplies	$ 68,154		
Nursing Equipment	$ 21,051		
Nursing Equipment Rental	$ 46,283		
Nursing Software Rental	$ 28,409		
Incontinence Supplies	$ 32,880		
IV Supplies	$ 117		
IV Expense	$ 1,626		
Physical Therapy Supplies	$ 433		
Pen Expense	$ 12,852		
Wound Care Supplies	$ 9,363		
Urological & Otomy Supplies	$ 1,405		
Social Services	$ 600		
Medical Waste	$ 5,799		
Total Other Resident Care	$ 228,972	$ -	$ -

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center, LLC	2392	9/30/2015	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
Healthcare Services Group	3220 Tillman Dr #300, Bensalem, PA 19020	○	⊙	N/A	Dietary	148,226			18	2b
Healthcare Services Group	3220 Tillman Dr #300, Bensalem, PA 19020	○	⊙	N/A	Laundry	311,685			19	3b
Healthcare Services Group	3220 Tillman Dr #300, Bensalem, PA 19020	○	⊙	N/A	Housekeeping	391,125			20	4b
Point Click Care (Wescom Solutions)	#213, Minneapolis, MN 55416	○	⊙	N/A	Nursing Software	24,943			20	5j
Genter Healthcare, Inc.	28 Ridgewood Rd, Sunapee, NH 03782	○	⊙	N/A	Nursing Equipment	24,399			20	5j
H & R Healthcare	1750 Oak St, Lakewood Township, NJ 08701	○	⊙	N/A	Nursing Equipment	14,536			20	5j
Strategic Healthcare Solutions	100 Mill Plain Road, Danbury, CT 06811	○	⊙	N/A	Managed Care Consulting Services	22,865			16	m11
CWPM LLC	P.O Box 415, Plainville CT 06062	○	⊙	N/A	Sanitation	20,676			22	6f
Classic Landscape Associates LLC	12 Kreyssig Rd, Broad Brook CT 06016	○	⊙	N/A	Landscaping	30,228			22	6f
Med-Net Compliance, LLC	A-10, Princeton, NJ 08540	○	⊙	N/A	Monthly Compliance Program Fees	11,201			16	m13
		○	○							
		○	○							
		○	○							
		○	○							

* 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).

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended			Page	of
Greensprings Healthcare and Rehabilitation Ce	2392	9/30/2015			22	37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	$	37,376	37,376			
b. Heat	$	29,612	29,612			
c. Light & Power	$	181,161	181,161			
d. Water	$	29,915	29,915			
e. Equipment Lease (*Provide detail on page 6*)	$	13,004	13,004			
f. Other (*itemize*) See Attached Schedule	$	134,447	134,447			
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	425,515	425,515			
7. Depreciation (*complete schedule page 23**)						
a. Land Improvements	$					
b. Building & Building Improvements	$					
c. Non-Movable Equipment	$	1,054	1,054			
d. Movable Equipment	$	861	861			
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	1,915	1,915			
8. Amortization (*Complete att. Schedule Page 24**)						
a. Organization Expense	$					
b. Mortgage Expense	$					
c. Leasehold Improvements	$	3,332	3,332			
d. Other (*Specify*)	$					
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	3,332	3,332			
9. Rental payments on leased real property less real estate taxes included in item 10b	$	300,000	300,000			
10. Property Taxes						
a. Real estate taxes paid by owner	$	177,141	177,141			
b. Real estate taxes paid by lessor	$					
c. Personal property taxes	$	22,963	22,963			
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	505,351	505,351			

* 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)
	-		
Maintenance Supplies	$ 20,827		
Maintenance Contracted Sevice	$ 30,539		
Maintenance: Sanitation & Incineration	$ 20,976		
Maintenance: Extermination	$ 2,397		
Maintenance: Landscaping	$ 30,228		
Maintenance: Minor Equipment	$ 24,932		
Maintenance: Equipment Rental	$ 4,548		
Total Other Repairs and Maintenance	$ 134,447	$ -	$ -

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

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center, LLC	2392	9/30/2015	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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule) Ⓐ	10,687		10,687		S/L	Various	1,054	
C-4. Subtotal								1,054

	Is a mileage logbook maintained?		Date of Acquisition								
	Yes	No	Month	Year	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
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												
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule) Ⓐ			Var	Var	2,584		2,584		S/L	3 Yrs	861	
D-3. Subtotal												861
E. *Total Depreciation*												1,915

