

Craig J. Lubitski Consulting LLC & CJLC LLC

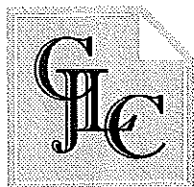
CERTIFIED PUBLIC ACCOUNTANTS & ADVISORS

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

Mr. LaVigne:

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

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



225 Pitkin Street
East Hartford
Connecticut 06108

860.610.9009 (t)
860.610.9030 (f)

cjl.com

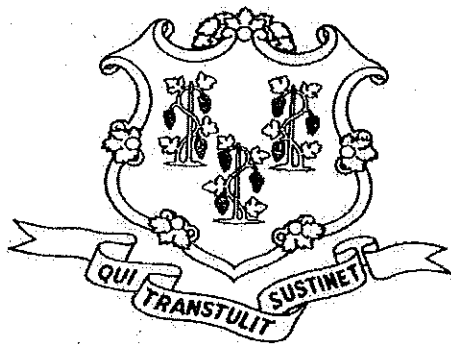
It is our understanding that the software utilized by the Department in the rate setting process computes the necessary disallowances for these areas and our intention is to eliminate the potential for a duplicate disallowance.

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

Respectfully,

Craig J. Lubitski, CPA
Partner

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015

Name of Facility (as licensed) Carlson Place, LLC	
Address (No. & Street, City, State, Zip Code) 17 Nelson Ave., Norwalk, CT 06851	
Type of Facility	
<input type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> 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 1878	Medicare Provider
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
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For Department Use Only

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

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) Carlson Place, LLC	License No. 1878	Report for Year Ended 9/30/2015	Page 1	of 37
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Administrator's/Owner's Certification

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

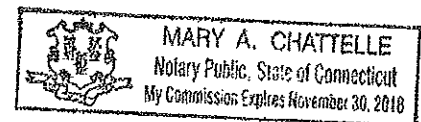
I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Carlson Place, LLC [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge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

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

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

Signed (Administrator) <i>Diane Mortali</i>	Date	Signed (Owner) <i>Diane Mortali</i>	Date
Printed Name (Administrator) Diane Mortali		Printed Name (Owner) Diane Mortali	
Subscribed and Sworn to before me:	State of CT	Date 2/8/16	Signed (Notary Public) <i>Mary A. Chappelle</i>
		Comm. Expires 11/30/18	
Address of Notary Public Lathrop Dr., Coventry, CT 06238			

(Notary Seal)



State of Connecticut
Department of Social Services
 25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Carlson Place, LLC		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility 17 Nelson Ave., Norwalk, CT 06851				
Report Prepared By Craig J. Lubitski Consulting LLC		Phone Number 860-610-9009	Date 2/8/2015	
Item	Total	CCNH	RHNS	Residential Care Home
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-339-5241		Report for Year Ended 9/30/2015	Page 2	of 37
Name of Facility (as shown on license) Carlson Place, LLC		Address (No. & Street, City, State, Zip) 17 Nelson Ave., Norwalk, CT 06851		
License Numbers:	CCNH	RHNS	Residential Care Home 1878	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 checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Diane Mortali		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 Carlson Place, LLC	License No. 1878	Report for Year Ended 9/30/2015	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No				
Andrew Mortali	P.O. Box 504, Old Saybrook, CT 06475	<input type="radio"/>	<input checked="" type="radio"/>	Loan	Pg. 34/L B3	(234,514)	(234,514)
Andrew Mortali	P.O. Box 504, Old Saybrook, CT 06475	<input type="radio"/>	<input checked="" type="radio"/>	Rent	Pg 22/L 9	95,146	95,146
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				

* 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 Carlson Place, LLC	License No. 1878	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 (See listing page 13)		
Maintenance and operation of plant		Square feet		
Property costs (depreciation)		Square feet		
Employee health and welfare		Gross salaries		
Management services		Appropriate cost center involved		
All other General Administrative expenses		Total of Direct and Allocated Costs		
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <input checked="" type="radio"/> Yes <input type="radio"/> 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.				
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)				
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				

