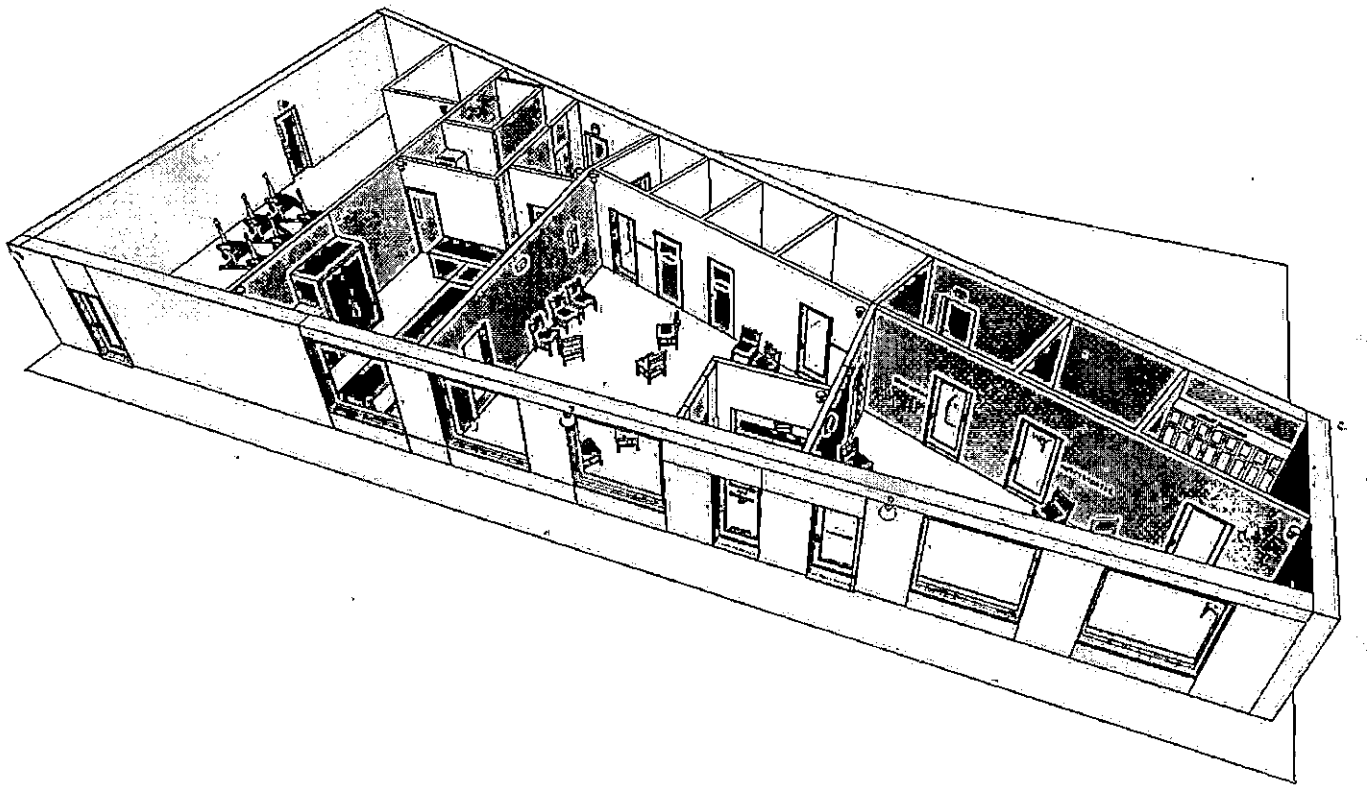
PROHEALTH AND WELLNESS CT

MMP - RFA

"REDACTED"

ProHealth and Wellness CT

972 Boston Post Rd
Milford, CT 06460
917 330-9233



"a professional organization dispensing
medical marijuana for the treatment of pain
and an improved quality of life"

Application for Medical Marijuana Dispensary Sept 17, 2015

ProHealth and Wellness CT
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Medical Marijuana Program

165 Capitol Avenue, Room 145, Hartford, CT 06106-1630 • (860) 713-6066
E-mail: dcp.mmp@ct.gov • Website: www.ct.gov/dcp/mmp

Appendix A
Dispensary Facility License Information Form

Section A: Business Information

1. Applicant business type:

☐ Sole Proprietorship	☐ Corporation	☑ Limited Liability Co.	☐ Partnership	☐ Limited Liability Partnership	☐ Unincorporated Association	☐ Other:

2. Legal Name of Applicant: Steven Jay RAND

3. Trade Name of Applicant: ProHealth and Wellness CT

4. Applicant's Business Address: 39 Flag Swamp Rd.

5. City: Roxbury	6. State: CT	7. Zip Code: 06783

8. Daytime Telephone Number: (917) 330-9233	9. E-mail Address: info@prohealthandwellnessct.com

10. Applicant's Mailing Address (if different than business address):			11. City:
12. State:	13. Zip Code:	14. Daytime Telephone Number:	15. Fax Number:

Section B: Contact Information

All communications from the department regarding this application will be sent to your primary contact and alternate contact, if one is designated. We will assume that you receive all communications sent to your designated contact(s) and it will be your responsibility to notify us if any of their contact information changes.

