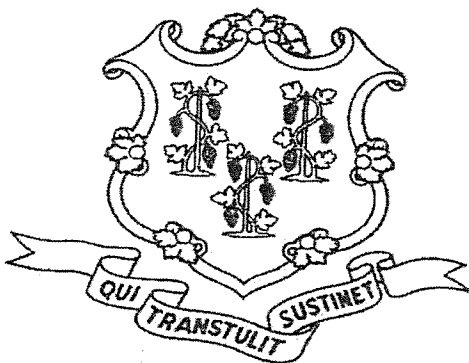


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as licensed) Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	
Address (No. & Street, City, State, Zip Code) 205 Chestnut Hill Road, Stafford Springs, CT 06076	
Type of Facility Chronic and Convalescent Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH) (RHNS)	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

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

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

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General Information

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

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

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

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

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

Signed (Administrator) <i>Christine M. McKinney</i>		Date 2-15-19	Signed (Owner) <i>[Signature]</i>		Date 2/15/19
Printed Name (Administrator) Christine M. McKinney			Printed Name (Owner) Lawrence Santilli		
Subscribed and Sworn to before me:	State of CT	Date 2/15/19	Signed (Notary Public) <i>[Signature]</i>	Comm. Expires 11/1/2020	
Address of Notary Public 484 Farmington Ave Hartford CT 06105					

(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 Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center		Period Covered:	From 10/1/2017	To 9/30/2018
Address of Facility 205 Chestnut Hill Road, Stafford Springs, CT 06076				
Report Prepared By Athena Health Care Associates, Inc		Phone Number (860) 751-3900	Date 2/25/2019	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-684-6341	9/30/2018	2	37

Name of Facility (as shown on license)	Address (No. & Street, City, State, Zip)
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care C	205 Chestnut Hill Road, Stafford Springs, CT 06076

License Numbers:	CCNH 2081C	RHNS (Specify)	Medicare Provider No. 07-5326
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Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)	

Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship	<input checked="" type="radio"/> LLC	<input type="radio"/> Partnership	<input type="radio"/> Profit Corp.
<input type="radio"/> Non-Profit Corp.	<input type="radio"/> Government	<input type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," explain fully.
--	---------------------------	-------------------------------------	--------------------------

Administrator		
Name of Administrator	Nursing Home Administrator's License No.:	
Christine M McKinney		001627

Other Operators/Owners who are assistant administrators (full or part time) of this facility.	
Name	License No.:
Not Applicable	

General Information and Questionnaire Related Parties*

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen Health	License No. 2081C	Report for Year Ended 9/30/2018	Page 4	of 37
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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 %**				
Athena Stafford Springs Landford LLC	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>	Lease of Property	Pg 22 L9	813,906	747,006
Athena Health Care Assoc 401k Plan	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>	Facility participates in common 401k plan			
Athena Health Care System	135 South Rd, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>	see attached			
Misc Facilities	Various Addresses	<input checked="" type="radio"/>	<input type="radio"/>	Interfacility Loans	Pg 33 A2		
Athena Health Insurance	135 South Rd, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>	Health Insurance	Pg 15, 1a5	1,338,532	1,338,532
Procure Pharmacy	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	Pharmacy Services	pg 20 5a2, 5b,	550,632	550,632
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				
		<input type="radio"/>	<input checked="" type="radio"/>				

* Use additional sheets if necessary.

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

Evergreen Health Care
RELATED PARTIES QUESTIONNAIRE
PAGE 4
Report for FYE 9/30/2018

FACILITY NAME	ADDRESS	Also Provided Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included In Annual Report Page # / Line #	Costs Reported	Actual Cost to the Related Party
		Yes	No %**				
Athena Health Care	135 South Rd Farmington, CT 06032	X	<50%	Management Fees, Marketing , Nursing Fill in Postage, Payroll, MIS , Gift Cards, Painters	Pg. 16 Ln 12, Pg 16 M3, Pg 13 Ln11a2 Pg 16 Ln M3, M13, M7, Pg 22 Ln 6a	\$1,258,945	\$628,420

