State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as	licensed)							
TGC Healthcare, Inc		ne Manor						
Address (No. & Street								
37 Clark Avenue Eas								
Type of Facility								
Chronic and C	Convalescent		Rest Home wit	th Nursing				
□ Nursing Home	e only		Supervision or	nly		Residenti	al Ca	re Home
(CCNH)	•		(RHNS)					
Report for Year Begi	nning		Report for Yea	ar Ending				
10/1/2014			9/30/2015					,
: 2 2	u n	5		n				
License Numbers:		CCNH	RHNS	Reside	ntial Care 1 1855	Home	Me	dicare Provider
Medicaid Provider N	umbers:	CC	CNH	RH	INS		IC	F-IID
Iviedicald Trovider iv	umocis.		ZIVII	Ki	uvo		10.	1-110
For Department Us	e Only							
Sequence Number	Signed and	Date	Sequence N	Number	Signed o	ınd Notari	zed	Date Received
Assigned	Notarized	Received	Assign	ned	Signed a	iliu Motali.	zeu	Date Received
				H 4 H 4 H 4		(4) (8) (7) (7 (9)		

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
TGC Healthcare, Inc. D/B/A Caroline Manor	1855	9/30/2015	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for TGC Healthcare, Inc. D/B/A Caroline Manor [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.

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Timothy Conroy, Jr.			Printed Name (Owner) Timothy Conroy, Jr.	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires
Address of Notary Public	h			-

(Notary Seal)

State of Connecticut

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CSP-1A Rev. 6/95

State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page 1A	of 37
Name of Facility		Period Cov	ered:	From	То
TGC Healthcare, Inc. D/B/A Caroline Manor				10/1/2014	9/30/2015
Address of Facility					9
37 Clark Avenue East Haven, CT 06512					
Report Prepared By		Phone Num		Date	
Brodeur & Co. CPAs, P.C.		860-388-46	27	2/9/2016	
Item		Total	CCNH	RHNS	Residentia 1 Care Home
Dietary wages paid	\$	33,874			33,874
2. Laundry wages paid	\$	8,291			8,291
3. Housekeeping wages paid	\$	15,985			15,985
4. Nursing wages paid	\$				
5. All other wages paid	\$	136,703			136,703
6. Total Wages Paid	\$_	194,853			194,853
7. Total salaries paid	\$	52,163			52,163
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	247,016			247,016

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire Type of Facility - Organization Structure

		Pho	ne No. of Fa	cility	Report for Ye	ear Ended	Page	of	
		203	-630-6432	39	9/30/2015		2	37	
Name of Facility (as shown on license)			Committee Commit		Street, City, Sto				
TGC Healthcare, Inc. D/B/A Caroline Manor					East Haven, C				
CCN	Ή		RHNS	Resi	dential Care H		Medicare I	rovider	No.
License Numbers:					1	855			
Type of Facility (Check appropriate box(es))									
Chronic and Convalescent Nursing Home only (CCNH)			t Home with ervision only			Resident	ial Care Hor	ne	
Type of Ownership (Check appropriate box)									
O Proprietorship O LLC O Partnersh	nip	0	Profit Corp.		Non-Profit Co	70	Government	O Tr	ust
If this facility opened or closed during report year p	rovid	e:		Date	e Opened	Date Clo	sed		
Has there been any change in ownership or operation during this report year?		0	Yes	0	No	If "Ves "	explain full	V	
Administrator									
Name of Administrator					Nursing He	ome	0		
Timothy Conroy, Jr.					Administra	tor's			
N 8					License 1	No.:			
Other Operators/Owners who are assistant administ	rators	(ful	l or part time	e) of t	his facility.				
Name					License 1	No.:			
a		*							
	9	:f:	**************************************						

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CSP-3 Rev. 10/2005

General Information and Questionnaire Partners/Members

Name of Facility TGC Healthcare, Inc. D/B/A C	aroline Manor		Report for Y 9/30/2015	ear Ended	Page of 37
Legal Name of Parts		Business A		State(s) and/o Which R	or Town(s) in
					٥
Name of Partners/Members	Business Ac	ldress	7	Γitle	% Owned
-					
		a ⁿ		٨	
e e s		а ч п	a s	¥ = -	, , , , ,
		9			
		-	-		
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,				7	
0		1/			

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Annual Report of Long-Term Care Facility

CSP-3A Rev. 10/2005

General Information and Questionnaire Corporate Owners

Name of Facility		Report for Year End	ded	Page of
TGC Healthcare, Inc. D/B/A Caroline Manor	1855	9/30/2015		3A 37
If this facility is owned or operated as a corporate	oration, provide the	e following informat	ion:	
Legal Name of Corporation	Busines	s Address	State(s) in Which	ch Incorporated
TGC Healthcare, Inc. D/B/A	37 Clark Ave. Eas	t Haven, CT 06512	CT	а
Caroline Manor				
	_	Ψ.		
				N. CI
Name of Directors, Officers	Busines	s Address	Title	No. Shares
SERVER AND TALLES THE SERVER SERVER AND THE SERVER				Held by Each
Timothy Conroy, Jr.	37 Clark Ave. Eas	t Haven, CT 06512	President	100
			100	3A - GAGES
5				
*				
- 27				
	- (a (a) (b)		n n	D 25 III
2				
Names of Stockholders Owning at Least				
10% of Shares				
-	a a			
	E 45 00 190 19 700 10 10 10 10 10 10 10 10 10 10 10 10 1			
			-	
				-
			ii.	
				11

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3B Rev. 10/2005

General Information and Questionnaire Individual Proprietorship

Name of Facility TGC Healthcare, Inc. D/B/A Caroline Manor	License No. 1855	Report for Year Ended 9/30/2015	Page of 3B 37
If this facility is owned or operated as an individua	al proprietorship, p		tion:
Ow	ner(s) of Facility		
5 159			н
	2 2	5 2 A A	= = =

	9 2		n 2
d	5		
	* 		
	7		

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

General Information and Questionnaire Related Parties*

Name of Facility TGC Healthcare, Inc. D/B/A Caroline Manor		License No. 185	No. 1855	Report for Year Ended 9/30/2015		Page 4	of 37
	8						
Are any individuals rece	Are any individuals receiving compensation from the facility related through	cility relat	ed through		If "Yes," provide the Name/Address and	e Name/Add	Iress and
marriage, ability to cont	marriage, ability to control, ownership, family or business	ss association?	ion? • 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	or services,	,				E
including the rental of p	including the rental of property or the loaning of funds to this facility,	o this facil	ity,				
related through family a association to any of the	related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?	control, or of this faci	business	O Yes O No	If "Yes " provide the following information:	e following	information.
			•		manuard for a		
		Also F	Also Provides		Indicate Where		28
	180 (Goods/S	Goods/Services to		Costs are Included		
Name of Related	Business	Non-Rela	4	Description	in Annual Report	Cost	Actual Cost to the
mulvidual of Company	Vaduress	x es	% ONI	Provided	Page # / Line #	Keported	Related Farty
Ratifive, Inc.	P O Box 239 Middlefield, CT 06450	0	• •	Real Estate Rental	Pg. 22, Line 9	000'09	900'09
Ratifive, Inc.	P O Box 239 Middlefield, CT 06450	0	•	Loan from Related Party	Pg. 34, Line B4	217,662	217,662
East Ridge Manor, Inc.	43 Preston Ave. Meriden, CT 06450	0		Loan from Related Party	Pg. 34, Line B4	22,072	22,072
Doreen Conroy	841 Norwich-New London Tpke Uncasville, CT 06382	0	• •	Loan from Related Party	Pg. 34, Line B4	66,667	299'99
Due to DCO Real Estate, LLC	841 Norwich-New London Tpke Uncasville, CT 06382	0	⊙	Loan from Related Party	Pg. 34, Line B4	8,939	8,939
Preston Real Estate	841 Norwich-New London Tpke Uncasville, CT 06382	0	• •	Loan from Related Party	Pg. 34, Line B4	2,500	2,500
Timothy Conroy, Jr.	37 Clark Ave. East Haven, CT 06512	0	•	Administrator	Pg. 10, Line A2	52,163	52,163
Timothy Conroy, Jr.	37 Clark Ave. East Haven, CT 06512	0	•	Loan from Owner	Pg. 34, Line B3	105,638	105,638
PAYHR	P O Box 239 Middlefield, CT	0	0	Darroll Drongering	NI/A No Boos		
* IIce additional cheets if necessary	o if necessary			t dylon thocosmig	ואלצו זאס דיכנים		

^{*} Use additional sheets if necessary.