16. Name of Primary Contact: Steven Jay RAND	17. Primary Contact Title: owner
18. Primary Contact E-mail Address: info@prohealthandwellnessct.com	19. Primary Contact Telephone Number: (917) 330-9233
20. OPTIONAL – Name of Alternate Contact:	21. Alternate Contact Title:
22. Alternate Contact E-mail Address:	23. Alternate Contact Telephone Number:

Section C: Formation/Incorporation Information

24. Date of Formation/Incorporation: 09 / 02 / 15	25. Place of Formation/Incorporation: New Haven CT
26. Registered with the Connecticut Secretary of State: ☑ Yes ☐ No	27. Sale and Use Tax Permit Number: **Provide a copy of your Sale and Use Tax permit with your application.**

Medical Marijuana Program

165 Capitol Avenue, Room 145, Hartford, CT 06106-1630 • (860) 713-6066
E-mail: dcp.mmp@ct.gov • Website: www.ct.gov/dcp/mmp

Section D: Proposed Dispensary Facility Information

28. Proposed Dispensary Facility Address:			29. City:
972 Boston Post Road			Milford
30. State: CT	31. Zip Code: 06460	32. Telephone Number: (917) 330-9233	33. Fax Number:

34. Own or Lease Property: ☐ Own ☑ Lease Provide a copy of the lease, deed or other documents evidencing the right to occupy if you are awarded a license.	35. Name of Property Owner: 771 BPR LLC Milford, CT

Section E: Business Association Information

36. Are you associated with any other dispensary facility licensee or license applicant or producer licensee or license applicant:

☐ Yes ☑ No

If yes, provide the name of all applicants with whom you are associated. Attach additional pages if necessary.

37. Applicant Name:	38. Licensee or Applicant Type: ☐ Dispensary Facility ☐ Producer
39. Applicant Name:	40. Licensee or Applicant Type: ☐ Dispensary Facility ☐ Producer

Section F: Proposed Dispensary Department Hours

41. State the proposed dispensary department hours of operation for each day. The dispensary department is where marijuana will be sold.

Monday	10	6	Friday	11	7
Tuesday	10	6	Saturday	10	3
Wednesday	11	7	Sunday	closed	closed
Thursday	10	6			

Section G: Proposed Dispensary Facility Hours

42. State the proposed dispensary facility hours of operation for each day. The dispensary facility includes areas where non-marijuana products and services will be offered.

Monday	10	6	Friday	11	7
Tuesday	10	6	Saturday	10	3
Wednesday	11	7	Sunday	closed	closed
Thursday	10	6			

Section H: Other Business Names & Addresses

List all names under which the applicant has done business or has held itself out to the public as doing business. Do not limit your response to business operations in Connecticut. Attach additional pages if necessary.

43. Name:	44. Time Period:
apexart curatorial program New York, NY 10013	1994-present

List all addresses, other than those listed in response to Section A, that the applicant owns, has owned or from which it has conducted business during the previous five years and give the approximate time periods during which such locations were owned or utilized. Attach additional pages if necessary.

45. Address:	46. Time Period:
291 Church Street New York, NY 10013 USA	1994-present

Section I: Dispensary Facility Backers

Provide the following information for each dispensary facility backer. A dispensary facility backer is any person (including any legal entity) with a direct or indirect financial interest in the applicant, except it shall not include a person with an investment interest provided the interest held by such person and such person's co-workers, employees, spouse, parent or child, in the aggregate, does not exceed five per cent of the total ownership or interest rights in the applicant and such person will not participate directly or indirectly in the control, management or operation of the dispensary facility if a license is granted.

Create additional copies of this page if necessary.

Each backer identified in response to this section must complete and sign Appendix B.

47. Name:	48. Percentage of ownership
Steven Jay RAND	100%

Section J: Directors, Owners, Officers and Other High-Level Employees

Provide the following information for each individual, including each dispensary facility backer, who will:

- directly or indirectly have control over, or participate in the management or operation of, the dispensary facility; or
- who currently receives, or who reasonably can be expected to receive, within one calendar year, compensation from the applicant exceeding $100,000.

Create additional copies of this page if necessary.

Each person identified in response to this section must complete and sign Appendix C.