General Information and Questionnaire
Accounting Basis

Name of Facility Carlson Place, LLC	License No. 1878	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			Address (No. & Street, City, State, Zip Code)	
1 Craig J. Lubitski Consulting LLC			225 Pitkin Street, East Hartford, CT 06108	
2 Connecticut Bookkeeper Service			PO Box 454, Essex, CT 06426	
3				
4				
Services Provided by This Firm (<i>describe fully</i>)				
1 Medicaid Cost Report Preparation/Bookkeeping			\$	12,394
2 Payroll Services			\$	3,636
3			\$	
4			\$	
			Charge for Services Provided	
			\$	16,030
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 PG 15/L 1d				
Legal Services Information				
Name of Legal Firm or Independent Attorney			Telephone Number	
1 Goldman, Gruder & Woods, LLC			203-899-8900	
2				
3				
4				
5				
Address (<i>No. & Street, City, State, Zip Code</i>)				
1 200 Connecticut Ave., Norwalk, CT 06854				
2				
3				
4				
5				
Services Provided by This Firm (<i>describe fully</i>)				
1 Review lease/general legal matters			\$	2,780
2 Collections			\$	878
3			\$	
4			\$	
5			\$	
			Charge for Services Provided	
			\$	3,658
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input type="radio"/> Yes <input type="radio"/> No				

Schedule of Resident Statistics

	Name of Facility Carlson Place, LLC	License No. 1878	Report for Year Ended 9/30/2015						Page 8	of 37									
			Period 10/1 Thru 6/30		Period 7/1 Thru 9/30														
			Total All Levels	Total CCNH Level	Total RHNS Level	Total Residential Care Home	Total	CCNH			RHNS	Residential Care Home	Total	CCNH	RHNS	Residential Care Home			
1. Certified Bed Capacity																			
A. On last day of PREVIOUS report period		29				29							29						29
B. On last day of THIS report period		29				29							29						29
2. Number of Residents																			
A. As of midnight of PREVIOUS report period		29				29							29						29
B. As of midnight of THIS report period		29				29							29						29
3. Total Number of Days Care Provided During Period																			
A. Medicare																			
B. Medicaid (Conn.)																			
C. Medicaid (other states)																			
D. Private Pay																			
E. State SSI for RCH		9,994				9,994							7,510					2,484	2,484
F. Other (Specify)																			
G. Total Care Days During Period (3A thru F)		9,994				9,994							7,510					2,484	2,484
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)		9,994				9,994							7,510					2,484	2,484

Schedule of Resident Statistics (Cont'd)

Name of Facility Carlson Place, LLC			License No. 1878			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? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	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-IID				
No. of Residents									29				
Per Diem Rate													
a. One bed rm.									87.00				
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													
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													
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		
Carlson Place, LLC	1878	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)					54,478	2,080
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)					40,294	2,152
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor					74,243	4,109
c. Dietary Workers						
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers					6,749	374
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers					33,747	1,868
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers					16,873	934
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					174,007	9,982
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers					50,620	2,801
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>					451,011	24,300

* 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.

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

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

Name of Facility Carlson Place, LLC	License No. 1878		Report for Year Ended 9/30/2015		Page 11	of 37					
	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
Name	CCNH	RHNS			Residential Care Home						
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).											
Andrew Mortali			40,294				Office Work	2,152 A4		N/A	
Cristina Mortali			5,652				Aide	471 A12d		N/A	
Miles Mortali			13,120				Aide	920 A12d		NA	

* 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***

Name of Facility (as licensed) Carlson Place, LLC		License No. 1878		Report for Year Ended 9/30/2015		Page 12	of 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 III - Administrators***									
Diane Mortali			54,478	Administrator	2,080	A2	N/A		
Section IV - Assistant Administrators									

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Carlson Place, LLC	1878	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 Carlson Place, LLC	License No. 1878	Report for Year Ended 9/30/2015	Page 15	of 37
Item	Total	CCNH	RHNS	Residential Care Home
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 15,591			15,591
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 6,549			6,549
4. Social Security (F.I.C.A.)	\$ 35,339			35,339
5. Health Insurance	\$ 14,298			14,298
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$			
9. Other (<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	\$ 16,030			16,030
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 3,658			3,658
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 1,401			1,401
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 3,239			3,239
2. Cellular Phones	\$ 2,258			2,258
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	\$ 98,612			98,612

* 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 Carlson Place, LLC	License No. 1878	Report for Year Ended 9/30/2015	Page 16	of 37
Item	Total	CCNH	RHNS	Residential Care Home
Subtotals Brought Forward:	98,612			98,612
I. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$ 175			175
3. Gifts to Staff and Residents	\$ 45			45
4. Employee Travel	\$			
5. Education Expenses Related to Seminars and Conventions	\$			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$			
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$			
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	\$ 412			412
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 700			700
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	\$ 7,873			7,873
C-14 Total Administrative & General Expenditures	\$ 107,817			107,817

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	Residential Care Home
Advertising - Promotional			
Total Other Advertising	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	Residential Care Home
CARCH			\$ 600
BP's Membership			\$ 100
Total Dues	\$ -	\$ -	\$ 700