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

State of Connecticut

Annual Report of Long-Term Care Facility

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General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No).	Report for Year Ended	Page	of
TGC Healthcare, Inc. D/B/A Caroline Manor	1855		9/30/2015	5	37
If the facility is licensed as CDH and/or RCH or	r provides A	IDS or TB	I services with special Medicaio	1 rates, costs	S
must be allocated to CCNH and RHNS as follow	ws:				
Item			Method of Allocation		
Dietary		The state of the s	meals served to residents		
Laundry		Number of	pounds processed		
Housekeeping			square feet serviced		
			hours of routine care provided		
Nursing		(n n n n n n n n n n n n n n n n n n n	classification, i.e., Director (or 0	(52)	30
		Registered	Nurses, Licensed Practical Nur	ses, Aides a	and
		Attendants			
Direct Resident Care Consultants		Number of	hours of resident care provided	l by EACH	
			(See listing page 13)		
Maintenance and operation of plant		Square fee			
Property costs (depreciation)		Square fee			
Employee health and welfare		Gross salar			
Management services		11 1	te cost center involved		
All other General Administrative expenses			irect and Allocated Costs		
The preparer of this report must answer the following	owing quest	ions applic			
1. In the preparation of this Report, were all	• Yes	O No	If "No," explain fully why sucl	1 allocation	was
costs allocated as required?	O 103		not made.	1	6
2. Explain the allocation of related company ex					
The facility shares telephone expenses (Vonage					
Home Depot card is shared with East Ridge Ma	mor as well.	Actual ex	penses for each facility are repo	rted on eacl	h
respective cost report.					
8					
3. Did the Facility appropriately allocate and se				me cost cen	iters?
(e.g., Assisted Living, Home Health, Outpati	ient Services	s, Adult Da	y Care Services, etc.)		
	O Yes	⊙ No	If "No," explain fully why such not made.	n allocation	was
N/A			One-by-55 (5575) 50 (755)		
* M					
= 4					

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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.

should not be meladed in these announces.							
Name of Facility			License No.	Report for Year Ended	ear Ended		Page of
TGC Healthcare, Inc. D/B/A Caroline Manor	ī		1855	9/30/2015			6 37
=	Related * 1	1 * to					
6 0	Owners,	ers,					
NO N	Operators	tors,		S		Annual	12
	Officers	ers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	ofLease	Claimed
ar a a	0	0	п				
	0	0	y	36			5-
	0	0					ь
	0	0					
	0	0		£2			
. 2 3	0	0		ÇA			2
	0	0					
***	0	0	9	10			*
. (8)	0	0	v				H7
	0	0					22
Is a Mileage Log Book Maintained for All Leased Vehicles?	eased Ve	hicles	O Yes	O No	No	Total ***	

Is a Mileage Log Book Maintained for All Leased Vehicles?

Total ***

^{*} Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

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

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

General Information and Questionnaire Accounting Basis

AND 177 AND TO 177	T			-	
Name of Facility TGC Healthcare, Inc. D/B/A Caroli	License No. 1855	Report for Year Ended 9/30/2015	- 1	Page 7	of 37
The state of the s		were maintained on the following basis:			31
The records of this facility for the p	eriou covered by this report	were maintained on the following basis.			
	Modified Cash				
Is the accounting basis for this					
period the same as for the •	Yes	If "No," explain.			
previous period?	No				
Y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
Independent Accounting Firm Name of Accounting Firm	- Y	Address (No. & Street, City, State, Zip Code)	-		
		10 Springbrook Rd. Old Saybrook, CT 0			
1 Brodeur & Co. CPA, P.C. 2		10 Springbrook Rd. Old Bayorook, C1 of	0475		
3					
4					
Services Provided by This Firm (de	scribe fully)				
Preparation of YE Trial Balance, Ann	ual Cost Report, Tax Returns, Aud	it Support	\$	10,715	
2		••	\$		
3			\$		
4			\$		
4	1 1 10			r Services Pro	wided
			S 20		vided
	the part of the south	Z C C C C C C C C C C C C C C C C C C C	\$	10,715	
Are These Charges Reflected in the Expend O Yes O No	Accounting & Auditing, Pg.	Yes, Specify Expense Classification and Line No.			
Legal Services Information	Accounting & Auditing, 1 g.	15,14	(6 N		UC: G
Name of Legal Firm or Independent	t Attorney		Telephone	Number	
1 Gallo & Associates, LLC					
2					
3					
4					
5					
Address (No. & Street, City, State, 2					
1 295 Main St. West Haven, CT	06516				
2					
3					
4					15
5 Services Provided by This Firm (de	proviha fully)				
		4		500	
1 Involuntary Eviction of a Resident/Ag	greement with DPH	The state of the s	\$	500	1
2			\$		
3			\$		
4	A .40		\$		
5			\$	201 100	
			Charge for	r Services Pro	ovided
			\$	500	
Are These Charges Reflected in the Expen		es, Specify Expense Classification and Line No.			
O Yes O No	Legal, Pg. 15, 1e				
1000 150000 1500 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 1500000 150000 150000 150000 150000 150000 150000 150000 150000 15000000 150000 150000 1500000 15000000 1500000 1500000 15000000 15000000 1500000 150000000 15000000 15000000 1500000000					

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

Schedule of Resident Statistics

	8.0				3				3				
Name of Facility	1:) (0::0::			License No.	No.			Report for	Report for Year Ended	o o		Page	of 27
1 GC nealineare, Inc. D/b/A Carollife Mailor	line Manor				623			7/30/201.				0	1
	8.1						Period 10/1 Thru 6/30	1 Thru 6/	30		Period 7/	Period 7/1 Thru 9/30	0
		Total All	Total	Total RHNS	Total Residential				Residential				Residential
	3/5	Levels	Level	Level	Care Home	Total	CCNH	RHNS	Care Home	Total	CCNH	RHNS	Care Home
Certified Bed Capacity On last day of PREVIOUS report period	eport period	16		.7	91	16		20	16	16			16
	eriod	16		-8	16	16			16	16			16
2. Number of Residents	No renort neriod	71			7	7.			71	71			7
	ort period	16			16	16			16	16			16
ta	ided During Period							74					
A. Medicare	()			10						1			
B. Medicaid (Conn.)	9												
C. Medicaid (other states)	330			9.									
D. Private Pay	(10)	19			61					61			61
E. State SSI for RCH	0.00	5,757			5,757	4,364			4,364	1,393			1,393
F. Other (Specify)	3.00 M			8).									Ċ.
G. Total Care Days During Period (3A thru F)	iod (3A thru F)	5,818			5,818	4,364			4,364	1,454			1,454
8 -	ded in Figures in 3G												9
									Œ				261
A. Medicaid Bed Reserve Days	3				4								
B. Other Bed Reserve Days	101							¥.					*
5. Total Resident Days (3G + 4A + 4B)	+ 4B)	5,818		8	5,818	4,364			4,364	1,454			1,454

Schedule of Resident Statistics (Cont'd)

Name of Faci	lity			Licer	ise No.				Report	for Year	Ended		Page	of
TGC Healthca	are, Inc.	D/B/A	Caroline Manor		1855					9/30/201	5		9	37
			in the certified b		pacity du	ring t	he repo	rt yea	r?	0	Yes	•	No	
11 113			Change	1011.	Cl	nanga	in Bed			Con	pacity Afte	or Changa		
		riace of	Residential		CI	lange	III Deu	5		Ca	pacity And	or Change		
Date of	CCNH	RHNS	Care Home		Lost		(Gaine	d			Residential		
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Care Home	Reason f	or Change
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNII	KIIINO	Care Home	ICason i	of Change
									-					
			· · · · · · · · · · · · · · · · · · ·											
	-	1				TES.								
									- 1					
			in certified bed o 90 days followir			the re	eport y	ear (as	report	ed in iten	4 above)	provide the nur		
													Residen	tial Care
			Change in Re	esiden	t Days					CC	NH	RHNS	Ho	me
1st chang	ge													
2nd chan														
3rd chan														
4th chan														
6. Number	of Resid	lents and	d Rates on Septe	mber			ar				10.70		0.1 0	
			Medicare		Medic	caid				Se	lf-Pay		Other Sta	te Assisted
				200				170000			20120300	Residential		
	Item		CCNH	<u>C</u>	CNH	RF	INS	CC	CNH	RE	NS	Care Home	R.C.H.	ICF-MR
No. of R				SUPERIOR STATE		Bullet State	(beneath)		WW. 250			1	15	
Per Dien				THE SECOND								105.00	01.50	
a. One b												105.00	81.58.	
c. Three														
bed r		3												
bed I	IIIS.								,					
		Physica	al Therapy Treat	ments						TO	ΓAL	CCNH	RHNS	Residential Care Home
			usive of Part B)				_			(1) (a)				
ъ.			Treatments											
			Treatments											·
	Other													
D.	Total P	hysical	Therapy Treatn	ients										
8. Total Nu	mber of	Speech	Therapy Treatm	ents	183	4 4								
A.	Medica	re - Part	. B				4							
В.	Medica	id (Excl	usive of Part B)											
			Treatments											
		orative '	Treatments											
	Other			-000/1000										
			herapy Treatme										production was	
			tional Therapy	reatn	nents									
		re - Part					Wi-				E ESTE CIUE	698 No. 11 (1980)		
В.			usive of Part B)											(FESTIVAL SALES
			Treatments Treatments											
	Other	STALIVE	reaments			00.00					W			
)ccupati	onal Therapy T	reatm	ents									