49. Name (First, Middle, Last):	50. Title:	51. Role:
Steven Jay RAND	Owner	Backer, compliance, oversig
Jill K BEBEY	Pharmacist	pharmacist/manager

Section K: Financial Statement

Set forth all expenses greater than $10,000 incurred in connection with the establishment of your business and the sources of the funds for each. Attach additional pages if necessary. The Department may require backup documentation.

52. Expense Item:	53. Cost:	54. Source of Funds:
location retention lease to landlord	$	Steven Jay RAND
legal fees	$	Steven Jay RAND
pharmacist pre agreement	$	Steven Jay RAND
various zoning letters, lic. fees and misc	$	Steven Jay RAND
application fee bonus	$ 0	Steven Jay RAND
	$	
	$	
	$	

Section L: Security System

Identify the company or companies that will provide security services for the dispensary facility if a license is awarded. If more than two companies will provide security services, complete this section for each such additional company.

55. Primary Security Company Name: J and J Security	
56. Primary Security Company Address (including Apartment or Suite #): 35 Platt St	57. City: Milford

58. State:	59. Zip Code:	60. Telephone Number:	61. Fax Number:
CT	06460	(203) 874-4090	

62. E-mail Address: jjsec@optonline.net

63. Backup Security Company Name (if applicable):

64. Backup Security Company Address (including Apartment or Suite #):	65. City:

66. State:	67. Zip Code:	68. Telephone Number:	69. Fax Number:

70. E-mail Address:

71. Attach a detailed description of the security plan to be offered by the security company or companies. Be sure to include a discussion of each of the required elements set forth in Section 21a-408-62 of the Regulations of Connecticut State Agencies.

Section M: Legal Proceedings

72. Has the applicant ever had any petition filed by or against it, or otherwise sought relief under, any provision of the Federal Bankruptcy Act or under any State insolvency law in the last ten year period? ☐ Yes ☑ No

If the answer above is "yes", attach a statement providing the details of such proceeding or petition.

73. Has the applicant ever had a professional license, permit or registration in Connecticut, or any other State, suspended, revoked or otherwise subjected to disciplinary action? ☐ Yes ☑ No

If the answer above is "yes", attach a statement providing the date(s), the type of license, permit or registration at issue, and a description of the circumstances relating to each suspension, revocation or other disciplinary action.

74. Is the applicant a party to any legal proceedings where damages, fines or civil penalties may reasonably be expected to exceed $500,000 above any insurance coverage available to cover the claim? ☐ Yes ☑ No

If the answer above is "yes", attach a statement describing the litigation, including the title and docket number of the litigation, the name and location of the court before which it is pending, the identify of all parties to the litigation, the general nature of the claims being made and the impact an unfavorable opinion may have on the applicant or the applicant's operations.

75. Has the applicant ever had any fines or other penalties over $10,000 assessed by any regulatory agency? ☐ Yes ☑ No

If the answer above is "yes", attach a statement providing the details of such fines or penalties.

Section N: Criminal Actions

76. Has the applicant ever been convicted of a crime or received a suspended sentence, deferred sentence, or forfeited bail for any offense in criminal or military court or are any such charges pending? ☐ Yes ☑ No

If the answer above is "yes", attach a statement providing the date(s) of conviction(s), name of individual(s) involved, the court(s) where the case(s) were decided, a description of the circumstances relating to each offense or for the pending charges and the outcome of the proceedings.

Section O: Criminal Background Check

I understand that the department may review criminal background records for purposes of evaluating the applicant's suitability to participate in the medical marijuana program. As the duly authorized representative of the applicant, I hereby authorize the release of any and all information of a confidential or privileged nature to the department and its agents.

77. Signature:	78. Date Signed:
▶	9/16/15

I hereby certify that the above information is correct and complete.

I fully understand that if I knowingly make a statement that is untrue and which is intended to mislead the Department of Consumer Protection or any person designated by the Department in the performance of their official function, I will be in violation of Section 53a-157b of the Connecticut General Statutes. As the duly authorized representative of the applicant, I hereby make the above certifications on behalf of the applicant.

79. Signature:	80. Date Signed:
▶	9/16/15

Appendix B
Dispensary Facility Backer Information Form

This form must be completed by each person or entity identified as a dispensary facility backer in Appendix A, section I.

Section A: Backer Information

1. Backer business type:

☐ Sole Proprietorship	☐ Corporation	☑ Limited Liability Co.	☐ Partnership	☐ Limited Liability Partnership	☐ Unincorporated Association	☐ Other:

2. Legal Name of Backer: Steven Jay RAND

3. Trade Name of Backer (if applicable):

4. Street Address (including Apartment or Suite #): 39 Flag Swamp Road

5. City:	6. State:	7. Zip Code:
Roxbury	CT	06783

8. Daytime Telephone Number:	9. Fax Number:	10. E-mail Address:
(917) 330-9233		steven.rand@prohealthandwellness

Section B: Backer Members

If you selected anything other than "Sole Proprietorship" in response to Section A, identify the members of your organization. A member is any person with a direct or indirect ownership interest greater than 5%. Attach additional pages if necessary.

