State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) Park Place			
Address (No. & Street, City, State, Zip Code) 5 Greenwood Street, Hartford CT 06106			
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)	
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016		

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2195-C			07-5250A

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	20081		

For Department Use Only

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

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General Information

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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 IMPRISIONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Park Place [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, 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
		2/1/17		2/1/17
Printed Name (Administrator) Doug Melanson			Printed Name (Owner) Sean Murphy	
Subscribed and Sworn to before me:	State of Connecticut	Date 2/1/17	Signed (Notary Public)	Comm. Expires 10/31/2019
Address of Notary Public 65 OXFORD DR. NEWINGTON, CT 06111				

(Notary Seal)

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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 Park Place	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 5 Greenwood Street, Hartford CT 06106				
Report Prepared By Gennaro Evangelista	Phone Number 860-871-5454		Date 2/1/2017	

Item		Total	CCNH	RHNS	(Specify)
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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-236-2901	9/30/2016	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Park Place	5 Greenwood Street, Hartford CT 06106

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2195-C			07-5250A

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ◉ LLC ○ Partnership ○ Profit Corp. ○ Non-Profit Corp. ○ Government ○ 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? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Doug Melanson	1689

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
Spectrum Healthcare Hartford, LLC DBA Greenwood	27 Naek Road, Vernon, CT 06066	Hartford, CT

Name of Partners/Members	Business Address	Title	% Owned
Howard Dickstein	27 Naek Road, Vernon, CT 06066	President & CEO	65
Brian Dickstein	27 Naek Road, Vernon, CT 06066	VP, Operation	17.5
Sean Murphy	27 Naek Road, Vernon, CT 06066	CFO	17.5

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10% of Shares			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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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	%**				
Spectrum Healthcare, LLC	27 Naek Rd., Vernon, CT 06066	○	◉		Home office costs consisting of admin., cleri	Page 16, line m 12	360,000	360,000
Spectrum Healthcare Derby	211 Chatfield St Derby, CT 06418	○	◉		Social Services	Page 10 Line a12m	4,741	4,741
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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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? ⊙ 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.

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.

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					

Is a Mileage Log Book Maintained for All Leased Vehicles ? O Yes O No **Total ***

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period?	⊙ Yes ○ No	If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Blum, Shapiro & Company	29 So. Main St., W Hartford, CT 06127
2 MidCap Funding	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Reviewed Financial Statements, Tax return preparation	$ 2,300
2	Due Diligence Exam	$ 14,858
3		$
4		$
	Charge for Services Provided	$ 17,158

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.

⊙ Yes ○ No Page15, Line 1.d.

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Treasurer, State of CT	
2 Michalik, Bauer, Silva & Ciccarillo LLP	
3 Marshall Charles Fisher	
4 State Marshall Jesse Smith	
5 MidCap Funding	

Address (*No. & Street, City, State, Zip Code*)

1 250 Constitution Plaza, Hartford, CT
2 35 Pearl St Suite 300 New Britain, CT
3
4
5

Services Provided by This Firm (*describe fully*)

1	Conservator Fees	$ 1,371
2	Collections	$ 5,605
3	Probate Fees for COE/COP Application	$ 172
4	Probate Fees for COE/COP Application	$ 116
5	Loan Amendments	$ 1,889
	Charge for Services Provided	$ 9,153

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.

⊙ Yes ○ No Page 15, Line 1 e

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	150	150			150	150			150	150		
B. On last day of THIS report period	150	150			150	150			150	150		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	146	146			146	146			135	135		
B. As of midnight of THIS report period	133	133			135	135			133	133		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,388	1,388			1,079	1,079			309	309		
B. Medicaid (Conn.)	45,110	45,110			33,353	33,353			11,757	11,757		
C. Medicaid (other states)												
D. Private Pay	1,588	1,588			1,341	1,341			247	247		
E. State SSI for RCH												
F. Other (Specify)	1,840	1,840			1,397	1,397			443	443		
G. Total Care Days During Period (3A thru F)	49,926	49,926			37,170	37,170			12,756	12,756		
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)**	49,926	49,926			37,170	37,170			12,756	12,756		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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	(Specify)
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	(Specify)	R.C.H.	ICF-MR
No. of Residents		125		8				
Per Diem Rate								
a. One bed rm.	Various	242.88		415.00				
b. Two bed rms.	Various	242.88		365.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,290	3,290		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	3,061	3,061		
2. Restorative Treatments				
C. Other	13	13		
D. ***Total Physical Therapy Treatments***	6,364	6,364		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	77	77		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	161	161		
2. Restorative Treatments				
C. Other				
D. ***Total Speech Therapy Treatments***	238	238		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,552	2,552		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	2,839	2,839		
2. Restorative Treatments				
C. Other	32	32		
D. ***Total Occupational Therapy Treatments***	5,423	5,423		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