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility TGC Healthcare, Inc. D/B/A Caroline Manor	License No. 1855		Report for Yea 9/30/2015	r Ended	Page 10	of 37
Are time records maintained by all individuals receiving co	mpensation?	•	Yes	0	No	
是一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个			Total Cost	and Hours		
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
A. Salaries and Wages*	Storage St					STATE OF THE STATE OF
1. Operators/Owners (Complete also Sec. I						
of Schedule A1)	(4)					
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)		A 1/41.			52,163	2,08
3. Assistant Administrator (Complete also Sec. IV	(1) 别之 (1) 以					
of Schedule A1)						
4. Other Administrative Salaries (telephone			医 可能重复表示		14.45	
operator, clerks, receptionists, etc.)					47,767	2,57
5. Dietary Service	COLOR MARKET					
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers					33,874	2,58
6. Housekeeping Service						ABLEE B
a. Head Housekeeper						
b. Other Housekeeping Workers					15,985	1,45
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor					0.004	
b. Other Laundry Workers					8,291	76
Barber and Beautician Services		-				35.510
10. Protective Services	W. 100 11 10 20 1		B (24 x 2 y 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			VIOLEN INTER
11. Accounting Services						S Property Con-
a. Head Accountant	-			-		
b. Other Accountants 12. Professional Care of Residents		E 12 (5 5 5 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	15 M. 17 M	CONTRACTOR OF THE PARTY OF THE	E STATE OF THE STA	ALCOHOLD DO
			STATES A STATE OF		The state of the s	
a. Directors and Assistant Director of Nurses	CHICAGA CANTANIA					
b. RN						
1. Direct Care					-	
Administrative** LPN					1 CO ASTUTUTO N	
						(A) 是人
Direct Care Administrative**		+				
d. Aides and Attendants					72,584	6,45
e. Physical Therapists		-				
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers					16,352	1,06
i. Physicians					AND STATE OF	P. B. S.
Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
1. Podiatrists						
m. Social Workers/Case Management						
n. Marketing						C
o. Other (Specify)	1000		CASSING AND	a Sharan Nasis	THE PERSON NAMED IN	
See Attached Schedule			 			404
A-13. Total Salary Expenditures					247,016	16,9

^{*} 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)

	CC	NH	RH	NS	Residential	Care Home
Position	\$	Hours	\$	Hours	\$	Hours
	S. V. Eller B. W. S. L.					
	I Section 1				Year of the	
	4. 图图 图象					THE PARTY
				The The Name of States		
	MARKA PEREN					
	ALERS VANS ON					
		TUNK TERMINAN				
				or Ferri Villago		
				ming and the state of the		
				11221-197-120		
N. 1	ď		\$ -		\$ -	
Cotal	\$ -		Φ -		φ -	-

Schedule of Other Fees (Page 13)

	Co	CNH	RI	INS	Residential	Care Home
Service	\$	Hours	\$	Hours	\$	Hours
				Marie San Marie		
						in hwa sa i
				+ + + + + +		
			A WAY THE REAL PROPERTY.			
						Version and the
				C (24) = 7-1		
as taken with the second of the second						
Total	\$ -		\$ -		\$ -	

State of Connecticut
Annual Report of Long-

Annual Report of Long-Term Care Facility CSP-11 Rev. 10/2005 Schedule A1 - Salary Information for Operators/Owners; Administrators,

Compensation Received of 37 Worked Total Hours Page Name and Address of All Other Employment** Assistant Administrators and Other Related Parties* Claimed on Line Where Report for Year Ended Page 10 9/30/2015 Total Hours Worked Full Description of Services Rendered (describe fully) Fringe Benefits and/or Other Payments 1855 License No. Residential Care Home Salary Paid RHINS TGC Healthcare, Inc. D/B/A Caroline Manor CCNH Assistant Administrators who Section I - Operators/Owners parties of Operators/Owners may be the Administrator or facility (EXCEPT those who are identified on Page 12). Section II - Other related employed in and paid by Name Name of Facility

^{*} 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*

		7	resistant	Aumona	Assistant Auministrators and Omer Instanta I ames	Ivolation	1 arrics			
Name of Facility (as licensed)				License No.		Report for Year Ended	ear Ended		Page	Jo
TGC Healthcare, Inc. D/B/A Caroline Manor	line Manor			1855		9/30/2015			12	37
	*	Salary Paid	q							
	8 B.C.		:	Fringe Benefits and/or Other	: :	Total	Line Where		Total	
Name	CCNH	RHINS	Residential Care Home	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section III - Administrators***	5.3									
Timothy Conroy, Jr.	ರಾ ಶರ		52,163	e .	Administrator	2,080	4	East Ridge Manor, Inc.43 Preston Ave. Meriden, CT 06450	2,088	35,496
	2523						3			0
	E. B. E. E			# T						
Section IV - Assistant Administrators	3 8 9		11	5			F			79
	동 영지 본 .			0.			::			4
	2 20 4			Я			ii.			±
3	2 8 8			ii.						34
				5			Di Co			
		- d see less		:	Lowinson to absorb Lowerithing and I had himson at weither	anima d				

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility TGC Healthcare, Inc. D/B/A Caroline Manor	License No.	55	Report for Y 9/30/2015	ear Ended	Page 13	of 37
IGC Healthcare, Inc. D/B/A Caroline Manor	10.	33	Total Cost	and Hours	13	37
			Total Cost	The Trouts		
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			The State of the S		Bezali Santani	SHELL STATE OF
8. Physicians						
a. Medical Director (entire facility)						OU (0 8 19
b. Utilization Review						
(Title 18 and 19 only) monthly meeting					-	
c. Resident Care**						
d. Administrative Services facility 1. Infection Control Committee						ill fex death
(Quarterly meetings)					1 1	
2. Pharmaceutical Committee			71			
(Quarterly meetings)						
Staff Development Committee (Once annually)	2 / B		18			
e. Other (Specify)						
9. Speech Therapist						建 规表生
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other				10.00		
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	Mark September 1			Residence in		CONTRACTOR OF THE PARTY OF THE
b. LPN					TO ESPASIBLE AND THE	
1. Direct Care						
2. Administrative***						
c. Aides				 	-	
d. Other		(C) (C) (D) (C)				NAME OF THE OWNER OWNER OF THE OWNER OWNE
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries						

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

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

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

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

Name of Facility TGC Healthcare, Inc. D/B/A Caroline Manor	License No. 1855		Report for Y 9/30/2015	ear Ended	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Operator	to Owners, rs, Officers	Expla		Relationship
0		Yes	No			
		0	0			
		0	0			
		0	0			
		0	0		1 1	-200 Lin = 500
		0	0			
		0	0			
		0	0			
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		0	0			
		0	0			
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		0	0			
		0	0			
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		0	0			
		0	0			
		0	0			

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	25/2/20	cense No.	Report for Y	ear Ended	Page	of L 27
ΓGC Healthcare, Inc. D/B/A Card	oline ivianor	1855	9/30/2015		15	37
						Residential
If	em		Total	CCNH	RHNS	Care Home
Administrative and General	CIII		Total	CCIVII	KITING	Care Home
a. Employee Health & Welfa	are Benefits					
Workmen's Compensa		9	2,986		CONTRACTOR OF THE PARTY OF THE	2,986
Disability Insurance	ition		3,700			2,500
Unemployment Insura	nce					12,366
4. Social Security (F.I.C.			18,621			18,621
5. Health Insurance	1.1.)		17,683			17,683
6. Life Insurance (employ	vees only)					
(not-owners and not-o	N 1/5/250	5	S			0.7
7. Pensions (Non-Discrir			S			
(not-owners and not-o					DESTRUCTION OF THE PARTY OF THE	
8. Uniform Allowance			S			
9. Other (Specify)		5				
See Attached Schedule	Э					
b. Personal Retirement Plans	, Pensions, and		S			
Profit Sharing Plans for O						
Operators (Discriminatory)*					
c. Bad Debts*		5	3			
d. Accounting and Auditing			10,715			10,715
e. Legal (Services should be	fully described on	Page 7)	500			500
f. Insurance on Lives of Own	ners and	9	S			
Operators (Specify)*						
g. Office Supplies			1,279			1,279
h. Telephone and Cellular Ph	nones					
 Telephone & Pagers 						2,747
Cellular Phones				X.		1,308
i. Appraisal (Specify purpose	e and	S	8		*******************************	
attach copy)*						
j. Corporation Business Tax		\$	250			250
k. Other Taxes (Not related t	o property - See P					
1. Income*						
2. Other (<i>Specify</i>)		5	8			
See Attached Schedule		0.0	· 注:			
3. Resident Day User Fee	2					
Subtotal			68,455		=	68,455

