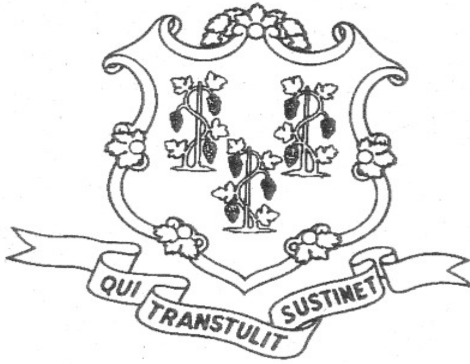
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Greensprings Healthcare and Rehabilitation Center,LLC		
Address (No. & Street, City, State, Zip Code) 51 Applegate Lane, East Hartford, CT 061 l8		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2016	Report for Year Ending 7/13/2017	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	10082		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center,LL	2392	7/13/2017	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, 2016 and ending July 13, 2017, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Katharine B. Sacks Receiver			Printed Name (Owner) Katharine B. Sacks Receiver	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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 10/1/2016	To 7/13/2017
Address of Facility 51 Applegate Lane, East Hartford, CT 061 l8					
Report Prepared By Fred Dalicandro		Phone Number 860-212-8558		Date 12/31/2017	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$	355,829	355,829		
2. Laundry wages paid	$	55,988	55,988		
3. Housekeeping wages paid	$	301,716	301,716		
4. Nursing wages paid	$	3,023,627	3,023,627		
5. All other wages paid	$	546,676	546,676		
6. ***Total Wages Paid***	$	4,283,836	4,283,836		
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	4,283,836	4,283,836		

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
	7/13/2017	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 061 l8

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
		7/13/2017

Has there been any change in ownership or operation during this report year? ⊙ Yes ○ No If "Yes," explain fully.

Facility went into state receivership effective 2/13/17

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Katharine B. Sacks Receiver	not applicable - receivers

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
Greensprings Healthcare and Rehabilitation Center,LL	2392	7/13/2017	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Greensprings Healthcare and Rehabilitation Center, LLC	703 Twin Oaks Road, Lakewood, NJ 08701	Connecticut

Name of Partners/Members	Business Address	Title	% Owned
David Blumenkrantz	703 Twin Oaks Road, Lakewood, NJ 08701	Owner	100

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation C	2392	7/13/2017	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
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
Greensprings Healthcare and Rehabilitation Center	2392	7/13/2017	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
Greensprings Healthcare and Rehabilitation Center,LL(	2392	7/13/2017	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	○	⦿		Rent paid to Applegate Realty LLC for three	Page 22/ Line 9	132,613	112,111
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* 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
Greensprings Healthcare and Rehabilitation Ce	2392	7/13/2017	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.

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

Not Applicable

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

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

Not Applicable

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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
Greensprings Healthcare and Rehabilitation Center,LLC	2392	7/13/2017	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Ecolab Institutional, 370 Wabasha St N, St Paul, MN 55102	○	⦿	Dish Machine	06/01/13	Open ended	2,201	2,201
H&RHEALTHCARE DME RENTALS	○	○	DME Rentals	03/31/17	Month to Month	39,456	39,456
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No **Total ***** 41,657

* 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
Greensprings Healthcare and Rehab	2392	7/13/2017	7	37

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

⦿ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Marcum LLP	555 Long Wharf Drive, New Haven, CT06511
2 Moore Stephens Lovelace	
3	
4	

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	Reimbursement consulting, financial review, Medicaid cost report preparation	$ 2,629
2	Preparation of Medicare cost report	$ 2,978
3		$
4		$
	Charge for Services Provided	$ 5,607

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

⦿ Yes ○ No Pa e l5, Line ld

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha Culling LLP	860-240-6000
2 Capozzi Adler, P.C.	717-233-4101
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 185 Asylum Street, Hartford, CT 06103-3469
2 P.O. Box 5866, Harrisburg, PA 17110
3
4
5

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	General Labor, Employee	$ 8,626
2	Collections (expense disallowed)	$ 260
3		$
4		$
5		$
	Charge for Services Provided	$ 8,885

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

⦿ Yes ○ No Page 15 Line 1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center,LLC	2392	7/13/2017	8	37

					Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	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						
2. Number of Residents												
A. As of midnight of PREVIOUS report period	95	95			95	95			25	25		
B. As of midnight of THIS report period					25	25						
3. Total Number of Days Care Provided During Period												
A. Medicare	232	232			232	232						
B. Medicaid (Conn.)	7,953	7,953			7,757	7,757			196	196		
C. Medicaid (other states)												
D. Private Pay	274	274			265	265			9	9		
E. State SSI for RCH												
F. Other (Specify)	104	104			104	104						
G. Total Care Days During Period (3A thru F)	8,563	8,563			8,358	8,358			205	205		
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)**	8,563	8,563			8,358	8,358			205	205		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation C	2392	7/13/2017	9	37

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

Date of Change	Place of Change CCNH (1)	Place of Change RHNS (2)	Place of Change (Specify) (3)	Lost (1)	Lost (2)	Lost (3)	Gained (1)	Gained (2)	Gained (3)	Capacity After Change CCNH	Capacity After Change RHNS	Capacity After Change (Specify)	Reason for Change
7/13/2017	X			145									

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

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

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

Item	Medicare CCNH	Medicaid CCNH	Medicaid RHNS	Self-Pay CCNH	Self-Pay RHNS	Self-Pay (Specify)	Other State Assisted R.C.H.	Other State Assisted ICF-MR
No. of Residents								
Per Diem Rate								
a. One bed rm.		236.21		381.00				
b. Two bed rms.		236.21		381.00				
c. Three or more bed rms.								

Item	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	556	556		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	1,302	1,302		
C. Other	5,087	5,087		
D. ***Total Physical Therapy Treatments***	6,945	6,945		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	1,074	1,074		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	794	794		
C. Other	1,092	1,092		
D. ***Total Speech Therapy Treatments***	2,960	2,960		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,693	1,693		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	1,369	1,369		
C. Other	2,635	2,635		
D. ***Total Occupational Therapy Treatments***	5,697	5,697		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center,LLC	2392	7/13/2017	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)	99,126	1,503				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	234,617	13,801				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	355,829	17,703				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	301,716	14,996				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	32,277	1,333				
b. Other Maintenance Workers	22,098	1,505				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	55,988	3,063				
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	83,662	1,334				
b. RN						
1. Direct Care	635,308	16,115				
2. Administrative**	158,814	4,517				
c. LPN						
1. Direct Care	753,476	24,810				
2. Administrative**						
d. Aides and Attendants	1,392,368	70,286				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	86,594	5,689				
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	71,765	2,375				
n. Marketing						
o. Other (Specify) See Attached Schedule	34,495	1,669				
A-13. Total Salary Expenditures	4,318,133	180,699				

* 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)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Medical Records	$ 34,495	1,669				
Total	$ 34,495	1,669	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Respiratory Therapy	$ 680	12				
Total	$ 680	12	$ -	-	$ -	-

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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
Greensprings Healthcare and Rehabilitation Center,LLC	2392	7/13/2017	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										
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.

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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
Greensprings Healthcare and Rehabilitation Center,LLC	2392	7/13/2017	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* **										
Patricia Worhunsky Quinn	85,214				Administrator	1,266	Page 10 Line	None		
Mary Tobin	13,912				Administrator	237	Page 10 Line	None		
					Administrator					
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
Greensprings Healthcare and Rehabilitation Center,I	2392	7/13/2017	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	17,640	235				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	114,605	1,736				
b. Other						
6. Social Worker						
7. Recreation Worker	8,743	350				
8. Physicians						
a. Medical Director (entire facility)	54,500	181				
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	48,808	740				
b. Other						
10. Occupational Therapist						
a. Resident Care	94,036	1,425				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	41,319	689				
2. Administrative***						
b. LPN						
1. Direct Care	16,758	372				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	680	12				
B-13 Total Fees Paid in Lieu of Salaries	397,089	5,740				

* 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
Greensprings Healthcare and Rehabilitation Center,LLC	2392	7/13/2017	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	○	◉	Not Applicable
HealthPro Therapy Services LLC, 10600 York Rd	Therapy Services	○	◉	Not Applicable
Hartford Hospital	Medical Director	○	◉	Not Applicable
Genter Healthcare Inc, PO Box 478, New London, NH 03257	Inhalation Therapy	○	◉	Not Applicable
Starling Physicians, PC	Medical Director	○	◉	Not Applicable
Ready Nurse	Nurse Agency	○	◉	Not Applicable
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Cent	2392	7/13/2017	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	173,034	173,034		
2. Disability Insurance	$	9,659	9,659		
3. Unemployment Insurance	$	65,823	65,823		
4. Social Security (F.I.C.A.)	$	333,425	333,425		
5. Health Insurance	$	599,196	599,196		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	105,988	105,988		
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$	63,692	63,692		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	32,242	32,242		
d. Accounting and Auditing	$	12,953	12,953		
e. Legal (*Services should be fully described on Page 7)*	$	10,736	10,736		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	15,963	15,963		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	25,781	25,781		
2. Cellular Phones	$	2,031	2,031		
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	$	474,464	474,464		
Subtotal	$	1,924,987	1,924,987		

