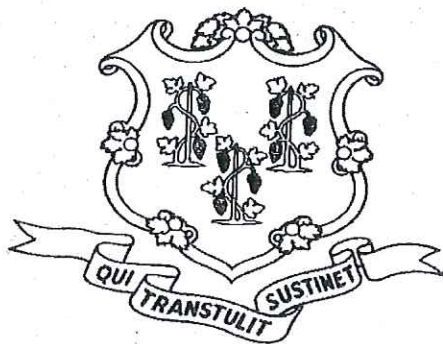


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015

Name of Facility (as licensed) TGC Healthcare, Inc. D/B/A Caroline Manor	
Address (No. & Street, City, State, Zip Code) 37 Clark Avenue East Haven, CT 06512	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH	RHNS	Residential Care Home 1855	Medicare Provider
------------------	------	------	-------------------------------	-------------------

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
----------------------------	------	------	---------

For Department Use Only

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

Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Leases	6
General Information and Questionnaire - Accounting Basis	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

General Information

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

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for 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					

(Notary Seal)

State of Connecticut
Department of Social Services
 55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility TGC Healthcare, Inc. D/B/A Caroline Manor		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility 37 Clark Avenue East Haven, CT 06512				
Report Prepared By Brodeur & Co. CPAs, P.C.		Phone Number 860-388-4627	Date 2/9/2016	
Item	Total	CCNH	RHNS	Residential Care Home
1. 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.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-630-6432		Report for Year Ended 9/30/2015	Page 2	of 37
Name of Facility (as shown on license) TGC Healthcare, Inc. D/B/A Caroline Manor		Address (No. & Street, City, State, Zip) 37 Clark Avenue East Haven, CT 06512		
License Numbers:	CCNH	RHNS	Residential Care Home 1855	Medicare Provider No.
Type of Facility (Check appropriate box(es))				
<input type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> Residential Care Home				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Timothy Conroy, Jr.		Nursing Home Administrator's License No.:		
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

**General Information and Questionnaire
 Related Parties***

Name of Facility TGC Healthcare, Inc. D/B/A Caroline Manor	License No. 1855	Report for Year Ended 9/30/2015	Page 4	of 37
---	---------------------	------------------------------------	-----------	----------

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? Yes No

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No				
Ratiffive, Inc.	P O Box 239 Middlefield, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>	Real Estate Rental	Pg. 22, Line 9	60,000	60,000
Ratiffive, Inc.	P O Box 239 Middlefield, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>	Loan from Related Party	Pg. 34, Line B4	217,662	217,662
East Ridge Manor, Inc.	43 Preston Ave. Meriden, CT 06450	<input type="radio"/>	<input checked="" type="radio"/>	Loan from Related Party	Pg. 34, Line B4	22,072	22,072
Doreen Conroy	841 Norwich-New London Tpke Uncasville, CT 06382	<input type="radio"/>	<input checked="" type="radio"/>	Loan from Related Party	Pg. 34, Line B4	66,667	66,667
Due to DCO Real Estate, LLC	841 Norwich-New London Tpke Uncasville, CT 06382	<input type="radio"/>	<input checked="" type="radio"/>	Loan from Related Party	Pg. 34, Line B4	8,939	8,939
Preston Real Estate	841 Norwich-New London Tpke Uncasville, CT 06382	<input type="radio"/>	<input checked="" type="radio"/>	Loan from Related Party	Pg. 34, Line B4	2,500	2,500
Timothy Conroy, Jr.	37 Clark Ave. East Haven, CT 06512	<input type="radio"/>	<input checked="" type="radio"/>	Administrator	Pg. 10, Line A2	52,163	52,163
Timothy Conroy, Jr.	37 Clark Ave. East Haven, CT 06512	<input type="radio"/>	<input checked="" type="radio"/>	Loan from Owner	Pg. 34, Line B3	105,638	105,638
PAYHR	P O Box 239 Middlefield, CT 06444	<input checked="" type="radio"/>	<input type="radio"/>	Payroll Processing	N/A No Fees		

* 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 TGC Healthcare, Inc. D/B/A Caroline Manor	License No. 1855	Report for Year Ended 9/30/2015	Page 5	of 37
---	---------------------	------------------------------------	-----------	----------

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (<i>See listing page 13</i>)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required? Yes No If "No," explain fully why such allocation was not made.

