Form **8879-S**

Department of the Treasury
Internal Revenue Service

IRS *e-file* Signature Authorization for Form 1120S

▶ Don't send to the IRS. Keep for your records.

▶ Information about Form 8879-S and its instructions is at *www.irs.gov/form8879s.*

For calendar year 2016, or tax year beginning , 2016, and ending , 20

OMB No. 1545-0123

2016

Name of corporation	Employer identification number
MINERVA HOME HEALTH CARE, INC.	27-4551015

Part I Tax Return Information (Whole dollars only)

1	Gross receipts or sales less returns and allowances (Form 1120S, line 1c)	1	860,432
2	Gross profit (Form 1120S, line 3)	2	860,432
3	Ordinary business income (loss) (Form 1120S, line 21)	3	38,436
4	Net rental real estate income (loss) (Form 1120S, Schedule K, line 2)	4	0
5	Income (loss) reconciliation (Form 1120S, Schedule K, line 18)	5	31,486

Part II Declaration and Signature Authorization of Officer (Be sure to get a copy of the corporation's return)

Under penalties of perjury, I declare that I am an officer of the above corporation and that I have examined a copy of the corporation's 2016 electronic income tax return and accompanying schedules and statements and to the best of my knowledge and belief, it is true, correct, and complete. I further declare that the amounts in Part I above are the amounts shown on the copy of the corporation's electronic income tax return. I consent to allow my electronic return originator (ERO), transmitter, or intermediate service provider to send the corporation's return to the IRS and to receive from the IRS **(a)** an acknowledgement of receipt or reason for rejection of the transmission, **(b)** the reason for any delay in processing the return or refund, and **(c)** the date of any refund. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the corporation's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at **1-888-353-4537** no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment. I have selected a personal identification number (PIN) as my signature for the corporation's electronic income tax return and, if applicable, the corporation's consent to electronic funds withdrawal.

Officer's PIN: check one box only

[X] I authorize MBANEFO & ASSOCIATES (ERO firm name) to enter my PIN 11009 (don't enter all zeros) as my signature on the corporation's 2016 electronically filed income tax return.

[ ] As an officer of the corporation, I will enter my PIN as my signature on the corporation's 2016 electronically filed income tax return.

Officer's signature ▶ _____ Date ▶ _____ Title ▶ PRESIDENT

Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit EFIN followed by your five-digit self-selected PIN. 26189819268 (don't enter all zeros)

I certify that the above numeric entry is my PIN, which is my signature on the 2016 electronically filed income tax return for the corporation indicated above. I confirm that I am submitting this return in accordance with the requirements of **Pub. 3112,** IRS *e-file* Application and Participation, and **Pub. 4163,** Modernized e-File (MeF) Information for Authorized IRS *e-file* Providers for Business Returns.

ERO's signature ▶ USO MBANEFO Date ▶ 4/12/2017

ERO Must Retain This Form — See Instructions
Don't Submit This Form to the IRS Unless Requested To Do So

For Paperwork Reduction Act Notice, see instructions. Form **8879-S** (2016)

HTA

MARYLAND FORM
EL101B

DO NOT MAIL
INCOME TAX DECLARATION FOR BUSINESSES ELECTRONIC FILING

16101B083

2016

OR FISCAL YEAR BEGINNING _____ 2016, ENDING _____

MINERVA HOME HEALTH CARE INC
Name of corporation or pass-through entity

274551015
Federal Employer Identification Number

2301 DORSEY ROAD SUITE 111 | GLEN BURNIE | MD | 21061 | +4
Street Address | City or town | State | ZIP code

PART I Tax Return Information (whole dollars only)

1. Amount of overpayment to be applied to 2017 estimated tax (Corporations only.) ..... 1. .00
2. Amount of overpayment to be refunded (Corporations only.) ..... REFUND 2. 75.00
3. Total amount due ..... 3. .00

PART II Declaration and Signature Authorization

Check appropriate box to consent to: [X] Direct Deposit of refund or [ ] Electronic Funds Withdrawal (direct debit)

4a. Type of account:
[X] Checking [ ] Savings

4b. Routing Number (9-digits): 055003201 4c. Account number: 2000059117463

4d. Direct debit settlement date (Enter the date (MMDDYY) you want the payment withdrawn from the account.) ..... 4d. _____

4e. Direct debit amount ..... 4e. _____ . __

[X] I consent that the corporation's refund be directly deposited as designated above and declare that the information shown is correct. By consenting, I also agree to disclose to the Maryland State Treasurer's Office certain income tax information including name, amount of refund and the above bank information. This disclosure is necessary to effect direct deposit.

[ ] I authorize the State of Maryland and its designated financial agent to initiate an electronic funds withdrawal payment entry to the financial institution account indicated for payment of the Maryland taxes owed by the corporation or pass-through entity and the financial institution to debit the entry to this account. Upon confirmation of consent during the filing of the corporation or pass-through entity state return, this authorization is to remain in full force and effect, and I may not terminate the authorization. I also authorize the financial institutions involved in the processing of this electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment.

[ ] I do not want direct deposit of the refund or an electronic funds withdrawal (direct debit) of the balance due.

Under penalties of perjury, I declare that I am an officer, general partner or managing member of the above corporation or of the pass-through entity. I have compared the information contained on my electronic return with the information that I provided to my electronic return originator or entered on-line and that the name(s), address and amounts described above agree with the amounts shown on the corresponding lines of my 2016 Maryland electronic income tax return. To the best of my knowledge and belief, the return is true, correct and complete. I consent that the return, including accompanying schedules and statements, be sent to the Maryland Revenue Administration Division by my electronic return originator or by the electronic return software provider.

Sign Here _____ PRESIDENT
Corporate officer, general partner or managing member's signature | Title | Date

Wait ten (10) days *after* the receipt of a valid acknowledgement before calling 1-800-638-2937 or from Central Maryland 410-260-7980, about the refund.

PART III Declaration of Electronic Return Originator (paid preparer)

I declare that I have reviewed the return of the corporation or pass-through entity and that the entries on this form are complete and correct to the best of my knowledge. I have obtained the signature of the corporate officer, general partner or managing member, before submitting the return to the Maryland Revenue Administration Division, have provided that official with a copy of all forms and information to be filed with the Maryland Revenue Administration Division, and have followed all other requirements described in the Maryland Business E-File Handbook. This declaration is to be retained at the site of the electronic return originator.

Electronic Return Originator Use Only

_____ 041217
Originator's Signature | Date

261898
EFIN

MBANEFO & ASSOCIATES
Firm's name (or yours if self-employed)

94 NORTH MAIN ST SUITE 10977
Address | ZIP code

8452621468
Telephone Number

Form **1120S**

Department of the Treasury
Internal Revenue Service

U.S. Income Tax Return for an S Corporation

▶ Do not file this form unless the corporation has filed or is attaching Form 2553 to elect to be an S corporation.

▶ Information about Form 1120S and its separate instructions is at *www.irs.gov/form1120s.*

OMB No. 1545-0123

2016

For calendar year 2016 or tax year beginning , ending

A S election effective date: 1/1/2015	Name: MINERVA HOME HEALTH CARE, INC.	D Employer identification number: 27-4551015
B Business activity code number (see instructions): 621610	TYPE OR PRINT — Number, street, and room or suite no. If a P.O. box, see instructions.: 2301 DORSEY ROAD SUITE 111	E Date incorporated: 1/14/2011
C Check if Sch. M-3 attached ☐	City or town: GLEN BURNIE; State: MD; ZIP code: 21061	F Total assets (see instructions): $ 60,017
	Foreign country name; Foreign province/state/county; Foreign postal code	

G Is the corporation electing to be an S corporation beginning with this tax year? ☐ Yes ☐ No If "Yes," attach Form 2553 if not already filed

H Check if: (1) ☐ Final return (2) ☐ Name change (3) ☐ Address change (4) ☐ Amended return (5) ☐ S election termination or revocation

I Enter the number of shareholders who were shareholders during any part of the tax year . . . . . ▶ 1

Caution: Include **only** trade or business income and expenses on lines 1a through 21. See the instructions for more information.

Income	1a	Gross receipts or sales	1a	860,432	
	b	Returns and allowances	1b		
	c	Balance. Subtract line 1b from line 1a			1c 860,432
	2	Cost of goods sold (attach Form 1125-A)			2
	3	Gross profit. Subtract line 2 from line 1c			3 860,432
	4	Net gain (loss) from Form 4797, line 17 (attach Form 4797)			4
	5	Other income (loss) (see instructions—attach statement)			5 99
	6	**Total income (loss).** Add lines 3 through 5			6 860,531
Deductions (see instructions for limitations)	7	Compensation of officers (see instructions — attach Form 1125-E)			7 73,972
	8	Salaries and wages (less employment credits)			8 379,302
	9	Repairs and maintenance			9 660
	10	Bad debts			10
	11	Rents			11 22,534
	12	Taxes and licenses			12 47,354
	13	Interest			13 4
	14	Depreciation not claimed on Form 1125-A or elsewhere on return (attach Form 4562)			14 1,706
	15	Depletion (**Do not deduct oil and gas depletion.**)			15
	16	Advertising			16 5,410
	17	Pension, profit-sharing, etc., plans			17
	18	Employee benefit programs			18
	19	Other deductions (attach statement)			19 291,153
	20	**Total deductions.** Add lines 7 through 19			20 822,095
	21	**Ordinary business income (loss).** Subtract line 20 from line 6			21 38,436
Tax and Payments	22a	Excess net passive income or LIFO recapture tax (see instructions)	22a		
	b	Tax from Schedule D (Form 1120S)	22b		
	c	Add lines 22a and 22b (see instructions for additional taxes)			22c 0
	23a	2016 estimated tax payments and 2015 overpayment credited to 2016	23a		
	b	Tax deposited with Form 7004	23b		
	c	Credit for federal tax paid on fuels (attach Form 4136)	23c		
	d	Add lines 23a through 23c			23d 0
	24	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ ☐			24
	25	**Amount owed.** If line 23d is smaller than the total of lines 22c and 24, enter amount owed			25 0
	26	**Overpayment.** If line 23d is larger than the total of lines 22c and 24, enter amount overpaid			26 0
	27	Enter amount from line 26 **Credited to 2017 estimated tax** ▶	**Refunded** ▶		27 0

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

▶ Signature of officer | Date | ▶ PRESIDENT Title

May the IRS discuss this return with the preparer shown below (see instructions)? ☒ Yes ☐ No

Paid Preparer Use Only

Print/Type preparer's name: USO MBANEFO	Preparer's signature: USO MBANEFO	Date: 4/12/2017	Check ☐ if self-employed	PTIN: P00700597
Firm's name ▶ MBANEFO & ASSOCIATES			Firm's EIN ▶	45-4806921
Firm's address ▶ 94 NORTH MAIN ST. SUITE 6			Phone no.	(845) 262-1468
City: SPRING VALLEY	State: NY		ZIP code:	10977

For Paperwork Reduction Act Notice, see separate instructions. Form **1120S** (2016)

HTA

Schedule B Other Information (see instructions)

		Yes	No
1	Check accounting method: a [X] Cash b [ ] Accrual c [ ] Other (specify) ▶		
2	See the instructions and enter the: a Business activity ▶ HEALTH CARE & SOCIAL ASSI b Product or service ▶ HOME HEALTH CARE SERVICES		
3	At any time during the tax year, was any shareholder of the corporation a disregarded entity, a trust, an estate, or a nominee or similar person? If "Yes," attach Schedule B-1, Information on Certain Shareholders of an S Corporation		X
4	At the end of the tax year, did the corporation:		
a	Own directly 20% or more, or own, directly or indirectly, 50% or more of the total stock issued and outstanding of any foreign or domestic corporation? For rules of constructive ownership, see instructions. If "Yes," complete (i) through (v) below		X

(i) Name of Corporation	(ii) Employer Identification Number (if any)	(iii) Country of Incorporation	(iv) Percentage of Stock Owned	(v) If Percentage in (iv) is 100%, Enter the Date (if any) a Qualified Subchapter S Subsidiary Election Was Made

b	Own directly an interest of 20% or more, or own, directly or indirectly, an interest of 50% or more in the profit, loss, or capital in any foreign or domestic partnership (including an entity treated as a partnership) or in the beneficial interest of a trust? For rules of constructive ownership, see instructions. If "Yes," complete (i) through (v) below		X
5 a	At the end of the tax year, did the corporation have any outstanding shares of restricted stock? If "Yes," complete lines (i) and (ii) below. (i) Total shares of restricted stock ▶ (ii) Total shares of non-restricted stock ▶		X
b	At the end of the tax year, did the corporation have any outstanding stock options, warrants, or similar instruments? If "Yes," complete lines (i) and (ii) below. (i) Total shares of stock outstanding at the end of the tax year ▶ (ii) Total shares of stock outstanding if all instruments were executed ▶		X
6	Has this corporation filed, or is it required to file, **Form 8918,** Material Advisor Disclosure Statement, to provide information on any reportable transaction?		X
7	Check this box if the corporation issued publicly offered debt instruments with original issue discount ▶ [ ] If checked, the corporation may have to file **Form 8281,** Information Return for Publicly Offered Original Issue Discount Instruments.		
8	If the corporation: **(a)** was a C corporation before it elected to be an S corporation **or** the corporation acquired an asset with a basis determined by reference to the basis of the asset (or the basis of any other property) in the hands of a C corporation **and (b)** has net unrealized built-in gain in excess of the net recognized built-in gain from prior years, enter the net unrealized built-in gain reduced by net recognized built-in gain from prior years (see instructions) ▶ $		
9	Enter the accumulated earnings and profits of the corporation at the end of the tax year. $		
10	Does the corporation satisfy **both** of the following conditions?		
a	The corporation's total receipts (see instructions) for the tax year were less than $250,000		X
b	The corporation's total assets at the end of the tax year were less than $250,000 If "Yes," the corporation is not required to complete Schedules L and M-1.		X
11	During the tax year, did the corporation have any non-shareholder debt that was canceled, was forgiven, or had the terms modified so as to reduce the principal amount of the debt? If "Yes," enter the amount of principal reduction $		X
12	During the tax year, was a qualified subchapter S subsidiary election terminated or revoked? If "Yes," see instructions		X
13 a	Did the corporation make any payments in 2016 that would require it to file Form(s) 1099?	X	
b	If "Yes," did the corporation file or will it file required Forms 1099?	X	

Schedule K	Shareholders' Pro Rata Share Items		Total amount
Income (Loss)	1 Ordinary business income (loss) (page 1, line 21)	1	38,436
	2 Net rental real estate income (loss) (attach Form 8825)	2	
	3a Other gross rental income (loss) 3a		
	b Expenses from other rental activities (attach statement) 3b		
	c Other net rental income (loss). Subtract line 3b from line 3a	3c	0
	4 Interest income	4	
	5 Dividends: a Ordinary dividends	5a	
	b Qualified dividends 5b		
	6 Royalties	6	
	7 Net short-term capital gain (loss) (attach Schedule D (Form 1120S))	7	
	8a Net long-term capital gain (loss) (attach Schedule D (Form 1120S))	8a	
	b Collectibles (28%) gain (loss) 8b		
	c Unrecaptured section 1250 gain (attach statement) 8c		
	9 Net section 1231 gain (loss) (attach Form 4797)	9	
	10 Other income (loss) (see instructions) Type ▶	10	
Deductions	11 Section 179 deduction (attach Form 4562)	11	
	12a Charitable contributions	12a	6,950
	b Investment interest expense	12b	
	c Section 59(e)(2) expenditures (1) Type ▶ (2) Amount ▶	12c(2)	
	d Other deductions (see instructions) Type ▶	12d	
Credits	13a Low-income housing credit (section 42(j)(5))	13a	
	b Low-income housing credit (other)	13b	
	c Qualified rehabilitation expenditures (rental real estate) (attach Form 3468, if applicable)	13c	
	d Other rental real estate credits (see instructions) Type ▶	13d	
	e Other rental credits (see instructions) Type ▶	13e	
	f Biofuel producer credit (attach Form 6478)	13f	
	g Other credits (see instructions) Type ▶	13g	
Foreign Transactions	14a Name of country or U.S. possession ▶		
	b Gross income from all sources	14b	
	c Gross income sourced at shareholder level	14c	
	Foreign gross income sourced at corporate level		
	d Passive category	14d	
	e General category	14e	
	f Other (attach statement)	14f	
	Deductions allocated and apportioned at shareholder level		
	g Interest expense	14g	
	h Other	14h	
	Deductions allocated and apportioned at corporate level to foreign source income		
	i Passive category	14i	
	j General category	14j	
	k Other (attach statement)	14k	
	Other information		
	l Total foreign taxes (check one): ▶ ☐ Paid ☐ Accrued	14l	
	m Reduction in taxes available for credit (attach statement)	14m	
	n Other foreign tax information (attach statement)		
Alternative Minimum Tax (AMT) Items	15a Post-1986 depreciation adjustment	15a	-729
	b Adjusted gain or loss	15b	
	c Depletion (other than oil and gas)	15c	
	d Oil, gas, and geothermal properties—gross income	15d	
	e Oil, gas, and geothermal properties—deductions	15e	
	f Other AMT items (attach statement)	15f	
Items Affecting Shareholder Basis	16a Tax-exempt interest income	16a	
	b Other tax-exempt income	16b	
	c Nondeductible expenses	16c	4,262
	d Distributions (attach statement if required) (see instructions)	16d	35,599
	e Repayment of loans from shareholders	16e	

