Craig J. Lubitski Consulting LLC & CJLC LLC

CERTIFIED PUBLIC ACCOUNTANTS & ADVISORS

Mr. Chris LaVigne
CON & Reimbursement
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Mr. LaVigne:

This enclosed 2015 Medicaid Cost Report intentionally omits the following disallowances:

- a. Administrator and Related Party salaries
- b. Dues and Membership Fees to Professional Associations
- c. Physical or Speech Therapy salaries or fees
- d. Depreciation and/or interest expense related to capitalized items previously deemed unallowable by the Department

It is our understanding that the software utilized by the Department in the rate setting process computes the necessary disallowances for these areas and our intention is to eliminate the potential for a duplicate disallowance.

If you have any questions, please contact me at 860-610-9009.

Respectfully,

Craig J. Lubitski, CPA

Partner

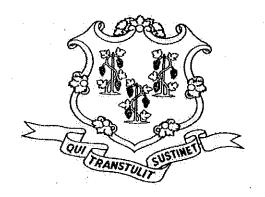


225 Pitkin Street East Hartford Connecticut 06108

860.610.9009 (t) 860.610.9030 (f)

cilc.com

State of Connecticut



Annual Report of Long-Term Care FacilityCost Year 2015

Name of Facility (as	licensed)							
Carlson Place, LLC		=		1				
Address (No. & Stree	et, City, State, Z	Cip Code)						
17 Nelson Ave., Nort	walk, CT 0685	1	***************************************					
Type of Facility								
Chronic and C Nursing Home (CCNH)			Rest Home wi Supervision or (RHNS)	_		Residenti	al Ca	re Home
Report for Year Begi 10/1/2014	nning		Report for Yea 9/30/2015	_				
							,	
License Numbers:		CCNH	RHNS	Reside	Residential Care Home Medicare			dicare Provider
Medicaid Provider N	umbers:	CC	CNH	RI	INS		IC	F-IID
For Department Use	o Only		· · · · · · · · · · · · · · · · · · ·					
Sequence Number Assigned	Signed and Notarized	Date Received	Sequence 1 Assign		Signed a	nd Notari	zed	Date Received

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General Information

·		**************************************		
Name of Facility (as licensed)	License No.	Report for Year Ended	Page	, of
Carlson Place, LLC	1878	9/30/2015	1	37

Administrator's/Owner's Certification

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

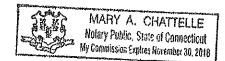
I HERBBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Carlson Place, LLC [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

		C	1	
Signed (Administrator)	Do	Date	Dun In	Date
Printed Name (Administrator)			Printed Name (Owher)	
Diane Mortali			Diane Mortali	
Subscribed and Sworn to before me:	State of	Date 2/8/16	Signed (Notary Public) Maiy a. Chattelle	Comm. Expires
Address of Notary Public Lathrop Dr., 4	Coventry,		1	

(Notary Scal)



State of Connecticut **Department of Social Services**

25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjus	tm	ent		Page	of
				1A	37
Name of Facility		Period Cov	ered:	From	То
Carlson Place, LLC				10/1/2014	9/30/2015
Address of Facility					
17 Nelson Ave., Norwalk, CT 06851		 		1	
Report Prepared By		Phone Nun		Date	
Craig J. Lubitski Consulting LLC		860-610-90)09	2/8/2015	
Item		Total	CCNH	RHNS	Residentia 1 Care Home
	Φ.	Total	CCITI	Turio	Trome
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Co	sts
----------------------------------	-----

General Information and Questionnaire Type of Facility - Organization Structure

	Phone No. of Fac	ility	_	ar Ended	-	of
	860-339-5241		9/30/2015		2	37
Name of Facility (as shown on license)	,		Street, City, Sta			
Carlson Place, LLC CCNH	RHNS		Norwalk, CT dential Care H		Modianro I	Provider No.
License Numbers:	KHINS	Resi		878	Medicare i	TOVIGET NO.
Type of Facility (Check appropriate box(es))				070		
Oliverite and Consularions	Rest Home with	Murci	no			
Nursing Home only (CCNH)	Supervision only			Residenti	ial Care Hor	ne
Type of Ownership (Check appropriate box)						
		_	31 D 61 G	•	~	0
O Proprietorship O LLC O Partnership	O Profit Corp.	O	Non-Profit Co	р. О	Government	O Trust
		Date	Opened	Date Clo	sed	
If this facility opened or closed during report year provide	le:					
Has there been any change in ownership	O V.	•	No	if IIVog II	avalain full	
or operation during this report year?	O Yes		No	n res,	explain full	у
	•					
Administrator						,
Name of Administrator			Nursing Ho	ome		
Diane Mortali			Administrat			
			License 1	No.:		
Other Operators/Owners who are assistant administrator	s (full or part time)	of th				
Name			License l	/o.:		
				ļ		
	,					

General Information and Questionnaire Partners/Members

Name of Facility Carlson Place, LLC		License No. 1878	Report for Y 9/30/2015	Year Ended	Page of 3
Legal Name of Part Carlson Place, LLC	Business A 17 Nelson Ave., CT 06851	State(s) and/o Address Which R		or Town(s) in Registered	
Name of Partners/Members	Business Ad	ldress	,	Title	% Owned
Diane Mortali	P.O. Box 504, Old Say 06475	brook, CT	Member		100

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year En	ded	Page of
Carlson Place, LLC	1878	9/30/2015		3A 37
If this facility is owned or operated as a corporate				
Legal Name of Corporation	Busines	s Address	State(s) in Whi	ch Incorporated
			NATA-	
			·	
Name of Directors, Officers	Busines	s Address	Title	No. Shares Held by Each
			,	
Names of Stockholders Owning at Least 10% of Shares				

State of Connecticut

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General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended 9/30/2015	Page of 3B 37
Carlson Place, LLC	1878		
If this facility is owned or operated as an individua	proprietorship, p	rovide the following informat	ion:
Owi	ner(s) of Facility		
·			
		· · · · · · · · · · · · · · · · · · ·	
		i	
	and the control of th		

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CSP-4 Rev. 10/2005

General Information and Questionnaire Related Parties*

Name of Facility Carlson Place, LLC		License No.	No. 1878	Report for 9/30/2015	Report for Year Ended 9/30/2015		Page 4	of 37
Are any individuals rece	Are any individuals receiving compensation from the facility	cility rel	related through	g		If "Yes," provide the Name/Address and	e Name/Ado	ress and
marriage, ability to cont	marriage, ability to control, ownership, family or business association?	ess associ		O Yes	O No	complete the information on Page 11 of the report.	nation on Pa	ge 11 of the report.
Are any individuals or c	Are any individuals or companies which provide goods or services,	or servic	es,					•
including the rental of prelated through family a	including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business	to this rac , control,	anty, or business		O Yes O No			
association to any of the	association to any of the owners, operators, or officials of this facility?	of this fa	cility?			If "Yes," provide the following information:	e following	information:
		Alsc	Also Provides			Indicate Where		
		Goods	Goods/Services to		· · · · · · · · · · · · · · · · · · ·	Costs are Included	ı	
Name of Related		Non-Re	러	·	Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company	_	Yes	%** No N	쏫	Provided	Page # / Line #	Reported	Related Party
Andrew Mortali	P.O. Box 504, Old Saybrook, CT 06475	0	• •	Loan		Pg. 34/L B3	(234,514)	(234,514)
Andrew Mortali	P.O. Box 504, Old Saybrook, CT 06475	0	•	Rent		Pg 22/L 9	95,146	95,146
- PROMININA	-	0	0					
	,	0	0	:				
	, -	0	0					
		0	0					
		0	0					
·		0	0					
		0	0					

^{*} Use additional sheets if necessary.

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

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No) .	Report for Year Ended	Page	of		
Carlson Place, LLC	1878		9/30/2015	5	37		
If the facility is licensed as CDH and/or RCH o	r provides A	IDS or TB	services with special Medicaio	d rates, c	osts		
must be allocated to CCNH and RHNS as follo-							
Item			Method of Allocation				
Dietary		Number of	meals served to residents				
Laundry		Number of	pounds processed				
Housekeeping			square feet serviced				
			hours of routine care provided	-			
Nursing			classification, i.e., Director (or				
		Registered	Nurses, Licensed Practical Nu	rses, Aid	es and		
		Attendants					
Direct Resident Care Consultants	•	Number of	hours of resident care provided	I by EAC	CH		
		specialist ((See listing page 13)				
Maintenance and operation of plant		Square feet					
Property costs (depreciation) Square feet							
Employee health and welfare Gross salaries							
Management services			e cost center involved				
All other General Administrative expenses	:		rect and Allocated Costs				
The preparer of this report must answer the foll	owing quest	tions applic	able to the cost information pro	rvided.			
1. In the preparation of this Report, were all	O Yes	O No	If "No," explain fully why such		ion was		
costs allocated as required? not made.							
			•				
2. Explain the allocation of related company ex	xpenses and	attach copy	of appropriate supporting data	ı .			
	*						
3. Did the Facility appropriately allocate and s	elf-disallow	direct and i	ndirect costs to non-nursing ho	me cost	centers?		
(e.g., Assisted Living, Home Health, Outpat	ient Service	s, Adult Da	y Care Services, etc.)				
(0,6,,1,00,000 = 1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1			If "No," explain fully why suc	h allocat	ion was		
	O Yes	O No	not made.	ii uiiooat	1011 1143		
			not made.				