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

The facility shares telephone expenses (Vonage) with related facilities: East Ridge Manor and Haughton Manor. A Home Depot card is shared with East Ridge Manor as well. Actual expenses for each facility are reported on each respective cost report.

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

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

N/A

General Information and Questionnaire
Accounting Basis

Name of Facility TGC Healthcare, Inc. D/B/A Caroli	License No. 1855	Report for Year Ended 9/30/2015	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain.				
Independent Accounting Firm				
Name of Accounting Firm 1 Brodeur & Co. CPA, P.C. 2 3 4		Address (No. & Street, City, State, Zip Code) 10 Springbrook Rd. Old Saybrook, CT 06475		
Services Provided by This Firm (<i>describe fully</i>)				
1	Preparation of YE Trial Balance, Annual Cost Report, Tax Returns, Audit Support	\$	10,715	
2		\$		
3		\$		
4		\$		
			Charge for Services Provided	
			\$ 10,715	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No Accounting & Auditing, Pg. 15, 1d				
Legal Services Information				
Name of Legal Firm or Independent Attorney 1 Gallo & Associates, LLC 2 3 4 5			Telephone Number	
Address (<i>No. & Street, City, State, Zip Code</i>) 1 295 Main St. West Haven, CT 06516 2 3 4 5				
Services Provided by This Firm (<i>describe fully</i>)				
1	Involuntary Eviction of a Resident/Agreement with DPH	\$	500	
2		\$		
3		\$		
4		\$		
5		\$		
			Charge for Services Provided	
			\$ 500	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No Legal, Pg. 15, 1e				

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

Schedule of Resident Statistics

Name of Facility TGC Healthcare, Inc. D/B/A Caroline Manor	License No. 1855	Report for Year Ended 9/30/2015						Page 8	of 37
		Period 10/1 Thru 6/30		Period 7/1 Thru 9/30		Total	Residential Care Home		
		Total CCNH Level	Total RHNS Level	Total CCNH	Total RHNS				
1. Certified Bed Capacity									
A. On last day of PREVIOUS report period	16			16		16		16	
B. On last day of THIS report period	16			16		16		16	
2. Number of Residents									
A. As of midnight of PREVIOUS report period	16			16		16		16	
B. As of midnight of THIS report period	16			16		16		16	
3. Total Number of Days Care Provided During Period									
A. Medicare									
B. Medicaid (Conn.)									
C. Medicaid (other states)									
D. Private Pay	61			61		61		61	
E. State SSI for RCH	5,757			5,757		4,364		1,393	
F. Other (Specify)									
G. Total Care Days During Period (3A thru F)	5,818			5,818		4,364		1,454	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds									
A. Medicaid Bed Reserve Days									
B. Other Bed Reserve Days									
5. Total Resident Days (3G + 4A + 4B)	5,818			5,818		4,364		1,454	

Schedule of Resident Statistics (Cont'd)

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

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

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	Residential Care Home	Lost			Gained			CCNH	RHNS	Residential Care Home	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				

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

Change in Resident Days	CCNH	RHNS	Residential Care Home
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	Residential Care Home	R.C.H.	ICF-MR
No. of Residents						1	15	
Per Diem Rate								
a. One bed rm.						105.00	81.58	
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	Residential Care Home
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. Total Physical Therapy Treatments				

8. Total Number of Speech Therapy Treatments

	TOTAL	CCNH	RHNS	Residential Care Home
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. Total Speech Therapy Treatments				

9. Total Number of Occupational Therapy Treatments

	TOTAL	CCNH	RHNS	Residential Care Home
A. Medicare - Part B				
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other				
D. Total Occupational Therapy Treatments				

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
TGC Healthcare, Inc. D/B/A Caroline Manor	1855	9/30/2015	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	Residential Care Home	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)					52,163	2,080
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)					47,767	2,573
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers					33,874	2,584
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers					15,985	1,457
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers						
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers					8,291	760
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses						
b. RN						
1. Direct Care						
2. Administrative**						
c. LPN						
1. Direct Care						
2. Administrative**						
d. Aides and Attendants					72,584	6,451
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers					16,352	1,066
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management						
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>					247,016	16,971

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

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

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

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

Name of Facility		License No.		Report for Year Ended		Page	of		
TGC Healthcare, Inc. D/B/A Caroline Manor		1855		9/30/2015		11	37		
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS							
Section I - Operators/Owners									
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).									