Schedule K	Shareholders' Pro Rata Share Items (continued)		Total amount
Other Information	17a Investment income	17a	
	b Investment expenses	17b	
	c Dividend distributions paid from accumulated earnings and profits	17c	
	d Other items and amounts (attach statement)		
Recon-ciliation	18 **Income/loss reconciliation.** Combine the amounts on lines 1 through 10 in the far right column. From the result, subtract the sum of the amounts on lines 11 through 12d and 14l	18	31,486

Schedule L	Balance Sheets per Books	Beginning of tax year		End of tax year	
	Assets	(a)	(b)	(c)	(d)
1	Cash		34,033		37,234
2a	Trade notes and accounts receivable				
b	Less allowance for bad debts		0		0
3	Inventories				
4	U.S. government obligations				
5	Tax-exempt securities (see instructions)				
6	Other current assets (attach statement)				19,000
7	Loans to shareholders				
8	Mortgage and real estate loans				
9	Other investments (attach statement)				
10a	Buildings and other depreciable assets	23,349		23,349	
b	Less accumulated depreciation	19,060	4,289	20,766	2,583
11a	Depletable assets				
b	Less accumulated depletion		0		0
12	Land (net of any amortization)				
13a	Intangible assets (amortizable only)				
b	Less accumulated amortization		0		0
14	Other assets (attach statement)		1,200		1,200
15	Total assets		39,522		60,017
	Liabilities and Shareholders' Equity				
16	Accounts payable		6,557		3,500
17	Mortgages, notes, bonds payable in less than 1 year				
18	Other current liabilities (attach statement)		1,210		850
19	Loans from shareholders				33,541
20	Mortgages, notes, bonds payable in 1 year or more				
21	Other liabilities (attach statement)		1,874		620
22	Capital stock		1,000		1,000
23	Additional paid-in capital				
24	Retained earnings		28,881		20,506
25	Adjustments to shareholders' equity (attach statement)				
26	Less cost of treasury stock				
27	Total liabilities and shareholders' equity		39,522		60,017

Schedule M-1 Reconciliation of Income (Loss) per Books With Income (Loss) per Return

Note: The corporation may be required to file Schedule M-3 (see instructions)

1	Net income (loss) per books	27,224	5	Income recorded on books this year not included on Schedule K, lines 1 through 10 (itemize):	
2	Income included on Schedule K, lines 1, 2, 3c, 4, 5a, 6, 7, 8a, 9, and 10, not recorded on books this year (itemize):			a Tax-exempt interest $	0
3	Expenses recorded on books this year not included on Schedule K, lines 1 through 12 and 14l (itemize):		6	Deductions included on Schedule K, lines 1 through 12 and 14l, not charged against book income this year (itemize):	
	a Depreciation $			a Depreciation $	0
	b Travel and entertainment $ 4,262	4,262	7	Add lines 5 and 6	0
4	Add lines 1 through 3	31,486	8	Income (loss) (Schedule K, line 18). Line 4 less line 7	31,486

Schedule M-2 Analysis of Accumulated Adjustments Account, Other Adjustments Account, and Shareholders' Undistributed Taxable Income Previously Taxed (see instructions)

		(a) Accumulated adjustments account	(b) Other adjustments account	(c) Shareholders' undistributed taxable income previously taxed
1	Balance at beginning of tax year	28,881		
2	Ordinary income from page 1, line 21	38,436		
3	Other additions			
4	Loss from page 1, line 21			
5	Other reductions	11,212		
6	Combine lines 1 through 5	56,105	0	0
7	Distributions other than dividend distributions	35,599		
8	Balance at end of tax year. Subtract line 7 from line 6	20,506	0	0

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☐ Final K-1 ☐ Amended K-1 OMB No. 1545-0123

Schedule K-1 (Form 1120S)
Department of the Treasury
Internal Revenue Service

2016

For calendar year 2016, or tax year beginning _____, 2016
ending _____, 20_____

Shareholder's Share of Income, Deductions, Credits, etc.

▶ See back of form and separate instructions.

Part I Information About the Corporation

A Corporation's employer identification number
27-4551015

B Corporation's name, address, city, state, and ZIP code

MINERVA HOME HEALTH CARE, INC.
2301 DORSEY ROAD SUITE 111
GLEN BURNIE, MD 21061

C IRS Center where corporation filed return
e-file

Part II Information About the Shareholder

D Shareholder's identifying number Shareholder: 1
121-78-3296

E Shareholder's name, address, city, state, and ZIP code

FOLASHADE GREEN
176 LEEDS CREEK CIRCLE
ODENTON, MD 21113

F Shareholder's percentage of stock ownership for tax year 100.000000%

For IRS Use Only

Part III Shareholder's Share of Current Year Income, Deductions, Credits, and Other Items

1	Ordinary business income (loss) 38,436	13	Credits
2	Net rental real estate income (loss)		
3	Other net rental income (loss)		
4	Interest income		
5a	Ordinary dividends		
5b	Qualified dividends	14	Foreign transactions
6	Royalties		
7	Net short-term capital gain (loss)		
8a	Net long-term capital gain (loss)		
8b	Collectibles (28%) gain (loss)		
8c	Unrecaptured section 1250 gain		
9	Net section 1231 gain (loss)		
10	Other income (loss)	15 A	Alternative minimum tax (AMT) items -729
11	Section 179 deduction	16 C	Items affecting shareholder basis 4,262
12 A	Other deductions 6,950	D	35,599
		17	Other information

* See attached statement for additional information.

FOLASHADE GREEN 121-78-3296

K-1 Statement (Sch K-1, Form 1120S)

Line 12 - Deductions

A	Code A - Cash contributions (50%)	A	6,950

Line 15 - AMT Items

A	Code A - Post-1986 depreciation adjustment	A	-729

Line 16 - Items affecting shareholder basis

C	Code C - Nondeductible expenses	C	4,262
D	Code D - Distributions	D	35,599

Form **7004**
(Rev. December 2016)
Department of the Treasury
Internal Revenue Service

Application for Automatic Extension of Time To File Certain Business Income Tax, Information, and Other Returns

▶ File a separate application for each return.
▶ Information about Form 7004 and its separate instructions is at *www.irs.gov/form7004.*

OMB No. 1545-0233

Print or Type

Name	Identifying number
MINERVA HOME HEALTH CARE, INC.	27-4551015

Number, street, and room or suite no. (If P.O. box, see instructions.)
2301 DORSEY ROAD SUITE 111

City, town, state, and ZIP code (If a foreign address, enter city, province or state, and country (follow the country's practice for entering postal code)).
GLEN BURNIE, MD 21061

Note: File request for extension by the due date of the return for which the extension is granted. See instructions before completing this form.

Part I Automatic Extension for C Corporations With Tax Years Ending December 31. See instructions.

1a Enter the form code for the return listed below that this application is for . . . . . [ ]

Application Is For:	Form Code	Application Is For:	Form Code
Form 1120	12	Form 1120-ND (section 4951 taxes)	20
Form 1120-C	34	Form 1120-PC	21
Form 1120-F	15	Form 1120-POL	22
Form 1120-FSC	16	Form 1120-REIT	23
Form 1120-H	17	Form 1120-RIC	24
Form 1120-L	18	Form 1120-SF	26
Form 1120-ND	19		

Part II Automatic Extension for Certain Estates and Trusts. See instructions.

b Enter the form code for the return listed below that this application is for . . . . . [ ]

Application Is For:	Form Code	Application Is For:	Form Code
Form 1041 (estate other than a bankruptcy estate)	04	Form 1041 (trust)	05

Part III Automatic Extension for Entities Not Using Part I, II, or IV. See instructions.

c Enter the form code for the return listed below that this application is for . . . . . [25]

Application Is For:	Form Code	Application Is For:	Form Code
Form 706-GS(D)	01	Form 1120-ND (section 4951 taxes)	20
Form 706-GS(T)	02	Form 1120-PC	21
Form 1041 (bankruptcy estate only)	03	Form 1120-POL	22
Form 1041-N	06	Form 1120-REIT	23
Form 1041-QFT	07	Form 1120-RIC	24
Form 1042	08	Form 1120S	25
Form 1065	09	Form 1120-SF	26
Form 1065-B	10	Form 3520-A	27
Form 1066	11	Form 8612	28
Form 1120	12	Form 8613	29
Form 1120-C	34	Form 8725	30
Form 1120-F	15	Form 8804	31
Form 1120-FSC	16	Form 8831	32
Form 1120-H	17	Form 8876	33
Form 1120-L	18	Form 8924	35
Form 1120-ND	19	Form 8928	36

Part IV Automatic Extension for C Corporations With Tax Years Ending June 30. See instructions.

d Enter the form code for the return listed below that this application is for . . . . . [ ]

Application Is For:	Form Code	Application Is For:	Form Code
Form 1120	12	Form 1120-ND (section 4951 taxes)	20
Form 1120-C	34	Form 1120-PC	21
Form 1120-F	15	Form 1120-POL	22
Form 1120-FSC	16	Form 1120-REIT	23
Form 1120-H	17	Form 1120-RIC	24
Form 1120-L	18	Form 1120-SF	26
Form 1120-ND	19		

Part V All Filers Must Complete This Part

2 If the organization is a foreign corporation that does not have an office or place of business in the United States, check here . . . . . ▶ ☐

3 If the organization is a corporation and is the common parent of a group that intends to file a consolidated return, check here . . . . . ▶ ☐
If checked, attach a statement listing the name, address, and Employer Identification Number (EIN) for each member covered by this application.

4 If the organization is a corporation or partnership that qualifies under Regulations section 1.6081-5, check here . . . . ▶ ☐

5 a The application is for calendar year 20 16 , or tax year beginning _____, 20 ____ , and ending _____, 20 ____

b **Short tax year.** If this tax year is less than 12 months, check the reason: ☐ Initial return ☐ Final return
☐ Change in accounting period ☐ Consolidated return to be filed ☐ Other (see instructions-attach explanation)

6	Tentative total tax	6	0	
7	**Total** payments and credits (see instructions)	7	0	
8	**Balance due.** Subtract line 7 from line 6 (see instructions)	8	0	

Form **8050**

(November 2016)
Department of the Treasury
Internal Revenue Service

Direct Deposit of Corporate Tax Refund

▶ **Attach to Form 1120 or 1120S.**

▶ **Information about Form 8050 and its instructions is at *www.irs.gov/form8050.***

OMB No. 1545-0123

Name of corporation (as shown on tax return)	Employer identification number
MINERVA HOME HEALTH CARE, INC.	27-4551015
	Phone number (optional)

1. Routing number (must be nine digits). The first two digits must be between 01 and 12 or 21 through 32.

055003201

2. Account number (include hyphens but omit spaces and special symbols):

2000059117463

3. Type of account (one box must be checked):

[X] Checking [ ] Savings

Form **1125-A**
(Rev. October 2016)
Department of the Treasury
Internal Revenue Service

Cost of Goods Sold

▶ Attach to Form 1120, 1120-C, 1120-F, 1120S, 1065, or 1065-B.
▶ Information about Form 1125-A and its instructions is at *www.irs.gov/form1125a.*

OMB No. 1545-0123

Name	Employer identification number
MINERVA HOME HEALTH CARE, INC.	27-4551015

1	Inventory at beginning of year	1		
2	Purchases	2		
3	Cost of labor	3		
4	Additional section 263A costs (attach schedule)	4		
5	Other costs (attach schedule)	5		
6	**Total.** Add lines 1 through 5	6	0	
7	Inventory at end of year	7		
8	**Cost of goods sold.** Subtract line 7 from line 6. Enter here and on Form 1120, page 1, line 2 or the appropriate line of your tax return. See instructions	8	0	

9 a Check all methods used for valuing closing inventory:
- *(i)* ☐ Cost
- *(ii)* ☐ Lower of cost or market
- *(iii)* ☐ Other (Specify method used and attach explanation.) ▶

b Check if there was a writedown of subnormal goods ▶ ☐

c Check if the LIFO inventory method was adopted this tax year for any goods (if checked, attach Form 970) ▶ ☐

d If the LIFO inventory method was used for this tax year, enter amount of closing inventory computed under LIFO — 9d

e If property is produced or acquired for resale, do the rules of section 263A apply to the entity? See instructions ☐ Yes ☐ No

f Was there any change in determining quantities, cost, or valuations between opening and closing inventory? If "Yes," attach explanation ☐ Yes ☐ No

Form **1125-E**
(Rev. October 2016)
Department of the Treasury
Internal Revenue Service

Compensation of Officers

▶ Attach to Form 1120, 1120-C, 1120-F, 1120-REIT, 1120-RIC, or 1120S
▶ Information about Form 1125-E and its separate instructions is at *www.irs.gov/form1125e.*

OMB No. 1545-0123

Name: MINERVA HOME HEALTH CARE, INC.

Employer identification number: 27-4551015

Note: Complete Form 1125-E only if total receipts are $500,000 or more. See instructions for definition of total receipts.

(a) Name of officer	(b) Social security number	(c) Percent of time devoted to business	Percent of stock owned (d) Common	Percent of stock owned (e) Preferred	(f) Amount of compensation
1 FOLASHADE GREEN	121-78-3296	100.00%	100.00%	%	73,972
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	
		%	%	%	

2	Total compensation of officers	2	73,972
3	Compensation of officers claimed on Form 1125-A or elsewhere on return	3	
4	Subtract line 3 from line 2. Enter the result here and on Form 1120, page 1, line 12 or the appropriate line of your tax return	4	73,972

For Paperwork Reduction Act Notice, see separate instructions.
Form **1125-E** (Rev. 10-2016)
HTA

Form **4562**

Department of the Treasury
Internal Revenue Service (99)

Depreciation and Amortization
(Including Information on Listed Property)

▶ Attach to your tax return.
▶ Information about Form 4562 and its separate instructions is at *www.irs.gov/form4562.*

OMB No. 1545-0172
2016
Attachment Sequence No. **179**

Name(s) shown on return	Business or activity to which this form relates	Identifying number
MINERVA HOME HEALTH CARE, INC.	1120S - HEALTH CARE & SOCIAL ASSISTANCE	27-4551015

Part I Election To Expense Certain Property Under Section 179

Note: If you have any listed property, complete Part V before you complete Part I.

1	Maximum amount (see instructions)	1	
2	Total cost of section 179 property placed in service (see instructions)	2	
3	Threshold cost of section 179 property before reduction in limitation (see instructions)	3	
4	Reduction in limitation. Subtract line 3 from line 2. If zero or less, enter -0-	4	0
5	Dollar limitation for tax year. Subtract line 4 from line 1. If zero or less, enter -0-. If married filing separately, see instructions	5	0

6	(a) Description of property	(b) Cost (business use only)	(c) Elected cost

7	Listed property. Enter the amount from line 29	7	
8	Total elected cost of section 179 property. Add amounts in column (c), lines 6 and 7	8	0
9	Tentative deduction. Enter the **smaller** of line 5 or line 8	9	0
10	Carryover of disallowed deduction from line 13 of your 2015 Form 4562.	10	
11	Business income limitation. Enter the smaller of business income (not less than zero) or line 5 (see instructions)	11	
12	Section 179 expense deduction. Add lines 9 and 10, but don't enter more than line 11	12	0
13	Carryover of disallowed deduction to 2017. Add lines 9 and 10, less line 12 ▶	13	0

Note: Don't use Part II or Part III below for listed property. Instead, use Part V.

Part II Special Depreciation Allowance and Other Depreciation (Don't include listed property.) (See instructions.)

14	Special depreciation allowance for qualified property (other than listed property) placed in service during the tax year (see instructions)	14	
15	Property subject to section 168(f)(1) election	15	
16	Other depreciation (including ACRS)	16	1,706

Part III MACRS Depreciation (Don't include listed property.) (See instructions.)