Item	Total Cost and Hours					
	CCNH	Hours	RHNS	Hours	(Specify)	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)	159,512	2,753				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	296,874	14,316				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	117,713	4,196				
c. Dietary Workers	428,141	24,158				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	125,160	4,769				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
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	191,364	3,888				
b. RN						
1. Direct Care	528,133	12,559				
2. Administrative**	288,082	6,667				
c. LPN						
1. Direct Care	1,502,742	49,952				
2. Administrative**						
d. Aides and Attendants	1,986,608	114,752				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	93,267	4,423				
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	80,617	2,521				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	58,572	3,829				
A-13. Total Salary Expenditures	5,856,784	248,783				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH $	CCNH Hours	RHNS $	RHNS Hours	(Specify) $	(Specify) Hours
Ward Clerks-Scheduler	$ 24,501	1,532				
Medical Records	$ 34,071	2,297				
Total	$ 58,572	3,829	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH $	CCNH Hours	RHNS $	RHNS Hours	(Specify) $	(Specify) Hours
Total	$ -	-	$ -	-	$ -	-

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

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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	(Specify)							
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.

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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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	(Specify)							
Section III - Administrators* **										
Doug Melanson 10/01/15-9/30/16	130,821					2,115	A2			
Lyndsey Brenes 10/01/15-9/30/16	28,691					638	A2			
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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Park Place	2195-C	9/30/2016	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	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	31,996	424				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	255,729	4,264				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	59,050	784				
b. Utilization Review (Title 18 and 19 only) monthly meeting	23,775	317				
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	20,812	278				
b. Other						
10. Occupational Therapist						
a. Resident Care	252,271	4,204				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	76,001	1,382				
2. Administrative***						
b. LPN						
1. Direct Care	20,067	576				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	739,702	12,229				

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Gilberto Ramirez, MD-701 Cottage Grove Rd., Ste D 230, Bloomfield, CT 06023	Medical Director	○	◉	
The Nurse Network-5 Central Ave, E Hartford, CT 06150	Pool Nursing	○	◉	
Pharamerica, PO Box 409251, Atlanta, GA 30384	Pharmacy Consultant	○	◉	
Accuscript Consulting Services-276 Cedar Bridge Ave., Lakewild, NJ 08701	Pharmacy Consultant	○	◉	
Select Rehabilitation, Inc., 550 Frontage Rd., Suite 2415 Northfield, IL 60093	Contract Therapy	○	◉	
Dr. Joseph Brenes-The Hospitalist Company-PO Box 844929, Los Angles, CA 90084-4929	Medical Director	○	◉	
Dr. David Fenton-Multispecialty Group-2110 Silas Deane Highway, Rocky Hill, CT 06067	Medical Director	○	◉	
Favorite Healthcare Staffing-PO Box 803356, Kansas City, MI 64180-3356	Pool Nursing	○	◉	
Ready Nurse-2602 Highlands Blvd. N. Palm Harbor, FL 34684	Pool Nursing	○	◉	
HealthDrive Dental Group-888 Worchester St., Wellesley. MA 02482-3744	Dental Consultant	○	◉	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

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Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	158,413	158,413		
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	617,414	617,414		
5. Health Insurance	$	969,098	969,098		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	307,032	307,032		
8. Uniform Allowance	$	25,859	25,859		
9. Other (*Specify*) See Attached Schedule	$	42,393	42,393		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	90,000	90,000		
d. Accounting and Auditing	$	17,158	17,158		
e. Legal (*Services should be fully described on Page 7*)	$	9,153	9,153		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	17,381	17,381		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	14,167	14,167		
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22*)					
1. Income*	$				
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	1,050,958	1,050,958		
Subtotal	$	3,319,024	3,319,024		

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

(Carry Subtotals forward to next page)