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
 ** Include all employment worked during the cost year.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
TGC Healthcare, Inc. D/B/A Caroline Manor	1855	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						
a. Medical Director (entire facility)						
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries						

* 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.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
TGC Healthcare, Inc. D/B/A Caroline Manor	1855	9/30/2015	15	37
Item	Total	CCNH	RHNS	Residential Care Home
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 2,986			2,986
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 12,366			12,366
4. Social Security (F.I.C.A.)	\$ 18,621			18,621
5. Health Insurance	\$ 17,683			17,683
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 10,715			10,715
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 500			500
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 1,279			1,279
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 2,747			2,747
2. Cellular Phones	\$ 1,308			1,308
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 250			250
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$			
Subtotal	\$ 68,455			68,455

d 588

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page	of
TGC Healthcare, Inc. D/B/A Caroline Manor	1855	9/30/2015	16	37
Item	Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:	68,455			68,455
l. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$			
3. Gifts to Staff and Residents	\$			
4. Employee Travel	\$			
5. Education Expenses Related to Seminars and Conventions	\$			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 1,166			1,166
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 1,333			1,333
4. Fund-Raising***	\$			
5. Medical Records	\$			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 175			175
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 125			125
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$			
10. Contributions*** See Attached Schedule	\$			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$			
12. Administrative Management Services**	\$			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 9,101			9,101
C-14 Total Administrative & General Expenditures	\$ 80,355			80,355

63,816 person use d 744

d.

releas other As of

* Do not include Subscriptions, which should go in item 9.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 *** Facility should self-disallow the expense on Page 28 of the Cost Report.

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	Residential Care Home
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	Residential Care Home
Website			\$ 1,333
Total Other Advertising	\$ -	\$ -	\$ 1,333

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
BJ Membership Renewal			\$ 125
Total Dues	\$ -	\$ -	\$ 125

*reclass
Other A+G*

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
401K Administration			\$ 400
Food Service License Renewal			\$ 350
Background Checks			\$ 400
Miscellaneous Expense			\$ 856
Payroll Processing Fees			\$ 2,537
Bank Service Fee			\$ 111
Penalties			\$ 4,447
Total Other Administrative and General	\$ -	\$ -	\$ 9,101

*d
d
d*

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 #

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
TGC Healthcare, Inc. D/B/A Caroline Manor		1855	9/30/2015		18	37
Item	Total	CCNH	RHNS	Residential Care Home		
2. Dietary						
a. In-House Preparation & Service						
1. Raw Food	\$ 32,939				32,939	
2. Non-Food Supplies	\$ 1,837				1,837	
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) _____	\$ _____					
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 34,776				34,776	
2F. Dietary Questionnaire	Total	CCNH	RHNS	Residential Care Home		
G. Resident Meals: Total no. of meals served per day:*	48				48	
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No						
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.		
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input checked="" type="radio"/> Yes <input type="radio"/> No				If yes, specify cost.	\$5,889	
L. Is any revenue collected from these people? <input checked="" type="radio"/> Yes <input type="radio"/> No				If yes, specify amt.	\$5,900	
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					Pg 30, Line IV8	
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.		
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.		
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)						

Reported on Line IV.1

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility TGC Healthcare, Inc. D/B/A Caroline Manor		License No. 1855	Report for Year Ended 9/30/2015	Page 19	of 37
Item		Total	CCNH	RHNS	Residential Care Home
3. Laundry					
a. In-House Processing*		Lbs.			
1.	Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	712		712
2.	Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
		Amt. \$			
3.	Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
		Amt. \$			
4.	Repair and/or purchase of linens.***	Lbs.			
		Amt. \$	393		393
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Management Services**		\$			
d. Other (Specify)		\$			
3E. Total Laundry Expenditures (3a + b + c + d)		\$	1,105		1,105
3F. Laundry Questionnaire					
G.	Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of	
TGC 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 by Personnel				
a. In-House Care					
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	5,662			5,662
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
	Amt. \$				
c. Management Services*		\$			
d. Other (<i>Specify</i>)		\$			
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	\$				
b. Medicine Cabinet Drugs	\$	122			122
c. Medical and Therapeutic Supplies	\$				
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$				
f. X-rays and Related Radiological Procedures***	\$				
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$				
i. Recreation	\$	1,098			1,098
j. Other (Specify)**** See Attached Schedule	\$	3,640			3,640
5K. Total Resident Care Expenditures (5a - 5j)		\$ 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.