Section A

17	MACRS deductions for assets placed in service in tax years beginning before 2016	17	
18	If you are electing to group any assets placed in service during the tax year into one or more general asset accounts, check here ▶ ☐		

Section B - Assets Placed in Service During 2016 Tax Year Using the General Depreciation System

	(a) Classification of property	(b) Month and year placed in service	(c) Basis for depreciation (business/investment use only—see instructions)	(d) Recovery period	(e) Convention	(f) Method	(g) Depreciation deduction
19	a 3-year property						
	b 5-year property						
	c 7-year property						
	d 10-year property						
	e 15-year property						
	f 20-year property						
	g 25-year property			25 yrs.		S/L	
	h Residential rental property			27.5 yrs.	MM	S/L	
				27.5 yrs.	MM	S/L	
	i Nonresidential real property			39 yrs.	MM	S/L	
					MM	S/L	

Section C - Assets Placed in Service During 2016 Tax Year Using the Alternative Depreciation System

20	a Class life					S/L	
	b 12-year			12 yrs.		S/L	
	c 40-year			40 yrs.	MM	S/L	

Part IV Summary (See instructions.)

21	Listed property. Enter amount from line 28	21	
22	**Total.** Add amounts from line 12, lines 14 through 17, lines 19 and 20 in column (g), and line 21. Enter here and on the appropriate lines of your return. Partnerships and S corporations—see instructions	22	1,706
23	For assets shown above and placed in service during the current year, enter the portion of the basis attributable to section 263A costs	23	

Line 5 (1120S) - Other Income (Loss)

1	Interest income derived in the ordinary course of business (i.e. interest charged on receivable balances)	1	99
2	Total other income (loss)	2	99

Line 19 (1120S) - Other Deductions

1	Travel, Meals and Entertainment				
	a Travel			1a	4,871
	b Meals and entertainment, subject to 50% limit	1b	8,524		
	c Meals and entertainment, subject to 80% limit (DOT)	1c			
	d Less disallowed	1d	4,262		
	e Subtract line d from lines b and c			1e	4,262
2	Automobile and truck expenses			2	4,622
3	Bank charges			3	1,200
4	Computer and internet			4	6,206
5	Consulting fees			5	9,182
6	Continuing Education			6	2,736
7	Criminal Background Check			7	112
8	Equipment Rental			8	1,337
9	Dues and subscriptions			9	1,729
10	Medical Records and Supplies			10	3,872
11	Insurance			11	16,808
12	Janitorial			12	2,804
13	Sub-Contrators			13	195,253
14	Legal and professional fees			14	8,281
15	Telephone			15	6,543
16	Uniforms			16	232
17	Recruiting Fees			17	8,875
18	Referral Management			18	1,970
19	Parking fees and tolls			19	992
20	Utilities			20	4,775
21	Postage			21	1,021
22	Office Expense			22	3,470
23	Total other deductions			23	291,153

Line 12a, Sch K (1120S) - Contributions

A	Code A - Cash contributions (50%)	A	6,950
	Total contributions	12a	6,950

Line 16d, Schedule K (1120S) - Distributions

A. Cash 35,599

B. Property

Description	Date Acquired	Date Distributed	FMV on date of distribution	Basis in property

Total property 0

C. Other . . . . .

Total distributions 35,599

Line 6, Sch L (1120S) - Other Current Assets

			Beginning		End
1	LINE OF CREDIT	1			19,000
2	Total other current assets	2	0		19,000

Line 14, Sch L (1120S) - Other Assets

			Beginning		End
1	SECURITY DEPOSIT	1	1,200		1,200
2	Total other assets	2	1,200		1,200

Line 18, Sch L (1120S) - Other Current Liabilities

			Beginning		End
1	TAX PAYABLE	1	1,210		850
2	Total other current liabilities	2	1,210		850

Line 21, Sch L (1120S) - Other Liabilities

			Beginning		End
1	OTHER	1	1,874		620
2	Total other liabilities	2	1,874		620

MARYLAND FORM **500**

CORPORATION INCOME TAX RETURN

165000083

2016

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OR FISCAL YEAR BEGINNING _____ 2016, ENDING _____

Print using Blue or Black Ink Only

274551015
Federal Employer Identification Number (9 digits)

FEIN Applied for Date (MMDDYY)

011411
▶ Date of Organization or Incorporation (MMDDYY)

621610
▶ Business Activity Code No. (6 digits)

MINERVA HOME HEALTH CARE INC
Name

2301 DORSEY ROAD SUITE 111
Current Mailing Address Line 1 (Street No. and Street Name or PO Box)

Current Mailing Address Line 2 (Apt No., Suite No., Floor No.)

GLEN BURNIE | MD | 21061 | +4 | ▶ ME | ▶ YE
City or Town | State | ZIP code

STAPLE CHECK HERE

CHECK HERE IF:

- ☐ Name or address has changed
- ☐ First filing of the corporation
- ▶ ☐ This tax year's beginning and ending dates are different from last year's due to an acquisition or consolidation.
- ☐ Inactive corporation
- ☐ Final Return

SEE CORPORATION INSTRUCTIONS. ATTACH A COPY OF THE FEDERAL INCOME TAX RETURN THROUGH SCHEDULE M2.

1a. Federal Taxable Income (Enter amount from Federal Form 1120 line 28 or Form 1120-C line 25.) See Instructions. Check applicable box:
☐ 1120 ☐ 1120-REIT ☐ 990T
☐ Other: _____ IF 1120S, FILE ON FORM 510 ..... 1a. _____ .___

1b. Special Deductions (Federal Form 1120 line 29b or Form 1120-C line 26b.) ..... 1b. _____ .___

1c. Federal Taxable Income before net operating loss deduction (Subtract line 1b from 1a) ..... ▶ 1c. _____ .___

MARYLAND ADJUSTMENTS TO FEDERAL TAXABLE INCOME
(All entries must be positive amounts.)
ADDITION ADJUSTMENTS

2a. Section 10-306.1 related party transactions ..... ▶ 2a. _____ .___

2b. Decoupling Modification Addition adjustment (Enter code letter(s) from instructions.) ____ ____ ____ ____ ▶ 2b. _____ .___

2c. Total Maryland Addition Adjustments to Federal Taxable Income (Add lines 2a and 2b) ..... 2c. _____ .___

SUBTRACTION ADJUSTMENTS

3a. Section 10-306.1 related party transactions ..... ▶ 3a. _____ .___

3b. Dividends for domestic corporation claiming foreign tax credits (Federal form 1120/1120C Schedule C line 15) ..... ▶ 3b. _____ .___

3c. Dividends from related foreign corporations (Federal form 1120/1120C Schedule C line 13 and 14) ..... ▶ 3c. _____ .___

3d. Decoupling Modification Subtraction adjustment (Enter code letter(s) from instructions.) J ____ ____ ____ ▶ 3d. 498 .___

3e. Total Maryland Subtraction Adjustments to Federal Taxable Income (Add lines 3a through 3d.) ..... 3e. 498 .___

4. Maryland Adjusted Federal Taxable Income before NOL deduction is applied (Add lines 1c and 2c, and subtract line 3e.) ..... 4. -498 .___

5. Enter Adjusted Federal NOL Carry-forward available from previous tax years (including FDSC Carry-forward) on a separate company basis (Enter NOL as a positive amount.) ..... ▶ 5. _____ .___

MARYLAND FORM **500**

CORPORATION INCOME TAX RETURN

165000183

2016 page 2

NAME MINERVA HOME HEALT FEIN 274551015

6.	**Maryland Adjusted Federal Taxable Income** (If line 4 is less than or equal to zero, enter amount from line 4.) (If line 4 is greater than zero, subtract line 5 from line 4 and enter result. If result is less than zero, enter zero.)	6.	-498 .
	MARYLAND ADDITION MODIFICATIONS		
	(All entries must be positive amounts.)		
7a.	State and local income tax ▶	7a.	.
7b.	Dividends and interest from another state, local or federal tax exempt obligation ▶	7b.	.
7c.	Net operating loss modification recapture (Do not enter NOL carryover. See instructions.) ▶	7c.	.
7d.	Domestic Production Activities Deduction ▶	7d.	.
7e.	Deduction for Dividends paid by captive REIT ▶	7e.	.
7f.	Other additions (Enter code letter(s) from instructions and attach schedule) ___ ___ ___ ___ ▶	7f.	.
7g.	Total Addition Modifications (Add lines 7a through 7f.)	7g.	.
	MARYLAND SUBTRACTION MODIFICATIONS		
	(All entries must be positive amounts.)		
8a.	Income from US Obligations ▶	8a.	.
8b.	Other subtractions (Enter code letter(s) from instructions and attach schedule) ___ ___ ___ ___ ▶	8b.	.
8c.	Total Subtraction Modifications (Add lines 8a and 8b.)	8c.	.
	NET MARYLAND MODIFICATIONS		
9.	Total Maryland Modifications (Subtract line 8c from 7g. If less than zero, enter negative amount.)	9.	.
10.	Maryland Modified Income (Add lines 6 and 9.)	10.	-498 .
	APPORTIONMENT OF INCOME		
	(To be completed by multistate corporations whose apportionment factor is less than 1, otherwise skip to line 13.)		
11.	Maryland apportionment factor (from page 4 of this form) (If factor is zero, enter .000001.) ▶	11.	
12.	Maryland apportionment income (Multiply line 10 by line 11.)	12.	.
13.	Maryland taxable income (from line 10 or line 12, whichever is applicable.)	13.	-498 .
14.	Tax (Multiply line 13 by 8.25%.)	14.	.
15a.	Estimated tax paid with Form 500D, Form MW506NRS and/or credited from 2015 overpayment ▶	15a.	.
15b.	Tax paid with an extension request (Form 500E) ▶	15b.	75 .
15c.	Nonrefundable business income tax credits from Part Y. (See instructions for Form 500CR.)		
15d.	Refundable business income tax credits from Part BB. (See instructions for Form 500CR.)		
15e.	The Heritage Structure Rehabilitation Tax Credit is claimed on line 1 of Part BB on Form 500CR. Check here ☐ if you are a non-profit corporation.		
15f.	Nonresident tax paid on behalf of the corporation by pass-through entities (Attach Maryland Schedule K-1.) ▶	15f.	.
15g.	Total payments and credits (Add lines 15a through 15f.)	15g.	75 .
16.	Balance of tax due (If line 14 exceeds line 15g, enter the difference.) ▶	16.	.
17.	Overpayment (If line 15g exceeds line 14, enter the difference.) ▶	17.	75 .
18.	Interest and/or penalty from Form 500UP _____ or late payment interest _____ TOTAL ▶	18.	.
19.	Total balance due (Add lines 16 and 18, or if line 18 exceeds line 17 enter the difference.)	19.	.
20.	Amount of overpayment to be applied to estimated tax for 2017 (not to exceed the net of line 17 less line 18) ▶	20.	.
21.	Amount of overpayment TO BE REFUNDED (Add lines 18 and 20, and subtract the total from line 17.) ▶	21.	75 .

You must file this form electronically to claim business tax credits from Form 500CR.

MARYLAND FORM **500**

CORPORATION INCOME TAX RETURN

165000283

2016 page 3

NAME MINERVA HOME HEALT FEIN 274551015

DIRECT DEPOSIT OF REFUND (See Instructions.) **Be sure the account information is correct.**

If this refund will go to an account outside of the United States, then to comply with banking rules, place a "Y" in this box and see Instructions. ▶ ☐

For the direct deposit option, complete the following information clearly and legibly.

22a. Type of account: ▶ ☒ Checking ☐ Savings

22b. Routing Number (9-digits): ▶ 055003201

22c. Account number: ▶ 2000059117463

INFORMATIONAL PURPOSES ONLY (LINES 23 & 24)

23. NOL generated in Current Year - Carryforward 20 years and back 2 years (If line 6 is less than zero, enter on line 23.) ..... 23. -498 .

24. NAM generated in Current Year - Carried Forward/Back with Loss on Line 23 per Section 10-205(e) (If line 6 is less than zero AND line 9 is greater than zero, enter the amount from line 9 on line 24.) ..... 24. .

NAME MINERVA HOME HEALT FEIN 274551015

Schedule A - COMPUTATION OF APPORTIONMENT FACTOR (Applies only to multistate corporations. See instructions.)

NOTE: Special apportionment formulas are required for rental/leasing, financial institutions, transportation and manufacturing companies.

		Column 1 TOTALS WITHIN MARYLAND	Column 2 TOTALS WITHIN AND WITHOUT MARYLAND	Column 3 DECIMAL FACTOR (Column 1 ÷ Column 2 rounded to six places)
1A. Receipts	a. Gross receipts or sales less returns and allowances			
	b. Dividends			
	c. Interest			
	d. Gross rents			
	e. Gross royalties			
	f. Capital gain net income			
	g. Other income (Attach schedule.)			
	h. Total receipts (Add lines 1A(a) through 1A(g), for Columns 1 and 2.)			.
1B. Receipts	Enter the same factor shown on line 1A, Column 3. Disregard this line if special apportionment formula is used			.
2. Property	a. Inventory			
	b. Machinery and equipment			
	c. Buildings			
	d. Land			
	e. Other tangible assets (Attach schedule.)			
	f. Rent expense capitalized (multiply by eight)			
	g. Total property (Add lines 2a through 2f, for Columns 1 and 2)			.
3. Payroll	a. Compensation of officers			
	b. Other salaries and wages			
	c. Total payroll (Add lines 3a and 3b, for Columns 1 and 2.)			.

4. **Total of factors** (Add entries in Column 3.) . . . . . .
5. **Maryland apportionment factor** Divide line 4 by four for three-factor formula, or by the number of factors used if special apportionment formula required. (If factor is zero, enter .000001 on line 11 page 2.) .

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MARYLAND FORM **500**

CORPORATION INCOME TAX RETURN

165000483

2016 page 5

NAME MINERVA HOME HEALT FEIN 274551015

SCHEDULE B - ADDITIONAL INFORMATION REQUIRED (Attach a separate schedule if more space is necessary.)

1. Telephone number of corporation tax department: 8452621468
2. Address of principal place of business in Maryland (if other than indicated on page 1):
3. Brief description of operations in Maryland: HOME HEALTH CARE SERVICES
4. Has the Internal Revenue Service made adjustments (for a tax year in which a Maryland return was required) that were not previously reported to the Maryland Revenue Administration Division? ☐ Yes ☒ No
   If "yes", indicate tax year(s) here: _____ and submit an amended return(s) together with a copy of the IRS adjustment report(s) under separate cover.
5. Did the corporation file employer withholding tax returns/forms with the Maryland Revenue Administration Division for the last calendar year? ☒ Yes ☐ No
6. Is this entity part of the federal consolidated filing? ▶ ☐ Yes ☒ No

If a multistate operation, provide the following:

7. Is this entity a multistate corporation that is a member of a unitary group? ▶ ☐ Yes ☒ No
8. Is this entity a multistate manufacturer with more than 25 employees? ▶ ☐ Yes ☒ No

SIGNATURE AND VERIFICATION

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements and to the best of my knowledge and belief it is true, correct and complete. If prepared by a person other than taxpayer, the declaration is based on all information of which the preparer has any knowledge.

Check here ☒ if you authorize your preparer to discuss this return with us.

Officer's Signature Date	USO MBANEFO Preparer's Signature
PRESIDENT Officer's Name and Title	MBANEFO & ASSOCIATES 8452621468 Preparer's name, address and telephone number
	94 NORTH MAIN ST SUITE 6 SPRING VALLEY NY 10
	▶ P00700597 Preparer's PTIN (required by law)

Make checks payable to and mail to:
Comptroller Of Maryland
Revenue Administration Division
110 Carroll Street
Annapolis, Maryland 21411-0001
(Write Your FEIN On Check Using Blue Or Black Ink.)

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MARYLAND FORM **510**

PASS-THROUGH ENTITY INCOME TAX RETURN

165100083

2016

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OR FISCAL YEAR BEGINNING _____ 2016, ENDING _____

274551015
▶ Federal Employer Identification Number (9 digits) FEIN Applied for Date (MMDDYY)

011411 621610
▶ Date of Organization or Incorporation (MMDDYY) ▶ Business Activity Code No. (6 digits)

Print Using Blue or Black Ink Only

MINERVA HOME HEALTH CARE INC
Name

Street Address - Line 1

2301 DORSEY ROAD SUITE 111
Street Address - Line 2

GLEN BURNIE MD 21061 +4
City or town State ZIP code

Do not write in this space.
▶ ME ▶ YE

TYPE OF ENTITY - Check the applicable box. ▶
[X] S Corporation [ ] Partnership [ ] Limited Liability Company [ ] Business Trust

Amended Return ▶ [ ]

CHECK HERE - Check applicable box(es).
[ ] Name or address has changed [ ] First filing of the entity [ ] Inactive entity [ ] Final Return
▶ [ ] This tax year's beginning and ending dates are different from last year's due to an acquisition or consolidation.