Ⓐ **Assets listed exclude historical assets from prior owner.**

Greensprings Healthcare and Rehabilitation Center, LLC
9/30/2015

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:					
Total additions for Building Improvements		$ -		$ -	*
Deletions:					
Total deletions for Building Improvements		$ -		$ -	**

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

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Various	See attached	$ 10,687	Various	$ 1,054	
Total additions for Non-Movable Equipment		$ 10,687		$ 1,054	*
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:					
5/1/2015	Dell Latitude 3440 (Total of 4)	$ 2,584	3	$ 861	
Total additions for Movable Equipment		$ 2,584		$ 861	*
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:					
Various	See attached	$ 43,278	Various	$ 3,332	
Total additions for Leasehold Improvement		$ 43,278		$ 3,332	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center, LLC	2392	9/30/2015	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	Var	Var	Various	43,278		S/L		3,332	
C-4. Subtotal									3,332
D. ***Total Amortization***									3,332

* 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.

Greensprings Healthcare and Rehabilitation Center, LLC
Depreciation Schedule
September 30, 2015

Vendor	Description	Date of Acquisition	Historical Cost	Useful Life	2015 Depr	2015 Acum	Net Book Value
Leasehold Improvements							
2015 Acquisitions							
Mountain Air	A/C Heat Unit	11/14/2014	8,920	15	595	595	8,325
Mountain Air	A/C Heat Unit Tax	12/1/2014	566	15	38	38	528
Mountain Air	Hot Water Valve	1/1/2015	2,036	10	204	204	1,832
Encore Fire Protection	Fire Sprinkler-Values+Repairs	2/19/2015	4,391	25	176	176	4,215
H&E Enterprize Jerry Daigle	Fireproofed Double Doors	3/1/2015	2,400	15	160	160	2,240
Mountain Air	Replaced Piping	3/3/2015	6,750	20	338	338	6,412
S&S Wired Systems, LLC	Install Security on Doors	4/24/2015	4,041	10	404	404	3,637
Fellner Associates Architectes LLC	Update As-Built CAD Plan	5/1/2015	14,173	10	1,417	1,417	12,756
Total 2015 Acquisitions			43,278		3,332	3,332	39,946
Total Leasehold Improvements			43,278		3,332	3,332	39,946
Non-moveable Equipment							
2015 Acquisitions							
Direct Supply, Inc.	GE Zoneline PTAC Heat Pump	7/20/2015	3,392	10	339	339	3,053
Mountain Air	compressor for nurses station	8/1/2015	2,624	12	219	219	2,405
Alpha-Med, Inc.	2 lifts with scales	9/17/2015	4,379	10	438	438	3,941
Apex Healthcare Systems	FIB Configuration Labor	8/15/2015	291	5	58	58	233
Total 2015 Acquisitions			10,687		1,054	1,054	9,633
Total Non-movable Equip			10,687		1,054	1,054	9,633
Moveable Equipment							
2015 Acquisitions							
Apex Healthcare Systems	Dell Latitude 3440 (Total of 4)	5/1/2015	2,584	3	861	861	1,723
Total 2015 Acquisitions			2,584		861	861	1,723
Total Movable Equipment			2,584		861	861	1,723
Leasehold Improvements			43,278	[redacted]	3,332	3,332	39,946
Non-Movable Equipment			10,687		1,054	1,054	9,633
Movable Equipment			2,584		861	861	1,723
Total 2015			56,549	-	5,247	5,247	51,302
Total Per Trial Balance			56,549		1,539	1,539	55,010
Variance			-	-	3,708	3,708	(3,708)
					(b)		(a)

Ties to coreresponding pages of Medicaid Cost Report

F/S vs C/R NBV (Page 31, Line B9)	3,708	(a)
F/S vs C/R Depreciation (Page 36, Line F1)	(3,708)	(b)

53,965

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilit	2392	9/30/2015	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ⊙ 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	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	
6. Square Footage	82,000
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)	Interest Only			
b. Date Mortgage Obtained	09/30/14			
c. Interest Rate for the Cost Year	10.00%			
d. Term of Mortgage (number of years)	2			
e. Amount of Principal Borrowed	1,900,000			
f. Principal balance outstanding as of 9/30/2015	1,900,000			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended			Page of
Greensprings Healthcare and Rehabilit	2392	9/30/2015			26 | 37

Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage $				
Name of Lender / Rate				
Address of Lender				
2. Second Mortgage $				
Name of Lender / Rate				
Address of Lender				
3. Third Mortgage $				
Name of Lender / Rate				
Address of Lender				
4. Fourth Mortgage $				
Name of Lender / Rate				
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount $				
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $				

(Carry Subtotals forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Greensprings Healthcare and Rehab	2392	9/30/2015	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*) Working Capital Interest			$	64,966	64,966		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	64,966	64,966		
14. Insurance							
a. Insurance on Property (buildings only)			$	47,563	47,563		
b. Insurance on Automobiles			$	791	791		
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*)			$	75,894	75,894		
2. Fire and Extended Coverage			$				
3. Other (*Specify*) Crime & Surity Bond Insurance			$	6,867	6,867		
14d. ***Total Insurance Expenditures (14a + b + c)***			$	131,115	131,115		
15. ***Total All Expenditures (A-13 thru C-14)***			$	11,224,476	11,224,476		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2002

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page
Greensprings Healthcare and Rehabilitation Center, LLC	2392	9/30/2015	28 of 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	B10a	Occupational Therapy $	145,021	145,021		
7.			Other - See attached Schedule $	1,750	1,750		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	82,619	82,619		
10.	15	1e	Accounting & Legal $	4,463	4,463		
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	1,732	1,732		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.	16	L3	Gifts, flowers and coffee shops $	458	458		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.	16	L4	Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $	23,710	23,710		
17.			Automobile Expense (e.g. personal use) $				
18.	16	m3	Unallowable Advertising * $	10,163	10,163		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.	16	m6	Barber and Beauty $	25	25		
23.			Other - See attached Schedule $	8,685	8,685		
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) $	278,626	278,626		

* 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)
13	12o	Respiratory Therapist	$ 1,750		
Total Other Fees Adjustments			$ 1,750	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m8a	Chamber of Commerce Dues	$ 725		
16	m13	Miscellaneous - Fraud	$ 55		
16	m13	Meals	$ 6,241		
16	m13	Employee Food/Meals	$ 798		
16	m13	Translation Services	$ 866		
Total Other A&G Adjustments			$ 8,685	$ -	$ -

Greensprings Healthcare and Rehabilitation Center, LLC
Disallowance Schedule for Cell Phones
September 30, 2015

	Amount	
Total Cell Phone Expense	3,172	TB Linked
Cell Phone Allowed Based on Bed Capacity	4	
Monthly Allowable amount per Cell Phone	$ 30	
Months in Cost Report Year	12	
Total Allowable Cost	$ 1,440	
Disallowed Cell Phone (Page 28, Line 12)	**$ 1,732**	

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 10/2006

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

Name of Facility	License No.	Report for Year Ended	Page of
Greensprings Healthcare and Rehabilitation Center, LLC	2392	9/30/2015	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	278,626	278,626		
*Page 20 - Resident Care Supplies****							
27.	20	5a2	Prescription Drugs $	79,843	79,843		
28.	20	5d	Ambulance/Limousine $	3,821	3,821		
29.	20	5f	X-rays, etc $	2,230	2,230		
30.	20	5h	Laboratory $	4,381	4,381		
31.			Medical Supplies $				
32.	20	5e2	Oxygen (non emergency) $	8,717	8,717		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	35,122	35,122		
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 $	72,274	72,274		
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 $	333	333		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			*Total Amount of Decrease (Items 1 - 50)* $	485,347	485,347		

*** 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.

Greensprings Healthcare and Rehabilitation Center, LLC
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5i	Cable TV Disallowance	$ 9,759		
20	5j	IV Supplies	$ 117		
20	5j	IV Expense	$ 1,626		
20	5j	Pen Expense	$ 12,852		
20	5j	Wound Care Expense	$ 9,363		
20	5j	Urological & Ostomy Expense	$ 1,405		
Total Other Ancillary Costs			$ 35,122	$ -	$ -

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)
27	12D	Working Capital Interest	$ 64,966	✓	
22	6e	Owner's Vehicle Lease	$ 7,308		
Total Other Property Adjustments			$ 72,274	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV 8	Miscellaneous Income	$ 333		
Total Other Adjustments			$ 333	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

Greensprings Healthcare and Rehabilitation Center, LLC **Pg. 29b**
Disallowance Schedule for Cable TV
September 30, 2015