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

Name of Facility		License No.	Report for Year Ended		Page	of
TGC Healthcare, Inc. D/B/A Caroline Manor		1855	9/30/2015		22	37
Item	Total	CCNH	RHNS	Residential Care 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>)	\$					
f. Other (<i>itemize</i>)	\$ 8,126				8,126	
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 37,426				37,426	
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
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 (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 1,044				1,044	
d. Other (<i>Specify</i>)	\$					
*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. Total Property Expenses (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	Residential Care Home
Fire Monitoring			\$ 2,434
Sewer Expense			\$ 2,577
Generator Service			\$ 602
Waste Removal			\$ 2,513
Total Other Repairs and Maintenance	\$ -	\$ -	\$ 8,126

Depreciation Schedule

Name of Facility		License No.		Report for Year Ended					Page	of
TGC Healthcare, Inc. D/B/A Caroline Manor		1855		9/30/2015					23	37
Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
								Yes	No	
A. Land Improvements										
1. Acquired prior to this report period										
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)										
A-4. Subtotal										
B. Building and Building Improvements										
1. Acquired prior to this report period	39,051		39,051	19,990	S/L	30	1,301			
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)										
B-4. Subtotal									1,301	
C. Non-Movable Equipment										
1. Acquired prior to this report period										
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)										
C-4. Subtotal										
D. Movable Equipment										
1. Motor Vehicles (Specify name, model and year of each vehicle)	Is a mileage logbook maintained?	Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year
		Yes	No							
a. 2013 Ford Explorer	X		10 2012	54,708		54,708	27,354	S/L	4	13,677
b.										
c.										
d.										
2. Movable Equipment										
a. Acquired prior to this report period			var	11,181		11,181	9,006	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)										
D-3. Subtotal										13,996
E. Total Depreciation										15,297

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

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line D2c
 **Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Leasehold Improvement		\$ -		\$ - *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3
 **Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility		License No.		Report for Year Ended		Page	of		
TGC Healthcare, Inc. D/B/A Caroline Manor		1855		9/30/2015		24	37		
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	var		various	36,965	32,264	S/L	var	1,044	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									1,044
									1,044

* 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 TGC Healthcare, Inc. D/B/A Caroline	License No. 1855	Report for Year Ended 9/30/2015	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description		Total		
1. Date Land Purchased				
2. Date Structure Completed		0/0/1964		
3. If NOT Original Owner, Date of Purchase		05/01/99		
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		16		
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed	Fixed		
b. Date Mortgage Obtained	11/20/00	06/30/98		
c. Interest Rate for the Cost Year	8.99%	8.00%		
d. Term of Mortgage (number of years)	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)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
TGC Healthcare, Inc. D/B/A Carolin		1855	9/30/2015			26	37
Item		Total	CCNH	RHNS	Residential Care Home		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$					

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
TGC Healthcare, Inc. D/B/A Caro		1855		9/30/2015		27	37
Item				Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$ 1,883			1,883
A. Item		Rate	Amount				
2013 Ford Explorer		5.39.%	55,580				
Lender							
Belmont Savings							
Address of Lender							
P O Box 150 Williamsville, NY 14231							
2. Other (<i>Specify</i>)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$ 1,883			1,883
12. D. Other Interest Expense (<i>Specify</i>)				\$ 6,340			6,340
EH Tax Coll \$5,116 F/C & Late Fees \$1,224							
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$ 8,223			8,223
14. Insurance							
a. Insurance on Property (buildings only)				\$ 3,617			3,617
b. Insurance on Automobiles				\$ 3,093			3,093
c. Insurance other than Property (as specified above)							
1. Umbrella (<i>Blanket Coverage</i>)				\$			
2. Fire and Extended Coverage				\$			
3. Other (<i>Specify</i>)				\$ 4,484			4,484
Liability							
14d. Total Insurance Expenditures (14a + b + c)				\$ 11,194			11,194
15. Total All Expenditures (A-13 thru C-14)				\$ 520,838			520,838

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
TGC Healthcare, Inc. D/B/A Caroline Manor				1855	9/30/2015	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 214			214
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.			Accounting & Legal	\$			
11.			Telephone	\$			
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 universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.	16	1.6.	Automobile Expense (e.g. personal use)	\$ 744			744
18.	16	m3	Unallowable Advertising *	\$ 1,333			1,333
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 5,456			5,456
Page 18 - Dietary Expenditures							
24.	18	2.a.1.	Meals to employees, guests and others who are not residents	\$ 5,889			5,889
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 14,224			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