* 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
7/13/2017

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Union Training Fund	$ 13,611		
Other Employee Benefits	$ 50,081		
Total	$ 63,692	$ -	$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center,Ll	2392	7/13/2017	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,924,987	1,924,987		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	24,183	24,183		
5. Education Expenses Related to Seminars and Conventions	$				
6. Automobile Expense (*not purchase or depreciation*)	$	1,314	1,314		
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	14,485	14,485		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	5,475	5,475		
4. Fund-Raising***	$				
5. Medical Records	$	1,045	1,045		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	1,821	1,821		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	7,073	7,073		
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	839,606	839,606		
C-14 Total Administrative & General Expenditures	$	2,819,989	2,819,989		

* 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)
General Advertising	$ 5,475		
Total Other Advertising	$ 5,475	$ -	$ -

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)
Receivership Professional Staff	$ 684,085		
Admin Payroll Services	$ 46,383		
Administrative Services Global	$ 25,000		
Administrative Services Apex	$ 30,500		
Forms and Printing	$ 768		
Training and education	$ 75		
Employee meals	$ 1,569		
Cost Report Fees	$ 5,578		
IT Fees	$ 20,179		
Background checks	$ 816		
License	$ 491		
Minor Equipment	$ 6,175		
Equipment Rental	$ 4,556		
Software Rental	$ 13,431		
Total Other Administrative and General	$ 839,606	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Greensprings Healthcare and Rehabilitatio	2392	7/13/2017	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Platinum Care Inc.	42,441	Payroll Management Services	
GHC Fiscal Group, LLC	25,000	Administrative Services	
Apex Healthcare Partners LLC	30,500	Management Services	

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Greensprings Healthcare and Rehabilitation Center,LL	2392	7/13/2017	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	171,048	171,048		
2. Non-Food Supplies	$	20,393	20,393		
3. Other (*Specify*)____________________	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$	92,676	92,676		
d. Other (*Specify*)________________________ Dietary equipment repairs and rentals	$	8,160	8,160		
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	292,277	292,277		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	3	3		

Question	Yes	No	
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.
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⦿ No	If yes, specify cost.
O. Is any revenue collected from employees?	○ Yes	⦿ No	If yes, specify 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.

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	7/13/2017	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.	400	400		
	Amt. $	581	581		
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)*	$				
c. Management Services**	$	15,992	15,992		
d. Other (*Specify*) Supplies	$	3,250	3,250		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	19,823	19,823		

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.

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 Cer	2392	7/13/2017	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel		82,000	82,000		
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	27,414	27,414		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
c. Management Services*		$	60,656	60,656		
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	88,070	88,070		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Pharmascript		$	128,693	128,693		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	75,208	75,208		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$	13,431	13,431		
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$	1,090	1,090		
g. Dental (*Not dentists who should be included under salaries or fees)*		$	5,623	5,623		
h. Laboratory***		$	7,974	7,974		
i. Recreation		$	3,755	3,755		
j. Other (Specify)**** See Attached Schedule		$	94,977	94,977		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	330,751	330,751		

* 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)
Social Services Supplies	$ 225		
Pen Supplies	$ 3,539		
Wound Care	$ 284		
Urological Supplies	$ 133		
Patient Transportation	$ 8,578		
Nursing equipment rental	$ 45,230		
Nursing minor equipment	$ 16,920		
Nursing Software Rental	$ 10,077		
Pjysical Therapy Equipment	$ 1,129		
Nursing Forms	$ 1,170		
Nurse education	$ 1,055		
Other	$ 6,637		
Total Other Resident Care	$ 94,977	$ -	$ -