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General Information and Questionnaire Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts. of 37

Page

Amount Claimed

Amount Annual ofLease Report for Year Ended Term of Lease 9/30/2015 Lease** Date of Description of Items Leased 1878 License No. Related * to οN 0 Operators, 0 0 0 O 0 0 0 0 Owners, Officers Yes 0 0 0 0 0 0 0 0 0 Name and Address of Lessor Carlson Place, LLC Name of Facility

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also. Is a Mileage Log Book Maintained for All Leased Vehicles?

0

O

Total ***

% 0

O Yes

^{**} Attach copies of newly acquired leases.

^{***} Amount should agree to Page 22, Line 6e.

General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended		Page	of
Carlson Place, LLC	1878	9/30/2015		7	37
The records of this facility for the p	eriod covered by thi	s report were maintained on the following basis:			
Accrual O Cash O	Modified Cash				_
Is the accounting basis for this					
1±	Yes	If "No," explain.			
previous period? O	No				
Independent Accounting Firm			``		
Name of Accounting Firm		Address (No. & Street, City, State, Zip Cod			
1 Craig J. Lubitski Consulting Ll		225 Pitkin Street, East Hartford, CT 06	108		
2 Connecticut Bookkeeper Servi3	ce	PO Box 454, Essex, CT 06426			
4					
Services Provided by This Firm (de	scribe fully)				
1 Medicaid Cost Report Preparation/Bo	ookkeeping		\$	12,394	
2 Payroll Services			\$	3,636	
3			\$		
4			\$		
			Charge fo	or Services P	rovided
			\$	16,030	
Are These Charges Reflected in the Expen-	diture Portion of This Re	port? If Yes, Specify Expense Classification and Line No.			
	PG 15/L 1d				
Legal Services Information					
Name of Legal Firm or Independen				e Number	
1 Goldman, Gruder & Woods, L	LC		203-899-	8900	
2					
3			ĺ		
4 5					
Address (No. & Street, City, State,	Zin Code)				
1 200 Connecticut Ave., Norwal					
2	., 01 0000				
3					
4					
5					
Services Provided by This Firm (de	escribe fully)				
1 Review lease/general legal matters			\$		
2 Collections			\$	878	
3			\$		
4			\$		
5			\$		
			Charge fo	or Services P	rovided
			\$	3,658	
Are These Charges Reflected in the Expen	diture Portion of This Re	eport? If Yes, Specify Expense Classification and Line No.			
O Yes O No		·	·		

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CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility			License No.	√o.			Report fo	Report for Year Ended	đ		Page	jo
Carlson Place, LLC			1	1878			9/30/2015				∞	37
					4	Period 10/1 Thru 6/30	1 Thru 6/.	30		Period 7/1 Thru 9/30	Thru 9/2	0
	Total All	Total CCNH	Total RHNS	Total Residential				Residential				Residential
	Levels	Level	Level	Care Home	Total	CCNH	RHINS	Care Home	Total	CCNH	RHINS	Care Home
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	29		-	29	29			29	29			29
B. On last day of THIS report period	29		-	29	29			29	29			29
2. Number of Residents												
A. As of midnight of PREVIOUS report period	29			29	29			29	29			29
B. As of midnight of THIS report period	29			29	29			29	29			29
3. Total Number of Days Care Provided During Period												
A. Medicare												
B. Medicaid (Conn.)												
C. Medicaid (other states)												
D. Private Pay												
E. State SSI for RCH	9,994			9,994	7,510			7,510	2,484			2,484
F. Other (Specify)			·									
G. Total Care Days During Period (3A thru F)	9,994			9,994	7,510			7,510	2,484			2,484
Total Number of Days Not Included in Figures in 3G	7 PG											
			·									
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	9,994			9,994	7,510			7,510	2,484			2,484

Schedule of Resident Statistics (Cont'd)

Name of Faci	lity			Licer	ise No.				Report	for Year	Ended		Page	of
Carlson Place	-			:	1878					9/30/201	5		9	37
	•										17.		3. T	
			in the certified b		pacity du	ring th	ie repo	rt year	r?	O	Yes	•	No	
If "YES	· · · · · · · · · · · · · · · · · · ·		llowing informa	tion:	Ot.		' D - 1			Con	i A G	Changa		
		Place of	f Change Residential	<u> </u>	Cr	ange	in Bed	5		Ca ₁	pacity Afte	er Change		
Date of	CCNIH	RHNS	Care Home		Lost		(Gaine	1					
Date of	CCIVII	KIIIVS	Oute Home		LOST			Junio				Residential		
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Care Home	Reason fo	or Change
	<u>`</u>	ì		· , ,		. ,	1							
5. If there	vas anv	change i	in certified bed	canaci	tv during	the re	port ve	ear (as	report	ed in item	4 above)	provide the nur	nber of	
	-		90 days followir					`	1			•		
(LDOID)		10 101	20 days 10110 1111	<i>.</i> 6										
			Change in Re	ssider	nt Dave					CC	NH	RHNS	Residential	Care Home
1st chan	ge.		Charge in Re	Janua	пъцз						2.12.2	1011		
2nd cha														
3rd char														
4th char	ge													
Number	of Resid	dents an	d Rates on Septe	mber			ar.				103		0.4 0.	
			Medicare	<u> </u>	Medi	caid				Se	lf-Pay		Otner Sta	te Assisted
	_		CO 111		(C) III	ъ.	75.10	O.	N TTT		73. ICI	Residential	рен	ICE III)
> T	Item		CCNH		CNH	KI	INS	CC	CNH	KI-	INS	Care Home	R.C.H.	ICF-IID
No. of F Per Die													29	
a. One			<u> </u>			25,000							87.00	
b. Two														
c. Three														
bed		•												
														Residential
			al Therapy Treat	ment	3					TO	TAL	CCNH	RHNS	Care Home
		ire - Par												
В			lusive of Part B) e Treatments										OF THE SEASON OF SEASON WAS	
			Treatments							-				
	Other	torative	Treatments											
		Physical	Therapy Treate	nents										
			Therapy Treats					-						
A	. Medica	are - Par	t B											
В			lusive of Part B)	ı										
			e Treatments											
	2. Res	torative	Treatments											
		Speech T	Therapy Treatm	ents										
			ational Therapy		ments									
		are - Par		11040									A STANCE OF THE PARTY OF THE PA	Niconal Association (Control of Control of C
В	. Medic	aid (Exc	lusive of Part B))			•							
	1. Ma	intenanc	e Treatments											
	A D	, ,	Tuontmanto							i		I	1	1
	. Other	torative	Treatments										-	

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Report of Ex	<u> </u>	- Salari			1	
Name of Facility	License No.		Report for Year	Ended	Page	of
Carlson Place, LLC	1878		9/30/2015		10	37
Are time records maintained by all individuals receiving co	mpensation?	•	Yes	0	No	
The time records mandamed by an man, reduced 1			Total Cost a	nd House		
		1	Total Cost a	na Hours		l "
					D : - 1 1	
			D		Residential	**
Item	CCNH	Hours	RHNS	Hours	Care Home	Hours
A. Salaries and Wages*						
Operators/Owners (Complete also Sec. I						
of Schedule A1)						
2. Administrator(s) (Complete also Sec. III					54,478	2,080
of Schedule A1)				CONTRACTOR CONTRACTOR	34,476	2,000
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						e e e e e e e e e e e e e e e e e e e
4. Other Administrative Salaries (telephone					40.204	2.15
operator, clerks, receptionists, etc.)					40,294	2,152
5. Dietary Service						
a. Head Dictitian				l	74,243	4,109
b. Food Service Supervisor c. Dietary Workers				<u> </u>	14,243	7,10
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers			1		6,749	374
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers					33,747	1,868
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers					16,873	934
Barber and Beautician Services		<u> </u>				
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
Directors and Assistant Director of Nurses						5.02 (2.02)
b. RN						
1. Direct Care			-			
2. Administrative** c. LPN						
c. LPN 1. Direct Care	200					STATE OF THE PARTY
2. Administrative**						
d. Aides and Attendants	1.1.				174,007	9,98
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers					50,620	2,80
i. Physicians						
Medical Director		<u> </u>				
Utilization Review						
3. Resident Care***						
4. Other (Specify)						
: Doutists			+	 	1	
j. Dentists k. Pharmacists		 		 	1	
k. Pharmacists 1. Podiatrists	 		-	1		
n. Social Workers/Case Management			1			
n. Marketing		 	1	1		
o. Other (Specify)						
See Attached Schedule						
A-13. Total Salary Expenditures					451,011	24,30

^{*} Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

^{**} Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and

Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

Schedule of Other Salaries and Wages (Page 10)

	C	CNH	RI	HNS	Residential	Care Home
Position	\$	Hours	\$	Hours	S	Hours
		10.00 (15.11)	o Next Carrier of Carrier			
						50 (50 E) E0 (42 H
					146 50 54 53 53	
					3 3 3 3	3.515535
		0 000 600 600 600 60	(* <u>64.24</u> 08.089.00.04).0	1 10 10 10 10 10 10 10 10 10 10 10 10 10	1000 000 000 000 000	
						901196 (GG-1002) 1857 GG-1003
And the state of t						A (5 - 4 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7
	5 AS 65 SS 615 SA	e laguige establica			F.25 S. R. 100 C.	10.35 20.00 11.91
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	9 9 9 9				7 0 0 0 0	
Total	\$ -		\$ -	-	\$ -	

Schedule of Other Fees (Page 13)

	CC	NH	RH	INS .	Residential	Care Home
Service	\$	Hours	\$	Hours	\$	Hours
			51 155 186 184 185 19	May delle con control men		
			2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			
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	50 160 35 55 55	5 to 31 to 42			3.5	
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Total	\$ -		\$ =	S 18 18 19 18 18 18 18 18 18 18 18 18 18 18 18 18	3 =	

State of Connecticut

Annual Report of Long-Term Care Facility CSP-11 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

The state of the s			Institution	onemiliary.		ייייייייייייייייייייייייייייייייייייייי	מאוואס ד ד		۶	
Name of Facility				License No.		Keport for	Keport for Year Ended		rage	10
Carlson Place, LLC				1878		9/30/2015			11	37
		Salary Paid	q					***************************************		
Name	CCNH	RHNS	Residential Care Home	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Section I - Operators/Owners										
				T. LINE STATE OF THE STATE OF T						-
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
Andrew Mortali	,		40,294		Office Work	2,152 A4	A4	N/A		
Cristina Mortali			5,652		Aide	471	471 A12d	N/A		
Miles Mortali			13,120		Aide	920	920 A12d	NA		
* No allowance for calaries will be considered unless full information is movided. Its additional sheets if remitted	he consider	ed imless f	ull information	is provided Tise	additional sheets if rear	rired.				