		Amount	
Total Cable TV Expense acct # 8510-087-00	$	13,359	TB Linked
Monthly Allowable amount	$	300	
Months in Cost Report Year		12	
Total Allowable Cost	$	3,600	
Disallowed Cable TV	$	9,759	

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitati	2392	9/30/2015	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	18,048,125	18,048,125		
b. Medicaid Room and Board Contractual Allowance **	$	(11,360,226)	(11,360,226)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,122,978	1,122,978		
b. Medicare Room and Board Contractual Allowance **	$	(210,423)	(210,423)		
4. a. Private-Pay Residents and Other	$	929,375	929,375		
b. Private-Pay Room and Board Contractual Allowance **	$	(413,186)	(413,186)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	47,975	47,975		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(47,975)	(47,975)		
c. Prescription Drugs - Non-Medicare	$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	171,197	171,197		
b. Physical Therapy - Medicare Contractual Allowance **	$	(117,645)	(117,645)		
c. Physical Therapy - Non-Medicare	$	82,047	82,047		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(77,162)	(77,162)		
4. a. Speech Therapy - Medicare	$	64,040	64,040		
b. Speech Therapy - Medicare Contractual Allowance **	$	(22,801)	(22,801)		
c. Speech Therapy - Non-Medicare	$	22,491	22,491		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(19,642)	(19,642)		
5. a. Occupational Therapy - Medicare	$	154,777	154,777		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(107,674)	(107,674)		
c. Occupational Therapy - Non-Medicare	$	61,821	61,821		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(58,273)	(58,273)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	8,269,819	8,269,819		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	333	333		
V. Total Other Revenue (1 thru 8)	$	333	333		
VI. Total All Revenue (III +V)	$	8,270,152	8,270,152		

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

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 IV 8	Miscellaneous Income	$ 333		
Total Other Revenue		$ 333	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilita	2392	9/30/2015	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 429,330
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,038,732
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 53,139
a. Prepaid Expenses		3,273		
b. Prepaid Licenses		67		
c. Prepaid RE Taxes		49,799		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,521,201
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	43,278		$ 39,946
	Accum. Depreciation	3,332	Net	
5. Non-Movable Equipment	*Historical Cost	10,687		$ 9,633
	Accum. Depreciation	1,054	Net	
6. Movable Equipment	*Historical Cost	2,584		$ 1,723
	Accum. Depreciation	861	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 3,708
F/S vs C/R NBV		3,708		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 55,010

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitat	2392	9/30/2015	32	37

Account			Amount
		Total Brought Forward:	$ 1,576,211
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)			$ 1,576,211

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Ce	2392	9/30/2015	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 1,206,287
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*)				$ 313,494
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*)				$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 207,046
Resident Funds	37,036	Accrued Accounting Fees	5,900	
Due to/from (Prior Owner)	(903)	Accrued Provider Tax	163,515	
Write-Offs - Sequester	1,938			
Other Accrued	(440)			
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 1,726,827

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation	2392	9/30/2015	34	37

Account	Amount
Total Brought Forward:	1,726,827
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*)		$ 2,800,000
Working Capital	2,800,000	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 2,800,000
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 4,526,827

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilit	2392	9/30/2015	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		$
6. Gain or Loss for Period	10/1/2014 thru 9/30/2015	$ (2,950,616)
7. Total Net Worth		$ (2,950,616)
C. ***Total Reserves and Net Worth***		$ (2,950,616)
D. ***Total Liabilities, Reserves, and Net Worth***		$ 1,576,211

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitatic	2392	9/30/2015	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			$
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 8,270,152
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 11,220,768
D.	Net Income or Deficit			$ (2,950,616)
E.	Balance			$ (2,950,616)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Expenses Per Page 27	11,224,476		
	(Less) C/R vs F/S Depreciation	(3,708)		
	Total F/S Expenses	11,220,768		
	2. Other (*itemize*)			
F-3.	Total Additions			$
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		$ (2,950,616)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

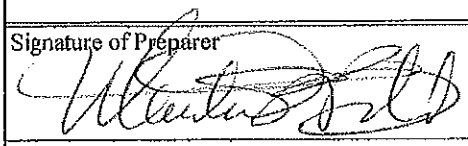
Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation	2392	9/30/2015	37	37

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
	PRINCIPAL	2/8/16

Printed Name of Preparer

Matthew S. Bavolack

Addres Address	Phone Number
555 Long Wharf Drive, New Haven, CT 06511	203-781-9600