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

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

TGC Healthcare, Inc. D/B/A Caroline Manor 9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Residential Care Home
Total	\$ -	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	Residential Care Home
Description	CCNH	RIIIS	Care Home
Total	\$ -	\$ -	\$ -

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

Name of Facility	License No.	t	Report for Y	ear Ended	Page	of	
TGC Healthcare, Inc. D/B/A Caroline Manor	1855		9/30/2015		16	37	
Item			Total	CCNH	RHNS	Residential Care Home	
Subto	tals Brought Forwa	ırd:	68,455			68,455	
Travel and Entertainment							
Resident Travel and Entertainment		\$		7	0: 0		
Holiday Parties for Staff		\$					
Gifts to Staff and Residents		\$	-	are the Assertation			>
4. Employee Travel		\$. 2
5. Education Expenses Related to Seminars	and Conventions	\$					63
6. Automobile Expense (not purchase or de	epreciation)	\$	1,166			1,166	d7
7. Other (Specify)		\$					
See Attached Schedule							
m. Other Administrative and General Expenses							
 Advertising Help Wanted (all such exper 	ises)	\$					
2. Advertising Telephone Directory (all suc	h expenses)***	\$					
3. Advertising Other (Specify)***		\$	1,333			1,333	d.
See Attached Schedule				51 pm			
4. Fund-Raising***		\$			ones in the latest and the latest an		
5. Medical Records		\$					
6. Barber and Beauty Supplies (if this servi	ce is supplied	\$					
directly and not by contract or fee for ser	vice)***						
7. Postage		\$	175			175	
* 8. Dues and Membership Fees to Profession	nal	\$	125			125	recla
Associations (Specify)							Dist
See Attached Schedule							
8a. Dues to Chamber of Commerce & Other Nor	-Allowable Org.***	\$					
9. Subscriptions		\$					
10. Contributions***		\$					
See Attached Schedule							
11. Services Provided by Contract (Specify a	nd Complete	\$					h
Schedule C-2, Page 21 for each firm or it							
12. Administrative Management Services**		Ψ					2 10
13. Other (Specify)		\$	9,101			9,101	l
See Attached Schedule							
C-14 Total Administrative & General Expenditur	es	\$	80,355			80,355	

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

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

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

Schedule of Other Travel and Entertainment

Description	CCN	ИH	R	HNS		lential Home
		A Mile		11.11.11		
		South	l da			
		6.6		11 1		
	(
Total Other Travel and Entertainment	S		S		s	

Schedule of Other Advertising

Description	CCNII	RHNS	Residentia Care Home	
Website			\$ 1,33	33
				186
Total Other Advertising	s -	\$ -	\$ 1,33	33

Schedule of Dues

Description	CCNH	RHNS		dential e Home	001055 Ball
BJ Membership Renewal		THE LOCAL PROPERTY OF	\$	125	reclass A&G
		Bairo de La			
			1 807		
			+		
Total Dues	s -	s -	s	125	

Schedule of Contributions

Description	CCNH	RHNS	Residential Care Home
Total Contributions	\$ -	s -	s -

Schedule of Other Administrative and General

Description	CCN	н	RH	INS -		idential é Home
401K Administration		17-1			\$	400
Food Service License Renewal					\$	350
Background Checks					\$	400
Miscellaneous Expense		714			\$	856
Payroll Processing Fees					\$	2,537
Bank Service Fee			431		\$	111
Penalties					\$	4,447
Total Other Administrative and General	S		S		s	9,101

State of Connecticut

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

Schedule C-1 - Management Services*

Name of Facility TGC Healthcare, Inc. D/B/A Caroline Ma	License No. 1855	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 #
			5
			đ
	,	^	
		E	
	e to -		
			e e

^{*} 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)

		1,			age 5)			_	
Nan	ne of Facility		Licens	e No	э.		Year Ended	Page	of
TG(C Healthcare, Inc. D/B/A Caroline Manor			18	55	9/30/201	5	18	37
									ntial Care
	Item				Total	CCNH	RHNS	H	ome
2.	Dietary								
	a. In-House Preparation & Service								
	1. Raw Food		\$	6	32,939				32,939
	2. Non-Food Supplies		\$	3	1,837				1,837
	3. Other (Specify)		_ \$	<u> </u>					
	b. Purchased Services (by contract other		\$						
	than through Management Services)								
	(Complete Schedule C-2 att. Page 21)		4						
	c. Management Services**		\$	-					
	d. Other (Specify)		_ \$						
2E.	Total Dietary Expenditures $(2a + b + c + d)$		\$	1	34,776				34,776
ZĽ.	Tomi Dienny Experiments (and a const	-	4	+	51,770			D 11	
	87.2W 001 2 30						PIPIG	2500 E 250 E 2	ntial Care
2F.	Dietary Questionnaire				Total	CCNH	RHNS	H- H-	ome
G.	Resident Meals: Total no. of meals served per	da	y:*		48			l	48
H.	Is cost of employee meals included in 2E?	0	Yes		•	No			10
_	21.	\sim	37			NI-	If yes, specify		
I.	Did you receive revenue from employees?	O	Yes		. •	No	amt.		
J.	Where is the revenue received reported in the	Co	st Repo	rt?	(Page/Line	Item)	P.		
	Is cost of meals provided to persons other			31			TC		
K.	than employees or residents (i.e., Board	0	Yes		0	No	If yes, specify		
	Members, Guests) included in 2E?						cost.		\$5,889
		_				**	If yes, specify		Φ. σ. ο ο ο
L.	Is any revenue collected from these people?	•	Yes		O	No	amt.		\$5,900
M.	Where is the revenue received reported in the	Co	st Repo	rt?	(Page/Line	Item)		Pg 30, L	ine IV8
	Is cost of food (other than meals, e.g.,								
	snacks at monthly staff meetings, board	\sim	*7		0	N	If yes, specify		
N.	meetings) provided to employees included	O	Yes		•	No	cost.		
10.04	in 2E?	5 (6)		.T .C.					
		_				N.T.	If yes, specify		
O.	Is any revenue collected from employees?	O	Yes		•	No	amt.		
Р.	Where is the revenue received reported in the	Co	et Reno	rt?	(Page/Line	Item)			
Ι.	where is the revenue received reported in the	CU	or recho		(1 ago/Dille	Tioni,			

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

Reported on Line IV.1

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

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

Name of Facility	License			Year Ended	0	of
ΓGC Healthcare, Inc. D/B/A Caroline Manor		1855	9/30/2015	5	19 3	7
					Residentia	l Care
Item		Total	CCNH	RHNS	Home)
3. Laundry a. In-House Processing*	Lbs.					
 Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.*** 	Amt. \$	712		5	11 22	712
Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.					
processed.***	Amt. \$					
3. Personal clothing of residents	Lbs.					ä
washed, ironed, and/or processed.***	Amt. \$		75			
4. Repair and/or purchase of linens.***	Lbs.					
	Amt. \$	393				393
b. Purchased Services (by contract other	\$					
than through Management Services)						
(Complete Schedule C-2 att. Page 21)						
c. Management Services**	\$	(4)			E 8 9	
d. Other (Specify)	\$					
BE. Total Laundry Expenditures (3a+b+c+d)	\$	1,105	en a pere kontra			1,105
3F. Laundry Questionnaire						
G. Is cost of employee laundry included in 3E?	Yes	0	No	If yes, specify cost.		
H. Did you receive revenue from employees?	Yes	0	No	If yes, specify amt.		
. Where is the revenue received reported in the Cos	t Report?		(Page/Line	e Item)		
Is Cost of laundry provided to persons other than employees or residents included in 3E?	Yes	•	No	If yes, specify cost.		
K. Did you receive revenue from these people? C	Yes	• • • •		If yes, specify amt.	A	
L. Where is the revenue received reported in the Cos	t Report?		(Page/Line	e Item)		