STAPLE CHECK HERE

1. Number of members:
   a. Individual (including fiduciary) residents of Maryland ▶ 1 c. Nonresident entities ▶ _____
   b. Individual (including fiduciary) nonresidents ▶ _____ d Others ▶ _____
   e. Total 1
2. Total distributive or pro rata share of income per federal return (Form 1065 or 1120S) - Unistate entities or multistate entities with no nonresident members also enter this amount on line 4. ▶ 2. 38436 .

ALLOCATION OF INCOME
(To be completed by multistate pass-through entities with nonresident members - unistate entities, and multistate entities with no nonresidents, go to line 4.)

3a. Non-Maryland income (for entities using separate accounting). Subtract this amount from line 2 and enter the difference on line 4 ▶ 3a. _____ .

3b. Maryland apportionment factor from computation worksheet on Page 3 (for entities using the apportionment method). Multiply line 2 by this factor and enter the result on line 4 (If factor is zero, enter 000001.) ▶ 3b. _____

4. Distributive or pro rata share of income allocable to Maryland 4. 38436 .

NOTE: Complete lines 5 through 19 only if there is an entry on line 1b or line 1c. Tax is calculated only for nonresident individual or nonresident entity members. (Investment partnerships see Specific Instructions.)

5. Percentage of ownership by individual nonresident members shown on line 1b (or profit/loss percentage, if applicable). If 100%, leave blank and enter the amount from line 4 on line 6. ▶ 5. _____
6. Distributive or pro rata share of income for nonresident individual members (Multiply line 4 by the percentage on line 5.) 6. _____ .
7. Nonresident individual tax (Multiply line 6 by 5.75%.) 7. _____ .
8. Special nonresident tax (Multiply line 6 by 1.75%.) 8. _____ .
9. Total Maryland tax on individual members (Add lines 7 and 8.) 9. _____ .
10. Percentage of ownership by nonresident entities shown on line 1c (or profit/loss percentage, if applicable) If 100%, leave blank and enter the amount from line 4 on line 11. ▶ 10. _____
11. Distributive or pro rata share of income for nonresident entity members (Multiply line 4 by percentage on line 10.) 11. _____ .

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MARYLAND FORM **510**

PASS-THROUGH ENTITY INCOME TAX RETURN

165100183

2016 page 2

NAME MINERVA HOME HE/ FEIN 274551015

12.	Nonresident entity tax (Multiply line 11 by 8.25%.)	12.	.
13.	Total nonresident tax (Add lines 9 and 12.)	13.	.
14.	Distributable cash flow limitation from worksheet. See instructions. If worksheet used, check here ▶ ☐	14.	.
15.	Nonresident tax due (Enter the lesser of line 13 or line 14.)	15.	.
16 a.	Estimated pass-through entity nonresident tax paid with Form 510D and MW506NRS	16a.	.
16 b.	Pass-through entity nonresident tax paid with an extension request (Form 510E)	16b.	.
16 c.	Credit for nonresident tax paid on behalf of the pass-through entity by another pass-through entity (Attach Maryland Schedule K-1 (510).)	16c.	.
16 d.	Total payments and credits (Add lines 16a through 16c.)	16d.	.
17.	Balance of tax due (If line 15 exceeds line 16d, enter the difference.)	17.	.
18.	Interest and/or penalty from Form 500UP _____ or late payment interest _____ Total	18.	.
19.	Total balance due. (Add lines 17 and 18.) Pay in full with this return	19.	.

NOTE: The total tax paid from lines 16d and 17 is to be reported either on the composite return or on the returns of the nonresident members. Nonresident entity and fiduciary members cannot file a composite return nor be included in the composite return filed by nonresident individual members. (See instructions.)

Complete line 20 only if there are no nonresident members. (Lines 1b and 1c are both zero.)

20.	Amount TO BE REFUNDED (Enter the amount from line 16d if the amount on line 13 is zero.)	20.	.

ADDITIONAL INFORMATION REQUIRED

1. Address of principal place of business in Maryland (if other than indicated on page 1): 2301 DORSEY ROAD
   GLEN BURNIE MD 21061
2. Address at which tax records are located (if other than indicated on page 1): 2301 DORSEY ROAD
   GLEN BURNIE MD 21061
3. Telephone number of pass-through entity tax department: 2046035025
4. State of organization or incorporatior MD
5. Has the Internal Revenue Service made adjustments (for a tax year in which a Maryland return was required) that were not previously reported to the Maryland Revenue Administration Division? ☐ Yes ☒ No
   If "yes", indicate tax year(s) here: _____ and submit an amended return(s) together with a copy of the IRS adjustment report(s) under separate cover.
6. Did the pass-through entity file employer withholding tax returns/forms with the Maryland Revenue Administration Division for the last calendar year? ☒ Yes ☐ No
7. Is this entity a multistate corporation that is a member of a unitary group? ☐ Yes ☒ No
8. Is this entity a multistate manufacturing corporation with more than 25 employees? ☐ Yes ☒ No

SIGNATURE AND VERIFICATION

Check here ☒ if you authorize your preparer to discuss this return with us.

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements and to the best of my knowledge and belief it is true, correct and complete. If prepared by a person other than taxpayer, the declaration is based on all information of which the preparer has any knowledge.

Signature of general partner, officer or member — Date

PRESIDENT
Title

MBANEFO & ASSOCIATES — USO MBANEFO
Preparer's Name — Preparer's Signature

94 NORTH MAIN ST SUITE 6
Preparer's address and telephone number

SPRING VALLEY NY 10977 8452621468

Make checks payable to and mail to:
Comptroller Of Maryland
Revenue Administration Division
110 Carroll Street
Annapolis, Maryland 21411-0001
(Write Your Federal Employer Identification Number On Check Using Blue Or Black Ink.)

▶ P00700597
Preparer's PTIN (required by law)

COM/RAD-069 12/02/16

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MARYLAND FORM **510**

PASS-THROUGH ENTITY INCOME TAX RETURN

165100283

2016 page 3

NAME MINERVA HOME HE/ FEIN 274551015

Schedule A - COMPUTATION OF APPORTIONMENT FACTOR (Applies only to multistate pass-through entities. See instructions.)

NOTE: Special apportionment formulas are required for rental/ leasing, transportation, financial institutions and manufacturing companies. See instructions.		Column 1 TOTALS WITHIN MARYLAND	Column 2 TOTALS WITHIN AND WITHOUT MARYLAND	Column 3 DECIMAL FACTOR (Column 1 ÷ Column 2 rounded to six places)
1A. Receipts	a. Gross receipts or sales less returns and allowances			
	b. Dividends			
	c. Interest			
	d. Gross rents			
	e. Gross royalties			
	f. Capital gain net income			
	g. Other income (Attach schedule.)			
	h. Total receipts (Add lines 1A(a) through 1A(g), for Columns 1 and 2.)			. ◄
1B. Receipts	Enter the same factor shown on line 1A, Column 3. Disregard this line if special apportionment formula is used			.
2. Property	a. Inventory			
	b. Machinery and equipment			
	c. Buildings			
	d. Land			
	e. Other tangible assets (Attach schedule.)			
	f. Rent expense capitalized (multiply by eight.)			
	g. Total property (Add lines 2a through 2f, for Columns 1 and 2.)			. ◄
3. Payroll	a. Compensation of officers			
	b. Other salaries and wages			
	c. Total payroll (Add lines 3a and 3b, for Columns 1 and 2.)			. ◄

4. **Total of factors** (Add entries in Column 3.) . . . . . .

5. **Maryland apportionment factor** Divide line 4 by four for three-factor formula, or by the number of factors used if special apportionment formula required. (If factor is zero, enter 000001 on line 3b, page 1.) . . . . . .

MARYLAND FORM **510** SCHEDULE B

PASS-THROUGH ENTITY INCOME TAX RETURN MEMBERS' INFORMATION

16510B083

2016

NAME MINERVA HOME HE/ FEIN 274551015

PART I – INDIVIDUAL MEMBERS' INFORMATION

Enter the information in Social Security Number order.

	Social Security Number and name of member	Address	Check here if Maryland: Resident	Check here if Maryland: Non-Resident	Distributive or pro rata share of income (See Instructions.)	Distributive or pro rata share of tax paid (See Instructions.)	Distributive or pro rata share of tax credit (See Instructions.)
1	121783296 FOLASHADE GREEN	176 LEEDS CREEK CIRCI ODENTON MD 21113	X		38436		
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
		SUBTOTAL from additional Form 510 Schedule B for individual members					
		TOTAL:					

You must file Maryland Form 510 electronically to pass on business tax credits from Maryland Form 500CR and/ or Maryland Form 502S to your members.

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MARYLAND SCHEDULE K-1 (510)

PASS-THROUGH ENTITY MEMBER'S INFORMATION

16510K083

2016

OR FISCAL YEAR BEGINNING _____ 2016, ENDING _____

INFORMATION ABOUT THE PASS-THROUGH ENTITY (PTE)

PTE Name	PTE FEIN
MINERVA HOME HEALTH CARE INC	274551015

Street Address	City	State	ZIP code	+ 4
2301 DORSEY ROAD SUITE 111	GLEN BURNIE	MD	21061	

INFORMATION ABOUT THE MEMBER

Member Number	Member Name	Member's SSN/FEIN
1	FOLASHADE GREEN	121783296

Street Address	City	State	ZIP code	+ 4
176 LEEDS CREEK CIRCLE	ODENTON	MD	21113	

Resident? [X] Yes [ ] No Distributive or Pro Rata Share Percentage 100.0000 %

A. Member's Income

1.	Distributive or pro rata share of income from federal Schedule K-1	1.	38436 .
2.	Distributive or pro rata share allocable to Maryland (Nonresidents only)	2.	.

B. Additions

1.	Non-Maryland municipal interest and dividends	1.	.
2.	Tax preference items	2.	.
3.	Net decoupling modification	3.	.
4.	Net decoupling modification from another PTE	4.	.
5.	Other additions (Specify additions with amounts in part F of this form.)	5.	.

C. Subtractions

1.	Income from U.S. obligations	1.	.
2.	Work opportunity credit salary expense	2.	.
3.	Net decoupling modification	3.	498 .
4.	Net decoupling modification from another PTE	4.	.
5.	Other subtractions (Specify subtractions with amounts in part F of this form.)	5.	.

D. Nonresident Tax - Enter the member's distributive or pro rata share

1.	Nonresident tax paid by this PTE	1.	.
2.	Nonresident tax paid by other PTEs on behalf of this entity	2.	.
3.	Total (Add lines 1 and 2. Members: Include this amount on Form 500, line 15f; Form 502CR, Part M, line 5; Form 504, line 29; Form 505, line 45; Form 510, line 16c.)	3.	.

E. Credits (*Required documentation or certification must be attached.)**

Nonrefundable Credits

1.	Enterprise Zone Tax Credit***	1.	.
2.	Maryland Disability Employment Tax Credit	2.	.
3.	Job Creation Tax Credit***	3.	.
4.	Community Investment Tax Credit.***	4.	.
5.	Businesses that Create New Jobs Tax Credit	5.	.
6.	Qualified Vehicle Tax Credit***	6.	.
7.	Employer-Provided Long-Term Insurance Tax Credit	7.	.
8.	Security Clearance Cost Tax Credit***	8.	.
9.	Small Businesses First-Year Leasing Security Clearance Costs Tax Credit***	9.	.
10.	Research and Development Tax Credit***	10.	.
11.	Commuter Tax Credit	11.	.
12.	Maryland-Mined Coal Tax Credit***	12.	.

MARYLAND SCHEDULE K-1 (510)

PASS-THROUGH ENTITY MEMBER'S INFORMATION

16510K183

2016 page 2

NAME FOLASHADE GREEN FEIN 121783296

13.	Oyster Shell Recycling Tax Credit***	13.	.
14.	Bio-Heating Oil Tax Credit***	14.	.
15.	Cellulosic Ethanol Technology Research & Development Tax Credit***	15.	.
16.	Wineries and Vineyards Tax Credit***	16.	.
17.	Endow Maryland Tax Credit***	17.	.
18.	Preservation and Conservation Easements Tax Credit	18.	.
	Refundable Credits		
19.	Cybersecurity Investment Incentive Tax Credit***	19.	.
20.	Film Production Activity Tax Credit***	20.	.
21.	Biotechnology Investment Incentive Tax Credit***	21.	.
22.	Clean Energy Incentive Tax Credit***	22.	.
23.	Health Enterprise Zone Hiring Tax Credit***	23.	.
24.	Small Business Research & Development Tax Credit***	24.	.
25.	Heritage Structure Rehabilitation Tax Credit***	25.	.
26.	Aerospace, Electronics, or Defense Contracts Tax Credit***	26.	.
	One Maryland Economic Development Tax Credit* ☐ Refundable ☐ Nonrefundable**		
27a.	Total number of "qualified employees"	27a.	
27b.	If the amount on line 27a is less than 25, has the PTE maintained at least 25 qualified employees for at least 5 years? ☐ Yes ☐ No		
28.	Tax year in which the project was put into service	28.	
	Enter Member's Distributive or Pro Rata share of the Following:		
29.	Portion of PTE's income attributable to project	29.	.
30.	Non-project taxable income from PTE	30.	.
31.	Number of "qualified employees" multiplied by $10,000	31.	.
32.	Amount of Maryland income tax required to be withheld from employees reported on line 27a of this form	32.	.
33.	Total eligible cumulative project costs ($500,000 PTE minimum, $5,000,000 PTE maximum)	33.	.
34.	Total cumulative eligible start-up costs ($500,000 PTE maximum)	34.	.

F. Additional Information

COM/RAD-045 12/02/16

MARYLAND FORM
500DM

DECOUPLING MODIFICATION

16500N083

2016

OR FISCAL YEAR BEGINNING _____ 2016, ENDING _____

MINERVA HOME HEALTH CARE INC
Name of taxpayer(s)

274551015
Taxpayer Identification Number

Use this form only if the Maryland return is affected by the use (for any tax year) of any of the following federal provisions from which Maryland has decoupled (Decoupled Provisions):

- Special Depreciation Allowance under the federal Job Creation and Worker Assistance Act of 2002 (JCWAA) as increased and extended under the federal Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA); and subsequent federal legislation, including the American Recovery and Reinvestment Act of 2009 (ARRA).
- Carryover of a net operating loss (NOL) under IRC Section 172 without regard to an election under IRC Section 172(b)(1)(H) for a carryback period of up to 5 years.
- Federal Section 179 depreciation deductions taken for a tax year beginning on or after January 1, 2003. For Maryland tax purposes, a taxpayer only is allowed to expense up to $25,000, reduced dollar-for-dollar by the amount over $200,000, of the cost of Section 179 property that is purchased and put in service for a trade or business for the tax year. For vehicles placed in service after May 31, 2004, Maryland also has decoupled from the higher depreciation deduction for certain heavy duty SUVs allowed under Internal Revenue Code Section 280F.
- Deferral of recognition of income from discharge of indebtedness under the ARRA.
- Deferral of deduction for original issue discount in debt for debt exchanges under the ARRA.

Read instructions and complete the worksheet.	Column 1 Federal Return as Filed	Column 2 Federal Return without Decoupled Provisions	Column 3 Difference Increase/ Decrease (-)
1. **Depreciation Deductions** Subtract the amount in Column 2 from the amount in Column 1 and enter in Column 3. If less than 0, enter as a negative amount (-).	1706 .	2204 .	-498 .
2. **NOL Deductions** Subtract the amount in Column 2 from the amount in Column 1 and enter in Column 3. If less than 0, enter as a negative amount (-).	.	.	.
3. **Original Issue Discounts** Subtract the amount in Column 1 from the amount in Column 2 and enter in Column 3. If less than 0, enter as a negative amount (-).	.	.	.
4. **Discharge of Business Indebtedness** Subtract the amount in Column 1 from the amount in Column 2 and enter in Column 3. If less than 0, enter as a negative amount (-).	.	.	.