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	Residential Care Home
Bank Service Fees			\$ 1,162
Late Fees/Finance Charges			\$ 4,822
Licenses			\$ 1,171
Uncategorized			\$ 313
Contractor			\$ 406
Total Other Administrative and General	\$ -	\$ -	\$ 7,873

Schedule C-1 - Management Services*

Name of Facility Carlson Place, LLC	License No. 1878	Report for Year Ended 9/30/2015	Page 17	of 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 Carlson Place, LLC		License No. 1878	Report for Year Ended 9/30/2015	Page 18	of 37
Item		Total	CCNH	RHNS	Residential Care Home
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 47,561			47,561
2.	Non-Food Supplies	\$ 4,971			4,971
3.	Other (<i>Specify</i>) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Management Services**		\$			
d. Other (<i>Specify</i>) _____ Small Equipment		\$ 204			204
2E. Total Dietary Expenditures (2a + b + c + d)		\$ 52,736			52,736
2F. Dietary Questionnaire		Total	CCNH	RHNS	Residential Care Home
G. Resident Meals: Total no. of meals served per day:*					
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 type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

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

** 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 Carlson Place, LLC		License No. 1878	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. \$			
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. \$	471		471
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Management Services**		\$			
d. Other (Specify) Supplies		\$	657		657
3E. Total Laundry Expenditures (3a + b + c + d)		\$	1,129		1,129
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 Carlson Place, LLC		License No. 1878	Report for Year Ended 9/30/2015	Page 20	of 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. \$				
	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. \$	23,391			23,391
	c. Management Services*	\$				
	d. Other (<i>Specify</i>) Supplies	\$	2,131			2,131
4E.	Total Housekeeping Expenditures (4a + b + c + d)	\$	25,521			25,521
5.	Resident Care (Supplies)**					
	a. Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$				
	b. Medicine Cabinet Drugs	\$	153			153
	c. Medical and Therapeutic Supplies	\$				
	d. Ambulance/Limousine***	\$				
	e. Oxygen					
	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	\$	5,616			5,616
	j. Other (<i>Specify</i>)**** See Attached Schedule	\$	294			294
5K.	Total Resident Care Expenditures (5a - 5j)	\$	6,063			6,063

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

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

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

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

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

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

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

Carlson Place, LLC
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:				
3/13/2015	Replace existing drop-in fixtures lights	\$ 3,420	5	\$ 684
9/8/2015	Repairs on back of Main roof	\$ 4,615	5	\$ 923
Total additions for Leasehold Improvement		\$ 8,035		\$ 1,607 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Carlson Place, LLC	License No. 1878	Report for Year Ended 9/30/2015		Page 24	of 37
		Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**		
Item	Date of Acquisition Month Year	Length of Amortization	Cost to Be Amortized		Totals
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	Various	Various	105,171	102,812	SL 103
2. Disposals (attach schedule)					
3. Acquired during this report period (attach schedule)			8,035		1,607
C-4. Subtotal					
D. Total Amortization					1,710
					1,710

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

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

Name of Facility Carlson Place, LLC	License No. 1878	Report for Year 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	08/08/06			
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase	08/08/06			
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	29			
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed	Fixed		
b. Date Mortgage Obtained	June, 2006	May, 2010		
c. Interest Rate for the Cost Year	6.00%	6.00%		
d. Term of Mortgage (number of years)	25	20		
e. Amount of Principal Borrowed	520,000	370,000		
f. Principal balance outstanding as of	504,200			
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
Carlson Place, LLC		1878	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 Carlson Place, LLC		License No. 1878		Report for Year Ended 9/30/2015			Page of 27 37	
Item				Total	CCNH	RHNS	Residential Care Home	
Subtotals Brought Forward:								
12. C. Movable Equipment								
1. Automotive Equipment				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
2. Other (Specify)				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
B. Item		Rate	Amount					
Lender								
Address of Lender								
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$				
12. D. Other Interest Expense (Specify) Other interest				\$				
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$				
14. Insurance								
a. Insurance on Property (buildings only)				\$ 8,569				8,569
b. Insurance on Automobiles				\$				
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)				\$				
2. Fire and Extended Coverage				\$				
3. Other (Specify)				\$				
14d. Total Insurance Expenditures (14a + b + c)				\$ 8,569				8,569
15. Total All Expenditures (A-13 thru C-14)				\$ 870,944				870,944