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

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

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

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

	ne of Facility	License No.	Repo	ort for Year E	nded	Page	of
TG	C Healthcare, Inc. D/B/A Caroline Manor	1855		9/30/2015		20	37
	Item			Total	CCNH	RHNS	Residential Care Home
4.	Housekeeping	Sq. Ft. Serviced					
	a. In-House Care1. Supplies - Cleaning (Mops, pails, brooms, etc.)	by Personnel Amt.	\$	5,662	6		5,662
	b. Purchased Services (by contract other than through Management Services)	Sq. Ft. Serviced by Personnel					
	(Complete Schedule C-2 att. Page 21)	Amt.	\$				
	c. Management Services*		\$				(iiii
	d. Other (Specify)		\$				
4E.	Total Housekeeping Expenditures (4a +	b+c+d)	\$	5,662			5,662
5.	Resident Care (Supplies)** a. Prescription Drugs*** 1. Own Pharmacy		\$				
	2. Purchased from	a # #	\$				
	b. Medicine Cabinet Drugs		\$	122			122
	c. Medical and Therapeutic Supplies		\$				
	d. Ambulance/Limousine***		\$				
	e. Oxygen 1. For Emergency Use		\$				
	Other*** f. X-rays and Related Radiological		\$				
	Procedures*** g. Dental (Not dentists who should be inc	ludad undar	\$				
	salaries or fees)	inded under					
0.0	h. Laboratory***		- \$				
	i. Recreation	11	\$	1,098			1,098
	j. Other (Specify)**** See Attached Schedule		\$	3,640			3,640
5K.	Total Resident Care Expenditures (5a - 5	j)	\$	4,860			4,860

^{*} 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 (soap,shampoo - non-discriminatory)			\$ 539
Cable TV			\$ 3,101
	rat kinabata		
表型是可能的20mb至20mb,但是是第三个20mb,20mb,20mb,20mb			
Total Other Resident Care	\$ -	\$ -	\$ 3,640

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 TGC Healthcare, Inc. D/B/A Caroline Manor	Caroline Manor			License INO. 1855	Keport for Year Ended 9/30/2015				Page 21	ot 37
		Related ** to Owners,	o Owners,							
	. 5 2	Operators, Officers	Officers		1		Total Cost	Total Cost/Page Ref.***		T
Name of Individual or Company	Address	Yes	%	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHINS	Residential Care Home	Pg	Line
		0	0							
	w 40 %	0	0		8					
	× a	0	0							
	is No he	0	0							
	E 3- 8	0	0							
	ar e	0	0							
	9 0	0	0							
	9 4	0	0							
	× =	0	0		3					
5		0	0		2					
	* :=:	0	0							
		0	0			3				
2		0	0	is a						
	s a s	0	0							
A STATE OF THE STA		3	7							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 License No.	Report for Ye	ear Ended		Page of
TGC Healthcare, Inc. D/B/A Caroline Manor 1855	9/30/2015			22 37
				Residential Care
Item	Total	CCNH	RHNS	Home
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance	\$ 8,461			8,461
b. Heat	\$ 5,108			5,108
c. Light & Power	\$ 13,533			13,533
d. Water	\$ 2,198			2,198
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 	N/A -2		
f. Other (itemize)	\$ 8,126			8,126
See Attached Schedule				
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 37,426			37,426
7. Depreciation (complete schedule page 23*)				
a. Land Improvements	\$	ii		
b. Building & Building Improvements	\$ 1,301			1,301
c. Non-Movable Equipment	\$ •			
d. Movable Equipment	\$ 13,996			13,996
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 15,297			15,297
8. Amortization (Complete att. Schedule Page 24*)				
a. Organization Expense	\$ 		(2)	8(5)
b. Mortgage Expense	\$			
c. Leasehold Improvements	\$ 1,044			1,044
d. Other (Specify)	\$			
*8e. Total Amortization Costs (8a + b + c + d)	\$ 1,044			1,044
9. Rental payments on leased real property less				
real estate taxes included in item 10b	\$ 60,000			60,000
10. Property Taxes				
a. Real estate taxes paid by owner	\$ 			
b. Real estate taxes paid by lessor	\$ 12,325			12,325
c. Personal property taxes	\$ 1,555			1,555
11. <i>Total Property Expenses</i> (7e + 8e + 9 + 10)	\$ 90,221			90,221

^{*} 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	idential e Home
Fire Monitoring			\$ 2,434
Sewer Expense			\$ 2,577
Generator Service			\$ 602
Waste Removal			\$ 2,513
Total Other Repairs and Maintenance	\$ -	\$ -	\$ 8,126

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

9		Depreci	Depreciation Schedule	hedule					
Name of Facility		License No.			Report for Year Ended	nded		Page	Jo
TGC Healthcare, Inc. D/B/A Caroline Manor		1855	2		9/30/2015			23	37
8		Historical			Accumulated				Si
e inc		Cost	Less	ć	Depreciation to	Method of		:	
Pronerty Item		Exclusive of Land	Value	Depreciated	Segming of Year's Operations	Computing	Userul	Depreciation for This Year	Totals
A. Land Improvements									
1. Acquired prior to this report period		,,,				¥			
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
A-4. Subtotal				ができる という できる	の 日本の 日本の 日本の 日本の 日本の 日本の 日本の 日本の 日本の 日本				
B. Building and Building Improvements									
1. Acquired prior to this report period		39,051		39,051	19,990 S/L	S/L	30	1,301	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
B-4. Subtotal								高い前屋所	1,301
C. Non-Movable Equipment	×								
 Acquired prior to this report period 									
2. Disposals (attach schedule)		*							
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
Is a mileage logbook maintained? Ac	Date of Acquisition	Historical Cost	Less		Accumulated Depreciation to	Method of		¥	
Σ	nth Year	Exclusive of Land	Salvage Value	Cost to Be Depreciated	Beginning of Computing Year's Operations Depreciation	Computing Depreciation	Useful	Depreciation for This Year	Totals
	35000								
Motor Vehicles (Specify name, model and wear of each vehicle)									
×	10 2012	54,708		54,708	27,354	S/L	4	13,677	
b.									
, , , , , , , , , , , , , , , , , , ,									
ď.									
2. Movable Equipment									
a. Acquired prior to this report period	var	11,181		11,181	3,006 S/L		various	319	
b. Disposals (attach schedule)	var	(2,605)		(2,605)	(2,605) S/L		various		
c. Acquired during this report period									
(attach schedule)									
(i)									13,996
E. Total Depreciation			A STATE OF S			· 第一年 · · · · · · · · · · · · · · · · · · ·			15,297

TGC Healthcare, Inc. D/B/A Caroline Manor 9/30/2015

Schedule of Land Improvements Acquired during this report period

			Useful	
equisition Date	Description of Item	Cost	Life	Depreciation
dditions:				
		Control of the second		
			THE STATE OF THE S	I 81.600 - 1.40.5
otal additions for Land Impro	vements	\$ -		\$ -
eletions:				
			H11 2 / 2/7	
otal deletions for Land Impro	vements	\$ -		\$ -

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Building	Improvements	\$ -		\$ -
Deletions:	impi o vemento	y		
	THE RESIDENCE THE PROPERTY OF THE PARTY OF T			
Total deletions for Building	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:				
		DESCRIPTION OF TAXABLE		
				1 at 2 at 10 h
				TWINE AND RELL
				(P. 10 - 12 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2
otal additions for Non-Movable	e Equipment	\$ -		s -
eletions:				
			AYEX BY GET	
			Office Service	Equipment of the second
			Court Francis	
Total deletions for Non-Movable	T .	s -		\$ -

^{*}Tics 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	Life	Depreciat	ion
Additions:					
					/E(
					N.
Total additions for Movable Equ	ipment	\$ -		S	. *
Deletions:					
			DE AVERNOU		
				The Marine Con-	
Total deletions for Movable Equ	ipment	\$ -		\$. *

^{*}Ties to Page 23, Line D2c **Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

1	Description of Item	Cost	Useful Life	Depreciation
Acquisition Date Additions:	Description of item	Cost	Line	Depreciation
Additions:				
Total additions for Leasehold I	nprovement	\$ -		\$ -
Deletions:				
			- TE And The	
		m Significant significant and military		
		0		s -
Total deletions for Leasehold In	nprovement	\$ -		9

^{*}Ties to Page 24, Line C3

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

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

Amortization Schedule*

43			,		,				
Name of Facility			License No.		Report tor Year Ended	r Ended		Page	of
TGC Healthcare, Inc. D/B/A Caroline Manor	ır		1855	55	9/30/2015	77		24	37
0 4					Accumulated				
el =	Dat	Date of			Amort. to				N.
	Acqu	Acquisition			Beginning of	Basis for			
: >						11			
			Length of	Cost to Be	Year's	Computing	Rate	Amortization	51
Item	Month	Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A. Organization Expense									
-									
2.									
3.			+:						
A-4. Subtotal									
B. Mortgage Expense						12			
1									
2.			=1			,t			
3,									
B-4. Subtotal									
C. Leasehold Improvements and Other	•								
1. Acquired prior to this report period	l var	var	various	36,965	32,264 S/L	S/L	var	1,044	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)									
C-4. Subtotal									1,044
D. Total Amortization									1,044
* Cturinht line mothed mint he was									

* 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; ORC. Remaining Life of Lease; ORD. Actual Life if owned by Related Party.