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

^{**} Include all employment worked during the cost year.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

Nime of The sitter (an income of the	-	1		I someo	I isance Mo	Report for Vear Ended	ar Ended		Раде	90
Name of Factory (as incensed)	-			TICCHEC INC.		יו וטו ווטליאו	ימו דיוותרת		_ 1 1 1 1 1 1	5
Carlson Place, LLC	-			1878		9/30/2015			12	37
	-	Salary Paid	ld				,			
				Fringe Benefits and/or Other		Total	Line Where		Total	-
,		of etter	Residential	Payments	Full Description of		Claimed on	Name and Address of All	Hours	Compensation
Name		CNICA	Cale frome	(frint agreem)	neranres rearries	navro M	1 486 10	Outer temproyment	A OT O	מברינים
Section III - Administrators										-
Diane Mortali	,		54 478	·	Administrator	2 080 42		∀ Z		
רומוס ואוס ואוס ואוס ואוס ואוס ואוס ואוס			27151			7,000,5		1		
				-						-
	-									
Section IV - Assistant Administrators										·
				-						
			,							

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

^{**} Include all other employment worked during the cost year.

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

Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	CS IIO	Report for Y		Page	of
Carlson Place, LLC	187	78	9/30/2015		13	37
			Total Cost	and Hours		
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians		2000				
a. Medical Director (entire facility)			16.0			
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**		*				
d. Administrative Services facility						
Infection Control Committee						
(Quarterly meetings)						·····
Pharmaceutical Committee (Quarterly meetings)		,				
3. Staff Development Committee						
(Once annually)						
e. Other (Specify)			200			
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist		33.4				
a. Resident Care						
b. Other						
11. Nurses and aides and attendants					100	
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN			p de la company			
Direct Care Administrative***					ļ	
			-			
c. Aides d. Other						
12. Other (Specify)						T00151
See Attached Schedule		S. Challes				
B-13 Total Fees Paid in Lieu of Salaries						
D-13 LOUI TEES FAIR IN LIEU OF SHIAITES	<u> </u>	L	[_12 and supported]		<u> </u>	<u> </u>

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

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

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

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

ame of Facility arlson Place, LLC	License No. 1878		Report for Y 9/30/2015	ear Ended	Page 14		of 37
Name & Address of Individual	Full Explanation of Service		to Owners, rs, Officers No	Expla	nation of	Relation	aship
		0	0				
		0	0				
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		0	0				
		0	0				

^{*} Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Carlson Place, LLC	1878		9/30/2015		15	37
		Ī				
						Residential
Item			Total	CCNH	RHNS	Care Home
Administrative and General						
 a. Employee Health & Welfare Benefits 						
1. Workmen's Compensation		\$	15,591			15,591
2. Disability Insurance		\$				
3. Unemployment Insurance		\$	6,549			6,549
4. Social Security (F.I.C.A.)		\$	35,339			35,339
5. Health Insurance		\$	14,298			14,298
6. Life Insurance (employees only)						
(not-owners and not-operators)		\$				
7. Pensions (Non-Discriminatory)		\$				
(not-owners and not-operators)						
8. Uniform Allowance		\$				
9. Other (Specify)		\$			-	
See Attached Schedule						
b. Personal Retirement Plans, Pensions, and		\$	ANN AND AND AND AND AND AND AND AND AND			
Profit Sharing Plans for Owners and						
Operators (Discriminatory)*						
c. Bad Debts*		\$				
d. Accounting and Auditing		\$	16,030			16,030
e. Legal (Services should be fully described	on Page 7)	\$	3,658			3,658
f. Insurance on Lives of Owners and		\$				
Operators (Specify)*						
g. Office Supplies		\$	1,401	200 HAVE AND		1,401
h. Telephone and Cellular Phones						
1. Telephone & Pagers		\$	3,239			3,239
2. Cellular Phones		\$	2,258			2,258
i. Appraisal (Specify purpose and		\$				
attach copy)*						
		_				
j. Corporation Business Taxes (franchise to		\$	250	West of the Control o		250
k. Other Taxes (Not related to property - Se	ee Page 22)					
1. Income*		\$				
2. Other (Specify)		\$				
See Attached Schedule						
3. Resident Day User Fee		\$				
Subtotal		\$	98,612		<u> </u>	98,612

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

(Carry Subtotals forward to next page)

*** DO NOT Include Holiday Parties / Awards / Gifts to Staff

Carlson Place, LLC 9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
	# 1		
			100000000000000000000000000000000000000
		Strategic Const.	
	2 A CONTRACTOR CONTRAC		
	1 000 000 000 000 000 000 000 000 000 0	0	Φ
Total	\$ -	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	- Residential Care Home
	0.4874010		
			6 3000 000 000 00 5 50 5 50 10 10 10 10
	0.000	35 SE 100	
Total	\$ -	\$ -	\$ -

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

Name of Facility	License No.	Report for	Year Ended	Page	of
Carlson Place, LLC	1878	9/30/2015		16	37
The state of the s					
					Residential
Item		Total	CCNH	RHNS	Care Home
Subtota	ls Brought Forward:	98,612			98,612
Travel and Entertainment					
Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	9	175			175
3. Gifts to Staff and Residents		45			45
4. Employee Travel					
5. Education Expenses Related to Seminars an					
6. Automobile Expense (not purchase or depr					
7. Other (Specify)	9				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (all such expense	s) \$				
2. Advertising Telephone Directory (all such a	expenses)***				
3. Advertising Other (Specify)***	9				
See Attached Schedule					
4. Fund-Raising***	\$				
5. Medical Records	4				
6. Barber and Beauty Supplies (if this service	is supplied				
directly and not by contract or fee for service	:e)***				
7. Postage					412
* 8. Dues and Membership Fees to Professional	\$	700			700
Associations (Specify)					
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-A					
9. Subscriptions	\$				
10. Contributions***	\$				
See Attached Schedule					
11. Services Provided by Contract (Specify and	Complete S			and the second s	
Schedule C-2, Page 21 for each firm or ind			To the second		
12. Administrative Management Services**			· ·		
13. Other (Specify)	Ş	7,873			7,873
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$	107,817			107,817

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

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

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

Schedule of Other Travel and Entertainment

			Residential
Description	CCNH	RHNS	Care Home
	40.000 (0.000)	49294555664	E
	38.687 (0)	- Pro- 122 1827 - FEE	
	Received Manager	120 500 505 55	
	S1 (8.152)	NOON SEEN TO THE	
	Strayally Capte		CHUMPHORAS HIDEO
Total Other Travel and Entertainment	\$ -	\$ -	s -

Schedule of Other Advertising

		Residential
CCNH	RHNS	Care Home
\$	S -	\$ -

Schedule of Ducs

Description	CCNH	RHNS	Residential Care Home
CARCH	recorde d'argun ancient recorde a management		\$ 600
BJ's Membership			\$ 100
	4.50 (2.00 (
	1000 1100 1000 1001 100	100000000000000000000000000000000000000	
	224 224 1000000		120001200000000000000000000000000000000
	(88)	and the second	565-766 [654-020]
	58 (50 (50 (68))	100000000000000000000000000000000000000	20120 0100
	50 (50 (60 50)	100000000000000000000000000000000000000	61 V 62 C 63 C
	55.200000000		VC 2002050 0E00
Total Dues	S	\$	\$ 700

Schedule of Contributions

			Residential
Description	CCNII	RHNS	Care Home
		100 Maille	Respondable
Total Contributions	\$ -	S	\$ +

Schedule of Other Administrative and General

Description	- CCNH	RÙNS	Residential Care Home
Bank Service Fees			\$ 1,162
Late Fees/Finance Charges		基本的名	\$ 4,822
Licenses			\$ 1,171
Uncategorized			\$ 313
Contractor	30100100100	153 N. T. 153	\$ 406
		(\$1.55.400.60)	3.165.25.35.35.0
	(S. 58) (S. 68)		Sec. 30. 130. 1
		aliano artigi	. S. (42 452 53) A
	63 (46) (6.8)	100000000000000000000000000000000000000	One Control of the Co
	disconstruis e	.500.00 (/2VE)	0.424.00.00
Total Other Administrative and General	\$ -	\$	\$ 7,873

Schedule C-1 - Management Services*

Name of Facility Carlson Place, LLC	License No. 1878	Report for Year Ended 9/30/2015	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