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Carlson Place, LLC			1878	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	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.	15	1a5	Discriminatory Benefits	\$ 14,298			14,298
9.			Bad Debts	\$			
10.	15	1e	Accounting & Legal	\$ 878			878
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 1,538			1,538
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.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$			
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 6,296			6,296
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
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)				\$ 23,010			23,010

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Carlson Place, LLC			1878	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				\$ 23,010			23,010
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	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51. Total Amount of Decrease (Items 1 - 50)				\$ 23,010			23,010

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

Carlson Place, LLC
9/30/2015

Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

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

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 Carlson Place, LLC	License No. 1878	Report for Year Ended 9/30/2015			Page 30	of 37
Item	Total	CCNH	RHNS	Residential Care Home		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$ 877,275			877,275		
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (All other states)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (all inclusive)	\$					
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$					
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 (Specify) - Medicare	\$					
b. Other (Specify) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 877,275			877,275		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (Specify)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (Specify)	\$ 2,223			2,223		
V. Total Other Revenue (1 thru 8)	\$ 2,223			2,223		
VI. Total All Revenue (III +V)	\$ 879,498			879,498		

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

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

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Carlson Place, LLC	1878	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	(19,842)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	49,412
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	10,641
a. Prepaid - Insurance	5,044			
b. Prepaid - Other	5,598			
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	7,303
Security Deposits	4,940			
Employee Loan	2,363			

A-9. Total Current Assets (Lines A1 thru 8)			\$	47,514
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>113,206</u>		\$	8,685
	Accum. Depreciation <u>104,521</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>76,216</u>		\$	6,927
	Accum. Depreciation <u>69,290</u>	Net		
7. Motor Vehicles	*Historical Cost <u>28,000</u>		\$	
	Accum. Depreciation <u>28,000</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

B-10. Total Fixed Assets (Lines B1 thru 9)			\$	15,611

* 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
Carlson Place, LLC		1878	9/30/2015	32	37
Account				Amount	
Total Brought Forward:				\$	63,126
C.	Leasehold or like property recorded for Equity Purposes.				
1.	Land				\$
2.	Land Improvements	*Historical Cost _____			
		Accum. Depreciation _____	Net	\$	
3.	Buildings	*Historical Cost _____			
		Accum. Depreciation _____	Net	\$	
4.	Non-Movable Equipment	*Historical Cost _____			
		Accum. Depreciation _____	Net	\$	
5.	Movable Equipment	*Historical Cost _____			
		Accum. Depreciation _____	Net	\$	
6.	Motor Vehicles	*Historical Cost _____			
		Accum. Depreciation _____	Net	\$	
7.	Minor Equipment-Not Depreciable				\$
C-8	Total Leasehold or Like Properties (C1 thru 7)				\$
D.	Investment and Other Assets				
1.	Deferred Deposits				\$
2.	Escrow Deposits				\$
3.	Organization Expense	*Historical Cost	29,312		
		Accum. Depreciation	29,312	Net	\$
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)				\$
					63,126

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Carlson Place, LLC		1878	9/30/2015	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	48,667
2. Notes Payable (<i>itemize</i>)				\$	
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	8,050
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	1,468
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	21,934
Accrued Expense		(2,762)			
Due to DSS		24,696			
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	80,120

* 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 Carlson Place, LLC		License No. 1878	Report for Year Ended 9/30/2015	Page 34	of 37
Account				Amount	
Total Brought Forward:				80,120	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
\$					
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$ (234,514)	
Name and Address of Lender	Amount	Loan Date			
Andrew Mortali	(234,514)				
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 3,625	
Lease Payable-NE Generator		3,625			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ (230,889)	
C. Total All Liabilities (Lines A-13 + B-5)				\$ (150,769)	

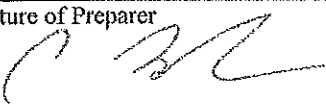
G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Carlson Place, LLC	1878	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			\$	205,341
6. Gain or Loss for Period			\$	8,554
7. Total Net Worth			\$	213,895
C. Total Reserves and Net Worth			\$	213,895
D. Total Liabilities, Reserves, and Net Worth			\$	63,126

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Carlson Place, LLC	1878	9/30/2015	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	243,510
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	879,498
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	870,944
D. Net Income or Deficit			\$	8,554
E. Balance			\$	252,064
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	252,064
				09/30/15

I. Preparer's/Reviewer's Certification

Name of Facility Carlson Place, LLC		License No. 1878	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 CPA		Date Signed 2-10-16	
Printed Name of Preparer Craig J. Lubitski Consulting LLC					
Address 225 Pitkin Street, East Hartford, CT 06108				Phone Number 860-610-9009	