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

Name of Facility License No.		Report fo		ided			Page	of
TGC Healthcare, Inc. D/B/A Caroline 185	55	9/30/201:	5				25	37
11. Property Questionnaire								
Part A								
Is the property either owned by the Facility						If "Yes,"	complete	e Part B.
or leased from a Related Party?*	•	Yes		0	No	If "No,"		
*If any owner or operator of this facility is related	by family m	arriane ova	nerchin ahi	lity to control or				
business association to any person or organization	from whom	buildings a	re leased, th	en it is considered				
a related party transaction.								
Description		To	otal					
Date Land Purchased								
Date Structure Completed			0/0/1964					
If NOT Original Owner, Date of Purchase	e		05/01/99					
4. Date of Initial Licensure								
Total Licensed Bed Capacity			16					
6. Square Footage								
7. Acquisition Cost								
a. Land			-					
b. Building		1-4 3 4		2nd Mortgage	2nd Mortgogo	1	h Mortga	αA
Part B - Owner and Related Parties		1St IVIO	ortgage	Ziid Mortgage	310 Mortgage	40	ii iviortga	gc
1. Financing	۵)	Fixed		Fixed				
a. Type of Financing (e.g., fixed, variable b. Date Mortgage Obtained	c)	rixeu	11/20/00					-
c. Interest Rate for the Cost Year		8.99.%	11/20/00	8.00.%				
d. Term of Mortgage (number of years)		0.77.70	20	20				
e. Amount of Principal Borrowed			225,000	100,000		***		
f. Principal balance outstanding as of 9.	/30/15		2,304	25,371	**			
Complete if Mortgage was Refinanced								
During Current Cost Year								
g. Type of Financing (e.g., fixed, variable	e)							
h. Date of Refinancing								
i. New Interest Rate								
j. Term of Mortgage (number of years)								
k. Amount of Principal Borrowed								
 Principal Outstanding on Note Paid-O 								
Part C - Arms-Length Leases for Real								
Name and Address of Lessor	Pro	perty Leas	sed	Date of Lease	Term of Lease	Annual	Amount	of Lease
						1		
			41.04				u, eicher	
			8					
		or # 11 8 E				-		
				17				

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
TGC Healthcare, Inc. D/B/A Caroline 1855		9/30/2015			26 37
					Residential Care
Item		Total	CCNH	RHNS	Home
12. Interest					
A. Building, Land Improvement & Non-Movabl	e				
Equipment 1. First Mortgage	\$				
Name of Lender	Rate				
Number of Editor	race				
Address of Lender					
Second Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
Address of Defider					
3. Third Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information	-				
	\$				
Original Loan Amount Original Loan Posts	Φ				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$				100 100 100 100 100 100 100 100 100 100
		(Com	v Subtotals i	Command to 1	aut naga)

(Carry Subtotals forward to next page)

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

Name of Facility License			Report for Y	ear Ended	100		of
TGC Healthcare, Inc. D/B/A Carol	855		9/30/2015				37
						Residenti	
Item		FAIR - CONT.	Total	CCNH	RHNS	Care Hon	1e
	totals Bro	ıght Forward:					
12. C. Movable Equipment							
Automotive Equipment		\$	1,883			1,	883
A. Item	Rate	Amount					
2013 Ford Explorer	5.39.%	55,580					
Lender							
Belmont Savings	9						
Address of Lender							
P O Box 150 Williamsville, NY 14231							
2. Other (Specify)		\$					
A. Item	Rate	Amount					
Lender							
Address of Lender							
B. Item	Rate	Amount					
	A STORY MARKET						
Lender							
Address of Lender		E 46					
12. C. 3. Total Movable Equipment Inte	rest						NAME OF TAXABLE PARTY.
Expense (C1 + 2)		\$	1,883			1.8	883
12. D. Other Interest Expense (Specify)		\$	6,340				340
EH Tax Coll \$5,116 F/C & Late	Fees \$1.2	1.20	Marian Maria	Control of the Contro			
13. Total All Interest Expense (12B7 + 12	2C3 + 12D	9) \$	8,223		A DE LES CHI SWAN	8.3	223
14. Insurance		, +	5,225			0,2	
a. Insurance on Property (buildings	only)	\$	3,617			3,	617
b. Insurance on Automobiles	J. 111.5 J	\$	3,093				093
c. Insurance other than Property (as	specified a		3,073			3,0	0,73
1. Umbrella (<i>Blanket Coverage</i>)	specified (\$	* 6 6 6 30 3 18				K :=
2. Fire and Extended Coverage		\$					
3. Other (Specify)		\$	4,484	NEW SOLES		1/	484
Liability		Φ	4,404			4,	707
Liaomty							
14d Total Inguigance Funanditures (14a)	h + a)	d)	11 104	TENSOR NO.	BODY NO STEEL	TO PERAMEDIA	104
14d. Total Insurance Expenditures (14a +		\$	11,194			11,1	
15. Total All Expenditures (A-13 thru C-	14)	\$	520,838			520,8	838

D. Adjustments to Statement of Expenditures

Name of			Inc. D/B/A Caroline Manor	Lic	cense No. 1855	Report for Ye 9/30/2015	ear Ended	Page 28	of 37
Item P	Page	Line			Total Amount of				tial Care
	No.		Item Description		Decrease	CCNH	RHNS	Но	me
	10 - S	alari	es and Wages						
1.			Outpatient Service Costs	\$					
2.			Salaries not related to Resident Care	\$				_	
3.			Occupational Therapy	\$	214				214
4.	12 1	un fan	Other - See attached Schedule	<u> </u>	214				214
5.	3 - P	rojes	Resident Care Physicians **	\$					
6.			Occupational Therapy	\$					
7.			Other - See attached Schedule	\$					
	15 &	16 -	Administrative and General	Ψ					
8.	15 0	10	Discriminatory Benefits	\$					
9.			Bad Debts	\$					
10.			Accounting & Legal	\$					
11.			Telephone	\$			7/2		
12.	15	h2	Cellular Telephone	\$	588				588
13.			Life insurance premiums on the life						
			of Owners, Partners, Operators	\$					
14.			Gifts, flowers and coffee shops	\$					
15.			Education expenditures to colleges or					755	
			universities for tuition and related costs						
			for owners and employees	\$					
16.			Travel for purposes of attending						
			conferences or seminars outside the						
			continental U.S. Other out-of-state	Φ					
		1.6	travel in excess of one representative	\$	744				744
17.	_	1.6.	Automobile Expense (e.g. personal use) Unallowable Advertising *	\$	744 1,333				1,333
18. 19.	16	m3	Income Tax / Corporate Business Tax	\$	1,555				1,333
20.			Fund Raising / Contributions	\$					
21.			Unallowable Management Fees	\$					
22.			Barber and Beauty	\$				1	
23.			Other - See attached Schedule	\$	5,456				5,456
	[8 - L	Dietar	y Expenditures						
24.			Meals to employees, guests and others	- 6 1					
			who are not residents	\$	5,889				5,889
Page 1	19 - L	auna	lry Expenditures						
25.			Laundry services to employees, guests						
			and others who are not residents	\$					
Page 2	20 - I	Iouse	keeping Expenditures						
26.			Housekeeping services to employees, guests						
			and others who are not residents	\$					
			Subtotal (Items 1 - 26)	\$	14,224			/18	14,224

^{*} 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

age Ref	Line Ref	Description	CCNH	RHNS	Reside Care H	
10 A	2	Admin Salary over Cap			\$	214
	*					
tal Other	Salaries	Adjustment	\$ -	\$ -	\$	214

Schedule of Fees Adjustments

Page Ref	Line Ref	Description		CCNH	RHNS		Resident Care Ho	
						K P		
			走。1995年1月1日 1月1日 1月1日					E G
								1
						Story		BY 0
								A.C.
Total Othe	r Fees Adj	istments	\$	•	\$	- 9	5	-