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen	License No. 2081C	Report for Year Ended 9/30/2018	Page 5	of 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 <i>(See listing page 13)</i>			
Maintenance and operation of plant	Square feet			
Property costs (depreciation)	Square feet			
Employee health and welfare	Gross salaries			
Management services	Appropriate cost center involved			
All other General Administrative expenses	Total of Direct and Allocated Costs			
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <input type="radio"/> Yes <input checked="" type="radio"/> No If "No," explain fully why such allocation was not made.				
Not Applicable				
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.)				
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen Health Care		License No. 2081C	Report for Year Ended 9/30/2018	Page 6	of 37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No				
Leal Capital, PO Box 742647 Cincinnati, OH 45274	<input type="radio"/>	<input checked="" type="radio"/>	12/30/15	48 Months	10,809	10,809
Pitney Bowes, PO Box 371887, Pittsburgh, PA 15250	<input type="radio"/>	<input checked="" type="radio"/>	01/04/16	63 Months	804	804
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
	<input type="radio"/>	<input checked="" type="radio"/>				
Is a Mileage Log Book Maintained for All Leased Vehicles ?			<input type="radio"/> Yes	<input checked="" type="radio"/> No	Total ***	
					11,613	

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

General Information and Questionnaire Accounting Basis

Name of Facility Stafford Springs CT SNF LLC d/b/	License No. 2081C	Report for Year Ended 9/30/2018	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual Cash Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1 Audit, Year End Financials, Tax Return and Medicare cost report	\$	27,125
2 Medicare Cost Report	\$	2,700
3	\$	
4	\$	
		Charge for Services Provided
		\$ 29,825

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

- Yes No Pg 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Murtha Cullina 2 Goldman, Gruder & Woods, LLP 3 State Marshall/probate 4 5	Telephone Number 860-240-6000 203-899-8900
--	--

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

- 1 185 Asylum St Hartford, CT 06103
 2 200 Connecticut Ave, Norwalk, CT 06854
 3
 4
 5

Services Provided by This Firm (*describe fully*)

1 Misc. Issues:Disallow (640): Audit Letter (570) Allow	\$	1,210
2 A/R:disallow	\$	18,828
3 conservatorship/probate fees/medicaid apps:disallow	\$	5,567
4	\$	
5	\$	
		Charge for Services Provided
		\$ 25,605

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

- Yes No Pg 15, Line 1e

Schedule of Resident Statistics (Cont'd)

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen		License No. 2081C		Report for Year Ended 9/30/2018			Page 9	of 37					
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
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	5		125		23		20						
Per Diem Rate													
a. One bed rm.	525.99		248.14		474.00		350.44						
b. Two bed rms.	525.99		248.14		464.00		350.44						
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments						TOTAL	CCNH	RHNS	(Specify)				
A. Medicare - Part B						7,306	7,306						
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments						1,528	1,528						
2. Restorative Treatments													
C. Other						23,015	23,015						
D. <i>Total Physical Therapy Treatments</i>						31,849	31,849						
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B						812	812						
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments						187	187						
2. Restorative Treatments													
C. Other						1,637	1,637						
D. <i>Total Speech Therapy Treatments</i>						2,636	2,636						
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B						3,486	3,486						
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments						1,339	1,339						
2. Restorative Treatments													
C. Other						21,720	21,720						
D. <i>Total Occupational Therapy Treatments</i>						26,545	26,545						

Report of Expenditures - Salaries & Wages

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen Health Care	License No. 2081C	Report for Year Ended 9/30/2018	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(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)	141,895	2,106				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	248,275	12,959				
5. Dietary Service						
a. Head Dietitian	61,249	2,167				
b. Food Service Supervisor	54,678	2,282				
c. Dietary Workers	397,774	26,367				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	142,618	11,243				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	85,930	2,201				
b. Other Maintenance Workers	128,526	5,572				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	123,393	8,102				
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	224,049	4,417				
b. RN						
1. Direct Care	1,080,052	29,478				
2. Administrative**	482,614	16,878				
c. LPN						
1. Direct Care	1,623,366	63,378				
2. Administrative**						
d. Aides and Attendants	2,559,253	154,502				
e. Physical Therapists	638,849	17,782				
f. Speech Therapists	90,963	2,291				
g. Occupational Therapists	419,912	12,351				
h. Recreation Workers	287,348	14,365				
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	223,995	8,880				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	9,014,739	397,321				