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	7/13/2017	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
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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
Greensprings Healthcare and Rehabilitation C	2392	7/13/2017	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	16,594	16,594		
b. Heat	$	26,522	26,522		
c. Light & Power	$	136,539	136,539		
d. Water	$	24,888	24,888		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	62,039	62,039		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	266,582	266,582		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	708	708		
d. Movable Equipment	$	1,368	1,368		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	2,076	2,076		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	834	834		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	834	834		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	132,613	132,613		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	57,766	57,766		
c. Personal property taxes	$	10,261	10,261		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	203,550	203,550		

* 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	$ 10,729		
Internet	$ 1,846		
Maintenance Exp-Contracted Service	19,359.64		
Maintenance Exp-Sanitation & Incineration	7,010.16		
Maintenance Exp-Extermination	2,397.88		
Maintenance Exp-Landscaping	11,182.00		
Maintenance Exp-Equip-Minor	2,539.46		
Maintenance Exp-Equip-Rental	6,975.35		
Total Other Repairs and Maintenance	$ 62,039	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center,LLC	2392	7/13/2017	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	13,899		13,899	2,342	s/l	various	708	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								708

	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					12,912		12,912	5,164	sl	3yrs	1,368	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												1,368
E. ***Total Depreciation***												2,076

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Schedule of Land Improvements Acquired during this report period

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

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

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Movable Equipment		$ -		$ -	*
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
Greensprings Healthcare and Rehabilitation Center,LLC	2392	7/13/2017	24	37

Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period			68,186	68,186	8,446	68,186		834	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									834
D. ***Total Amortization***									834

* 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
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11. Property Questionnaire

Part A

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

⦿ Yes ○ No

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
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)	3			
e. Amount of Principal Borrowed	1,900,000			
f. Principal balance outstanding as of ___________	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.

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

Name of Facility	License No.	Report for Year Ended	Page of
Greensprings Healthcare and Rehabili	2392	7/13/2017	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*)

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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
Greensprings Healthcare and Rehal	2392	7/13/2017	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	$	39,699	39,699		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)	$	39,699	39,699		
14. Insurance a. Insurance on Property (buildings only)	$	53,429	53,429		
b. Insurance on Automobiles	$				
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*)	$	21,898	21,898		
2. Fire and Extended Coverage	$				
3. Other (*Specify*) Crime and Surety Bond	$	955	955		
14d. ***Total Insurance Expenditures (14a + b + c)***	$	76,282	76,282		
15. ***Total All Expenditures (A-13 thru C-14)***	$	8,852,245	8,852,245		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Greensprings Healthcare and Rehabilitation Center,LLC	2392	7/13/2017	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	$				
4.			Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.			Occupational Therapy	$	69,093	69,093		
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.			Bad Debts	$	32,242	32,242		
10.			Accounting & Legal	$	2,978	2,978		
11.			Telephone	$				
12.			Cellular Telephone	$				
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 *	$				
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$				
21.			Unallowable Management Fees	$				
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$				
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)	$	104,313	104,313		

* 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)
Total Other A&G Adjustments			$ -	$ -	$ -

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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	7/14/2017	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	104,313	104,313		
Page 20 - Resident Care Supplies*								
27.			Prescription Drugs	$	114,888	114,888		
28.			Ambulance/Limousine	$				
29.			X-rays, etc	$	1,090	1,090		
30.			Laboratory	$	7,974	7,974		
31.			Medical Supplies	$				
32.			Oxygen (non emergency)	$				
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	14,685	14,685		
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	$	39,699	39,699		
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	$				
51.			***Total Amount of Decrease (Items 1 - 50)***	$	282,649	282,649		

*** 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.

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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	7/14/2017	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	104,313	104,313		
Page 20 - Resident Care Supplies*								
27.			Prescription Drugs	$	114,888	114,888		
28.			Ambulance/Limousine	$				
29.			X-rays, etc	$	1,090	1,090		
30.			Laboratory	$	7,974	7,974		
31.			Medical Supplies	$				
32.			Oxygen (non emergency)	$				
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	14,685	14,685		
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	$	39,699	39,699		
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	$				
51.			***Total Amount of Decrease (Items 1 - 50)***	$	282,649	282,649		

*** 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

Greensprings Healthcare and Rehabilitation Center,LLC
7/14/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Pen Supplies	$ 3,539		
20	5j	Wound Care	$ 284		
20	5j	Urological Supplies	$ 133		
22	6f		$ 10,729		
Total Other Ancillary Costs			$ 14,685	$ -	$ -

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)
29	39	Working Capital Interest	$ 39,699		
Total Other Property Adjustments			$ 39,699	$ -	$ -