Schedule of Other A&G Adjustments

age Ref	Line Ref	Description	CCNH	RHNS	Reside Care H	
15	a 3,4,5	Fringe benefits associated with Salary > cap			\$	42
. 16	m13.	Unallowable Bank Service Charge			\$. 111
16	m13	Miscellaneous Expense			\$	856
16	m13	Penalties				4447
otal Othe	er A&G Ac	ljustments	\$ -	\$ -	\$	5,456

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

Nam	e of Fa	acility		Lic	ense No.	Report for Y	ear Ended	Page	of
TGC	Healt	hcare,	Inc. D/B/A Caroline Manor		1855	9/30/2015		29	37
					Total				
Item	Page	Line			Amount of			Reside	ntial Care
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	. H	ome
			Subtotals Brought Forward	\$	14,224				14,224
Page	20 - 1	Reside	ent Care Supplies***						
27.			Prescription Drugs	\$					
28.			Ambulance/Limousine	\$					
29.			X-rays, etc	\$	3				
30.			Laboratory	\$			1 _0		
31.			Medical Supplies	\$					
32.			Oxygen (non emergency)	\$					
33.			Occupational Therapy	\$					
34.			Other - See Attached Schedule	\$					
Page	22 - N	Maint	enance and Property		The state of the				
35.			Excess Movable Equipment Depreciation						
			See Attached Schedule	\$	11,416				11,416
36.			Depreciation on Unallowable						
			Motor Vehicles	\$					
37.	22	10.b	Unallowable Property and Real		THE RESERVE				
			Estate Taxes	\$	3,882				3,882
38.			Rental of Building Space or Rooms	\$					
. 39.			Other - See Attached Schedule	\$	5,736				5,736
Page	27 - I	nsura	nce						
40.	27		Mortgage Insurance	\$					
41.	27	14.c	Property Insurance	\$	992				992
Othe	r - Mis	scella	neous						
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.	2 2 2		Other (include personnel and other		科学				100
			costs unrelated to resident care) - See						
			Attached Schedule	\$	6,340				6,340
Not I	For Pr	ofit P	roviders Only						
50.			Building/Non Movable Eq. Depreciation		We to second				
			Unallowable Building Interest						
			See Attached Schedule	\$					
51.	Total	Amo	unt of Decrease (Items 1 - 50)	\$	42,590				42,590

^{***} 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.

1 96500 ene

Laby 31

TGC Healthcare, Inc. D/B/A Caroline Manor 9/30/2015

Schedule of Other Ancillary Costs

Line Ref Description	CCNH	RHNS	Residential Care Home
		Miles de la se	
er Ancillary Costs	s -	\$ -	\$ -
	Line Ref Description		

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	2000000	sidential re Home
22	7d	Excess Mov Equip Depre - 2013 Ford Explorer - disallow 54.3%			\$	2,688
22	7d	Mov Equip Depre 2013 Ford Explorer - Personal Use			\$	8,728
ALDES SEE						
Total Exce	ss Movable	e Equipment Depreciation	\$ -	\$ -	\$	11,416

Schedule of Other Property Adjustments

ze Ref Line Re	f Description	CCNH	RHNS	Residential Care Home	الااه
27 14b	Insurance on Auto - personal use			Care Home \$ 1,974 \$ 493	reclass Jilai
22 10.c	Personal Property Tax (Auto) Personal use			\$ 493	- reclass a.
27 12.c.1	Interest Expense (vehicle) Personal Use				-9b
22 6.d	Water - rental portion (see pg 29a)		* 5 * * 5 * *	\$ - 372	-1
22 6.f	Sewer - rental portion (see pg 29a)			\$ 436	
22 6.f	Waste Removal - rental portion (see pg 29a)			\$ 426	
22 6.f	Generator Service - rental portion (see pg 29a)			\$ 165	
22 6.f	Fire Protection - rental portion (see pg 29a)			\$ 668	
tal Other Proper	ty Adjustments	\$ -	\$ -	\$ 5,736	

Page Ref	Line Ref	Description	CCNH	RHNS	sidential re Home
27	12D	Finance Charges - Late Fees		The Minister	\$ 1,224
27	12D	Collector of Taxes East Haven - Interest			\$ 5,116
美MITTER 1975					
100					
Cotal Othe	r Adjustm	ents	\$ -	\$ -	\$ 6,340

Schedule of Unallowable Building Interest

Page Ref	Line Ref Description	CCNH	RHNS	Residential Care Home
	Andrew Market Colored Street Colored			F Star Thomas
			Φ.	•
Total Unal	lowable Building Interest	\$ -	\$ -	\$ -

F. Statement of Revenue

F. Statement of Re-		5000			In a
Name of Facility License No.		Report for Ye 9/30/2015	Page of 30 37		
ΓGC Healthcare, Inc. D/B/A Caroline Ma 1855	-	9/30/2013		I	
Item		Total	CCNH	RHNS	Residential Ca Home
. Resident Room, Board & Routine Care Revenue					
a. Medicaid Residents (CT only)	\$	479,972		A CONTRACTOR OF	479,97
b. Medicaid Room and Board Contractual Allowance **	\$.,,,,,,			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (all inclusive)	\$		7		
b. Medicare Room and Board Contractual Allowance **	\$				
A. a. Private-Pay Residents and Other	\$	6,710			6,71
•	\$	0,710			5,71
b. Private-Pay Room and Board Contractual Allowance **	φ				
II. Other Resident Revenue					
a. Prescription Drugs - Medicare	\$				
b. Prescription Drugs - Medicare Contractual Allowance **	\$		-		
c. Prescription Drugs - Non-Medicare	\$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$				
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$	-			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$				
b. Speech Therapy - Medicare Contractual Allowance **	\$				1 1 1
c. Speech Therapy - Non-Medicare	\$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$				
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (Specify) - Medicare	\$				
b. Other (Specify) - Non-Medicare	\$				
III. Total Resident Revenue (Section I. thru Section II.)	\$	486,682			486,68
IV. Other Revenue*		MA ANDRES			
Meals sold to guests, employees & others	\$	5,900		ADDRESS NO.	5,90
Rental of rooms to non-residents	\$	3,700			5,50
	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				100
5. Interest Income (Specify)					-
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$	10.501			10.50
8. Other (Specify)	\$	19,581			19,58
V. Total Other Revenue (1 thru 8)	\$	25,481			25,48
VI. Total All Revenue (III +V)	\$	512,163			512,16

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref Description	CCNH	RHNS	Residential Care Home
		11/15/21/14/21	
	HILLSWAN AND DESCRIPTION		A SERVICE ASSO
Total Other Resident Revenue - Medicare	\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	Co	CNH	RH	NS	Reside Care I	
		对外的特殊性是是实现的是组织的 是是			į linkų		
							Service of
Total Othe	l er Resident Revenue	\$	-	\$	- 1	\$	-

Interest Income

Account

Page Ref Account	Balance	CCNH	RHNS	Residential Care Home
				TO THE STATE OF TH
Total Interest Income		\$ -	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	sidential re Home
30IV8	Personal Use of Auto			\$ 13,140
30IV8	Rental Overhead Reimbursement			\$ 6,441
Total Oth	er Revenue	\$ -	\$ -	\$ 19,581

G. Balance Sheet

Name of Facility TGC Healthcare, Inc. D/B/A Ca	License No.	Report for Year Ended 9/30/2015	Page 31	of 37
Toe Heatmoure, me. BrBitt ee	Account			Amount
Assets				
A. Current Assets				
1. Cash (on hand and in	banks)	=	\$	196
	ceivable (Less Allowance		\$	24,856
3. Other Accounts Recei	vable (Excluding Owners	or Related Parties)	\$	
4 Inventories			\$	1,318
Prepaid Expenses			\$	2,938
a. Prepaid Insurance		2,938		
b				
d.				
Interest Receivable			\$	
Medicare Final Settler			\$	Signature State
8. Other Current Assets (- 444	\$	5,312
Payroll Taxes for 10/1/	15 Payroll	5,312		
	4-0-1-4-0-1-4-0-1-4-0-1-4-0-1-4-0-1-4-0-1-4-0-1-4-0-1-4-0-1-4-0-1-4-0-1-4-0-1-4-0-1-4-0-1-4-0-1-4-0-1-4-0-1-4	1		
A-9. Total Current Assets (Lin	nes A1 thru 8)		\$	34,620
B. Fixed Assets				
1. Land		·	\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Deprecia	ation Net		
3. Buildings	*Historical Cost	39,051	\$	17,760
	Accum. Deprecia	ation 21,291 Net		
4. Leasehold Improveme	ents *Historical Cost	36,965	\$	3,657
*	Accum. Deprecia	ation 33,308 Net		
5. Non-Movable Equipm	ent *Historical Cost		\$	
	Accum. Deprecia	ation Net		
6. Movable Equipment	*Historical Cost	8,576	\$	1,856
	Accum. Deprecia	ation 6,720 Net		
7. Motor Vehicles	*Historical Cost	54,708	\$	13,67
	Accum. Depreci	ation 41,031 Net		
8. Minor Equipment-Not			\$	
9. Other Fixed Assets (it	emize)	1240	\$	
	h			
B-10. Total Fixed Assets (I	ines B1 thru 9)		\$	36,950
D-10. Total I Men 7 Docto (L			Ψ	50,550