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

Name of Facility	License No.	Report for Year Ended		Page	of						
		9/30/2018	11			37					
Name	Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center	CCNH	RHNS	(Specify)	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
Section I - Operators/Owners	2081C										
Not Applicable											
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).											
Not Applicable											

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

** Include all employment worked during the cost year.

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		
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Center		2081C		9/30/2018		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***									
Christine M McKinney (10/1/17 - 9/30/18)	141,895		Health & Life Insurance, Payroll Taxes	Day to day operations if the nursing home facility	2,106				
Section IV - Assistant Administrators									

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Stafford Springs CT SNF LLC d/b/a Evergreen Hea	2081C	9/30/2018	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	20,794	96				
3. Pharmacist	17,309	96				
4. Podiatrist	163	2				
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	18,337	596				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	1,482					
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	8,959	144				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	67,044	934				

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

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

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

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

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergreen Health C		License No. 2081C	Report for Year Ended 9/30/2018	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
HealthDrive Dental Group, 888 Worcester St, Wellesley, MA 02482	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
ProCare LTC, 110 Bi-County Blvd. Suite 121, Farmingdale, NY 11735	Pharmacy Consulting/Nursing Consultants	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners:Minority Interest	
Bay State Family Podiatry, 74 Palomba Drive, Enfield, CT 06082	Podiatrist	<input type="radio"/>	<input checked="" type="radio"/>		
Athena Health Care 135 South Rd Farmington, CT 06032	MDS Fill-In	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners	
Dushyant Parikh, 146 Hazard Ave, Enfield CT 06082	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
HealthDrive Audiology, 888 Worcester St, Wellesley, MA 02482	Audiology services	<input type="radio"/>	<input checked="" type="radio"/>		
HealthDrive Eye Care Group, 888 Worcester St, Wellesley, MA 02482	Eye Care Services	<input type="radio"/>	<input checked="" type="radio"/>		
HHC Physicians Care Inc, PO Box 417695, Boston, MA 02241-7695	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
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		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		

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

C. Expenditures Other Than Salaries - Administrative and General

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

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health	2081C	9/30/2018		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	3,738,900	3,738,900			
I. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 5,539	5,539			
3. Gifts to Staff and Residents	\$ 8,750	8,750			
4. Employee Travel	\$ 1,416	1,416			
5. Education Expenses Related to Seminars and Conventions	\$ 809	809			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 3,010	3,010			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 27,747	27,747			
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 24,204	24,204			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 13,079	13,079			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$ 4,200	4,200			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$				
12. Administrative Management Services**	\$ 607,118	607,118			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 104,507	104,507			
C-14 Total Administrative & General Expenditures	\$ 4,539,279	4,539,279			

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 27,747		
Total Other Advertising	\$ 27,747	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF Dues	\$ 13,079		
Total Dues	\$ 13,079	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Miscellaneous	\$ 4,200		
Total Contributions	\$ 4,200	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Licenses	\$ 900		
Bank Charges	\$ 14,188		
Payroll Processing Fees	\$ 17,493		
Employee Physicals/Background Checks	\$ 16,667		
Data Processing/ Software Maint. Fees	\$ 46,340		
Clear energy Audit	\$ 4,694		
Citation 2017-01-LTC-246	\$ 4,225		
Total Other Administrative and General	\$ 104,507	\$ -	\$ -

Schedule C-1 - Management Services*

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health		2081C	9/30/2018		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 455,489	455,489			
2.	Non-Food Supplies	\$ 34,200	34,200			
3.	Other (Specify) _____ Dishes=\$2,182	\$ 2,182	2,182			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Other (Specify) _____ Management Services		\$ 137,790	137,790			
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 629,661	629,661			
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)	
G.	Resident Meals: Total no. of meals served per day:*	506	506			
H.	Is cost of employee meals included in 2E?	<input checked="" type="radio"/> Yes	<input type="radio"/> No			
I.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input checked="" type="radio"/> Yes	<input type="radio"/> No	If yes, specify cost.		\$1,156
L.	Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
O.	Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

**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
Stafford Springs CT SNF LLC d/b/a Evergreen Health C		2081C	9/30/2018	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. \$	162,044	162,044	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Other (Specify) Supplies=\$5,032		\$	5,032	5,032	
3D. Total Laundry Expenditures (3a + b + c)		\$	167,076	167,076	
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			

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

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

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

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

* 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.