Each member of a backer identified in response to this section must complete either:

- Appendix C if they are also a director, owner, officer or other high-level employee of the applicant; or
- Appendix E in all other instances.

11. Name (First, Middle, Last):	12. Percentage of ownership interest
Steven Jay RAND	100%

Section C: Licenses, Permits and Registrations

Provide information regarding all state licenses, permits or registrations ever held, current or expired, by you. Attach additional pages if necessary.

13. State	14. Issue Date (month/year): / Expiration Date (month/year): /	15. Type:	16. Number:
17. State	18. Issue Date (month/year): / Expiration Date (month/year): /	19. Type:	20. Number:

Section D: Legal Proceedings

21. Have you, or has any entity over which you exercised management or control, had any petition filed by or against you, or otherwise sought relief under, any provision of the Federal Bankruptcy Act or under any State insolvency law in the last ten year period?

☐ Yes ☑ No

If the answer above is "yes", attach a statement providing the details of such proceeding or petition.

22. Have you, or has any entity over which you exercised management or control, ever had a professional license, permit or registration in Connecticut, or any other State, suspended, revoked or otherwise subjected to disciplinary action?

☐ Yes ☑ No

If the answer above is "yes", attach a statement providing the date(s), the type of license, permit or registration at issue, and a description of the circumstances relating to each suspension, revocation or other disciplinary action.

23. Are you a party to any legal proceedings where damages, fines or civil penalties may reasonably be expected to exceed $500,000 above any insurance coverage available to cover the claim?

☐ Yes ☑ No

If the answer above is "yes", attach a statement describing the litigation, including the title and docket number of the litigation, the name and location of the court before which it is pending, the identify of all parties to the litigation, the general nature of the claims being made and the impact an unfavorable opinion may have on your ability to serve as a backer for the applicant.

24. Have you, or has any entity over which you exercised management or control, ever had any fines or other penalties over $10,000 assessed by any regulatory agency?

☐ Yes ☑ No

If the answer above is "yes", attach a statement providing the details of such fines or penalties.

Section E: Criminal Actions

25. Have you ever been convicted of a crime or received a suspended sentence, deferred sentence, or forfeited bail for any offense in criminal or military court or do you have any charges pending? ☐ Yes ☑ No

If the answer above is "yes", attach a statement providing the date(s) of conviction(s), name of individual(s) involved, the court(s) where the case(s) were decided, a description of the circumstances relating to each offense or for the pending charges and the outcome of the proceedings.

Section F: Criminal Background Check

I understand that the department may review criminal background records for purposes of evaluating my suitability to participate in the medical marijuana program. As the backer, or duly authorized representative of the backer, I hereby authorize the release of any and all information of a confidential or privileged nature to the department and its agents.

26. Signature: ▶	27. Date Signed: 9/16/15

I hereby certify that the above information is correct and complete.

I fully understand that if I knowingly make a statement that is untrue and which is intended to mislead the Department of Consumer Protection or any person designated by the Department in the performance of their official function, I will be in violation of Section 53a-157b of the Connecticut General Statutes.

28. Signature: ▶	29. Date Signed: 9/16/15

Appendix C
Directors, Owners, Officers or Other High-Level Employees Background Information Form

To be completed by all persons identified in your response to Appendix A, section J.

Section A: Personal Information

1. Name (First, Middle, Last): Jill K BEBEY			
2. Street Address (including Apartment or Suite #): 606 Cascade Dr.			
3. City: Fairfield		4. State: CT	5. Zip Code: 06825
6. Title: pharmacist	7. Telephone Number: (203) 256-9187	8. E-mail Address: jillbebey@gmail.com	
9. Date of Birth:	10. Social Security Number:	11. Gender: ☐ Male ☑ Female	

Section B: Employment Information

12. Current or Most Recent Employer: pharmacist Grieb's Darien Pharmacy Inc		13. Date of Employment: Start Date: 09 / / 11 End Date: / /	
14. Employer Address (including Apartment or Suite #): 1021 Post Rd			
15. City: Darien		16. State: CT	17. Zip Code: 06820
18. Telephone Number: (203) 655-1000	19. Fax Number: (203) 656-0172	20. E-mail Address:	

Section C: Pharmacy Business Experience

21. Do you have any experience controlling, managing, operating or working for a pharmacy?

☑ Yes ☐ No

22. Are you currently associated with a pharmacy in any state?

☑ Yes ☐ No

23. If you answered "yes" to question 21 or 22, attach a statement setting forth, for each pharmacy with which you have been associated, the following information:

- The pharmacy name;
- The pharmacy's location;
- All titles and responsibilities held by you at the pharmacy, including the time frame for each;
- The dates of your association with the pharmacy;
- Whether you currently have a role at the pharmacy and, if not, when your involvement terminated and why; and
- Whether the pharmacy was ever alleged to have violated the laws or regulations of the state in which it operates during the time period when you were associated with the pharmacy and, if so, how those allegations were resolved.