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)
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Greensprings Healthcare and Rehabilitati	2392	7/14/2017	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	10,376,988	10,376,988		
b. Medicaid Room and Board Contractual Allowance **	$	(5,406,195)	(5,406,195)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	967,472	967,472		
b. Medicare Room and Board Contractual Allowance **	$	(176,927)	(176,927)		
4. a. Private-Pay Residents and Other	$	368,320	368,320		
b. Private-Pay Room and Board Contractual Allowance **	$	(156,109)	(156,109)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	41,724	41,724		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(41,724)	(41,724)		
c. Prescription Drugs - Non-Medicare	$	4,925	4,925		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(3,033)	(3,033)		
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	$	83,946	83,946		
b. Physical Therapy - Medicare Contractual Allowance **	$	(60,250)	(60,250)		
c. Physical Therapy - Non-Medicare	$	57,473	57,473		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(42,474)	(42,474)		
4. a. Speech Therapy - Medicare	$	38,050	38,050		
b. Speech Therapy - Medicare Contractual Allowance **	$	(21,361)	(21,361)		
c. Speech Therapy - Non-Medicare	$	55,069	55,069		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(39,814)	(39,814)		
5. a. Occupational Therapy - Medicare	$	90,692	90,692		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(64,091)	(64,091)		
c. Occupational Therapy - Non-Medicare	$	49,537	49,537		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(42,779)	(42,779)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	6,079,439	6,079,439		
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*)	$				
V. Total Other Revenue (1 thru 8)	$				
VI. Total All Revenue (III +V)	$	6,079,439	6,079,439		

* *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 Medicare	$ 3,932		
30	IV Medicare contractual	$ (3,932)		
30	Lab Medicare	$ 852		
30	Lab Medicare contractual	$ (852)		
30	Radiology Medicare	$ 140		
30	Radiology Medicare Contractual	$ (140)		
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)
Total Other Revenue		$ -	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilita	2392	7/14/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$
a.				
b.				
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$
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	68,186		$ 58,906
	Accum. Depreciation	9,280	Net	
5. Non-Movable Equipment	*Historical Cost	13,899		$ 10,849
	Accum. Depreciation	3,050	Net	
6. Movable Equipment	*Historical Cost	12,912		$ 6,380
	Accum. Depreciation	6,532	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 76,135

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

(*Carry Total forward to next page*)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Greensprings Healthcare and Rehabilita	2392	7/14/2017	32 | 37

Account				Amount
			Total Brought Forward:	$ 76,135
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)				$ 76,135

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation C	2392	7/14/2017	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 1,683,294
2. Notes Payable (*itemize*)	$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)	$
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*)	$
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 1,683,294

* 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
Greensprings Healthcare and Rehabilitation	2392	7/14/2017	34 | 37

Account				Amount
			Total Brought Forward:	1,683,294
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*)				$ 7,965,000
Working Capital		5,630,000		
Net Receivership Advances due to CT Medicaid		2,335,000		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 7,965,000
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 9,648,294

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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	7/14/2017	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				$ (6,799,353)
6. Gain or Loss for Period	10/1/2016	thru	7/14/2017	$ (2,772,806)
7. Total Net Worth				$ (9,572,159)
C. ***Total Reserves and Net Worth***				$ (9,572,159)
D. ***Total Liabilities, Reserves, and Net Worth***				$ 76,135

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page of
Greensprings Healthcare and Rehabilitati	2392	7/14/2017	36 | 37

	Account			Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016			$ (5,931,213)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 6,079,439
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 8,852,245
D.	Net Income or Deficit			$ (2,772,806)
E.	Balance			$ (8,704,019)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
	Impact of Pre Receivership adjustments	(868,140)		
F-3.	Total Additions			$ (868,140)
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*** 07/14/17			$ (9,572,159)

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and	2392	7/14/2017	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. My representations below is limited to my engagement for the receivership period alone, which commenced on 2/14/17-7/14/17 when this facility closed. While I had to rely on books and records found on site describing the time period 10/1/16-2/13/17, I cannot attest to the completeness or accuracy of these books and records. I have accepted them in good faith as routine business records but cannot be responsible for any inacuracies.

Signature of Preparer	Title	Date Signed
	Accountant	1/2/2018

Printed Name of Preparer

Frederick J. Dalicandro

Address	Phone Number
74 Bidwell Street Glastonbury CT 06033	8602128558