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

Name of Facility	License No.	Report for Year Ended			Page	of
Stafford Springs CT SNF LLC d/b/a Evergree	2081C	9/30/2018			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 157,154	157,154				
b. Heat	\$ 152,159	152,159				
c. Light & Power	\$ 191,778	191,778				
d. Water	\$ 339,441	339,441				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 11,613	11,613				
f. Other (<i>itemize</i>)	\$ 171,482	171,482				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 1,023,627	1,023,627				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 152,041	152,041				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 152,041	152,041				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 62,981	62,981				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 62,981	62,981				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 813,906	813,906				
10. Property Taxes						
a. Real estate taxes paid by owner	\$ 196,588	196,588				
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$ 13,618	13,618				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,239,134	1,239,134				

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

Amortization Schedule*

Name of Facility	License No.	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	Page	of
		Month	Year								
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care C	2081C									24	37
A. Organization Expense											
1.											
2.											
3.											
A-4. Subtotal											
B. Mortgage Expense											
1. Finance Fees		12	15	10 years	51,000	8,925					
2.											
3.											
B-4. Subtotal											
C. Leasehold Improvements and Other											
1. Acquired prior to this report period		9	2017	Various	345,051	37,600			34,415		
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)		9	2018	Various	800,257						
C-4. Subtotal									28,566		
D. Total Amortization											
											62,981
											62,981

* Straight-line method must be used.
 ** Specify which of the following bases were used:
 A. Minimum of 5 years or 60 months.
 B. Life of mortgage; OR
 C. Remaining Life of Lease; OR
 D. Actual Life if owned by Related Party.

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Oct-17	Burnisher	\$ 1,149	15	\$ 38
Oct-17	Mitel phone	\$ 1,041	5	\$ 104
Nov-17	Medical equipment	\$ 1,514	10	\$ 76
Nov-17	Nursing station kiosk	\$ 7,231	15	\$ 241
Nov-17	patient furniture	\$ 70,361	15	\$ 2,345
Nov-17	piano/accessories	\$ 17,133	10	\$ 857
Nov-17	patient furniture	\$ 14,026	15	\$ 468
Nov-17	fish tank	\$ 5,562	20	\$ 139
Nov-17	patient furniture	\$ 17,783	15	\$ 593
Nov-17	artwork	\$ 10,304	5	\$ 1,030
Nov-17	supplies	\$ 24,444	5	\$ 2,444
Nov-17	patient furniture	\$ 1,581	15	\$ 53
Nov-17	Medical equipment	\$ 73,829	10	\$ 3,691
Nov-17	patient furniture	\$ 25,467	15	\$ 849
Nov-17	Medical equipment	\$ 9,537	10	\$ 477
Nov-17	patient furniture	\$ 3,303	15	\$ 110
Nov-17	patient furniture	\$ 8,883	15	\$ 296
Nov-17	recreation supplies	\$ 1,027	5	\$ 103
Nov-17	patient furniture	\$ 6,915	15	\$ 231
Nov-17	food warmers	\$ 3,134	10	\$ 157
May-18	Devixe Measurement Bedsystem	\$ 1,224	5	\$ 122
May-18	diathermy	\$ 4,088	10	\$ 204
May-18	resident room TV's	\$ 4,885	5	\$ 489
Jun-18	resident room TV's	\$ 4,224	5	\$ 422
Jun-18	resident room TV's	\$ 1,965	5	\$ 197
Aug-18	bed rails	\$ 1,608	5	\$ 161
Aug-18	resident room TV's	\$ 10,154	5	\$ 1,015
Aug-18	resident room TV's	\$ 2,702	5	\$ 270
Aug-18	resident room TV's	\$ 19,542	5	\$ 1,954
Sep-18	resident room TV's	\$ 1,975	15	\$ 66
Sep-18	ultracare bed	\$ 72,403	10	\$ 3,620
Sep-18	hoyer lift	\$ 12,859	5	\$ 1,286
Sep-18	resident room TV's			
various	see attached		various	
Total additions for Movable Equipment		\$ 441,853		\$ 24,108 *
Deletions:				
Various				
Total deletions for Movable Equipment		\$		\$ **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

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

Name of Facility Stafford Springs CT SNF LLC d/b/a E	License No. 2081C	Report for Year Ended 9/30/2018	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description		Total		
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase		12/29/15		
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		180		
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)		Conventional		
b. Date Mortgage Obtained		12/29/15		
c. Interest Rate for the Cost Year		6.18%		
d. Term of Mortgage (number of years)		4		
e. Amount of Principal Borrowed		15,750,000		
f. Principal balance outstanding as of 9/30/2018		15,750,000		
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, 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.