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

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

		_		n Page 5)		· -·	
	Name of Facility			e No.	Report for Y	Page of	
Car	lson Place, LLC			1878	9/30/201	5	18 37
							Residential Car
	Item			Total	CCNH	RHNS	Home
2.	Dietary						
	a. In-House Preparation & Service			The Section	13.00		
	1. Raw Food		\$	47,561			47,56
	2. Non-Food Supplies		\$				4,97
	3. Other (Specify)		\$				
	b. Purchased Services (by contract other		\$				
	than through Management Services)		·				
	(Complete Schedule C-2 att. Page 21)						
	c. Management Services**		\$				
	d. Other (Specify)		 \$				20
	Small Equipment		·				3 954
	1 - k						
2E.	Total Dietary Expenditures (2a+b+c+d)		\$	52,736			52,73
			<u></u>				
OΒ	Distance Occasion and the			t	000.111	DID IO	Residential Car
	Dietary Questionnaire			Total	CCNH	RHNS	Home
G.	Resident Meals: Total no. of meals served per of	day:	*				
H.	Is cost of employee meals included in 2E?	<u> </u>	Yes	•	No		
I.	Did you receive revenue from employees?) i	Yes	•	No	If yes, specify amt.	
J.	Where is the revenue received reported in the C	Cost	Repor	t? (Page/Line	Item)		
	Is cost of meals provided to persons other	·		1-1-1111-1		TO 10	
K.	than employees or residents (i.e., Board) Y	Yes	•	No	If yes, specify	
	Members, Guests) included in 2E?					cost.	
L.			Yes	•	No	If yes, specify	
M	Where is the revenue received reported in the C	oet	Renor	t? (Page/Line	[tem]	amt.	
,,	Is cost of food (other than meals, e.g.,	, O.S.	торы	. Tugorimo			
N.	snacks at monthly staff meetings hoard	? C	Yes	•	No	If yes, specify cost.	
O.	Is any revenue collected from employees?	7 C	Yes	0	No	If yes, specify amt.	
P.	Where is the revenue received reported in the C	Cost	Repor	t? (Page/Line	Item)		

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

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

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

	ne of Facility	License			Year Ended	Page of
Carl	son Place, LLC		1878	9/30/2013	5	19 37
						Residential Care
	Item		Total	CCNH	RHNS	Home
3.	Laundry					
	a. In-House Processing*	Lbs.			i	
	1. Bed linens, cubicle curtains, draperies,					
	gowns and other resident care items	Amt. \$				
	washed, ironed, and/or processed.***					
	2. Employee items including uniforms,	Lbs.				
	gowns, etc. washed, ironed and/or					
	processed.***	Amt t				
		Amt. \$				
	3. Personal clothing of residents	Lbs.				
	washed, ironed, and/or processed.***	A 6				
<u> </u>		Amt. \$				
	4. Repair and/or purchase of linens.***	Lbs.				
	•	Α	4771			471
<u> </u>		Amt. \$	471			471
	b. Purchased Services (by contract other) p				
	than through Management Services)					
	(Complete Schedule C-2 att. Page 21)	dr.				
	c. Management Services**	\$ \$	655			<i>(27)</i>
	d. Other (Specify)	\$	657			657
	Supplies (2-11-10-14)	\$	1 100			1 100
3E.	Total Laundry Expenditures (3a+b+c+d)	3	1,129			1,129
3F.	Laundry Questionnaire				TO	
G.	Is cost of employee laundry included in 3E?	Yes	•	No	If yes,	
					specify cost.	•
H.	Did you receive revenue from employees?	Yes	•	No	If yes, specify amt.	
Т	Where is the revenue received reported in the Cost	Report?		(Page/Lin		
١٠		Roporti		(Tuge/Eiii	· · · · · · · · · · · · · · · · · · ·	
J.	Is Cost of laundry provided to persons other	Yes	•	No	If yes, specify cost.	
	than employees or residents included in 3E?					
Κ.	Did you receive revenue from these people? O	Yes		No	If yes,	
T.		D 42		(Doca/1 *	specify amt.	
<u>L.</u>	Where is the revenue received reported in the Cost	Report?	100 14	(Page/Lin	е пеш)	

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

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

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

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

· · · · · · · · · · · · · · · · · · ·			Rep	ort for Year E	nded	Page	of
Car	Ison Place, LLC	1878		9/30/2015		20	37
	Item			Total	CCNH	RHNS	Residential Care Home
4.	Housekeeping	Sq. Ft. Serviced		1000	001111	XIII IB	oure Home
7.	a. In-House Care	by Personnel					
	Supplies - Cleaning (Mops, pails, brooms, etc.)	Amt.	\$				
<u> </u>	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att. Page 21)	Amt.	\$	23,391			23,391
\vdash	c. Management Services*		\$				
	d. Other (Specify)		\$	2,131			2,131
	Supplies			-,			, , ,
4E.	Total Housekeeping Expenditures (4a+	b+c+d	\$	25,521			25,521
5.	Resident Care (Supplies)**						
	a. Prescription Drugs***						
	1. Own Pharmacy		\$				
	2. Purchased from		\$				
			.				
	b. Medicine Cabinet Drugs		\$	153			153
	c. Medical and Therapeutic Supplies		\$				
	d. Ambulance/Limousine***		\$				
	e. Oxygen						250
	1. For Emergency Use		\$				
	2. Other***		\$				
	f. X-rays and Related Radiological		\$				
	Procedures***						
ĺ	g. Dental (Not dentists who should be inc	luded under	\$	-			
	salaries or fees)						
	h. Laboratory***		\$		·		
	i. Recreation		\$	5,616			5,616
	j. Other (Specify)****		\$	294			294
	See Attached Schedule						
	Total Resident Care Expenditures (5a - 5		\$	6,063			6,063

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	Residential Care Home
Resident care supplies			\$ 294
	0.35 (3.11)		
	STATES OF THE STATES		
	20 Table 19 19 19 19 19 19 19 19 19 19 19 19 19	30.00	
	and the second		
		160,000 (0.00)	
			12.00
Total Other Resident Care	\$ -	\$ -	\$ 294

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

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

Name of Facility Carlson Place, LLC				License No. 1878	Report for Year Ended 9/30/2015				Page 21	of 37
		Related ** to Owners, Operators, Officers	o Owners, Officers				Total Cost	Total Cost/Page Ref.***		
Name of Individual or Company	Address	Yes	N O	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHINS	Residential Care Home	Pg I	Line
Oaks & Acorn Cleaning Service, LLC	15 Green Valley Lake Road, East Lyme, CT	0	•	None	Includes resident rooms and common areas			23,391	20 4b	ب و
		0	0							
	,	0	0							
		0	0							•
		0	0							
		0	0							
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	•	0	0							
							1			

^{*} List all contracted services over \$10,000. Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

^{***} Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	icense No.	Report for Yo	ear Ended		Page of
Carlson Place, LLC	1878	9/30/2015			22 37
					Residential Care
Item		Total	CCNH	RHNS	Home
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$	9,614			9,614
b. Heat	\$	17,473			17,473
c. Light & Power	\$	14,663			14,663
d. Water	\$	4,345			4,345
e. Equipment Lease (Provide detail on page	ge 6) \$				
f. Other (itemize)	. \$	45,666			45,666
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6	f) \$	91,761			91,761
7. Depreciation (complete schedule page 23*))				
a. Land Improvements	\$				
b. Building & Building Improvements	\$				
c. Non-Movable Equipment	\$				
d. Movable Equipment	\$	4,175			4,175
*7e. Total Depreciation Costs $(7a + b + c + d)$	\$	4,175			4,175
8. Amortization (Complete att. Schedule Page	24*)				
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$	1,710			1,710
d. Other (Specify)	\$				
*8e, Total Amortization Costs $(8a+b+c+d)$	\$	1,710			1,710
9. Rental payments on leased real property les	S				
real estate taxes included in item 10b	\$	95,146			95,146
10. Property Taxes					•
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$	24,839			24,839
c. Personal property taxes	\$	467.			
11. <i>Total Property Expenses</i> (7e + 8e + 9 + 10)) \$	126,337			126,337

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	Residential Care Home
Minor Equipment			\$ 3,793
R&M Purchased Services			\$ 41,873
		9	
		1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
		las succession of	
Total Other Repairs and Maintenance	\$ -	\$ -	\$ 45,666

State of Connecticut
Annual Report of Long-Term Care Facility
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Depreciation Schedule

I I I I I I I I I I I I I I I I I I I			Deprec	Depreciation Schedule	hedule						
Name of Facility			License No.			Report for Year Ended	nded		Page	of	
Carlson Place, LLC			1878	8		9/30/2015			23	37	
			Historical			Accumulated					
-			Cost	Less		Depreciation to	Method of				
-			Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation		
Property Item			Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals	
A. Land Improvements											
 Acquired prior to this report period 			,						2,1		-
Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	h schedule)										
A-4. Subtotal											
B. Building and Building Improvements											
 Acquired prior to this report period 					•			•			
2. Disposals (attach schedule)											
3. Acquired during this report period (attach schedule)	h schedule)										
C. Non-Movable Equipment										38	
									<i>x</i>		
2. Disposals (attach schedule)											
	h schedule)										
	Is a mileage logbook	Date of	Historical			Accumulated					
<u>r</u>	maintained?	Acquisition	Cost	Less		Depreciation to	Method of				
			Exclusive of	Salvage	Cost to Be	Beginning of	Computing		Depreciation		*
	Yes No	Month Year	Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals	
D. Movable Equipment 1 Motor Vehicles (Specify name model											
and more of south untitals)											
	×	11 2006	28.000		28.000	28.000	72	4			
b.											
٦.											
·											
2. Movable Equipment											
a. Acquired prior to this report period		Various Various	76,218		76,218	65,115	TS	Various	4,175		
b. Disposals (attach schedule)											
c. Acquired during this report period											
(attach schedule)											
φį										4,175	
E. Total Depreciation										4,175	