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

Park Place
9/30/2016

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Union Training Fund	$ 38,388		
Employee Background Check	$ 4,005		
Total	$ 42,393	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Total	$ -	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Park Place	2195-C	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,319,024	3,319,024		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	4,660	4,660		
2. Holiday Parties for Staff	$	3,229	3,229		
3. Gifts to Staff and Residents	$	3,734	3,734		
4. Employee Travel	$	9,947	9,947		
5. Education Expenses Related to Seminars and Conventions	$	2,405	2,405		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*) See Attached Schedule	$	5,255	5,255		
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	13,500	13,500		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	3,330	3,330		
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	$	5,344	5,344		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	15,403	15,403		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	53,227	53,227		
12. Administrative Management Services**	$	360,000	360,000		
13. Other (*Specify*) See Attached Schedule	$	70,002	70,002		
C-14 Total Administrative & General Expenditures	$	3,869,060	3,869,060		

* 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	(Specify)
Meals	$ 5,255		
Total Other Travel and Entertainment	$ 5,255	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Marketing Expenses	$ 3,330		
Total Other Advertising	$ 3,330	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Dues	$ 15,403		
Total Dues	$ 15,403	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Total Contributions	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Fees	$ 4,627		
Software Fees-Ivans	$ 1,616		
Computer Maintenance	$ 17,973		
Cable Television	$ 14,346		
Archives	$ 7,264		
Licenses	$ 1,214		
Printing	$ 5,854		
Copier Equipment	$ 9,458		
Small Equipment Purchase	$ 715		
Professional Fees	$ 6,636		
Miscellaneous	$ 300		
Total Other Administrative and General	$ 70,002	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Park Place	License No. 2195-C	Report for Year Ended 9/30/2016	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 #
Spectrum Healthcare, LLC	360,000	Home office services, Accounting, Personnel & Benefits admin., Treasury, Operations, QA	Page 16, line m. 12

*** 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.**

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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
Park Place	2195-C	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	298,274	298,274		
2. Non-Food Supplies	$	65,283	65,283		
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)	$	363,557	363,557		
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*					

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ 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.

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CSP-19 Rev. 9/2002

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

Name of Facility Park Place	License No. 2195-C	Report for Year Ended 9/30/2016	Page 19 of 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $	8,600	8,600		
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. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	343,678	343,678		
c. Management Services**	$				
d. Other (*Specify*) Supplies/Small Equipment Purchased	$	942	942		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	353,219	353,219		

3F. Laundry Questionnaire			
G. Is cost of employee laundry included in 3E?	O Yes	⊙ No	If yes, specify cost.
H. Did you receive revenue from employees?	O Yes	⊙ 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?	O Yes	⊙ No	If yes, specify cost.
K. Did you receive revenue from these people?	O Yes	⊙ 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.

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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
Park Place	2195-C	9/30/2016	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	12,609	12,609		
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel					
(*Complete Schedule C-2 att. Page 21*)	Amt.	$	343,678	343,678		
c. Management Services*		$				
d. Other (*Specify*) Equipment Rental		$	101	101		
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	356,388	356,388		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	139,129	139,129		
b. Medicine Cabinet Drugs		$	30,705	30,705		
c. Medical and Therapeutic Supplies		$	198,018	198,018		
d. Ambulance/Limousine***		$	553	553		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	27,087	27,087		
f. X-rays and Related Radiological Procedures***		$	13,332	13,332		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	10,113	10,113		
i. Recreation		$	4,409	4,409		
j. Other (Specify)**** See Attached Schedule		$	1,138	1,138		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	424,484	424,484		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Dues & Subscriptions	$ 45		
IV Therapy	$ 87		
Audiology Services	$ 58		
Outside Medical Services	$ 948		
Total Other Resident Care	$ 1,138	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Park Place	2195-C	9/30/2016	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Automatic Data Processing	Waltham, MA 02454	○	⊙		Payroll Processing	32,378			16	M11
MDI	St. Louis, MO 63146	○	⊙		GL/AR/AP/Clinical Program	20,849			16	M11
Healthcare Services Group	Bensalem, PA 19020	○	⊙		Laundry Services	343,678			19	3b
Healthcare Services Group	Bensalem, PA 19020	○	⊙		Housekeeping Services	343,678			20	4b
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* List all contracted services over $10,000. Use additional sheets if necessary.
** Refer to Page 4 for definition of related.
*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility Park Place	License No. 2195-C	Report for Year Ended 9/30/2016			Page 22 of 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	48,778	48,778		
b. Heat	$	18,916	18,916		
c. Light & Power	$	198,934	198,934		
d. Water	$	63,859	63,859		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	72,860	72,860		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	403,345	403,345		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	321,987	321,987		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	11,725	11,725		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	333,712	333,712		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	7,667	7,667		
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	7,667	7,667		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	300,000	300,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	240,381	240,381		
c. Personal property taxes	$	8,473	8,473		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	890,233	890,233		