Section D: Marijuana Business Experience

24. Other than the applicant, do you have any experience controlling, managing, operating or working for a marijuana business?

☐ Yes ☑ No

25. Other than the applicant, are you currently associated with a marijuana business in any state or country?

☐ Yes ☑ No

26. If you answered "yes" to question 24 or 25, attach a statement setting forth the following information for each marijuana business with which you have been associated:

- The business name;
- The business location;
- All titles and responsibilities held by you at the business, including the time frame for each;
- The dates of your association with the business;
- Whether you currently have a role at the business and, if not, when your involvement terminated and why; and
- Whether the business was ever alleged to have violated the laws or regulations of the state or country in which it operates during the time period when you were associated with the business and, if so, the nature and resolution of those allegations.

Section E: Other Relevant Business Experience

27. Do you have any experience controlling, managing, operating or working for any other business that you believe may be relevant to the department's evaluation of the applicant with whom you are associated?

☑ Yes ☐ No

28. If you answered "yes" to question 27, attach a statement setting forth the following information for each such business with which you have been associated:

- The business name;
- Products or services offered;
- The business location;
- All titles and responsibilities held by you at the business, including the time frame for each;
- The dates of your association with the business;
- Whether you currently have a role at the business and, if not, when your involvement terminated and why;
- Whether the business was ever alleged to have violated the laws or regulations of the state or country in which it operates during the time period when you were associated with the business and, if so, the nature and resolution of those allegations; and
- How this experience is relevant to the department's evaluation of the RFA response of the applicant with whom you are associated.

Section F: Licenses, Permits and Registrations

Provide information regarding all state licenses, permits or registrations ever held, current or expired, by you. Attach additional pages if necessary.

29. State	30. Issue Date (month/year): 08 / 90 Expiration Date (month/year): 01 / 16	31. Type:	32. Number:
CT		Pharmacist	Lic.07446 CT
33. State	34. Issue Date (month/year): / Expiration Date (month/year): /	35. Type:	36. Number:

Section G: Legal Proceedings

37. Have you, or has any entity over which you exercised management or control, had any petition filed by or against you, or otherwise sought relief under, any provision of the Federal Bankruptcy Act or under any State insolvency law in the last ten year period?

Yes ✓ No

If the answer above is "yes", attach a statement providing the details of such proceeding or petition.

38. Have you, or has any entity over which you exercised management or control, ever had a professional license, permit or registration in Connecticut, or any other State, suspended, revoked or otherwise subjected to disciplinary action?

Yes ✓ No

If the answer above is "yes", attach a statement providing the date(s), the type of license, permit or registration at issue, and a description of the circumstances relating to each suspension, revocation or other disciplinary action.

39. Are you a party to any legal proceedings where damages, fines or civil penalties may reasonably be expected to exceed $500,000 above any insurance coverage available to cover the claim?

☐ Yes ✓ No

If the answer above is "yes", attach a statement describing the litigation, including the title and docket number of the litigation, the name and location of the court before which it is pending, the identify of all parties to the litigation, the general nature of the claims being made and the impact an unfavorable opinion may have on the applicant or the applicant's operations.

40. Have you, or has any entity over which you exercised management or control, ever had any fines or other penalties over $10,000 assessed by any regulatory agency?

Yes ☑ No

If the answer above is "yes", attach a statement providing the details of such fines or penalties.

Section H: Criminal Actions

41. Have you ever been convicted of a crime or received a suspended sentence, deferred sentence, or forfeited bail for any offense in criminal or military court or do you have any charges pending? ☐ Yes ✓ No

If the answer above is "yes", attach a statement providing the date(s) of conviction(s), name of individual(s) involved, the court(s) where the case(s) were decided, a description of the circumstances relating to each offense or for the pending charges and the outcome of the proceedings.

Section I: Criminal Background Check

I understand that the department may review criminal background records for purposes of evaluating my suitability to participate in the medical marijuana program. I hereby authorize the release of any and all information of a confidential or privileged nature to the department and its agents.

42. Signature:	43. Date Signed:
▶ [signature]	09/14/15

I hereby certify that the above information is correct and complete.	
I fully understand that if I knowingly make a statement that is untrue and which is intended to mislead the Department of Consumer Protection or any person designated by the Department in the performance of their official function, I will be in violation of Section 53a-157b of the Connecticut General Statutes.	
44. Signature: ▶	45. Date Signed: 09/14/15

Medical Marijuana Program

165 Capitol Avenue, Room 145, Hartford, CT 06106-1630 • (860) 713-6066
E-mail: dep.mmp@ct.gov • Website: www.ct.gov/dep/mmp

Appendix D
Dispensary Facility Manager Information Form

This form must be completed and signed by the person who will serve as the dispensary facility manager if the applicant is awarded a dispensary facility license.