Useful

Schedule of Land Improvements Acquired during this report period

Description of Item	Cost	Useful Life	Depreciation
1			
			15 (15 of 15)
		2 22 82 63 56	
		500000000000000000000000000000000000000	a Seal Bridge Store
mprovements	\$ -		\$ -
. "			
			1.112 (\$0.00) (\$0.00) 1.112 (\$0.00) (\$0.00)
		8 62 C 63 60 8	
		and an execution	
	180 080 08 FAVS 100 (FAVS)	A 150 A 4 8 A 19 A 18 A	
		\$1485.580 Bushin	
nprovements	\$	Brown Star	\$ -
		mprovements \$	Description of Item Cost Life The second s

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
SUCCESS (80 80 98 98)		A	Seles (60 (58 48))	1000,050,050,050
		6.30.60.60.60.	95.008.000.000.004.7	1.76 (50.05.400)
		544-534-54-54-54-54-54-54-54-54-54-54-54-54-54	E GERGERAL SE	
Total additions for Built	ling Improvements	\$ -		\$ -
Deletions:		-		
A 5 (20 - 20 - 20 - 20 - 20 - 20 - 20 - 20		\$100.000		
		40 (50 (00 (00 (00)) 10 (10 (00))		11 (11)
		9 8 3 5		5 10 0 5 0 5 0 5
		50.460.000.000		- 250 - 250 - 250
		Santa Santa Santa	5 (5) (5)	
Total deletions for Build	ling Improvements	\$ -		\$ -

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

	,		Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
99 SP 35 10 10 10 19 1				
		\$100 BUSD		
100000000000000000000000000000000000000		Spara Causion (A)		100 00 90 30
				6 NOT 2017 P. CO.
<u>(25</u> 1-252-1007-1007-1007-1007-1007-1007-1007-100	The state of the s	36.000 100.000	0.454.584.584.684	
		C5 4000 000 000 000	10.000.000.000.000	
		\$ -	954 0000 0000 465 466 466 V	\$ -
Lotal additions for	Non-Movable Equipment	\$ -	\$1,000 ptd (180) 115 Pt (1801) 1	
Deletions:				
		60 LEG 125 LOS 180	5.6.3.5.60	
		6. 500 5 06 55	\$ 90 min con 50	50480 (500 p4) (500 p
S 65, 25, 62, 65, 65			Andre (State (See	0.00
(\$1.80 OE (\$1.50 OE) (\$1.50 OE)		9.0.0.55	E. 65 (78 E.S. 61)	
			8-38-18-18-18-18-18-18-18-18-18-18-18-18-18	40.000.000.00
Annual Control of the		\$ -	100000000000000000000000000000000000000	o .
I otal deletions for	Non-Movable Equipment	ъ -		\$ -

^{*}Ties to Page 23, Line C3

^{**}Ties to Page 23, Line A2

^{**}Ties to Page 23, Line B2

^{**}Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
No. of the Control of			12.012.000.000	2014
			\$20 ASS (\$40 ASS)	400000000000000000000000000000000000000
		Name of the second	20180.034.65.624.	-0.000.0000.000.000.00
		35 (SE VO 102 60)	905000000000000000000000000000000000000	
Cotal additions for	Movable Equipment	\$		\$ -
Deletions:				
				0.00
			60.000.000.000	
			50.000.000.000	
			\$31,585A, \$26,555\$, 5356	14-10-138-131-131-1
Fotal deletions for	Movable Equipment	\$ -	#0.00000000000000000000000000000000000	\$ -

^{*}Tics to Page 23, Line D2c

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
3/13/2015	Replace existing drop-in fixtures lights	\$ 3,420		\$ 684
9/8/2015	Repairs on back of Main roof	\$ 4,615		\$ 923
		18/08/30/30 (3)		
(\$1.00 to 10.00)				
2000 (2000 CE COLOR COLOR COLOR COLOR CE COLOR C			100000000000000000000000000000000000000	0.05108-00-050
Total additions for	Leasehold Improvement	\$ 8,035		\$ 1,607
Deletions:				
				1000
Complete State of the State of		500 100 100 100 100		
		25 55 55 55 55 55 55 55 55 55 55 55 55 5		
Total deletions for	Leasehold Improvement	\$ -		\$ -

^{*}Ties to Page 24, Line C3

^{**}Ties to Page 23, Line D2b

^{**}Ties to Page 24, Line C2

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

Amortization Schedule*

Nam	Name of Facility		License No.		Report for Year Ended	r Ended		Page	fo
Carl	Carlson Place, LLC	<i>y</i>	1878	8	9/30/2015			24	37
	1 1111111111111111111111111111111111111				Accumulated				
		Date of	,		Amort. to				
		Acquisition			Beginning of	Basis for			
			Length of	Cost to Be	Year's	Computing	Rate	Amortization	
	Item	Month Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
Ą.	Organization Expense								
	1.								
	2.								
<u> </u>	3.					·			
A-4	A-4. Subtotal								
Б.	Mortgage Expense								
	1.								
	2.								
	3.	7							
B-4	B-4. Subtotal								
<u>ဂ</u>	Leasehold Improvements and Other								
	1. Acquired prior to this report period	Variou Variou Various	Various	105,171	102,812 SL	SL		103	
	2. Disposals (attach schedule)								
	3. Acquired during this report period								
	(attach schedule)			8,035				1,607	
C-4	C-4. Subtotal								1,710
D.	Total Amortization								1,710

* Straight-line method must be used. ** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.

B. Life of mortgage; OR.
C. Remaining Life of Lease; OR

D. Actual Life if owned by Related Party.

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

Name of Facility Carlson Place, LLC	License No. 1878	Report for Year Er 9/30/2015	nded	, ,	Page of 25 37
	10,0	JAN 1013			20 01
11. Property Questionnaire Part A	automater a la serie e e e				
Is the property either owned by the or leased from a Related Party?*	(9 Yes		No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this fa business association to any person a related party transaction.					
Description		Total			
Date Land Purchased		08/08/06			
2. Date Structure Completed	CD 1	20100105			
 If NOT Original Owner, Dat Date of Initial Licensure 	e of Purchase	08/08/06			
5. Total Licensed Bed Capacity		29			
6. Square Footage					
7. Acquisition Cost		and the second			
a. Land					
b. Building					
Part B - Owner and Related Pa	rties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing		SIMPLE NEW YORK OF			
a. Type of Financing (e.g., 1	ixed, variable)	Fixed	Fixed		
b. Date Mortgage Obtained	¥7	June, 2006	May, 2010		
c. Interest Rate for the Cost d. Term of Mortgage (numb		6.00%	6.00%		
e. Amount of Principal Born		520,000	370,000		,
f. Principal balance outstan		504,200	310,000		
Complete if Mortgage was					
During Current Cost Yo					
g. Type of Financing (e.g., 1					
h. Date of Refinancing		,			
i. New Interest Rate					
j. Term of Mortgage (numb					
k. Amount of Principal Born I. Principal Outstanding on					
I. Principal Outstanding on Part C - Arms-Length Leas		/ Improvements Only	<u> </u>		
Name and Address of Lesso		roperty Leased		Term of Lease	Annual Amount of Lease
Traine and Trainess of 130350	,,	operty zoused	Date of Bease	TOTAL OF ESCAPE	THIRAGIT MICCIAL OF DOUBLE
	·				
			I	-	1

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

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

Name of Facility	License No.		Report for Ye	ar Ended		Page of
Carlson Place, LLC	1878		9/30/2015			26 37
						Residential Care
Item			Total	CCNH	RHNS	Home
12. Interest						
A. Building, Land Improven Equipment	ient & Non-Movabl	e				
Equipment 1. First Mortgage		\$				
Name of Lender		Rate				
			6.35			
Address of Lender						
2. Second Mortgage		\$	7-200			
Name of Lender		Rate				tellares
Address of Lender					100	
Address of Lender						E. S. British
3. Third Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
		<u></u>	Constitution of the second			
4. Fourth Mortgage Name of Lender		\$ Rate				
Name of Lender		Rate				
Address of Lender		<u>.l.</u>				Ballett Ballett
B. CHEFA Loan Information	1			160		and the distance of
1. Original Loan Amoun		\$				
2. Loan Origination Date	•					
3. Interest Rate %						
4. Term						
5. CHEFA Interest Exper	nse					
		\$				
12 B7. Total Building Interest Expense	ise (A1 - A4 + B3)			y Subtotals t	* * * * * * * * * * * * * * * * * * * *	

(Carry Subtotals forward to next page)

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

Name of Facility	License No.		Report for Y	ear Ended		Page	of
Carlson Place, LLC	1878		9/30/2015	· · · · · · · · · · · · · · · · · · ·		27	37
	_					Reside	
	Item		Total	CCNH	RHNS	Care H	ome
		ought Forward:					
12. C. Movable Equipment		٨					
1. Automotive Equi		\$					
A. Item	Rate	Amount					
Lender					L. B. C.		
Address of Lender							
2. Other (Specify)		\$					
A. Item	Rate	Amount					
A. Rem	Rate	Amount					
Lender						100	
Address of Lender							
B. Item	Rate	Amount					
2, 1,							
Lender							
1 t 1		MATERIAL CONTROL CO.					
Address of Lender							
12. C. 3. Total Movable E	-						
Expense (C1 + 2)		\$					
12. D. Other Interest Exper	nse (Specify)	\$					
Other interest							
13. Total All Interest Expen	10a (12B7 + 12C3 + 12T	D) \$					
14. Insurance	12L + 12CJ + 12L	Ψ					
a. Insurance on Proper	ty (buildings only)	\$	8,569				8,569
b. Insurance on Autom		\$					2,202
	Property (as specified	<u> </u>					
1. Umbrella (Blank		\$					
2. Fire and Extende		\$, , , , , , , , , , , , , , , , , , ,			
3. Other (Specify)		\$					
, , ,							
14d. Total Insurance Expend		\$					8,569
15. Total All Expenditures	(A-13 thru C-14)	\$	870,944			87	70,944