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
10	A2	Admin Salary over Cap			\$ 214
Total Other Salaries Adjustment			\$ -	\$ -	\$ 214

gb

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Fees Adjustments			\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
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
Total Other A&G Adjustments			\$ -	\$ -	\$ 5,456

gb

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

Name of Facility			License No.	Report for Year Ended	Page	of	
TGC Healthcare, Inc. D/B/A Caroline Manor			1855	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward				\$ 14,224			14,224
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
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	\$ 11,416			11,416 ✓
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.	22	10.b	Unallowable Property and Real Estate Taxes	\$ 3,882			3,882 ✓ gb 500 error
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 5,736			5,736
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.	27	14.c	Property Insurance	\$ 992			992 ✓
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	\$ 6,340			6,340 gb
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51. Total Amount of Decrease (Items 1 - 50)				\$ 42,590			42,590

reported on 3/11/14

*** 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.

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RIINS	Residential Care Home
Total Other Ancillary Costs			\$ -	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care 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
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ 11,416

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
27	14b	Insurance on Auto - personal use			\$ 1,974
22	10.c	Personal Property Tax (Auto) Personal use			\$ 493
27	12.c.1	Interest Expense (vehicle) Personal Use			\$ 1,202
22	6.d	Water - rental portion (see pg 29a)			\$ 372
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
Total Other Property Adjustments			\$ -	\$ -	\$ 5,736

reclass 2/1/11
- reclass 2/1/37
- gb

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
27	12D	Finance Charges - Late Fees			\$ 1,224
27	12D	Collector of Taxes East Haven - Interest			\$ 5,116
Total Other Adjustments			\$ -	\$ -	\$ 6,340

g^b
g^b

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Residential Care Home
Total Unallowable Building Interest			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility TGC Healthcare, Inc. D/B/A Caroline Ma 1855		License No. Ma 1855		Report for Year Ended 9/30/2015		Page of 30 37	
Item				Total	CCNH	RHNS	Residential Care Home
I. Resident Room, Board & Routine Care Revenue							
1.	a.	Medicaid Residents (<i>CT only</i>)	\$	479,972			479,972
	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 (<i>all inclusive</i>)	\$				
	b.	Medicare Room and Board Contractual Allowance **	\$				
4.	a.	Private-Pay Residents and Other	\$	6,710			6,710
	b.	Private-Pay Room and Board Contractual Allowance **	\$				
II. Other Resident Revenue							
1.	a.	Prescription Drugs - Medicare	\$				
	b.	Prescription Drugs - Medicare Contractual Allowance **	\$				
	c.	Prescription Drugs - Non-Medicare	\$				
	d.	Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2.	a.	Medical Supplies - Medicare	\$				
	b.	Medical Supplies - Medicare Contractual Allowance **	\$				
	c.	Medical Supplies - Non-Medicare	\$				
	d.	Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3.	a.	Physical Therapy - Medicare	\$				
	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 **	\$				
	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 (<i>Specify</i>) - Medicare	\$				
	b.	Other (<i>Specify</i>) - Non-Medicare	\$				
III. Total Resident Revenue (Section I. thru Section II.)				\$	486,682		486,682
IV. Other Revenue*							
1.	Meals sold to guests, employees & others		\$	5,900			5,900
2.	Rental of rooms to non-residents		\$				
3.	Telephone		\$				
4.	Rental of Television and Cable Services		\$				
5.	Interest Income (<i>Specify</i>)		\$				
6.	Private Duty Nurses' Fees		\$				
7.	Barber, Coffee, Beauty and Gift shops		\$				
8.	Other (<i>Specify</i>)		\$	19,581			19,581
V. Total Other Revenue (1 thru 8)				\$	25,481		25,481
VI. Total All Revenue (III +V)				\$	512,163		512,163

* 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
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	Residential Care Home
Total Other Resident Revenue		\$ -	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	Residential Care Home
Total Interest Income			\$ -	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Residential Care Home
301V8	Personal Use of Auto			\$ 13,140
301V8	Rental Overhead Reimbursement			\$ 6,441
Total Other Revenue		\$ -	\$ -	\$ 19,581