Section A: Dispensary Facility Manager Information

1. Name (First, Middle, Last): Jill K BEBEY			
2. Home Address (including Apartment or Suite #): 606 Cascado Dr.			3. City: Fairfield
4. State: CT	5. Zip Code: 06825	6. Date of Birth:	7. Telephone Number: (203) 520-4856
8. Social Security Number:			9. Gender: ☐ Male ■ Female
10. E-mail Address: jillbebey@gmail.com		11. Connecticut Pharmacist License Number: 07446	

Section B: Employment Information

12. Current or Most Recent Employer: Grieb's Darien Pharmacy Inc		13. Date of Employment: Start Date: 09 / /01 End Date: : / /	
14. Employer Address (including Apartment or Suite #): 1021 Post Rd			
15. City: Darien		16. State: CT	17. Zip Code: 06820
18. Daytime Telephone Number: (203) 655-1000	19. Fax Number:	20. E-mail Address:	

Section C: Pharmacy Business Experience

21. Do you have any experience controlling, managing, operating or working for a pharmacy?
☑Yes ☑No

22. Are you currently associated with a pharmacy in any state?
☑Yes ☐No

23. If you answered "yes" to question 21 or 22, attach a statement setting forth, for each pharmacy with which you have been associated, the following information:

- The pharmacy name;
- The pharmacy's location;
- All titles and responsibilities held by you at the pharmacy, including the time frame for each;
- The dates of your association with the pharmacy;
- Whether you currently have a role at the pharmacy and, if not, when your involvement terminated and why; and
- Whether the pharmacy was ever alleged to have violated the laws or regulations of the state in which it operates during the time period when you were associated with the pharmacy and, if so, the nature and resolution of those allegations.

Section D: Criminal Actions

24. Have you ever been convicted of a crime or received a suspended sentence, deferred sentence, or forfeited bail for any offense in criminal or military court or do you have any charges pending? ○ Yes • No

If the answer above is "yes", attach a statement providing the date(s) of conviction(s), name of individual(s) involved, the court(s) where the case(s) were decided, a description of the circumstances relating to each offense or for the pending charges and the outcome of the proceedings.

Section E: Criminal Background Check

I understand that the department may review criminal background records for purposes of evaluating my suitability to participate in the medical marijuana program. I hereby authorize the release of any and all information of a confidential or privileged nature to the department and its agents.

25. Signature:	26. Date Signed:
▶ [signature]	09/14/15

I hereby certify that the above information is correct and complete.

I fully understand that if I knowingly make a statement that is untrue and which is intended to mislead the Department of Consumer Protection or any person designated by the Department in the performance of their official function, I will be in violation of Section 53a-157b of the Connecticut General Statutes.

27. Signature:	28. Date Signed:
▶ [signature]	09/14/15

Medical Marijuana Program

165 Capitol Avenue, Room 145, Hartford, CT 06106-1630 • (860) 713-6066
E-mail: dcp.mmp@ct.gov • Website: www.ct.gov/dcp/mmp

Appendix E
Backer Members
Authorization for Release of Personal History Form

This form must be completed and signed by any member of a Backer that is not required to complete Appendix C.

Section A: Member Information			
1. Name (First, Middle, Last):			
2. Street Address (including Apartment or Suite #):			
3. City:		4. State:	5. Zip Code:
6. Daytime Phone Number:	7. Fax Number:	8. E-mail Address:	

Section B: Criminal Actions
9. Have you ever been convicted of a crime or received a suspended sentence, deferred sentence, or forfeited bail for any offense in criminal or military court or do you have any charges pending? ☐ Yes ☐ No
If the answer above is "yes", attach a statement providing the date(s) of conviction(s), name of individual(s) involved, the court(s) where the case(s) were decided, a description of the circumstances relating to each offense or for the pending charges and the outcome of the proceedings.

Section C: Criminal Background Check	
I understand that the department may review criminal background records for purposes of evaluating my suitability to participate in the medical marijuana program. I hereby authorize the release of any and all information of a confidential or privileged nature to the department and its agents.	
10. Signature: ▶	11. Date Signed:

I hereby certify that the above information is correct and complete.	
I fully understand that if I knowingly make a statement that is untrue and which is intended to mislead the Department of Consumer Protection or any person designated by the Department in the performance of their official function, I will be in violation of Section 53a-157b of the Connecticut General Statutes.	
12. Signature: ▶	13. Date Signed:

A2. Business Information of Applicant

Business Experience
Applicant has more than 21 years of experience running a 501c3 not for profit educational organization in lower Manhattan. As Executive Director he has managed a staff of 5 people and performed the role of compliance officer while bringing the organization to International prominence. http://www.apexart.org

Applicant serves on the board of ACE – Association of Community Employment Programs for the Homeless and substantially supports the organization financially and otherwise. http://www.acenewyork.org/

Applicant has had considerable success in real estate, building and business transactions is self-funded and able to cover all aspects of the operation without any risk of compromise due to underfunding. One person will be taking the responsibility for all aspects. Applicant's intent is not to maximize profit but to maximize the benefits to the community he serves.