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

G. Balance Sheet (cont'd)

	e of Facil		License No.	Report for Year Ended		Page	1	of
TGC	Healthca	are, Inc. D/B/A Caroline		9/30/2015	_	32		37
			Account	T-t-1 Days old Formand	. 0	Ai	noun	
	- 4		1 10 D '- D	Total Brought Forward	: 9			71,570
C.		ld or like property recor	ded for Equity Purpos	ses.	σ.			
	1. Land		#II' · ' 10 ·		\$			
	2. Land	d Improvements	*Historical Cost	Not	φ.			
		11	Accum. Depreciation	on Net	\$			
	3. Buil	dings	*Historical Cost	Not	0			
		Nr. 11 D '	Accum. Depreciation	on Net	\$			
	4. Non	-Movable Equipment	*Historical Cost	Not				
		11 7	Accum. Depreciation	on Net	\$			
	5. Mov	able Equipment	*Historical Cost	N.,	0			
			Accum. Depreciation	on Net	\$		-	
	6. Mot	or Vehicles	*Historical Cost		Ι,			
			Accum. Depreciati	on Net	\$			
		or Equipment-Not Depr			\$			
C-8		easehold or Like Proper	ties (C1 thru 7)		\$			(2)
D.		ent and Other Assets						
		erred Deposits			\$			
	2. Escr	ow Deposits		Western Committee of the Committee of th	\$			
91	3. Orga	anization Expense	*Historical Cost					
		7 7	Accum. Depreciati	on Net	\$			
		dwill (Purchased Only)	200		\$			
	5. Inve	stments Related to Resi	dent Care (itemize)		\$		-	
	A . 							
	6. Loai	ns to Owners or Related	Parties (itemize)	T	\$			
		Name and Address	Amount	Loan Date				
				0				
		Δ.						
		•						
	7. Othe	er Assets (itemize)		·	\$			
		,						
D-8	Total In	vestments and Other A	ssets (Lines D1 thru	7)	\$			
D 0	Total A	Il Assets (Lines A9 + B	10 + C8 + D8		\$			71,570

^{*} 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 Fac		I DD/A C - !' - M	License No.	Report for Year En	nded		Page 33	of 37
TGC Health	care,	Inc. D/B/A Caroline Manor		9/30/2013			Amou	
Liabilities			Account				Amot	iiit
A.	Cu	rrent Liabilities						
A.	1.	Trade Accounts Payable				\$		81,821
	2.	Notes Payable (itemize)				\$		
			1)					
	3.	Loans Payable for Equipn				\$		9,476
		Name of Lender	Purpose	Amount	Date Due			
		V000 38 (V175e)		0.456				
		Belmont Savings	2013 Ford Explorer	9,476	various			
			1					
5								
	4.	Accrued Payroll (Exclusive	ve of Owners and/or St	ockholders only)	1	\$		5,942
	5.	Accrued Payroll (Owners				\$		1,598
	6.	Accrued Payroll Taxes Pa	yable			\$		579
	7.	Medicare Final Settlemen	t Payable			\$		
	8.	Medicare Current Financi	ng Payable			\$		
	9.	Mortgage Payable (Curre	nt Portion)			\$		
	10	. Interest Payable (Exclusiv	re of Owner and/or Rel	ated Parties)		\$		
(c.	11	. Accrued Income Taxes*				\$		250
	12	. Other Current Liabilities	(itemize)	-		\$		196,252
		Accrued Accounting Fees	3,01	5 cash overdraft	4,922			
		Due to DSS	161,41	3 * Accrued Rent	4,800			
	* (*)	Pension Payable	24	0				
		Accrued Propety Taxes	21,86	2		A		205.010
A-13	3. To	otal Current Liabilities (Li	nes A1 thru 12)			\$		295,918

^{*} 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.	Report for Year	Ended		Page 34	270	of
TGC Healthcare, Inc. D/B/A Caroline Man	Inc. D/B/A Caroline Man 1855 9/30/2015 Account						37
F		Aı	moun				
		Total Brough	it Forward:				295,918
Liabilities (cont'd)							
B. Long-Term Liabilities	(itawina)			\$			20,551
	1. Loans Payable-Equipment (itemize) Name of Lender Purpose Amount Date Due					10	20,331
Name of Lender	Turpose	Zillodit	Date Due				
Belmont Savings	2013 Ford Explorer	20,551	various				
	a a						
2. Mortgages Payable		· ·		\$			
3. Loans from Owners or Rel	ated Parties (itemize)			\$			105,638
Name and Address of Lender	Amount	Loan D	ate				
	e a		s				
Timothy Conroy Jr	105,638	various					
4. Other Long-Term Liabilitie	es (itemize)	1		\$			317,840
Due to East Ridge Manor,		22,072					
Due to Ratifive, Inc. (relate	ed party)	217,662	2 2 2 C 3 5 5				
Due to Doreen Conroy/Pre							
Due to DCO Real Estate (r	elated party)	8,939				西	
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$			444,029
C. Total All Liabilities (Lines A-	13 + B-5)			\$			739,947

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

	ne of Facility C Healthcare, Inc. D/B/A Caroline License No. Report for Year Ended 9/30/2015	Page of 35 37
100	Account	Amount
A.	Reserves	
	1. Reserve for value of leased land	\$
	 Reserve for depreciation value of leased buildings and appurtenances to be amortized 	\$
	3. Reserve for depreciation value of leased personal property (<i>Equity</i>)	\$
	4. Reserve for leasehold real properties on which fair rental value is based	\$
	5. Reserve for funds set aside as donor restricted	\$
	6. Total Reserves	\$
В.	Net Worth 1. Owner's Capital	\$
	2. Capital Stock	\$
	3. Paid-in Surplus	\$
	4. Treasury Stock	\$
	5. Cumulated Earnings	\$ (659,702)
	6. Gain or Loss for Period 10/1/2014 thru 9/30/2015	\$ (8,675)
2	7. Total Net Worth	\$ (668,377)
C.	Total Reserves and Net Worth	\$ (668,377)
D.	Total Liabilities, Reserves, and Net Worth	\$ 71,570

H. Changes in Total Net Worth

Name of Facility License No.	Report for Year	Ended	Page	of
TGC Healthcare, Inc. D/B/A Caroline M 1855	9/30/2015		36	37
Account				ount
A. Balance at End of Prior Period as shown on Report o		9		(662,177)
B. Total Revenue (From Statement of Revenue Page 30		9		512,163
C. Total Expenditures (From Statement of Expenditures	Page 27)			520,838
D. Net Income or Deficit		\$		(8,675)
E. Balance		\$	3	(670,852)
F. Additions				
1. Additional Capital Contributed (itemize)				
2				
2. Other (itemize)				
pr yr adj - misc expense	2,137			
pr yr adj - uncashed p/r checks	441			
pr yr adj - remove duplicate payment (maint)	287			
Programmy remove any programmy				
F-3. Total Additions		9		2,865
G. Deductions			_ N N	
1. Drawings of Owners/Operators/Partners (Specify)	9	}	
Name and Address (No., City, State, Zip)	Title	Amount		
2. Other Withdrawings (Specify)		1		390
Purpose	Amo			
	Time	206		
pr yr adj - W/C Ins		184		
pr yr adj - water		104		
				200
3. Total Deductions		9	10%	390
H. Balance at End of Period 09/30)/15	9)	(668,377)

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of	
TGC Healthcare, Inc. D/B/A Caroline	1855	9/30/2015	37	37	
Check appropriate category					
Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS				
Preparer/Reviewer Certification					
I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.					
Signature of Preparer	Title	Date Signed	=		
Printed Name of Preparer					
5					
Michael J. Michaud, CPA					
Addres Address		Phone Number	Phone Number		
34 W 35 O 10	E E E E	r a s t			
P O Box 164 Old Saybrook, CT 06475		860-388-4627 Ext 226	860-388-4627 Ext 226		