5. **Other Changes** (See instructions.) . . . . . .
6. **Net Decoupling Modification** Net the amounts on lines 1 through 5 of Column 3. This is the Decoupling Modification. Enter here and include as a positive number on the appropriate line of the Maryland return being filed. Also enter the applicable letter code(s) on the lines provided on the return. See table below. -498 .
7. **Decoupling from PTE.** Enter code letter dp. (See instructions.) . . . . . .

Return Filed	If line 6 above is positive enter on the line for:	Use the following code if there is an amount above on: Line 1 only	Line 2 only	Line 4 only	Multiple Lines	If line 6 above is negative enter on the line for:	Use the following code if there is an amount above on: Line 1 only	Line 2 only	Line 4 only	Multiple Lines
500	Addition Adjustments	e	f	cd	dm	Subtraction Adjustments	j	k	cd	dm
502	Other Additions	l	m	cd	dm	Other Subtractions	bb	cc	cd	dm
504	Other Additions	No code required				Other Subtractions	No code required			
505	Other Additions	j	k	cd	dm	Other Subtractions	bb	cc	cd	dm
500X	Total Addition Modifications	No code required				Total Subtraction Modifications	No code required			
502X	Additions to Income	No code required				Subtractions from Income	No code required			
505X	Additions to Income	No code required				Subtractions from Income	No code required			

FORM EFT

Tax Type: Check type(s)

- ☐ Withholding
- ☐ Corporation Income Tax
  (Pass-through Entities are not eligible.)
- ☐ Motor Fuel Taxes

Comptroller of Maryland
Authorization Agreement for
Electronic Funds Transfers

- ☐ New
- ☐ Revision: Effective Date _____

Allow 10 business days for revisions.

Complete this section:

Name of Business MINERVA HOME HEALTH CAR
Maryland Central Registration Number
Federal Employer Identification Number 274551015
Motor Fuel Tax Account Number (if applicable)

A CONTACT PERSON(S)

This section must be completed by all taxpayers

Primary EFT contact person _____

Address 2301 DORSEY ROAD SUITE 111

GLEN BURNIE MD 21061

City State ZIP code Telephone number

Secondary EFT contact person _____

Address _____

City State ZIP code Telephone number

Signature of owner, partner, or officer Title Date

CHOOSE ONLY ONE OF THE TWO PAYMENT OPTIONS BELOW

B ACH DEBIT

This section to be completed only if you choose the ACH DEBIT OPTION

If ACH Debit is chosen, you authorize the Comptroller of Maryland to present the debit entries to your bank for the tax identified above. Only you can initiate a debit by calling the State's Service Bureau and indicating the amount of tax to be paid by electronic funds transfer.

Bank name _____

Bank address _____

City State ZIP code

Bank account number _____ Bank routing/transfer number _____

☐ Checking ☐ Savings

Signature of owner, partner, or officer Title Date

C ACH CREDIT

This section to be completed only if you choose the ACH CREDIT OPTION

An AUTHORIZED REPRESENTATIVE of your bank must complete and sign this section confirming that you and your bank are capable of initiating ACH CREDITS in the required CCD + TXP format.

Bank name _____

Bank address _____

City State ZIP code

Printed name of bank representative Telephone number

Signature of bank representative Date

This form must be completed and faxed to 410-260-6214 or mailed to:
Electronic Funds Transfer Program, P.O. Box 1509, Annapolis, MD 21404-1509

Wells Fargo Business Choice Checking

Account number: **2000059117463** ■ May 1, 2017 - May 31, 2017 ■ Page 1 of 6

WELLS FARGO

MINERVA HOME HEALTH CARE INC
176 LEEDS CREEK CIR
ODENTON MD 21113-3903

Questions?

Available by phone 24 hours a day, 7 days a week:
Telecommunications Relay Services calls accepted
1-800-CALL-WELLS (1-800-225-5935)
TTY: 1-800-877-4833
En español: 1-877-337-7454

Online: wellsfargo.com/biz

Write: Wells Fargo Bank, N.A. (336)
P.O. Box 6995
Portland, OR 97228-6995

Your Business and Wells Fargo

Cash flow is a key indicator of the financial health of your business. Find tips and strategies for effective cash flow management at wellsfargoworks.com.

Account options

A check mark in the box indicates you have these convenient services with your account(s). Go to wellsfargo.com/biz or call the number above if you have questions or if you would like to add new services.

Business Online Banking	☑
Online Statements	☑
Business Bill Pay	☑
Business Spending Report	☑
Overdraft Protection	☐

Activity summary

Beginning balance on 5/1	$9,165.28
Deposits/Credits	95,320.60
Withdrawals/Debits	- 87,365.46
Ending balance on 5/31	**$17,120.42**
Average ledger balance this period	$23,833.79

Account number: **2000059117463**
MINERVA HOME HEALTH CARE INC
Maryland account terms and conditions apply
For Direct Deposit use
Routing Number (RTN): 055003201
For Wire Transfers use
Routing Number (RTN): 121000248

Overdraft Protection
This account is not currently covered by Overdraft Protection. If you would like more information regarding Overdraft Protection and eligibility requirements please call the number listed on your statement or visit your Wells Fargo store.

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WELLS FARGO

Transaction history

Date	Check Number	Description	Deposits/ Credits	Withdrawals/ Debits	Ending daily balance
5/1		eDeposit IN Branch/Store 04/29/17 12:54:18 Pm 7568 Ridge Rd Hanover MD 6467	23,508.85		
5/1		Purchase authorized on 04/28 National Pen CO LI 858-675-3000 CA S307117856716752 Card 6467		201.70	
5/1		Purchase authorized on 04/28 Bonefish Grill #81 Gambrills MD S307118029684329 Card 6467		88.56	
5/1		Online Transfer to Green F Checking xxxxxxxxx9751 Ref #Ib03D4Jkbs on 04/29/17		5,000.00	
5/1		Purchase authorized on 04/29 Costco Gas #0325 Hanover MD P00587119790363599 Card 6467		46.11	
5/1		Recurring Transfer to Minerva Home Healthcare Business Checking Ref #Op03D93Z4Y xxxxxx5026		500.00	26,837.76
5/2		ATM Check Deposit on 05/01 7846 Quarterfield Prk Severn MD 0000085 ATM ID 0276Q Card 6467	4,920.00		
5/2		ATM Check Deposit on 05/02 7568 Ridge Road Hanover MD 0002745 ATM ID 0266R Card 6467	1,535.00		
5/2		Transfer From Popoola Emmanuel on 05/02 Ref # Ppey2R7Kmr Loan Payment	100.00		
5/2		Recurring Payment authorized on 05/01 Devero 800-2190664 CA S307121278560737 Card 6467		500.00	
5/2		Purchase authorized on 05/01 Nextiva*Voip Servi 800-9834289 AZ S467121303778669 Card 6467		170.67	32,722.09
5/3		Purchase authorized on 05/01 Royal Farms 040 Severn MD S587121552434010 Card 6467		20.59	
5/3		Purchase authorized on 05/02 E-Zpass MD Rebill 800-950-1292 MD S587122213511493 Card 6467		100.00	
5/3		Online Transfer to Minerva Home Healthcare Inc Business Checking xxxxxx6945 Ref #Ib03Djd6Xg on 05/03/17		1,000.00	
5/3		Bill Pay at & T Recurringxxxx82208 on 05-03		42.56	31,558.94
5/4		ATM Check Deposit on 05/04 7568 Ridge Road Hanover MD 0003348 ATM ID 0266R Card 6467	7,118.75		38,677.69
5/5		St. Vendor Pmts. EFT Trnsfr 050417 xxxxx6889 Rmt*IV*974220 *0000133281*M00 *41076755	1,332.81		
5/5		Bill Pay Verizon Communic Recurringxxxxxxxxx00105 on 05-05		135.58	39,874.92
5/8		ATM Check Deposit on 05/08 7846 Quarterfield Prk Severn MD 0001887 ATM ID 0276Q Card 6467	5,665.35		
5/8		Online Dep Detail & Images - Bob		3.00	
5/8		Quickbooks Banking		14.95	
5/8		Purchase authorized on 05/04 Cantina Mama Lucia Hanover MD S167124644792521 Card 6467		58.78	
5/8		WF Bus Credit Auto Pay 170505 90469200457216 Green,Folashade E		140.42	
5/8	10424	Check		140.00	45,183.12
5/9		Purchase authorized on 05/08 Wawa 8507 0008 Glen Burnie MD S307128562011816 Card 6467		19.14	
5/9		Allstate Ins CO Ins Prem May 17 000000998445962 Green		139.74	45,024.24
5/11		Online Transfer to Minerva Home Healthcare Inc Business Checking xxxxxx6945 Ref #Ib03F4Cn92 on 05/10/17		29,000.00	
5/11		Online Transfer to Green F Checking xxxxxxxxx9751 Ref #Ib03F4Cnk8 on 05/10/17		2,000.00	14,024.24
5/12		St. Vendor Pmts. EFT Trnsfr 051117 xxxxx0690 Rmt*IV*982350 *0000116304*M00 *41076755	1,163.04		
5/12		Purchase authorized on 05/11 IN *Kaleida System 704-8144429 NC S467131742671415 Card 6467		75.00	
5/12		Bill Pay Workers Compensa Recurringxx75878 on 05-12		905.00	
5/12		Bill Pay Workers Compensa Recurringxx75878 on 05-12		905.00	
5/12	10427	Check		140.00	13,162.28
5/15		Transfer From Popoola Emmanuel on 05/15 Ref # Ppekglcr5W Loan	100.00		

WELLS FARGO

Transaction history (continued)

Date	Check Number	Description	Deposits/ Credits	Withdrawals/ Debits	Ending daily balance
5/15		Purchase authorized on 05/12 Panera Bread #2037 410-721-9041 MD S587131611417047 Card 6467		84.77	
5/15		Purchase authorized on 05/13 Panera Bread #2037 301-931-6707 MD S587131627603013 Card 6467		105.98	
5/15		Purchase authorized on 05/11 Exxonmobil 4782 Hyattsville MD S587131813897713 Card 6467		20.54	
5/15		Purchase authorized on 05/13 Nandos of Arundel Hanover MD S387133807787297 Card 6467		63.23	
5/15		Recurring Transfer to Minerva Home Healthcare Business Checking Ref #Op03FG4Cvx xxxxxx5026		500.00	12,487.76
5/16		Bill Pay State Employees Recurringxxxxx47688 on 05-16		500.00	
5/16		Zirmed.Com Cash Con 128606 Minerva Home Healthcar		124.00	11,863.76
5/17		ATM Check Deposit on 05/17 7568 Ridge Road Hanover MD 0007914 ATM ID 0266R Card 6467	14,374.75		
5/17		Bill Pay Timothy F. Pasch Recurringno Account Number on 05-17		350.00	25,888.51
5/18		Carecentrix EFT for PR 170516 Trn*1*0270338*1113454103~	510.00		26,398.51
5/19		St. Vendor Pmts. EFT Trnsfr 051817 xxxxx1264 Rmt*IV*990792 *0000107500*M00 *41076755	1,075.00		
5/19		Online Transfer Ref #Ibe2Yc8Lhc to Wells Fargo Business Secured Credit Cardxxxxxxxxxxxx7216 on 05/19/17		1,500.00	
5/19		Online Transfer Ref #Ibev5R6Gmy to Platinum Card Xxxxxxxxxxx3159 on 05/19/17		200.00	25,773.51
5/22		Recurring Payment authorized on 05/18 Wyndham Vacation R 888-739-4016 NV S387138350651695 Card 6467		250.06	
5/22		Purchase authorized on 05/19 Bonefish 8103 Glen Burnie MD S587139005630879 Card 6467		43.94	
5/22		Recurring Payment authorized on 05/19 Club Wyndham Plus 888-739-4022 NV S387139286763438 Card 6467		61.25	
5/22		Purchase authorized on 05/19 Exxonmobil 4786 Hanover MD S307139398429225 Card 6467		24.44	
5/22		Purchase authorized on 05/19 Devero 800-2190664 CA S307139815528244 Card 6467		21.11	25,372.71
5/23		Bill Pay Volt Recurringxxxt0027 on 05-23		682.34	24,690.37
5/24		ATM Check Deposit on 05/24 7568 Ridge Road Hanover MD 0000263 ATM ID 0266R Card 6467	18,920.00		
5/24		Purchase authorized on 05/23 Royal Farms #193 Linthicum Hei MD S467143075008947 Card 6467		12.12	
5/24		Bill Pay Airport South CO Recurringno Account Number on 05-24		1,865.00	41,733.25
5/25		Carecentrix EFT for PR 170523 Trn*1*0271344*1113454103~	170.00		
5/25		One Call Care MA Occm Dr 05 170524 1309150 Minerva Home Health CA	525.00		
5/25		Purchase authorized on 05/25 Marylandgovpay Annapolis MD S467145032929783 Card 6467		300.00	
5/25		Purchase authorized on 05/25 MD.Gov Service Fee Annapolis MD S387145032935515 Card 6467		9.00	
5/25		Online Transfer to Minerva Home Healthcare Inc Ref #Ib03G6T3MI Business Checking Payroll		33,000.00	
5/25		Online Transfer to Green F Checking xxxxxxxxx9751 Ref #Ib03G6T4L8 on 05/25/17		2,000.00	7,119.25
5/26		St. Vendor Pmts. EFT Trnsfr 052517 xxxxx1661 Rmt*IV*998828 *0000150500*M00 *41076755	1,505.00		
5/26		Purchase authorized on 05/25 Royal Farms 040 Severn MD S387145050977393 Card 6467		20.47	
5/26		Recurring Payment authorized on 05/25 AT&T*Bill Payment 800-331-0500 TX S587145714359691 Card 6467		250.15	
5/26		Purchase authorized on 05/25 Dnh*Godaddy.Com 480-5058855 AZ S387145795395050 Card 6467		224.20	
5/26		Recurring Transfer to Minerva Home Healthcare Inc Business Market Rate Savings Ref #Op03G8Hp2Z xxxxxxxxx8729		2,500.00	
5/26		Purchase authorized on 05/26 USPS PO 23829803 819 Reec Severn MD P00387146543843567 Card 6467		98.00	5,531.43

WELLS FARGO

Transaction history (continued)

Date	Check Number	Description	Deposits/ Credits	Withdrawals/ Debits	Ending daily balance
5/30		ATM Check Deposit on 05/28 8210 Gateway Overlook Elkridge MD 0008138 ATM ID 0763P Card 6467	4,239.45		
5/30		Purchase authorized on 05/27 Rmg*Regus 972-340-2021 TX S307147229803298 Card 6467		828.04	
5/30		Purchase authorized on 05/27 Royal Farms 149 Odenton MD S467147715135087 Card 6467		17.02	
5/30	120102	Check		363.00	8,562.82
5/31		ATM Check Deposit on 05/31 7846 Quarterfield Prk Severn MD 0007969 ATM ID 0276Q Card 6467	8,557.60		17,120.42
Ending balance on 5/31					**17,120.42**
Totals			**$95,320.60**	**$87,365.46**	

The Ending Daily Balance does not reflect any pending withdrawals or holds on deposited funds that may have been outstanding on your account when your transactions posted. If you had insufficient available funds when a transaction posted, fees may have been assessed.

Summary of checks written *(checks listed are also displayed in the preceding Transaction history)*

Number	Date	Amount	Number	Date	Amount	Number	Date	Amount
10424	5/8	140.00	10427 *	5/12	140.00	120102 *	5/30	363.00

* *Gap in check sequence.*

Monthly service fee summary

For a complete list of fees and detailed account information, please see the Wells Fargo Fee and Information Schedule and Account Agreement applicable to your account or talk to a banker. Go to wellsfargo.com/feefaq to find answers to common questions about the monthly service fee on your account.

Fee period 05/01/2017 - 05/31/2017	Standard monthly service fee $14.00	You paid $0.00
How to avoid the monthly service fee	Minimum required	This fee period
Have any **ONE** of the following account requirements		
· Average ledger balance	$7,500.00	$23,834.00 ☑
· Qualifying transaction from a linked Wells Fargo Business Payroll Services account	1	0 ☐
· Qualifying transaction from a linked Wells Fargo Merchant Services account	1	0 ☐
· Total number of posted Wells Fargo Debit Card purchases and/or payments	10	28 ☑
- Enrollment in a linked Direct Pay service through Wells Fargo Business Online	1	0 ☐
· Combined balances in linked accounts, which may include	$10,000.00	☑
- Average ledger balances in business checking, savings, and time accounts		
- Most recent statement balance in eligible Wells Fargo business credit cards and lines of credit, and combined average daily balances from the previous month in eligible Wells Fargo business and commercial loans and lines of credit		
- For complete details on how you can avoid the monthly service fee based on your combined balances please refer to page 7 of the Business Account Fee and Information Schedule at www.wellsfargo.com/biz/fee-information		

wx/wx

Account transaction fees summary

Service charge description	Units used	Units included	Excess units	Service charge per excess units ($)	Total service charge ($)
Cash Deposited ($)	0	7,500	0	0.0030	0.00
Transactions	35	200	0	0.50	0.00
Total service charges					**$0.00**

WELLS FARGO

IMPORTANT ACCOUNT INFORMATION

Helpful information about avoiding the monthly service fee on this checking account.