Applicant makes substantial donations to hospitals, universities, and municipalities. Among other things he donated a minivan and funds for maintenance to the Senior Center in Roxbury, CT. Applicant supports many civic and hardship issues in Roxbury and NYC.

Applicant has authored 4 books that are used in many university programs including Yale, Harvard and Brown and lectures extensively on ethics and creativity in the arts.

The greatest strength of the applicant is his ability to start, manage and oversee a complex, legally compliant organization successfully with a strong commitment to the community and the health, benefit and well being of others.

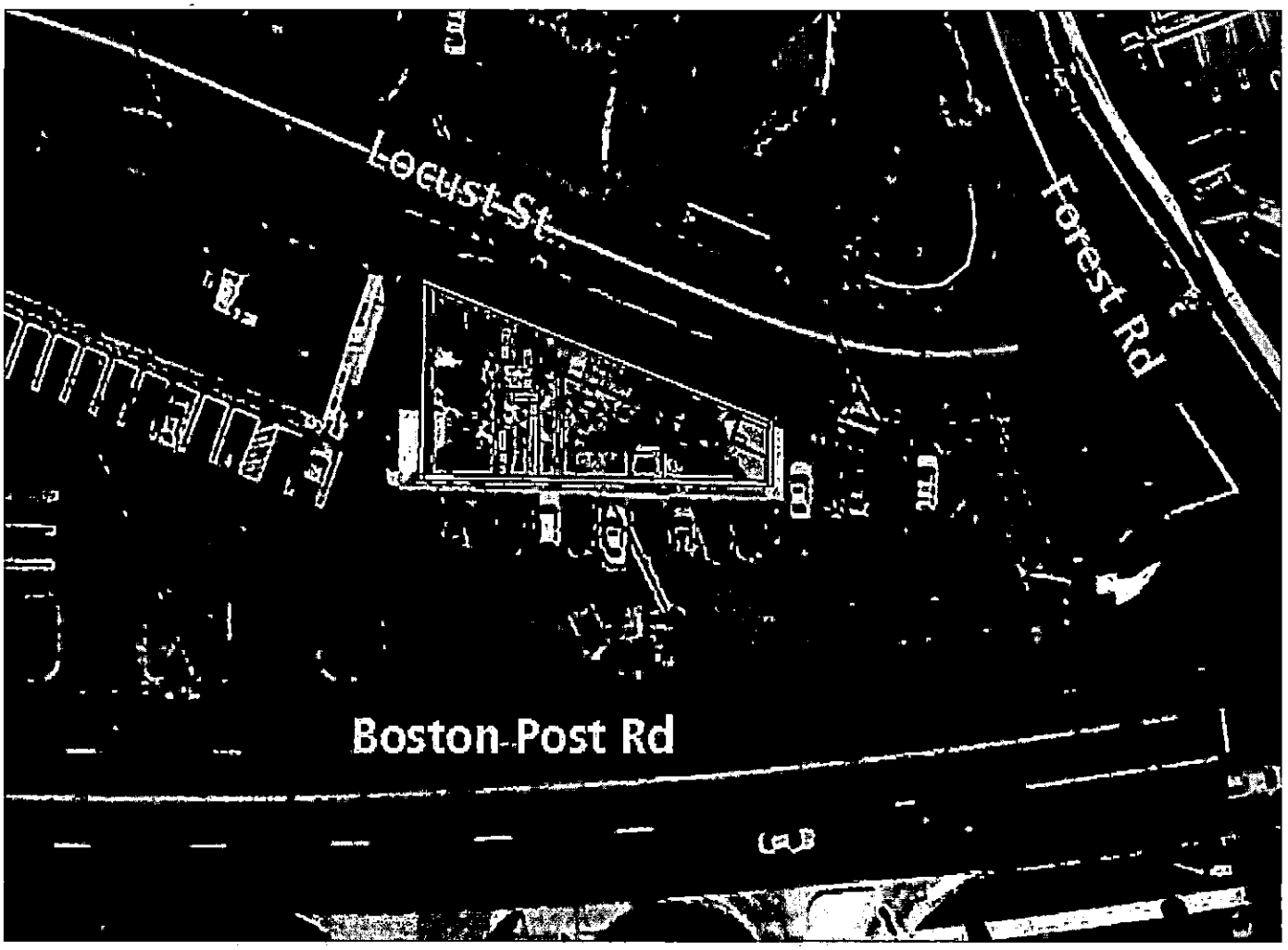
Applicant has no indebtedness whatsoever and owns all properties later noted, outright and without encumbrance.