D. Adjustments to Statement of Expenditures

1	e of Fa			Lic	cense No.	Report for Yea	ır Ended	Page	of
Carls	on Pla	ce, LI	LC		1878	9/30/2015		28	37
Τ.	_	. .			Total			 	
	Page		T. D		Amount of	CONTI	DIDIO	Resident	
	No.		Item Description		Decrease	CCNH	RHNS	Но	me
	10-5		es and Wages						
1.			Outpatient Service Costs	\$					
2.			Salaries not related to Resident Care	\$					
3.			Occupational Therapy	\$					
4.	70 7		Other - See attached Schedule	\$					
	13 - F		sional Fees	Φ					100
5.			Resident Care Physicians **	\$					
6.			Occupational Therapy	\$					
7.	1 = 0	1.0	Other - See attached Schedule	\$					
			Administrative and General	ф	14.000				14.000
8.	15		Discriminatory Benefits	\$	14,298				14,298
9.			Bad Debts	\$	0.00				070
10.	15	1e	Accounting & Legal	\$	878				878
11.			Telephone	\$	1.500	1			1 500
12.	15	1h2	Cellular Telephone	\$	1,538				1,538
13.			Life insurance premiums on the life	ሑ					
- 1			of Owners, Partners, Operators	\$					
14.			Gifts, flowers and coffee shops	\$					
15.			Education expenditures to colleges or						
			universities for tuition and related costs	Φ					
			for owners and employees	\$					
16.			Travel for purposes of attending						
			conferences or seminars outside the						
			continental U.S. Other out-of-state	Δ					
			travel in excess of one representative	\$					
17.	1.5		Automobile Expense (e.g. personal use)	\$:				
18.	16	m3	Unallowable Advertising *	\$					
19.			Income Tax / Corporate Business Tax	\$					
20.			Fund Raising / Contributions	\$					
21.			Unallowable Management Fees	\$					
22.			Barber and Beauty	\$	6.006				6006
23.	10 7		Other - See attached Schedule	\$	6,296				6,296
			Expenditures						
24.			Meals to employees, guests and others	φ					
			who are not residents	\$					
1	T	aund	ry Expenditures						
25.			Laundry services to employees, guests	ሑ					
			and others who are not residents	\$					
_			keeping Expenditures						
26.			Housekeeping services to employees, guests	дь.					
			and others who are not residents	\$	62.010				02.010
			Subtotal (Items 1 - 26)	\$	23,010	<u> </u>			23,010

^{*} All except "Help Wanted".

⁽Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	5 (84) (A) (S) (S)				
				0.000 08.70 B. E.	
			1970 (100 (100 (100 (100 (100 (100 (100 (1		
	1 N 35 5 5				
NE 000 (000)			4		
	140000000000			10 mm	
Total Othe	r Salaries	Adjustment	\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
					5 5 5 5 6 6 6
					9 9 9 9 9
35-01-35-03			10017604900000000000000000000000000000000000	000 000 000 000 000	
	100000000000000000000000000000000000000				
91913	17613-63				
tan esse des esse	- 200 CO 45 G		7 2 2 2 2 2		
			9.00.00.00.00.00		
Se excessed					81 (3) (5) (6) (3) (6)
Total Othe	r Fees Adi	ustments	\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
16	m13	Bank Service Fees			\$ 1,162
∴ 16	m13	Late Fees/Finance Charges		4	\$ 4,822
16	m13	Uncategorized			\$ 313
			Tropic de Germania		Marie Annier (St.) 166 Ser
	(3) (A) (A) (B)				NULE 18 74 65 70
Total Othe	r A&G Ad	justments	\$ -	\$ -	\$ 6,296

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

Name of Facility				D. Adjustments to Statemen						
Item Page Line No. No. No. Item Description Subtotals Brought Forward \$ 23,010			-		Lic			ear Ended		-]
Item Page Line No. No. Item Description Decrease CCNH RHNS Residential Can Home Subtotals Brought Forward \$ 23,010 23,010 23,010 23,010 23,010 23,010 23,010 23,010 23,010 23,010 23,010 23,010 23,010 23,010 23,010 23,010 23,010 23,010 23,010 24,010	Carls	on Pla	ice, L	LC			9/30/2015		29 37	
No. No. No. No. Subtotals Brought Forward \$ 23,010 2						Total				\neg
Subtotals Brought Forward \$ 23,010 23,010	Item	Page	Line			Amount of			Residential Ca	re
Page 20 - Resident Care Supplies*** 27.	No.	No.	No.	Item Description		Decrease	CCNH	RHNS	Home	
27. Prescription Drugs \$					\$	23,010			23,01	0
28. Ambulance/Limousine \$ 29. X-rays, etc \$ 30. Laboratory \$ 31. Medical Supplies \$ 32. Oxygen (non emergency) \$ 33. Occupational Therapy \$ 34. Other - See Attached Schedule \$ Page 22 - Maintenance and Property \$ 35. Excess Movable Equipment Depreciation See Attached Schedule \$ 36. Depreciation on Unallowable Motor Vehicles \$ 37. Unallowable Property and Real Estate Taxes \$ 38. Rental of Building Space or Rooms \$ 39. Other - See Attached Schedule \$ Page 27 - Insurance \$ 40. Mortgage Insurance \$ 41. Property Insurance \$ 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$	Page	20 - I	Reside	nt Care Supplies***			\$ 100 EM 100			
29.	27.				\$					
30. Laboratory \$ 31. Medical Supplies \$ 32. Oxygen (non emergency) \$ 33. Occupational Therapy \$ 34. Other - See Attached Schedule \$ Page 22 - Maintenance and Property 35. Excess Movable Equipment Depreciation See Attached Schedule \$ 36. Depreciation on Unallowable Motor Vehicles \$ 37. Unallowable Property and Real Estate Taxes \$ 38. Rental of Building Space or Rooms \$ 39. Other - See Attached Schedule \$ Page 27 - Insurance 40. Mortgage Insurance \$ 41. Property Insurance \$ 41. Property Insurance \$ 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only				Ambulance/Limousine						
31. Medical Supplies \$										
32. Oxygen (non emergency) \$ 33. Occupational Therapy \$ 34. Other - See Attached Schedule \$ Page 22 - Maintenance and Property 35. Bexess Movable Equipment Depreciation See Attached Schedule \$ 36. Depreciation on Unallowable Motor Vehicles \$ 37. Unallowable Property and Real Estate Taxes \$ 38. Rental of Building Space or Rooms \$ 39. Other - See Attached Schedule \$ Page 27 - Insurance \$ 40. Mortgage Insurance \$ 41. Property Insurance \$ 41. Property Insurance \$ 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only					\$					
33. Occupational Therapy 34. Other - See Attached Schedule *Page 22 - Maintenance and Property 35. Excess Movable Equipment Depreciation See Attached Schedule \$ 36. Depreciation on Unallowable Motor Vehicles \$ 37. Unallowable Property and Real Estate Taxes \$ 38. Rental of Building Space or Rooms \$ 39. Other - See Attached Schedule \$ **Page 27 - Insurance 40. Mortgage Insurance \$ 41. Property Insurance \$ 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec Attached Schedule **Not For Profit Providers Only** **Not For Profit Providers Only** **Not For Profit Providers Only**				Medical Supplies						
34. Other - See Attached Schedule \$ Page 22 - Maintenance and Property 35. Excess Movable Equipment Depreciation See Attached Schedule \$ 36. Depreciation on Unallowable Motor Vehicles \$ 37. Unallowable Property and Real Estate Taxes \$ 38. Rental of Building Space or Rooms \$ 39. Other - See Attached Schedule \$ Page 27 - Insurance \$ 40. Mortgage Insurance \$ 41. Property Insurance \$ 41. Property Insurance \$ 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	32.			Oxygen (non emergency)	\$					
Page 22 - Maintenance and Property 35. Excess Movable Equipment Depreciation \$ See Attached Schedule \$ \$ Depreciation on Unallowable Motor Vehicles \$ \$ \$	33.			Occupational Therapy	\$				·	
Sec Attached Schedule \$	34.			Other - See Attached Schedule	\$					
See Attached Schedule \$ 36. Depreciation on Unallowable Motor Vehicles \$ 37. Unallowable Property and Real Estate Taxes \$ 38. Rental of Building Space or Rooms \$ 39. Other - See Attached Schedule \$ Page 27 - Insurance 40. Mortgage Insurance \$ 41. Property Insurance \$ 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	Page	22 - A	1ainte	enance and Property						
36. Depreciation on Unallowable Motor Vehicles \$ 37. Unallowable Property and Real Estate Taxes \$ 38. Rental of Building Space or Rooms \$ 39. Other - See Attached Schedule \$ Page 27 - Insurance \$ 40. Mortgage Insurance \$ 41. Property Insurance \$ 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	35.			Excess Movable Equipment Depreciation						
Motor Vehicles \$ 37.				See Attached Schedule	\$					
37. Unallowable Property and Real Estate Taxes \$ 38. Rental of Building Space or Rooms \$ 39. Other - See Attached Schedule \$ Page 27 - Insurance 40. Mortgage Insurance \$ 41. Property Insurance \$ 0ther - Miscellaneous 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	36.			Depreciation on Unallowable						
Estate Taxes \$ 38. Rental of Building Space or Rooms \$ 39. Other - See Attached Schedule \$ Page 27 - Insurance 40. Mortgage Insurance \$ 41. Property Insurance \$ Other - Miscellaneous \$ 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only				Motor Vehicles	\$					
38. Rental of Building Space or Rooms 39. Other - See Attached Schedule **Page 27 - Insurance 40. Mortgage Insurance \$ 41. Property Insurance **Other - Miscellaneous 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec **An Accounts Rec **Other (include personnel and other costs unrelated to resident care) - See Attached Schedule **Not For Profit Providers Only**	37.			Unallowable Property and Real						
39. Other - See Attached Schedule \$ Page 27 - Insurance 40. Mortgage Insurance \$ 41. Property Insurance \$ Other - Miscellaneous 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only				Estate Taxes	\$					
Page 27 - Insurance 40. Mortgage Insurance \$ 41. Property Insurance \$ Other - Miscellaneous \$ 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only \$	38.			Rental of Building Space or Rooms	\$					٦
40. Mortgage Insurance \$ 41. Property Insurance \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	39.			Other - See Attached Schedule	\$					\neg
41. Property Insurance \$ Other - Miscellaneous 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	Page	27 - I	nsura	nce						
Other - Miscellaneous 42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	40.			Mortgage Insurance	\$		·			
42. Research or Experimental Activities \$ 43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	41.			Property Insurance	\$					٦
43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	Other	r - Mis	cella	reous						
43. Radio and Television Revenue \$ 44. Vending Machine Revenue \$ 45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	42.			Research or Experimental Activities	\$					
45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	43.				\$					٦
45. Purchase Discounts and Allowances \$ 46. Duplications of functions or services \$ 47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	44.			Vending Machine Revenue	\$					٦
47. Expenditures made for the protection, enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	45.				\$					٦
enhancement or promotion of the providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	46.			Duplications of functions or services	\$					٦
providers interest \$ 48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	47.			Expenditures made for the protection,						
48. Interest Income on Accounts Rec \$ 49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only				enhancement or promotion of the						
49. Other (include personnel and other costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only				providers interest	\$					
costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only	48.			Interest Income on Accounts Rec	\$,				
costs unrelated to resident care) - See Attached Schedule \$ Not For Profit Providers Only				Other (include personnel and other						
Not For Profit Providers Only			- '		-					
Control of the Contro				Attached Schedule	\$	The state of the s				تم
Control of the Contro	Not I	or Pr	ofit P	roviders Only						
50. Building/Non Movable Eq. Depreciation	50.			Building/Non Movable Eq. Depreciation	╗					
Unallowable Building Interest -								75,000		
See Attached Schedule \$				<u> </u>	\$					
51. Total Amount of Decrease (Items 1 - 50) \$ 23,010 23,010	51.	Total	Amoi	int of Decrease (Items 1 - 50)	\$	23,010			23,010)