None of the options to avoid the monthly service fee for this account have changed. All of the options are listed under the "Monthly service fee summary" section of this statement.

Below are the details for the 10 or more posted debit card purchases/payments option to avoid the monthly service fee each fee period:
- Debit card purchases include: PIN, Signature, Online and Phone purchases that post during the fee period
- Debit card payments include: one-time and recurring payments of bills made with your debit card that post during the fee period
- Not Included: any transactions made at an ATM (Wells Fargo or Non-Wells Fargo), and ACH (Automated Clearing House) transactions
- Fee period: debit card transactions must post during the fee period to count. The dates of your fee period are located in the "Monthly service fee summary" section of this statement. Transactions received after the applicable cut-off time or on a non-business day (Saturday, Sunday and federal holidays) are posted on the next business day.

If you have any questions about how to avoid the monthly service fee on your account, please contact your local banker or call the number listed on this statement.

Please note the following in connection with your Wells Fargo Debit or ATM Card:
At certain ATMs inside Wells Fargo branches, during branch hours, your daily ATM withdrawal limit may not apply, and you may be able to access and perform transactions on accounts that are not linked to your card. At most ATMs, however, your daily ATM withdrawal limit will apply, and you will only have access to accounts linked to your card.

The Consumer Account Agreement, Business Account Agreement, and Selected Terms and Conditions for Wells Fargo Consumer Debit and ATM Cards; Business Debit, ATM and Deposit Cards; Campus Debit Card and Campus ATM Card; Wells Fargo Advisors Accounts; and Private Bank Debit Cards are revised as follows:

In the sections entitled, "Electronic fund transfer services", "Issuance of a card and Personal Identification Number (PIN)", "What you can do at Wells Fargo ATMs", "Daily limits and funds available for use with cards" and "Linking accounts for card access and designating primary account", references to "linked account(s)" and "accounts linked to your card" have been changed to "account(s)".

In the section entitled, "Daily limits and funds available for use with cards", modifications have been made to reflect that at certain ATMs inside Wells Fargo branches, during branch hours, your daily ATM withdrawal limit may not apply, and you may be able to access and perform transactions on accounts that are not linked to your card. At most ATMs, however, your daily ATM withdrawal limit will apply, and you will only have access to accounts linked to your card.

General statement policies for Wells Fargo Bank

■ **Notice:** Wells Fargo Bank, N.A. may furnish information about accounts belonging to individuals, including sole proprietorships, to consumer reporting agencies. If this applies to you, you have the right to dispute the accuracy of information that we have reported by writing to us at: Overdraft Collections and Recovery, P.O. Box 5058, Portland, OR 97208-5058.

You must describe the specific information that is inaccurate or in dispute and the basis for any dispute with supporting documentation. In the case of information that relates to an identity theft, you will need to provide us with an identity theft report.

Account Balance Calculation Worksheet

1. Use the following worksheet to calculate your overall account balance.
2. Go through your register and mark each check, withdrawal, ATM transaction, payment, deposit or other credit listed on your statement. Be sure that your register shows any interest paid into your account and any service charges, automatic payments or ATM transactions withdrawn from your account during this statement period.
3. Use the chart to the right to list any deposits, transfers to your account, outstanding checks, ATM withdrawals, ATM payments or any other withdrawals (including any from previous months) which are listed in your register but not shown on your statement.

ENTER

A. The ending balance shown on your statement . . . . $ ____________

ADD

B. Any deposits listed in your register or transfers into your account which are not shown on your statement.

$ ____________
$ ____________
$ ____________
+ $ ____________

. . . . TOTAL $ ____________

CALCULATE THE SUBTOTAL
(Add Parts A and B)

. . . . TOTAL $ ____________

SUBTRACT

C. The total outstanding checks and withdrawals from the chart above . . . . - $ ____________

CALCULATE THE ENDING BALANCE
(Part A + Part B - Part C)
This amount should be the same as the current balance shown in your check register . . . . $ ____________

Number	Items Outstanding	Amount
	Total amount $	

Wells Fargo Business Choice Checking

Account number: **2000059117463** ■ June 1, 2017 - June 30, 2017 ■ Page 1 of 7

WELLS FARGO

MINERVA HOME HEALTH CARE INC
176 LEEDS CREEK CIR
ODENTON MD 21113-3903

Questions?

Available by phone 24 hours a day, 7 days a week:
Telecommunications Relay Services calls accepted
1-800-CALL-WELLS (1-800-225-5935)
TTY: 1-800-877-4833
En español: 1-877-337-7454

Online: wellsfargo.com/biz

Write: Wells Fargo Bank, N.A. (336)
P.O. Box 6995
Portland, OR 97228-6995

Your Business and Wells Fargo

Cash flow is a key indicator of the financial health of your business. Find tips and strategies for effective cash flow management at wellsfargoworks.com.

Account options

A check mark in the box indicates you have these convenient services with your account(s). Go to wellsfargo.com/biz or call the number above if you have questions or if you would like to add new services.

Business Online Banking	☑
Online Statements	☑
Business Bill Pay	☑
Business Spending Report	☑
Overdraft Protection	☐

Activity summary

Beginning balance on 6/1	$17,120.42
Deposits/Credits	105,702.50
Withdrawals/Debits	- 80,649.84
Ending balance on 6/30	**$42,173.08**
Average ledger balance this period	$9,705.07

Account number: **2000059117463**
MINERVA HOME HEALTH CARE INC
Maryland account terms and conditions apply
For Direct Deposit use
Routing Number (RTN): 055003201
For Wire Transfers use
Routing Number (RTN): 121000248

Overdraft Protection
This account is not currently covered by Overdraft Protection. If you would like more information regarding Overdraft Protection and eligibility requirements please call the number listed on your statement or visit your Wells Fargo store.

WELLS FARGO

Transaction history

Date	Check Number	Description	Deposits/ Credits	Withdrawals/ Debits	Ending daily balance
6/1		Recurring Transfer to Minerva Home Healthcare Business Checking Ref #Op03Gpqd3Z xxxxxx5026		500.00	
6/1	120101	Check		283.01	16,337.41
6/2		St. Vendor Pmts. EFT Trnsfr 060117 xxxxx9979 Rmt*IV*006675 *0000150500*M00 *41076755	1,505.00		
6/2		Purchase authorized on 05/30 Bonefish Grill #81 Gambrills MD S467150701406120 Card 6467		38.76	
6/2		Purchase authorized on 05/31 Highs 32 Fulton MD S307151659402021 Card 6467		13.53	
6/2		Recurring Payment authorized on 06/01 Devero 800-2190664 CA S387152279222572 Card 6467		500.00	
6/2		Purchase authorized on 06/01 Nextiva*Voip Servi 800-9834289 AZ S587152321268427 Card 6467		172.84	
6/2		Purchase authorized on 06/01 Dnh*Godaddy.Com 480-505-8855 AZ S387152480114616 Card 6467		25.98	
6/2		Bill Pay at & T Recurringxxxx82208 on 06-02		332.35	16,758.95
6/5		Purchase authorized on 06/02 Royal Farms 047 Chase MD S467153543447510 Card 6467		15.14	
6/5		Purchase authorized on 06/03 Bonefish Grill #81 Gambrills MD S467154060790125 Card 6467		147.03	
6/5		Purchase authorized on 06/04 Sakura Japanese St Laurel MD S587155701547860 Card 6467		120.15	
6/5	120104	Check		200.00	16,276.63
6/6		ATM Check Deposit on 06/05 7568 Ridge Road Hanover MD 0004905 ATM ID 0266R Card 6467	4,031.25		
6/6		ATM Check Deposit on 06/06 7568 Ridge Road Hanover MD 0005212 ATM ID 0266R Card 6467	2,512.50		
6/6		Recurring Payment authorized on 06/05 AT&T*Bill Payment 800-331-0500 TX S387157020007066 Card 6467		332.35	
6/6		Bill Pay Verizon Communic Recurringxxxxxxxxxx00105 on 06-06		135.58	22,352.45
6/7		Purchase authorized on 06/05 Bonefish 8103 Glen Burnie MD S587156827000323 Card 6467		96.29	
6/7		Purchase authorized on 06/06 Royal Farms 040 Severn MD S467157033574812 Card 6467		16.01	
6/7		Online Transfer to Minerva Home Healthcare Inc Business Checking xxxxxx6945 Ref #Ib03Hblhpp on 06/07/17		20,000.00	2,240.15
6/8		Online Dep Detail & Images - Bob		3.00	
6/8		Quickbooks Banking		14.95	
6/8		Online Transfer to Minerva Home Healthcare Inc Business Checking xxxxxx6945 Ref #Ib03Hbp5T8 on 06/07/17		1,000.00	
6/8		Allstate Ins CO Ins Prem Jun 17 000000998445962 Green		172.74	
6/8	120106	Check		660.67	388.79
6/9		St. Vendor Pmts. EFT Trnsfr 060817 xxxxx0302 Rmt*IV*014396 *0000150500*M00 *41076755	1,505.00		
6/9		Purchase authorized on 06/08 E-Zpass MD Rebill 800-950-1292 MD S467159213667198 Card 6467		100.00	
6/9		Purchase authorized on 06/09 USPS PO 23829803 819 R Severn MD P00587160611090627 Card 6467		98.00	1,695.79
6/12		ATM Check Deposit on 06/11 7846 Quarterfield Prk Severn MD 0001385 ATM ID 0276Q Card 6467	5,222.05		
6/12		ATM Deposit Adjustment	100.00		
6/12		Purchase authorized on 06/08 Royal Farms #193 Linthicum Hei MD S467159713639828 Card 6467		15.42	
6/12		Purchase authorized on 06/09 IN *Kaleida System 704-8144429 NC S587160568112575 Card 6467		122.32	
6/12		Transfer to Associates Mbanefo Ref #Ppe5Vgpjdt 2ND Payment		775.00	6,105.10
6/13		Transfer From Popoola Emmanuel on 06/12 Ref # Pper8Rrdbh Loan	100.00		
6/13		Purchase authorized on 06/11 Royal Farms 040 Severn MD S307162811178923 Card 6467		36.42	

WELLS FARGO

Transaction history (continued)

Date	Check Number	Description	Deposits/ Credits	Withdrawals/ Debits	Ending daily balance
6/13		Purchase authorized on 06/12 Devero 800-2190664 CA S587163774198569 Card 6467		14.84	
6/13		Online Transfer to Green F Checking xxxxxxxxx9751 Ref #Ib03Hp32KY on 06/13/17		1,000.00	
6/13		Online Transfer Ref #Ibey2Vs9Zr to Wells Fargo Business Secured Credit Cardxxxxxxxxxxxx7216 on 06/13/17		500.00	
6/13		Bill Pay Workers Compensa Recurringxx75878 on 06-13		905.00	3,748.84
6/14		Bill Pay Timothy F. Pasch Recurringno Account Number on 06-14		350.00	
6/14		Bill Pay State Employees Recurringxxxxx47688 on 06-14		500.00	
6/14	120105	Check		378.00	2,520.84
6/15		Purchase authorized on 06/13 Shell Oil 57525765 Baltimore MD S307164843710296 Card 6467		25.36	
6/15		Recurring Transfer to Minerva Home Healthcare Business Checking Ref #Op03Hszr7W xxxxxx5026		500.00	
6/15		Purchase authorized on 06/15 Costco Whse #0325 Hanover MD P00467167008121853 Card 6467		97.48	1,898.00
6/16		Zirmed.Com Cash Con 128606 Minerva Home Healthcar		124.00	1,774.00
6/19	10428	Check		140.00	1,634.00
6/20		Purchase authorized on 06/18 The Chop House - A Annapolis MD S387170067523163 Card 6467		297.24	
6/20	120103	Check		200.00	1,136.76
6/21		Online Transfer From Manufacturers & Traders Tr CO Chk xxxxxx8499 F. Green Ref #F203Hycktk on 06/15/17	5,000.00		
6/21		ATM Check Deposit on 06/20 7568 Ridge Road Hanover MD 0000041 ATM ID 0266R Card 6467	35,720.00		
6/21		Recurring Payment authorized on 06/19 Wyndham Vacation R 888-739-4016 NV S387170273648954 Card 6467		250.06	
6/21		Online Transfer Ref #Ibencqyf89 to Platinum Card Xxxxxxxxxxx3159 on 06/21/17		450.00	
6/21		Bill Pay Volt Recurringxxxt0027 on 06-21		682.34	
6/21		WF Credit Card Auto Pay 170620 90154331943159 Green,Folashade E		26.27	40,448.09
6/22		Recurring Payment authorized on 06/20 Club Wyndham Plus 888-739-4022 NV S587171312684242 Card 6467		61.25	
6/22		Purchase authorized on 06/21 IN *Mycopyguy-Choi 410-7212151 MD S467172457020763 Card 6467		306.07	
6/22		Online Transfer to Minerva Home Healthcare Inc Business Checking xxxxxx6945 Ref #Ib03Jfv9Q2 on 06/22/17		35,000.00	
6/22		Online Transfer to Minerva Home Healthcare Inc Business Checking xxxxxx6945 Ref #Ib03Jfzn4V on 06/22/17		1,500.00	3,580.77
6/23		St. Vendor Pmts. EFT Trnsfr 062217 xxxxx4783 Rmt*IV*029942 *0000258000*M00 *41076755	2,580.00		
6/23		Purchase authorized on 06/22 Wawa 595 0000 Gambrills MD S387173554923821 Card 6467		17.63	
6/23	120100	Check		450.00	
6/23	120107	Check		52.00	5,641.14
6/26		Online Transfer to Minerva Home Healthcare Business Checking xxxxxx5026 Ref #Ib03Jm37MT on 06/24/17		250.00	
6/26		Recurring Payment authorized on 06/25 AT&T*Bill Payment 800-331-0500 TX S307176733399957 Card 6467		250.15	
6/26		Bill Pay Airport South CO on-Line No Account Number on 06-26		1,919.00	3,221.99
6/27		ATM Check Deposit on 06/27 7568 Ridge Road Hanover MD 0002207 ATM ID 0266R Card 6467	16,203.70		
6/27		Purchase authorized on 06/26 Rmg*Regus 972-340-2021 TX S307177221890078 Card 6467		828.04	
6/27		Purchase authorized on 06/27 Sunoco 00136291 Myersville MD P00000000439904294 Card 6467		18.00	18,579.65
6/28		Purchase authorized on 06/26 Seasons 52 0004 Columbia MD S467177704891138 Card 6467		29.57	
6/28		Purchase authorized on 06/27 E-Zpass MD Rebill 800-950-1292 MD S307178208306052 Card 6467		100.00	

WELLS FARGO

Transaction history (continued)

Date	Check Number	Description	Deposits/ Credits	Withdrawals/ Debits	Ending daily balance
6/28		Online Transfer to Green F Checking xxxxxxxxx9751 Ref #Ib03Jvqstn on 06/28/17		3,000.00	15,450.08
6/30		ATM Check Deposit on 06/29 7568 Ridge Road Hanover MD 0001009 ATM ID 0968Q Card 6467	31,223.00		
6/30		Online Sched Payment Ref #Ope2Ygn94F to Wells Fargo Business Secured Credit Cardxxxxxxxxxxxx7216		2,000.00	
6/30		Recurring Transfer to Minerva Home Healthcare Inc Business Market Rate Savings Ref #Op03Jyt67K xxxxxxxxx8729		2,500.00	42,173.08
Ending balance on 6/30					**42,173.08**
Totals			**$105,702.50**	**$80,649.84**	

The Ending Daily Balance does not reflect any pending withdrawals or holds on deposited funds that may have been outstanding on your account when your transactions posted. If you had insufficient available funds when a transaction posted, fees may have been assessed.

Summary of checks written *(checks listed are also displayed in the preceding Transaction history)*

Number	Date	Amount	Number	Date	Amount	Number	Date	Amount
10428	6/19	140.00	120103 *	6/20	200.00	120106	6/8	660.67
120100 *	6/23	450.00	120104	6/5	200.00	120107	6/23	52.00
120101	6/1	283.01	120105	6/14	378.00			

* *Gap in check sequence.*

Monthly service fee summary

For a complete list of fees and detailed account information, please see the Wells Fargo Fee and Information Schedule and Account Agreement applicable to your account or talk to a banker. Go to wellsfargo.com/feefaq to find answers to common questions about the monthly service fee on your account.