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

Name of Facility		License No.	Report for Year Ended		Page	of
Stafford Springs CT SNF LLC d/b/a		2081C	9/30/2018		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)

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

Name of Facility		License No.		Report for Year Ended		Page of	
Stafford Springs CT SNF LLC d/b/		2081C		9/30/2018		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)				\$	2,488	2,488	
Vender Interest = \$2,488							
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	2,488	2,488	
14. Insurance							
a. Insurance on Property (buildings only)				\$	100,536	100,536	
b. Insurance on Automobiles				\$	154	154	
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$	100,690	100,690	
15. Total All Expenditures (A-13 thru C-14)				\$	18,036,386	18,036,386	

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care Ce				2081C	9/30/2018	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.	10	A12g	Occupational Therapy	\$ 419,912	419,912		
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **	\$ 1,482	1,482		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.	15	1a9	Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 102,430	102,430		
10.	15	1d&e	Accounting	\$			
10a.			Legal	\$ 25,035	25,035		
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 393	393		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	1 3	Gifts, flowers and coffee shops	\$ 8,750	8,750		
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.	16	m2&3	Unallowable Advertising *	\$ 27,747	27,747		
19.	15	1j&k	Income Tax / Corporate Business Tax	\$ (250)	(250)		
20.	16	m4&	Fund Raising / Contributions	\$ 4,200	4,200		
21.	16	m12	Unallowable Management Fees	\$ 416,146	416,146		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 18,413	18,413		
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents	\$ 1,156	1,156		
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)				\$ 1,025,414	1,025,414		

* All except "Help Wanted"

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Charges	\$ 14,188	\$ -	\$ -
			\$ -	\$ -	\$ -
16	M13	Fine: Citation No. 2017-01-LTC 246	\$ 4,225	\$ -	\$ -
			\$ -	\$ -	\$ -
			\$ -	\$ -	\$ -
			\$ -	\$ -	\$ -
Total Other A&G Adjustments			\$ 18,413	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Stafford Springs CT SNF LLC d/b/a Evergreen Health Care			2081C	9/30/2018	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,025,414	1,025,414		
Page 20 - Resident Care Supplies***							
27.	20	5a1&	Prescription Drugs	\$ 467,114	467,114		
28.	20	5d	Ambulance/Limousine	\$ 4,375	4,375		
29.	20	5f	X-rays, etc	\$ 29,396	29,396		
30.	20	5h	Laboratory	\$ 39,804	39,804		
31.	20	5c	Medical Supplies	\$ 24,200	24,200		
32.	20	5e2	Oxygen (non emergency)	\$ 45,650	45,650		
33.	20	5j	Occupational Therapy	\$ 2,660	2,660		
34.			Other - See Attached Schedule	\$ 88,687	88,687		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 106,261	106,261		
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$ 32	32		
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$ 113,494	113,494		
46.			Management Fees Indirect	\$ 100,884	100,884		
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 2,047,971	2,047,971		

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5L	Medical Equipment Rental - Other	\$ 40,765		
20	5b	Ebox	\$ 22,195		
20	5L	Radio & Television	\$ 25,727		
Total Other Ancillary Costs			\$ 88,687	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Movable Equipment Carryforward AJE	\$ 106,261		
Total Excess Movable Equipment Depreciation			\$ 106,261	\$ -	\$ -

Schedule of Other Property Adjustments

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

F. Statement of Revenue

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

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

** Facility should report all contractual allowances and/or payer discounts.

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Ev	2081C	9/30/2018	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	385,854
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,754,799
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	26,168
5. Prepaid Expenses			\$	379,691
a. Prepaid Insurance	378,228			
b. Health Insurance (Wellness)	1,463			
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	3,257,966
Working Capital Reserve	3,257,966			

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	5,804,478
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 <u>1,145,308</u>		\$	1,044,727
	Accum. Depreciation <u>100,581</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>770,397</u>		\$	432,901
	Accum. Depreciation <u>337,496</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	710,698