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
			95.3 (S. S. S.		
			100 00 00 00 00 00 00 00 00 00 00 00 00		
	78450 (000000) -5				
					3 3 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
	10.00		200 100 100 100 100 100 100 100 100 100	(SA 165 - 151 - 151 - 151 - 151 - 151 - 151 - 151 - 151 - 151 - 151 - 151 - 151 - 151 - 151 - 151 - 151 - 151	S 1600 DECEMBER OF THE
4 S 0 8	%. 153 50 50 50 50 50 50 50 50 50 50 50 50 50				
	80,000,000,000,000,000 800,000,000,000,0				
	4 15 15 15 15 15 15 15 15 15 15 15 15 15		41.40.50.50.00.00		
Fotal Othe	r Ancillary	Costs	\$ -	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
			REPORT OF THE PERSON		
	S. 12 (2) (3)		80 CT 00 E E		
(6	S (51.40 (5)		45 Ar. (8. (1. (1. (1. (1. (1. (1. (1. (1. (1. (1		
			selvoi en en en en en		(ASI) (600.ASI) (ASI)
	100 000 000 000 61 000 000 000				
	S 68 10 78				2012/03/02
	0.000				
			30 30 65 55		
Total Exce	ss Movabio	Equipment Depreciation	\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
			\$ 8 8 5 6		
\$6100.00			334 PA 935 W2 35		Tool of the control
6 /	C. 100 101 101				
(5x (5x (5) 4)	68-02-65000				
(E)				32 23 25 23 23	
	68 (28 - 1971) (3)			The second second	
	5 17 12				
	57.00-02.05			18 18 18 19 18 18 18 18 18 18 18 18 18 18 18 18 18	
45.0 45.0 50.0	10.07 (3.50)	48 <u>26 50 2</u> 2 15 10 10 10 10 10 10 10 10 10 10 10 10 10			
Total Othe	r Property	Adjustments	\$ -	\$	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
60.025 (0.05)	51.78.55.163		211 000 000 000 000	(40.000.000.000.000.000.000	
Karaji di ses	3 (8) (5)				
			grande in the second se		(a) (b) (b) (b) (b) (b) (b) (b)
	6 9 0 5 5 24 5 5		G-12-100-100-10-10		
	(a) (a) (a) (a)		75733 1575 2573 3	2000	
	5-15-15-15				
NO 153 (23)	94 (400) (45) (46)		32 30 34 47 38	# 10 E E	
Total Othe	r Adjustm	ents	\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
	(\$ N(V) 12 1800 10 (\$)				
80.000.600.60	3. (U.Sh. (a)		56 55 58 55 85 8	15 5 5 5 5	
	2018/02/08		\$4.000 \$1.00	80.00	
			30.000.000.000		
				6000000 (Carlotta 1800)	000000000000000000000000000000000000000
	8508 6310		2012 12 15 15 15	666666	
				20 (20 (21 (31 (22)	
800000000000000000000000000000000000000				0.000	
Total Unal	llowable Bı	illding Interest	\$ -	\$ -	\$ -

F. Statement of Revenue

	F. Statement of Rev	en					
1	ense No.		Report for Y	ear Ended		Page	of
Carlson Place, LLC 1	878		9/30/2015		I	30	37
Ite	m		Total	CCNH	RHNS		ntial Care ome
I. Resident Room, Board & Routine Car	e Revenue						
1. a. Medicaid Residents (CT only)		\$	877,275				877,275
b. Medicaid Room and Board Contr	actual Allowance **	\$					
2. a. Medicaid (All other states)		\$					
b. Other States Room and Board Co	ntractual Allowance **	\$					
3. a. Medicare Residents (all inclusive)	\$					
b. Medicare Room and Board Contr	actual Allowance **	\$					
4. a. Private-Pay Residents and Other		\$					
b. Private-Pay Room and Board Co	ntractual Allowance **	\$					
II. Other Resident Revenue							
a. Prescription Drugs - Medicare		\$					
b. Prescription Drugs - Medicare Co	ontractual Allowance **	\$					
c. Prescription Drugs - Non-Medica	re	\$					
d. Prescription Drugs - Non-Medica	re Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare		\$					
b. Medical Supplies - Medicare Con	tractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	9	\$					
d. Medical Supplies - Non-Medicard	e Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare		\$					
b. Physical Therapy - Medicare Con	tractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	3	\$					
d. Physical Therapy - Non-Medicare	e Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare		\$					
b. Speech Therapy - Medicare Conti	ractual Allowance **	\$					
c. Speech Therapy - Non-Medicare		\$					
d. Speech Therapy - Non-Medicare	Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicar	e	\$					
b. Occupational Therapy - Medicar	e Contractual Allowance **	\$					
c. Occupational Therapy - Non-Me	dicare	\$					
d. Occupational Therapy - Non-Me	dicare Contractual Allowance **	\$					
6. a. Other (Specify) - Medicare		\$					
b. Other (Specify) - Non-Medicare		\$					
III. Total Resident Revenue (Section I. th	ru Section II.)	\$	877,275				877,275
IV. Other Revenue*							
1. Meals sold to guests, employees & o	thers	\$					
2. Rental of rooms to non-residents		\$					
3. Telephone		. \$					
4. Rental of Television and Cable Serv	ices	\$		-			
5. Interest Income (Specify)		\$					
6. Private Duty Nurses' Fees		\$					
7. Barber, Coffee, Beauty and Gift sho	ps	\$					
8. Other (Specify)		\$	2,223				2,223
V. Total Other Revenue (1 thru 8)		\$	2,223				2,223
VI. Total All Revenue (III+V)		\$	879,498				
ra aventan acrosse (m · 1)		Ψ	8/9,498		<u> </u>	<u> </u>	879,498

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

		Residential
CCNH	RHNS	Carc Home
	2011.010.00.010.00.00	100 (46) 000 (40) 48er
601000000000000000000000000000000000000	500000000000000000000000000000000000000	100000000000000000000000000000000000000
66.80.66.65		
	(\$10.00 a.00 a.00 a.00 a.00 a.00 a.00 a.00	
	00 000 000 000	5 (55 (56 (56 (56)
\$	\$ -	\$ -
	CCNH	CCNH RHNS