Fee period 06/01/2017 - 06/30/2017	Standard monthly service fee $14.00	You paid $0.00
How to avoid the monthly service fee	Minimum required	This fee period
Have any **ONE** of the following account requirements		
· Average ledger balance	$7,500.00	$9,705.00 ☑
· Qualifying transaction from a linked Wells Fargo Business Payroll Services account	1	0 ☐
· Qualifying transaction from a linked Wells Fargo Merchant Services account	1	0 ☐
· Total number of posted Wells Fargo Debit Card purchases and/or payments	10	29 ☑
- Enrollment in a linked Direct Pay service through Wells Fargo Business Online	1	0 ☐
· Combined balances in linked accounts, which may include	$10,000.00	☑
- Average ledger balances in business checking, savings, and time accounts		
- Most recent statement balance in eligible Wells Fargo business credit cards and lines of credit, and combined average daily balances from the previous month in eligible Wells Fargo business and commercial loans and lines of credit		
- For complete details on how you can avoid the monthly service fee based on your combined balances please refer to page 7 of the Business Account Fee and Information Schedule at www.wellsfargo.com/biz/fee-information		

WX/WX

WELLS FARGO

Account transaction fees summary

Service charge description	*Units used*	*Units included*	*Excess units*	*Service charge per excess units ($)*	*Total service charge ($)*
Cash Deposited ($)	0	7,500	0	0.0030	0.00
Transactions	25	200	0	0.50	0.00
Total service charges					**$0.00**

IMPORTANT ACCOUNT INFORMATION

Revised Agreement for Online Access
We're updating our Online Access Agreement effective September 15, 2017.
To see what is changing, please visit wellsfargo.com/onlineupdates.

Periodically, it is necessary to update selected sections of the disclosures you received when you opened your account. These updates provide you with the most up to date account information and are very important; so please review this information carefully and feel free to contact us with any questions or concerns.

We are updating the Account Agreement ("Agreement") dated April 24, 2017. Effective August 15, 2017, in the section titled "Rights and Responsibilities", the subsections "When can you close your account?" and "If you request to close your account, we may allow you to keep funds in your account to cover outstanding Items to be paid" are deleted and replaced with the following:

When can you close your account?

You can request to close your account at any time if the account is in good standing (e.g., does not have a negative balance or restrictions such as legal order holds or court blocks on the account). At the time of your request, we will assist you in withdrawing or transferring any remaining funds, bringing your account balance to zero.
- All outstanding Items need to be processed and posted to your account before your request to close. Once the account is closed Items will be returned unpaid.
- Any recurring payments or withdrawals from your account need to be cancelled before your request to close (examples include bill payments, debit card payments, and direct deposits) otherwise, they may be returned unpaid.

We will not be liable for any loss or damage that may result from not honoring Items or recurring payments or withdrawals that are presented or received after your account is closed.

At the time of your request to close:
- For interest-earning accounts, it stops earning interest from the date you request to close your account.
- Overdraft Protection and/or Debit Card Overdraft Service will be removed on the date you request to close your account.
- The Agreement continues to apply.
- If you have requested to close your account and a positive balance remains, we may send you a check for the remaining balance. Even after your account is closed, you will remain responsible for any negative balance.

In California branches you can request to close your account at any time if the account does not have any restrictions such as legal order holds or court blocks. Even after your account is closed, you will remain responsible for any negative balance.

All other aspects of the Agreement remain the same. If there is a conflict between the updated language above and the Agreement, the updated language will control.

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Thank you for being a Wells Fargo customer. As a valued Wells Fargo customer, we hope you find this information helpful. Again, if you have questions or concerns about these changes, please contact your local banker or call the number listed on your statement.

WELLS FARGO

General statement policies for Wells Fargo Bank

■ **Notice:** Wells Fargo Bank, N.A. may furnish information about accounts belonging to individuals, including sole proprietorships, to consumer reporting agencies. If this applies to you, you have the right to dispute the accuracy of information that we have reported by writing to us at: Overdraft Collections and Recovery, P.O. Box 5058, Portland, OR 97208-5058.

You must describe the specific information that is inaccurate or in dispute and the basis for any dispute with supporting documentation. In the case of information that relates to an identity theft, you will need to provide us with an identity theft report.

Account Balance Calculation Worksheet

1. Use the following worksheet to calculate your overall account balance.
2. Go through your register and mark each check, withdrawal, ATM transaction, payment, deposit or other credit listed on your statement. Be sure that your register shows any interest paid into your account and any service charges, automatic payments or ATM transactions withdrawn from your account during this statement period.
3. Use the chart to the right to list any deposits, transfers to your account, outstanding checks, ATM withdrawals, ATM payments or any other withdrawals (including any from previous months) which are listed in your register but not shown on your statement. .

ENTER

A. The ending balance shown on your statement . . . . $ ____________

ADD

B. Any deposits listed in your register or transfers into your account which are not shown on your statement.
$ ____________
$ ____________
$ ____________
+ $ ____________

. . . . **TOTAL** $ ____________

CALCULATE THE SUBTOTAL
(Add Parts A and B)

. . . . **TOTAL** $ ____________

SUBTRACT

C. The total outstanding checks and withdrawals from the chart above . . . . - $ ____________

CALCULATE THE ENDING BALANCE
(Part A + Part B - Part C)
This amount should be the same as the current balance shown in your check register . . . . $ ____________

Number	Items Outstanding	Amount
	Total amount $	

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M&T Bank

14700 Main Street, Upper Marlboro, MD 20772
301 952 5712 FAX 301 952 5711

Date: July 05, 2017

To: Maryland Health Care Commission

Regarding Customer:

MINERVA HOME HEALTH CARE, INC

2301 DORSEY RD STE 207

GLEN BURNIE, MD 21061

RE: MINERVA HOME HEALTHCARE

To Whom It May Concern:

This letter is verification that the customer named above has an account with M&T Bank. This account number ending in 12044473335096001, has a current balance of $75,000.00 Line of Credit and is immediately available for use. This fund is designated for use by Minerva Home Health Care at 2301 Dorsey Rd STE 207, Glenburnie, MD 21061.

Sincerely,

Derin Abass-Teniola

Vice President | M & T Bank

Upper Marlboro | Sr Branch Manager

14700 Main Street , Upper Marlboro MD 20772

301 952 5705 (F) 301 952 5711

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No: R3104R

Issued to: Minerva Home Healthcare, Inc.
2301 Dorsey Road
Suite 207
Glen Burnie, MD 21061

Type of Facility or Community Program:
RESIDENTIAL SERVICE AGENCY

Date Issued: November 16, 2014

Service(s) Provided: Skilled Nursing and Aides; Level of Care: Complex Care Provided by RN/LPN and RN Supervision of Aides

Other: REPLACEMENT LICENSE

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, COMAR Section 19-4A et Seq.,. Annotated Code of Maryland and is subject to any and all statutory provisions including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration Date: November 16, 2017

Patricia Tomaka May, MD

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

The Joint Commission

May 12, 2016

Shade Green, RN BSN
Administrator
Minerva Home Healthcare
2301 Dorsey Road Suite 207
Glen Burnie, MD 21061

Joint Commission ID #: 535602
Program: Home Care Accreditation
Accreditation Activity: 45-day Evidence of Standards Compliance
Accreditation Activity Completed: 05/12/2016

Dear Ms. Green:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- **Comprehensive Accreditation Manual for Home Care**

This accreditation cycle is effective beginning April 09, 2016. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

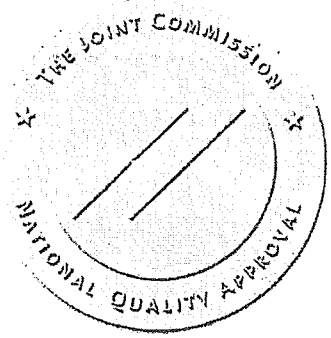
Chief Operating Officer

Division of Accreditation and Certification Operations

Minerva Home Healthcare

Glen Burnie, MD

has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Home Care Accreditation Program

June 9, 2013

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD.
Chair, Board of Commissioners

Organization ID #: 535602
Print/Reprint Date: 06/19/13

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY
SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No: R3587

Issued to: MINERVA REHABILITATION SERVICES, INC
2301 DORSEY ROAD SUITE 111
GLEN BURNIE, MD 21061

Type of Facility or Community Program:
RESIDENTIAL SERVICE AGENCY

Date Issued: March 14, 2015

Service(s) Provided: OCCUPATIONAL THERAPY, PHYSICAL THERAPY, AND SPEECH THERAPY ONLY

Other: N/A

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, COMAR Section 19-4A et Seq.,. Annotated Code of Maryland and is subject to any and all statutory provisions including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration Date: March 14, 2018

Patricia Tomaho May MD

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

Commonwealth of Virginia
Virginia Department of Health

Home Care License Number: **HCO 151193**

In accordance with the provisions of Title 32.1. Chapter 5, Article 7, of the Code of Virginia 1950, as amended.

Shade Green
(Operator)

is Authorized to Operate

(Name of Organization)

Minerva Home Healthcare

a Home Care Organization located at:

1940 Duke Street, Suite 200, Alexandria, Virginia 22314

Expiration Date **07/31/2015**

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

Erik O. Bodin, Director
Office of Licensure and Certification

124

The Joint Commission

March 18, 2016

Re: # 568222
CCN: Pending
Program: Home Health Agency
Accreditation Expiration Date: February 26, 2019

Shade Green
Administrator
Minerva Home Healthcare
1940 Duke St., Ste 200
Alexandria, Virginia 22314

Dear Ms. Green:

This letter confirms that your February 23, 2016 - February 25, 2016 unannounced initial survey was conducted for the purposes of assessing compliance with the Medicare conditions for home health agencies through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on March 17, 2016, The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of March 17, 2016.

The Joint Commission is also recommending your organization for Medicare certification effective March 17, 2016. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is responsible for notifying the State Survey Agency that a recommendation for Medicare certification has been made. Please provide your State agency with a copy of your accreditation report, accreditation award letter, and this Medicare recommendation letter.

This recommendation applies to the following location(s):

Minerva Home Healthcare
1940 Duke St., Ste 200, Alexandria, VA, 22314

This recommendation includes your home health services as providers of home health aides, occupational therapy, physical therapy, skilled nursing and speech language pathology.

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 3 /Survey and Certification Staff

www.jointcommission.org

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

Minerva Home Healthcare Rates

Home Health Rates

Services	Rate/hr	Rate/FU Visit	Rate per SOC
Hi Tech RN	$95.00	$130.00	$150.00
Registered Nurse	$90.00	$130.00	$135.00
RN IVIG Infusion	$90.00	$95 for after 5pm	
RN Wkd/Holiday Rate	$ 100.00	$ 150.00	$ 250.00
LPN	$80.00	$95.00	N/A
CNA/Home Health Aide	$28.00	$50.00	N/A
Homemaker/Comp	$22.00	$45.00	N/A
Physical Therapy	N/A	$150.00	$200.00
PTA	N/A	$130.00	$150.00
Occup. Therapy	N/A	$150.00	$200.00
Speech Therapy	N/A	$150.00	$200.00

Medical Social Worker	N/A	$150.00	$200.00

Minerva Recruitment and Retention of Plan

1. Minerva will create a recruitment timeline. Work in reverse, starting with the date by which you must fill the position and moving backward to the date you intend to advertise the position. Make certain you include an application deadline date and several dates for interviews. Also include time for background and criminal checks, if required.

2. We have a list the positions that needs to fill, along with complete job descriptions for each.

3. Minerva will examine each position and job description, then create a list of desirable traits for each. Keep the list reasonable, about five traits in total, and take into account factors such as expected experience level of the candidates. We will use our selected traits as a means of narrowing down the number of applicants, omitting those who don't meet expectations.

4. We will create an advertising plan. Include the location of the ads as well as how widely you wish to advertise the opening. Place a national ad in an industry publication or an ad on online job boards as needed for suitable candidates.

5. Minerva will include others in the interview process. Choose managers who will be in a supervisory role over the new hire, or those with extensive experience in the department with the opening. Schedule interviews to accommodate the other staff members' schedules and interview together.

6. Minerva will work with the other interviewers to create a list of questions to ask the interviewee. Concentrate on job-related questions and those geared toward finding out whether the potential employee will fit within the culture of the company. Meet with someone from the company's human resources department to review the questions to make certain we are not violating any laws.

7. Set up the interview process. Allow opportunities for second or even third interviews, if necessary. Leave time between the final interview and the position fill date for the successful hire to provide the current employer with notice upon leaving.

8. Keep careful documentation of the interviews and interview decisions. Attach the notes to each interviewee's resume so that we can keep track of how we went about making our hiring decision, in case of litigation or complaint from a disgruntled applicant.

SUBJECT: PATIENT SATISFACTION SURVEY & QUESTIONAIRE	REFERENCE #5017
	PAGE: 1 OF: 3
DEPARTMENT: HOME HEALTHCARE	EFFECTIVE: 08/01/2011
APPROVED BY: ADMINISTRATOR	REVISED: 01/20/2017

POLICY:

The Agency will collect data from current and former patients about their satisfaction with the care and services the received. The administrator will supervise and evaluate the patient satisfaction survey report and assure that all areas of concern are addressed.

PURPOSE:

To assess current performance in satisfying customers and design care and services that meet patient and family needs and expectation.

PROCEDURE:

1. Within 60 days following the discharge date, a satisfaction survey questionnaire will be mailed to the patient, along with a self-addressed envelope for the patient to return the form.

2. Within the first 90 days from start of care a satisfaction survey questionnaire may be mailed to the patient, along with a self-addressed envelope for the patient to return the form or the satisfaction survey questionnaire with a self-addressed stamped envelope may be added to the admission pack and given to the patient or caregiver on the day of admission.

3. The return response will be assessed by the Administrator/DOPCS and place in a binder labeled Patient Satisfaction Questionnaire.

4. Trends and patterns will be determined by the QI department with a written report to the QI Committee for actions/recommendations.

5. Results of the survey, recommendations and actions will be reported to the Administrator, Professional Advisory Committee and Governing Body for Follow-up and recommendations.

SUBJECT: PATIENT SATISFACTION SURVEY & QUESTIONAIRE	REFERENCE #5017
	PAGE: 2 OF: 3
DEPARTMENT: HOME HEALTHCARE	EFFECTIVE: 08/01/2011
APPROVED BY: ADMINISTRATOR	REVISED: 01/20/2017

HOME HEALTHCARE SERVICE QUESTIONNAIRE

To continuously improve the quality of care received by our home healthcare patients, we conduct an ongoing review of the service provided. To help us identify problem areas and/or concerns, we have developed a questionnaire survey for you to complete. Please answer all questions and document any concerns in the space provided below. An envelope has been provided for your convenience. Thank you for your participation.

	Strongly Agree	Agree	Somewhat Agree	Strongly Disagree
1. When you were discharged from the hospital or left the physician's office, did you receive adequate information regarding your home care?	❑	❑	❑	❑
2. When you have telephone contact with the Minerva Home Healthcare staff, are you treated in a courteous manner?	❑	❑	❑	❑
3. When Minerva Home Healthcare staff (i.e., nurse, certified nurse aide) come into your home, are they dependable?	❑	❑	❑	❑
4. Are you given clear instructions and education regarding your home care?	❑	❑	❑	❑
5. Do you feel that the Minerva Home Healthcare staff is accessible to answer your questions?	❑	❑	❑	❑
6. Were your pain management issues addressed adequately?	❑	❑	❑	❑
7. Were you treated in a respectful and supportive manner by our staff during your home care visit(s)?	❑	❑	❑	❑
8. Were mutual goals of treatment discussed at the time of admission?	❑	❑	❑	❑

SUBJECT: PATIENT SATISFACTION SURVEY & QUESTIONAIRE	REFERENCE #5017
DEPARTMENT: HOME HEALTHCARE	PAGE: 3 OF: 3
	EFFECTIVE: 08/01/2011
APPROVED BY: ADMINISTRATOR	REVISED: 01/20/2017

Comments: _____

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_____

Survey Completed By: _____

Relationship _____ Date _____

Patient Name: _____ Date Sent to Patient _____

Date received by Agency: _____

Minerva Home Healthcare

PATIENT SATISFACTION SURVEY

HEALTHCARE SERVICE QUESTIONNAIRE

To continuously improve the quality of care received by our home healthcare patients, we conduct an ongoing review of the service provided. To help us identify problem areas and/or concerns, we have developed a questionnaire survey for you to complete. Please answer all questions and document any concerns in the space provided below. An envelope has been provided for your convenience. Thank you for your participation.