* 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	(Specify)
Trash Removal	$ 14,265		
Hazard Waste Removal	$ 5,392		
Service Contracts	$ 21,396		
Supplies	$ 8,465		
Grounds Maintenance	$ 6,267		
Grounds Landscaping	$ 7,444		
Small Equipment Purchase	$ 1,356		
Equipment Rental	$ 4,357		
Purchased Services	$ 3,917		
Total Other Repairs and Maintenance	$ 72,860	$ -	$ -

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Depreciation Schedule

Name of Facility Park Place	License No. 2195-C	Report for Year Ended 9/30/2016	Page 23	of 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
A. **Land Improvements**								
1. Acquired prior to this report period	5,304		5,304	5,304				
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	6,953,886		6,953,886	4,399,651			320,988	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	19,975		19,975				999	
B-4. Subtotal								321,987
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	76,936		76,936	76,936				
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	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	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					1,444,657		1,444,657	1,393,429			9,917	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					22,677		22,677				1,808	
D-3. Subtotal												11,725
E. ***Total Depreciation***												333,712

Park Place
9/30/2016

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:					
11/18/2015	Hot Water Heater	$ 6,019	10	$ 301	
01/20/2016	New Transfer Switch for Generator	$ 9,484	10	$ 474	
06/22/2016	Compressor	$ 4,472	10	$ 224	
Total additions for Building Improvements		$ 19,975		$ 999	*
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:					
10/28/2015	Portable AC/Heating Units	$ 3,021	5	$ 302	
12/31/2015	Portable AC/Heating Units	$ 1,812	5	$ 181	
02/26/2016	Portable AC/Heating Units	$ 3,855	5	$ 386	
07/13/2016	Computer	$ 1,221	3	$ 204	
09/22/2016	Washer	$ 10,841	10	$ 542	
09/30/2016	Portable AC/Heating Units	$ 1,927	5	$ 193	
Total additions for Movable Equipment		$ 22,677		$ 1,808	*
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**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Park Place	2195-C	9/30/2016	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	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
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3. Deferred Financing Costs	07	2013	3 years	30,666	22,999			7,667	
B-4. Subtotal									7,667
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									7,667

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Park Place	2195-C	9/30/2016	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ 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	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	150
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)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of				
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.

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

Name of Facility	License No.	Report for Year Ended	Page of
Park Place	2195-C	9/30/2016	26 | 37

Item	Total	CCNH	RHNS	(Specify)
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*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Park Place	2195-C	9/30/2016	27 | 37

Item			Total	CCNH	RHNS	(Specify)
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*) Working Capital and Vendor Interest		$	392,941	392,941		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	392,941	392,941		
14. Insurance						
a. Insurance on Property (buildings only)		$	86,122	86,122		
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)***		$	86,122	86,122		
15. ***Total All Expenditures (A-13 thru C-14)***		$	13,735,835	13,735,835		

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CSP-28 Rev. 9/2002

D. Adjustments to Statement of Expenditures

Name of Facility: Park Place				License No. 2195-C	Report for Year Ended 9/30/2016		Page 28 of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
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.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	90,000	90,000		
10.			Accounting & Legal $				
11.			Telephone $				
12.			Cellular Telephone $				
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 * $	3,330	3,330		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	300	300		
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) $	93,630	93,630		

* 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	(Specify)
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Miscellaneous	$ 300		
Total Other A&G Adjustments			$ 300	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Park Place	2195-C	9/30/2016	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	93,630	93,630		
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 $	96,756	96,756		
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)*** $	190,386	190,386		