Schedule of Other Non-Medicare Resident Revenue

Related Exp

				Residential
Page Ref	Description	CCNH	RHNS	Care Home
			100 (100 (100 (100 (100 (100 (100 (100	
			100 40 00000 40	
637 (637,685)		-0.000	ing comparing of	
		1486 450 250 250 25	SC 40 TE SV 50	
000000000000000000000000000000000000000			(2.23) (2.16) (2.33)	
Total Othe	er Resident Revenue	\$ -	\$ -	\$ =

Interest Income

Account

Page Ref Account	Balance	CCNH	RHNS	- Residential Care Home
	Dalauce	l = CCIA	King	Care nome
	7540246845945	5 (02.00) 145.00(25 (3) (3)	N. 60062-600
	100000000000000000000000000000000000000	1000-000-000-000		
l'otal Interest Income		\$ -	\$	\$ -

Schedule of Other Revenue

	Description	CCNH	RHNS	Residential Care Home
22/6¢	Prior Year Tax Credit			\$ 2,223
			70710110011001	of of the section
			2546 (295) Selection (334) 434	
			ACC 100 ACC 100 ACC	000.000 000.000
		. 615 (No. 51 (St.)	1981-301-331-4-159	65.665.0560556.65
60.000.000		108-38-88-88-8	30 12 10 50 10	30 23 00 03 03
			41.600.000	
			30 30 30	0.550.05.5
				100.00
Total Othe	er Revenue	\$ -	\$	\$ 2

G. Balance Sheet

Name	of	f Facility	License No.	Report for Year Ende	d	Page	of
Carlso	n :	Place, LLC	1878	9/30/2015		31	37
		ME HE 19 1/3 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Account			An	nount
Asset	S						
A.	Cu	rrent Assets					
	1.	Cash (on hand and in banks))		\$		(19,842)
1	2.	Resident Accounts Receivab	le (Less Allowance fo	r Bad Debts)	\$		49,412
	3.	Other Accounts Receivable (Excluding Owners or	Related Parties)	\$		
4	4	Inventories			\$		
:	5.	Prepaid Expenses			\$		10,641
		a. Prepaid - Insurance		5,044			
		b. Prepaid - Other		5,598			
		с.					
		d.					
(6.	Interest Receivable			\$		
7	7.	Medicare Final Settlement R	eceivable		\$		
	8.	Other Current Assets (itemize	e)		\$		7,303
		Security Deposits		4,940			
		Employee Loan		2,363		in the Albert Court	
			·				
A-9.	To	tal Current Assets (Lines A1	thru 8)		\$		47,514
B. 1	Fix	ked Assets					-
	1.	Land			\$		
	2.	Land Improvements	*Historical Cost		\$		
			Accum. Depreciatio	n Net			
	3.	Buildings	*Historical Cost		\$		
			Accum. Depreciatio	n Net			
		Leasehold Improvements	*Historical Cost	113,206	\$		8,685
		1	Accum. Depreciatio				,
	5.	Non-Movable Equipment	*Historical Cost		\$		
		1 1	Accum. Depreciatio	n Net			
	6.	Movable Equipment	*Historical Cost	76,216	\$		6,927
	••		Accum. Depreciatio		ľ		-,
,	7.	Motor Vehicles	*Historical Cost	28,000	\$		
			Accum. Depreciatio		• • • • •		
	8.	Minor Equipment-Not Depre			\$		
	9	Other Fixed Assets (itemize)	1		\$		
-	,,	Onto I mod Hood (nomine)	·		Ψ		
B-10.		Total Fixed Assets (Lines B	1 thru 9)		\$		15,611

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

G. Balance Sheet (cont'd)

1		Facility	License No.	Report for Year Ended		Page	of
Carl:	son :	Place, LLC	1878	9/30/2015		32	37
			Account			Amo	
				Total Brought Forward:	\$		63,126
C.	Lea	asehold or like property recor	ded for Equity Purposes	3.			
		Land			\$		
	2.	Land Improvements	*Historical Cost				
			Accum. Depreciation	Net	\$		
	3.	Buildings	*Historical Cost				
			Accum. Depreciation	Net	\$		
	4.	Non-Movable Equipment	*Historical Cost				
			Accum. Depreciation	Net	\$		
	5.	Movable Equipment	*Historical Cost		Ì		
			Accum. Depreciation	Net	\$		
	6.	Motor Vehicles	*Historical Cost				
			Accum. Depreciation	Net	\$		
	7.	Minor Equipment-Not Depre	eciable		\$	·	
C-8	To	tal Leasehold or Like Proper	ties (C1 thru 7)		\$		
D.	Inv	restment and Other Assets					
	1.	Deferred Deposits			\$		
	2.	Escrow Deposits			\$		
	3.	Organization Expense	*Historical Cost	29,312			
			Accum. Depreciation	29,312 Net	\$		
	4.	Goodwill (Purchased Only)			\$		
	5.	Investments Related to Resid	dent Care (itemize)		\$		
	6.	Loans to Owners or Related	Parties (itemize)		\$		
		Name and Address	Amount	Loan Date			
:					-		
	7.	Other Assets (itemize)			\$		
		, ,		•			
D-8.	To	tal Investments and Other As	ssets (Lines D1 thru 7)		\$		
		tal All Assets (Lines A9 + B)			\$		63,126

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

G. Balance Sheet (cont'd)

Name of Fa	cility		License No.	Report for Year	Ended	Page	of
Carlson Plac	ce, LL	·C	1878	9/30/2015		33	37
			Account			Ame	ount
Liabilities							
Α.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable					48,667
!	2.	Notes Payable (itemize)			\$		
							
	2	Lang Parable for Equipm	ant (Carmont noution	m) (itamiza)	\$		
	٥.	Loans Payable for Equipm Name of Lender	Purpose	Amount	Date Due		
		Name of Lender	1 dipose	Amount	Bate Bue		
			İ				
							Transfer of the Control of the Contr
	4.	Accrued Payroll (Exclusiv	e of Owners and/or	Stockholders only)	\$		8,050
	5.	Accrued Payroll (Owners	and/or Stockholders	only)	\$		
	6.	Accrued Payroll Taxes Pa	yable		\$		1,468
	7.	Medicare Final Settlemen	t Payable		\$		
	8.	Medicare Current Financi			\$		
	9.	Mortgage Payable (Curre			\$		
	-	. Interest Payable (Exclusiv	e of Owner and/or R	Related Parties)	\$		
		. Accrued Income Taxes*			\$		
	12	. Other Current Liabilities (itemize)		4		21,934
		Accrued Expense		,762)			
		Due to DSS	24	,696			
					<u> </u>		
		. T.CT Y . T . ET	4141 10\				00.100
A-13	3. To	tal Current Liabilities (Lin	ies A i thru 12))	80,120

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

G. Balance Sheet (cont'd)

Name of Facility	License No.		r Ended	Page	of
Carlson Place, LLC		9/30/2015		34	37
				Aı	nount
T !-A-!!!! (Total Broug	ht Forward:		80,120
,					
1	(itomizo)		\$		
		Amount			A DESCRIPTION
2 M / P 11					
	oted Parties (itamiza)		\$ \$		(00 4 71 4)
		Logn			(234,514)
		Doun D			
	•	3,625	\$		3,625
B-5. Total Long-Term Liabilities (\$		(230,889)
C. Total All Liabilities (Lines A-	13 + B-5)		\$		(150,769)

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

	me of Facility	License No.	Report for Year Ended		Page		of
Car	lson Place, LLC	Account	9/30/2015		35 Amo		37
A .	Reserves	Account			Alik	Juni	
	Reserve for value of leased	l land		\$			
	Reserve for depreciation v to be amortized	\$					
	to be amortized		· · · · · · · · · · · · · · · · · · ·	D D		•	
	3. Reserve for depreciation v	alue of leased perso	nal property (Equity)	\$			
	4. Reserve for leasehold real	properties on which	fair rental value is based	\$			
	5. Reserve for funds set aside	as donor restricted		\$			
	6. Total Reserves			\$	4.5		
В.	Net Worth						
	1. Owner's Capital			\$			
	2. Capital Stock	·		\$			
	3. Paid-in Surplus			\$			
	4. Treasury Stock			\$			
	5. Cumulated Earnings			\$		205,3	341
	6. Gain or Loss for Period	10/1/20	9/30/2015	\$		8,5	554
	7. Total Net Worth			- · · \$ ·		-213,8	395
C.	Total Reserves and Net Worth	i		\$		213,8	395
D.	Total Liabilities, Reserves, an	d Net Worth		\$		63,1	126

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year	Ended	Page	of
Carlson Place, LLC	1878	9/30/2015		36	37
	Account		\$	****	ount 243,510
	A. Balance at End of Prior Period as shown on Report of 09/30/2014				
C. Total Expenditures (From Statement of Expenditures Page 27)					870,944 8,554
<u> </u>					
F. Additions 1. Additional C	Capital Contributed (itemize)				
F-3. Total Additions	3 Total Additions				
G. Deductions					
	Drawings of Owners/Operators/Partners (Specify)				
	Address (No., City, State, Zip)	Title	Amount		
2. Other Withdrawings (Specify)			\$	8	
	Purpose	Amo	Amount		
3. Total Deductions			\$		
H. Balance at End				S	252,064

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of				
Carlson Place, LLC	1878	9/30/2015	37	37				
Check appropriate category								
Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	☑ Residential Care Home	☑ Residential Care Home					
Preparer/Reviewer Certification								
I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.								
Signature of Preparer	Title (PA	Date Signed	Date Signed					
Printed Name of Preparer								
Craig J. Lubitski Consulting LLC								
Address		Phone Number						
225 Pitkin Street, East Hartford, CT 06108	860-610-9009	860-610-9009						