	Strongly Agree	Agree	Somewhat Agree	Strongly Disagree
1. When you were discharged from the hospital or left the physician's office, did you receive adequate information regarding your home care?	❑	❑	❑	❑
2. When you have telephone contact with the Minerva Home Healthcare staff, are you treated in a courteous manner?	❑	❑	❑	❑
3. When Minerva Home Healthcare staff (i.e., nurse, certified nurse aide) come into your home, are they dependable?	❑	❑	❑	❑
4. Are you given clear instructions and education regarding your home care?	❑	❑	❑	❑
5. Do you feel that the Minerva Home Healthcare staff is accessible to answer your questions?	❑	❑	❑	❑
6. Were your pain management issues addressed adequately?	❑	❑	❑	❑
7. Were you treated in a respectful and supportive manner by our staff during your home care visit(s)?	❑	❑	❑	❑
8. Were mutual goals of treatment discussed at the time of admission?	❑	❑	❑	❑

COMMENTS & SUGGESTIONS:

_____

_____

Survey Completed By: _____

Relationship _____ Date _____

Patient Name: _____ Date Sent to Patient _____

Date received by Agency: _____

SUBJECT: PERFORMANCE MEASUREMENT	REFERENCE #9002
	PAGE: 1 OF: 5
DEPARTMENT: HOME HEALTH	EFFECTIVE: 01/01/2015
APPROVED BY: ADMINISTRATOR	REVISED: 01/20/2017

POLICY:

- Measurement of process outcomes facilitates improvement in the quality of patient care.
- MINERVA HHA selects and utilizes a performance measurement system that meets accrediting organization requirements for inclusion in the accreditation process and simultaneously best promotes attainment of the HHA's strategic measurement goals.
- Performance measures are selected by Administrator/DON based on their impact on patient care, services offered, clinical practice, fiscal accountability and cost effectiveness.
- Areas targeted for improvement include, but are not limited to, those that are high-cost, high-risk, high-volume and problem-prone. Additionally, these areas offer genuine opportunities to improve the quality of care.
- The HHA shall also collect data on evaluation and improvement of conditions in the environment, infection prevention and control, and the medication management systems.

PROCEDURE:

- Data is collected and evaluated to ensure that the selected measures fulfill the criteria of high-volume, high-risk, high-cost and/or problem-prone.
- Data is collected to measure performance of each of the following:
  - Significant medication errors
  - Significant adverse drug reactions
  - Patient perception of the safety and quality of care, treatment, or services delivered by the HHA
  - Patient satisfaction with and complaints about products and services
  - The timeliness of response to patient questions, problems and concerns
  - The impact of the organization's business practices on the adequacy of patient access to equipment, items, services and information

- Adverse events involving patients due to inadequate or malfunctioning equipment, supplies, or services, i.e., injuries, accidents, signs and symptoms of infection, hospitalizations
- Staff opinions and needs
- Staff perceptions of risk to individuals
- Staff suggestions for improving patient safety
- Staff willingness to report adverse events (conditions in the organization or patient environment that are related to care, treatment or services)

- MINERVA HHA shall also establish data priorities particular to its needs.
- Multiple internal/external data sources are organized to monitor and assess home health services for quality of healthcare.
- Internal data sources include, but are not limited to, the following:
  - Patient clinical records
  - Patient accident/incident reports
  - Medication error reports, including reports of near misses
  - Infection prevention and control reports
  - Patient perception of care/satisfaction questionnaires
  - Patient letters and/or comments regarding services
  - Staff competency assessments
  - Cost benefit analysis
  - Performance improvement activity form

- Staff orientation, inservice and continuing education records
- Inter/Intradepartmental committee meeting minutes
- Patient case conferences
- Utilization Review reports
- Risk Management activities
- Structure, process and outcome study data
- Accreditation/licensure/certification survey requirements
- Patient classification data
- Patient care standards
- Observations
- Financial reports
- Other data relating directly/indirectly to patient care

- External Data sources include, but are not limited to, the following:
  - Professional organizations
  - Regulatory agencies
  - Review agencies
  - Insurers
  - Continuing education conferences
  - Professional conferences
  - Professional literature

- Valid and relevant structures, processes and outcomes of patient care and/or clinical practice criteria that:
  - Are developed to define the focus for monitoring and assessing quality of healthcare services
  - Are appropriately implemented to monitor and assess quality of healthcare services
- Corrective action plans are developed and implemented.
- Developed corrective action plans describe:
  - All corrective actions required to resolve knowledge, performance and systems areas of concern.
  - Measurable objectives for each corrective action, including degree of expected change in patient care and/or clinical practices.
  - Person(s) responsible for implementing, monitoring, evaluating and reassessing corrective actions.
  - Date corrective action is to be implemented.
  - Date corrective action is to be evaluated for effectiveness.
  - Names/titles of staff responsible for overseeing implementation of the outlined corrective actions.
- Appropriate and valid study methods include, but are not limited to, the following:
  - Audits
  - Patient admission interviews
  - Submitted patient concerns
  - Patient survey forms

- Staff survey forms
- Community analysis survey forms
- Individual patient and staff interviews by telephone and in person
- Patient discharge/transfer interviews
- Group interviews
- HHA staff exit interviews
- HHA staff discipline meetings
- Patient/family case conferences
- Direct/indirect observations
- Patient education surveys

- Data regarding the effectiveness, i.e., the ability to achieve positive outcomes, of the action plans is collected, compiled and analyzed on a monthly basis. Samples are of sufficient size to provide an adequate representation of the areas/issues being studied. Monitored corrective actions are evaluated for actual or potential effectiveness in improvement in the delivery of healthcare.

- Confidentiality of patient information will be maintained in a manner that is consistent with applicable HIPAA regulations and HHA policies and procedures to preserve any confidentiality or privilege of information.

- The data is displayed graphically within the HHA and is analyzed by the Performance Improvement Committee at least on a quarterly basis to ensure that targeted outcomes are being achieved.

- Statistically valid (± 0.10) variances are analyzed immediately upon detection to facilitate improvement of processes, structure or outcomes.

- Performance measurement data is submitted to the Board of Directors for review and evaluation at least annually and more often if necessary.

PERFORMANCE IMPROVEMENT MONITORING AND EVALUATION PLAN

Department: Home Healthcare

Scope: Provide skilled services to patients requiring care and treatment of their disease processes, including instruction, monitoring, assessment and evaluation of their response to treatment modalities, in their place of residence.

Date: 01/13/2014

Responsibility: Case Manager, Nurse Clinician, Nurse Executive, Clinical Supervisors, PI Committee

Priority Focus Area	Performance Measures/Outcomes	Related Functions	Benchmark / Goal	Data Collection (Methodology)	Integration and Collaboration
Assessment and Care/Service	Management of Patient with MS: - Assessment of physical, cognitive, sensory, and bowel and bladder function as evidenced by documentation on each nursing visit - Assessment of response to medications by documented monitoring and managing MS patients for medication-related side effects and communication with physician - Adequate education and counseling patients on medication benefits and adverse effects.	Management of Information Provision of Care, Treatment and Service	90%	Data will be collected from the office patient record on a monthly basis by a member of the PI Department/ Committee/Case Manager/Clinical Supervisor. Data will be aggregated, reviewed and reported on a quarterly basis to the organization's PI Committee, the Nurse Administrator/ Director of Patient Care Services/ Management Committee. Aggregate reports will be submitted to the Administrator and Professional Advisory Committee on a quarterly basis and summarized annually.	Nursing Staff (Employee and Contract) and Nursing Managers Referring Physician

PERFORMANCE IMPROVEMENT MONITORING AND EVALUATION PLAN

Department: Home Healthcare

Scope: Provide skilled services to patients requiring care and treatment of their disease processes, including instruction, monitoring, assessment and evaluation of their response to treatment modalities, in their place of residence.

Date: 01/13/2014

Responsibility: Case Manager, Nurse Clinician, Nurse Executive, Clinical Supervisors, PI Committee

Priority Focus Area	Performance Measures/Outcomes	Related Functions	Benchmark / Goal	Data Collection (Methodology)	Integration and Collaboration
Assessment and Care/Service (continued)	Management of Patient with MS (continued): - Documented patient/ caregiver/significant other understanding of MS teaching (signs/symptoms to report) - Discharge instructions provided to patient/caregiver/ significant other address all of the following: • Impaired mobility • Visual and hearing impairment • Medications • Dysphagia • Cognitive dysfunction • Signs and symptoms to report • Sexual dysfunctions and reproductive issues • Mood Dysfunction • Sensory symptoms, Fatigue • Follow-up appointments	Management of Information Provision of Care, Treatment and Service	90%	Data will be collected from the office patient record on a monthly basis by a member of the PI Department/ Committee/Case Manager/Clinical Supervisor. Data will be aggregated, reviewed and reported on a quarterly basis to the organization's PI Committee, the Nurse Administrator/ Director of Patient Care Services/ Management Committee. Aggregate reports will be submitted to the Administrator and Professional Advisory Committee on a quarterly basis and summarized annually.	Nursing Staff (Employee and Contract) and Nursing Managers Referring Physician

PERFORMANCE IMPROVEMENT MONITORING AND EVALUATION PLAN

Department: Home Healthcare

Scope: Provide skilled services to patients requiring care and treatment of their disease processes, including instruction, monitoring, assessment and evaluation of their response to treatment modalities, in their place of residence.

Date: 01/13/2014

Responsibility: Case Manager, Nurse Clinician, Nurse Executive, Clinical Supervisors, PI Committee

Priority Focus Area	Performance Measures/Outcomes	Related Functions	Benchmark / Goal	Data Collection (Methodology)	Integration and Collaboration
Assessment and Care/Service (continued)	Pain Management: - All patients are assessed for the presence of pain on admission to the organization according to an objective pain scale - All patients with diagnoses that have the potential for causing pain will have their pain level assessed and documented according to an objective pain scale during each skilled visit - Effectiveness of pain medication, if used by the patient, will be assessed and documented during each skilled visit - Effectiveness of pain management techniques will be assessed and documented during each skilled visit - Documented communication with patient's physician and other team members providing care/service when change in patient's pain level/response to medications/other pain management techniques	Ethics, Rights and Responsibilities Provision of Care, Treatment and Service Medication Management Management of Information	100%	Data will be collected from the office patient record within five (5) days of the Start of Care visit by the Case Manager/Clinical Supervisor and on a weekly basis thereafter while the patient remains on service by a member of the PI Department/ Committee/Case Manager/Clinical Supervisor. Data will be aggregated, reviewed and reported on a monthly basis to the organization's PI Committee, Nurse Administrator/ Director of Patient Care Services/ Management Committee. Aggregate reports will be submitted to the Administrator and Professional Advisory Committee on a quarterly basis and summarized annually.	Clinical Staff (SN) and Managers Referring Physician Risk Management

PERFORMANCE IMPROVEMENT MONITORING AND EVALUATION PLAN

Department: Home Healthcare

Scope: Provide skilled services to patients requiring care and treatment of their disease processes, including instruction, monitoring, assessment and evaluation of their response to treatment modalities, in their place of residence.

Date: 01/13/2014

Responsibility: Case Manager, Nurse Clinician, Nurse Executive, Clinical Supervisors, PI Committee

Priority Focus Area	Performance Measures/Outcomes	Related Functions	Benchmark / Goal	Data Collection (Methodology)	Integration and Collaboration
Assessment and Care/Service (continued)	Management of Patients with Open Wounds - Open wounds are assessed and measured during admission and each subsequent skilled nursing visit - Open wounds are photographed one time weekly - Wound care management coincides with physician orders - Aseptic/clean technique/ Standard Precautions followed during wound care procedure - Documented patient/caregiver/ significant understanding of wound care management	Provision of Care, Treatment and Service Management of Information Medication Management Surveillance, Prevention and Control of Infection	100%	Data will be collected from in-office patient charts upon receipt of Start of Care information and weekly thereafter and from direct observation during supervisory visits by the Case Manager/Clinical Supervisor. Data will be reviewed and reported to the Director of Patient Care Services/ Management/PI Committee on a monthly basis. Quarterly reports and annual summaries of the aggregated data will be submitted to the Administrator and Professional Advisory Committee.	Nursing Staff (Employees and Contract) and Nursing Management Medical Director Referring Physician

PERFORMANCE IMPROVEMENT MONITORING AND EVALUATION PLAN

Department: Home Healthcare

Scope: Provide skilled services to patients requiring care and treatment of their disease processes, including instruction, monitoring, assessment and evaluation of their response to treatment modalities, in their place of residence.

Date: 01/13/2014

Responsibility: Case Manager, Nurse Clinician, Nurse Executive, Clinical Supervisors, PI Committee

Priority Focus Area	Performance Measures/Outcomes	Related Functions	Benchmark / Goal	Data Collection (Methodology)	Integration and Collaboration
Assessment and Care/Service (continued)	- Patient/caregiver/significant other education needs and level of understanding are assessed and documented at each skilled visit - Education materials appropriate to the level of understanding and language are provided and reviewed with the patient/caregiver/significant other	Ethics, Rights and Responsibilities Provision of Care, Treatment and Service Leadership	90%	Data will be collected from the office patient record on a weekly basis by a member of the PI Department/ Committee/Case Manager/Clinical Supervisor. Data will be collected by direct observation and by review of the home chart during supervisory visits to the patient's place of residence by the Clinical Supervisor on a monthly basis. Data will be aggregated, reviewed and reported monthly to the Director of Professional Staff/Management/ PI Committee.	All Clinical Staff (SN) and Managers

PERFORMANCE IMPROVEMENT MONITORING AND EVALUATION PLAN

Department: Home Healthcare

Scope: Provide skilled services to patients requiring care and treatment of their disease processes, including instruction, monitoring, assessment and evaluation of their response to treatment modalities, in their place of residence.

Date: 01/13/2014

Responsibility: Case Manager, Nurse Clinician, Nurse Executive, Clinical Supervisors, PI Committee

Priority Focus Area	Performance Measures/Outcomes	Related Functions	Benchmark / Goal	Data Collection (Methodology)	Integration and Collaboration
Patient Safety	- Basic home safety assessment is conducted and documented at the time of the initial visit - Fall assessment is conducted and documented on every patient during each skilled visit - Documented patient/caregiver/ significant other level of understanding of fall prevention precautions	Environmental Safety and Equipment Management Management of Information Medication Management Provision of Care, Treatment and Service	100%	Data will be collected from the in-office patient record and direct observation by the Risk Manager/ Clinical Supervisor on a monthly basis. Data will be aggregated, reviewed and reported to the Administrator/Director of Patient Care Services/Management Committee on a monthly basis and to the Administrator and Professional Advisory Committee on a quarterly basis and summarized annually.	Clinical Personnel (Employee and Contract SN) and Managers Risk Management

PERFORMANCE IMPROVEMENT MONITORING AND EVALUATION PLAN

Department: Home Healthcare

Scope: Provide skilled services to patients requiring care and treatment of their disease processes, including instruction, monitoring, assessment and evaluation of their response to treatment modalities, in their place of residence.

Date: 01/13/2014

Responsibility: Case Manager, Nurse Clinician, Nurse Executive, Clinical Supervisors, PI Committee

Priority Focus Area	Performance Measures/Outcomes	Related Functions	Benchmark / Goal	Data Collection (Methodology)	Integration and Collaboration
Patient Safety (continued)	- Patients are identified using two (2) identifiers before all procedures, medications and treatments - On admission the patient's name, spelling and number is visually confirmed with information on the health insurance card	Management of Information Provision of Care, Treatment and Service	100%	Data will be collected from the office patient chart on a weekly basis by a PI member designee. Data will be aggregated, reviewed and reported on a monthly basis to the organization's PI and Management Committee.	All Clinical Personnel, i.e., SN, (employees and contractors) and Managers Risk Management Billing Department
3	- Upon arrival at the patient's place of residence, staff members address the patient by his/her first and last names - During admission and all subsequent visits each staff member confirms with the patient and documents the correct site(s) for treatment, i.e., wounds, IV/phlebotomy sites, mastectomy sites, shunts, treatment of any extremity	As above	As above	Data will be collected by direct observation by the Case Manager/ Clinical Supervisor on a quarterly basis, and aggregated and reported monthly to the Administrator/Director of Patient Care Services.	As above