See Schedule	710,698			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	2,188,326

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

(Carry Total forward to next page)

Evergreen Moveable Equipment Carryforward Schedule

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Ev	2081C	9/30/2018	32	37
Account			Amount	
Total Brought Forward:			\$	7,992,804
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)				
\$ 262,123				
5. Investments Related to Resident Care (<i>itemize</i>)				
\$				
6. Loans to Owners or Related Parties (<i>itemize</i>)				
\$				
Name and Address		Amount	Loan Date	
7. Other Assets (<i>itemize</i>)				
\$ 2,057,845				
See Schedule			2,057,845	
D-8. Total Investments and Other Assets (Lines D1 thru 7)				
\$ 2,319,968				
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)				
\$ 10,312,772				

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Evergree		2081C	9/30/2018	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	2,877,249
2. Notes Payable (<i>itemize</i>)				\$	(4,637,000)
Due From related party					(4,637,000)

See Schedule					
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	209,290
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	13,256
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	446,375
Acc'd Operating Expenses		162,961			
Acc'd Expense - Sales Tax		1			
Provider Taxes Due		281,857			
Accd Health insurance		1,556	Sec Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	(1,090,830)

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

(Carry Total forward to next page)

EVERGREEN
ACCRUED EXPENSES-OPERATIONS
September 30, 2018

ACCT. # 2170

<u>2017</u>	
Health Insurance	(63,073.60)
Insurance Doouble booked Invoice	9,208.98
IBNR-Insurance	<u>(18,216.40)</u>
Beginning Balance	(72,081.02)

<u>2018</u>	
Accounting	-\$22,500.00
Management Fee	-\$68,380.46

Balance 9/30/17	<u><u>(\$162,961.48)</u></u>
-----------------	------------------------------

G. Balance Sheet (cont'd)

Name of Facility Stafford Springs CT SNF LLC d/b/a Evergr		License No. 2081C	Report for Year Ended 9/30/2018	Page 34	of 37
Account				Amount	
Total Brought Forward:				(1,090,830)	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
Name of Lender		Purpose	Amount	Date Due	\$
2. Mortgages Payable					
\$					
3. Loans from Owners or Related Parties (<i>itemize</i>)					
\$					
Name and Address of Lender		Amount	Loan Date		
Working Capital Reserve					
4. Other Long-Term Liabilities (<i>itemize</i>)					
Notes Payable Related Landlord			8,524,242	\$ 8,524,242	
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 8,524,242	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 7,433,412	

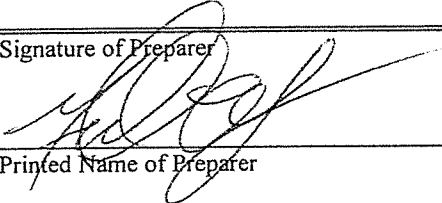
G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a E	2081C	9/30/2018	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 (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	573,318
6. Gain or Loss for Period			\$	2,306,042
	10/1/2017	thru	9/30/2018	
7. Total Net Worth			\$	2,879,360
C. Total Reserves and Net Worth			\$	2,879,360
D. Total Liabilities, Reserves, and Net Worth			\$	10,312,772

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Stafford Springs CT SNF LLC d/b/a Eve	2081C	9/30/2018	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2017			\$	2,005,739
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	20,342,388
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	18,036,346
D. Net Income or Deficit			\$	2,306,042
E. Balance			\$	4,311,781
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2017 AJE - expense adjustments			1,474	
2017 AJE - Health Insurance			59,081	
2017 AJE - loss on extinguished debt			(95,575)	
Inter Company Loan Adjustment			(1,550,000)	
2. Other (<i>itemize</i>)				
preferred equity payments			152,599	
F-3. Total Additions			\$	(1,432,421)
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <i>Balance at End of Period</i>		09/30/18	\$	2,879,360

I. Preparer's/Reviewer's Certification

Name of Facility Stafford Springs CT SNF LLC d/b/a	License No. 2081C	Report for Year Ended 9/30/2018	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>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.</p>				
Signature of Preparer 	Title CFO	Date Signed 2/15/19		
Printed Name of Preparer Athena Health Care Associates, Inc				
Address 135 South Road Farmington, CT 06032		Phone Number (860) 751-3900		