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
TGC Healthcare, Inc. D/B/A Caroline N	1855	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	196
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	24,856
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	1,318
5. Prepaid Expenses			\$	2,938
a. Prepaid Insurance	2,938			
b. _____				
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	5,312
Payroll Taxes for 10/1/15 Payroll	5,312			
A-9. Total Current Assets (Lines A1 thru 8)			\$	34,620
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost <u>39,051</u>		\$	17,760
	Accum. Depreciation <u>21,291</u>	Net		
4. Leasehold Improvements	*Historical Cost <u>36,965</u>		\$	3,657
	Accum. Depreciation <u>33,308</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>8,576</u>		\$	1,856
	Accum. Depreciation <u>6,720</u>	Net		
7. Motor Vehicles	*Historical Cost <u>54,708</u>		\$	13,677
	Accum. Depreciation <u>41,031</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	36,950

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
TGC Healthcare, Inc. D/B/A Caroline N		1855	9/30/2015	32	37
Account				Amount	
Total Brought Forward:				\$	71,570
C. Leasehold or like property recorded for Equity Purposes.					
1. Land				\$	
2. Land Improvements		*Historical Cost _____	Net	\$	
		Accum. Depreciation _____			
3. Buildings		*Historical Cost _____	Net	\$	
		Accum. Depreciation _____			
4. Non-Movable Equipment		*Historical Cost _____	Net	\$	
		Accum. Depreciation _____			
5. Movable Equipment		*Historical Cost _____	Net	\$	
		Accum. Depreciation _____			
6. Motor Vehicles		*Historical Cost _____	Net	\$	
		Accum. Depreciation _____			
7. Minor Equipment-Not Depreciable				\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)				\$	
D. Investment and Other Assets					
1. Deferred Deposits				\$	
2. Escrow Deposits				\$	
3. Organization Expense		*Historical Cost _____	Net	\$	
		Accum. Depreciation _____			
4. Goodwill (Purchased Only)				\$	
5. Investments Related to Resident Care (<i>itemize</i>)				\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)				\$	
Name and Address		Amount	Loan Date		

7. Other Assets (<i>itemize</i>)				\$	

D-8. Total Investments and Other Assets (Lines D1 thru 7)				\$	
D-9. Total All Assets (Lines A9 + B10 + 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 Facility		License No.	Report for Year Ended	Page	of
TGC Healthcare, Inc. D/B/A Caroline Manor		1855	9/30/2015	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	81,821
2. Notes Payable (<i>itemize</i>)				\$	

3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	9,476
Name of Lender		Purpose	Amount	Date Due	
Belmont Savings		2013 Ford Explorer	9,476	various	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	5,942
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	1,598
6. Accrued Payroll Taxes Payable				\$	579
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	250
12. Other Current Liabilities (<i>itemize</i>)				\$	196,252
Accrued Accounting Fees		3,015 cash overdraft	4,922		
Due to DSS		161,413 * Accrued Rent	4,800		
Pension Payable		240			
Accrued Property Taxes		21,862			
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	295,918

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility TGC Healthcare, Inc. D/B/A Caroline Man		License No. 1855	Report for Year Ended 9/30/2015	Page 34	of 37
Account				Amount	
Total Brought Forward:				295,918	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
				\$	20,551
Name of Lender	Purpose	Amount	Date Due		
Belmont Savings	2013 Ford Explorer	20,551	various		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$	105,638
Name and Address of Lender	Amount	Loan Date			
Timothy Conroy Jr	105,638	various			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$	317,840
Due to East Ridge Manor, Inc. (related party)		22,072			
Due to Ratifive, Inc. (related party)		217,662			
Due to Doreen Conroy/Preston RE (related party)		69,167			
Due to DCO Real Estate (related party)		8,939			
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

Name of Facility	License No.	Report for Year Ended	Page	of
TGC Healthcare, Inc. D/B/A Caroline	1855	9/30/2015	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(659,702)
6. Gain or Loss for Period			\$	(8,675)
	10/1/2014	thru 9/30/2015		
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			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	(662,177)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	512,163
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	520,838
D. Net Income or Deficit			\$	(8,675)
E. Balance			\$	(670,852)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
pr yr adj - misc expense			2,137	
pr yr adj - uncashed p/r checks			441	
pr yr adj - remove duplicate payment (maint)			287	
F-3. Total Additions			\$	2,865
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	390
Purpose		Amount		
pr yr adj - W/C Ins		206		
pr yr adj - water		184		
3. Total Deductions			\$	390
H. Balance at End of Period		09/30/15	\$	(668,377)

I. Preparer's/Reviewer's Certification

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