*** 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.

Park Place
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Ancillary Costs			$ -	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12d	Vendor Interest	$ 96,756		
Total Other Adjustments			$ 96,756	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Park Place	2195-C	9/30/2016	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	16,937,542	16,937,542		
b. Medicaid Room and Board Contractual Allowance **	$	(5,480,091)	(5,480,091)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	529,035	529,035		
b. Medicare Room and Board Contractual Allowance **	$	172,051	172,051		
4. a. Private-Pay Residents and Other	$	1,345,506	1,345,506		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	157,485	157,485		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(157,485)	(157,485)		
c. Prescription Drugs - Non-Medicare	$	54,970	54,970		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(54,970)	(54,970)		
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	$	202,770	202,770		
b. Physical Therapy - Medicare Contractual Allowance **	$	(118,454)	(118,454)		
c. Physical Therapy - Non-Medicare	$				
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$	6,304	6,304		
b. Speech Therapy - Medicare Contractual Allowance **	$	(3,070)	(3,070)		
c. Speech Therapy - Non-Medicare	$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	210,181	210,181		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(144,511)	(144,511)		
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.)	$	13,657,264	13,657,264		
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)*	$	2	2		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	8,246	8,246		
V. Total Other Revenue (1 thru 8)	$	8,249	8,249		
VI. Total All Revenue (III +V)	$	13,665,513	13,665,513		

* *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	(Specify)
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue		$ -	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income		$ 2		
Total Interest Income			$ 2	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Medical Records	$ 776		
	UHC Participation Plan	$ 7,470		
Total Other Revenue		$ 8,246	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Park Place	2195-C	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ (56,016)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 3,381,974
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (43,261)
4 Inventories				$ 9,582
5. Prepaid Expenses				$ 349,621
a. Prepaid-Expenses		1,737		
b. Prepaid-Insurance		347,884		
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 143,412
Deposits		67,990		
Resident Refunds		74,162		
Due From Prior Owner		1,260		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 3,785,313
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	4,100,707		$ 2,163,229
	Accum. Depreciation	1,937,478	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	39,610		$
	Accum. Depreciation	39,610	Net	
6. Movable Equipment	*Historical Cost	393,529		$ 62,180
	Accum. Depreciation	331,349	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ (1,956,815)
Net Book Value F/S vs C/R		(1,956,815)		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 268,594

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Park Place	2195-C	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 4,053,907
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost	5,304		
	Accum. Depreciation	5,304	Net	$
3. Buildings	*Historical Cost	2,873,154		
	Accum. Depreciation	2,784,160	Net	$ 88,994
4. Non-Movable Equipment	*Historical Cost	37,326		
	Accum. Depreciation	37,326	Net	$
5. Movable Equipment	*Historical Cost	1,073,805		
	Accum. Depreciation	1,073,805	Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$ 88,994
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 4,142,901

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Park Place	2195-C	9/30/2016	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 1,266,557
2. Notes Payable (*itemize*)				$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 287,187
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 11,601
7. Medicare Final Settlement Payable				$
8. Medicare Current Financing Payable				$
9. Mortgage Payable (*Current Portion*)				$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 6,122,109
Prepaid Property Taxes	(230,737)	Due To Related	2,428,492	
Accrued Expenses	413,668	Accrued Rent	115,000	
Working Capital Line of Credit	2,880,489			
Accrued Provider Tax	515,197			
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 7,687,454

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Park Place	2195-C	9/30/2016	34	37

Account	Amount
Total Brought Forward:	7,687,454
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 7,687,454

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

Name of Facility	License No.	Report for Year Ended	Page	of
Park Place	2195-C	9/30/2016	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 (*Equity)*	$ 125,382
	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	$ 125,382
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (3,599,603)
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ (70,332)
	7. Total Net Worth	$ (3,669,935)
C.	***Total Reserves and Net Worth***	$ (3,544,553)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 4,142,901

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Park Place	2195-C	9/30/2016	36	37

Account			Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2015			$ (2,497,810)
B. Total Revenue (*From Statement of Revenue Page 30*)			$ 13,665,513
C. Total Expenditures (*From Statement of Expenditures Page 27*)			$ 13,735,835
D. Net Income or Deficit			$ (70,322)
E. Balance			$ (2,568,132)
F. Additions			
1. Additional Capital Contributed (*itemize*)			
2. Other (*itemize*)			
Depreciation		333,712	
F-3. Total Additions			$ 333,712
G. Deductions			
1. Drawings of Owners/Operators/Partners (*Specify*)			$
Name and Address (*No., City, State, Zip*)	Title	Amount	
2. Other Withdrawings *(Specify)*			$
Purpose		Amount	
3. Total Deductions			$
H. ***Balance at End of Period***	09/30/16		$ (2,234,420)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Park Place	2195-C	9/30/2016	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed
Gennaro Evangelista	Accounting Manager	2/1/17

Printed Name of Preparer	
Gennaro Evangelista	
Addres Address	**Phone Number**
27 Naek Rd., Vernon, CT 06066	860-871-5454