A3. Costs incurred to date re. application

Location fee to hold property - 972 BPR		
Signing fee for Pharmacist		
Attorney fees re lease		
Printing fees		
Filing fee		
Various CT fees		
Design costs		
TOTAL		

ProHealth and Wellness CT

972 Boston Post Road
Milford, CT 06460
917 330-9233



a patient sensitive facility meeting the interests of the community

B2a

ProHealth and Wellness CT

972 Boston Post Road
Milford, CT 06460
917 330-9233

Milford Fire Department - Fire Marshal Office
72 New Haven Ave
Milford, Ct 06460

Plan Review Report

Date: Wednesday September 9, 2015

Applicant:
Steve Rand - Pro Health & Wellness CT
39 Flag Swamp Rd
Roxbury, CT 06783

Occupancy:
ARNOLD PECK
972 Boston Post Rd
Milford, CT 06460

Project: Plan Review - Interior
Pro Health & Wellness CT

This office has reviewed the plans received on September 09, 2015.

The above-referenced plan was reviewed for compliance with the 2005 Edition of the Connecticut State Fire Safety Code (CSFSC) and all applicable codes and standards. All plan reviews conducted by this office are performed in accordance with Section 29-292 of the Connecticut General Statutes.

The following items were noted and shall be addressed:

Provide Building Department with full submittal package for permitting.

A full submittal package (shop drawings, specifications, cut-sheets, calculations, etc.) is required for any fire alarm system work. The submittal package is required for review and approval prior to the issuance of any associated permits.

A full submittal package (shop drawings, specifications, cut-sheets, calculations, etc.) is required for any sprinkler system work. The submittal package is required for review and approval prior to the issuance of any associated permits.

The following inspections are required by this Office:
Above-ceiling prior to the closing of ceilings.
Fire-rated construction
Final Inspection

This plan has been : **APPROVED as Submitted**

ProHealth and Wellness CT

B2b

972 Boston Post Road
Milford, CT 06460
917 330-9233

Planning and Zoning Office
City of Milford, Connecticut

Certificate of Zoning Compliance for Use of Land or Building

August 14, 2015

This is to certify that Section 5.19.2, Standards for Location, of the zoning regulations of the City of Milford allows a medical marijuana dispensary use to be located at 972 Boston Post Road, and that a public or parochial school is not located within the 300-foot mandatory buffer.

Signed:

Stephen Harris, C.Z.E.O
Zoning Enforcement Officer

Requested by: Pro Health Wellness CT
39 Flag Swamp Road
Roxbury, CT 06783

Fee: $85.00
Rec#

THIS IS NOT A CERTIFICATE OF OCCUPANCY AS REQUIRED BY THE ZONING REGULATIONS

No building permit or certificate of occupancy shall be issued for a building, use or structure subject to the zoning regulation of a municipality without certification in writing by the official charged with the enforcement of such regulations that such building, use or structure is in conformity with such regulations or is a valid nonconforming use under such regulations. Such official shall inform the applicant any such certification that such applicant may provide notice of such certification by either (1) publication in a newspaper having substantial circulation in such municipality stating that the certification has been issued, or (2) any other method provided for by local ordinance. Any such notice shall contain (A) a description of the building, use or structure; (B) the location of the building, use or structure. (C) the identity of the applicant; and (D) a statement that an aggrieved person may appeal to the Zoning Board of Appeals in accordance with the provisions of Section 8-7, as amended by this act.

B3

ProHealth and Wellness CT

972 Boston Post Road
Milford, CT 06460
917 330-9233

771 BPR, LLC
500 BOSTON POST ROAD
MILFORD, CT 06460

September 10, 2015

Connecticut Department of Consumer Protection
Drug Control Division
Medical Marijuana Program
165 Capitol Avenue, Room 145
Hartford, CT 06106

Re: Application of Prohealth and Wellness CT, LLC
972 Boston Post Road
Milford, CT 06460

Dear Sir or Madam:

771 BPR, LLC is the owner and landlord of the real property known as 972 Boston Post Road, Milford, Connecticut (the "Property"). This letter will serve to confirm and certify to the Department of Consumer Protection ("DCP") that in the event Prohealth and Wellness CT, LLC is awarded a Medical Marijuana Dispensary Facility License for the Property, 771 BPR, LLC consents to Prohealth and Wellness CT, LLC operating a medical marijuana dispensary facility on the Property in compliance with all statutes, laws and regulations governing such use.

771 BPR, LLC

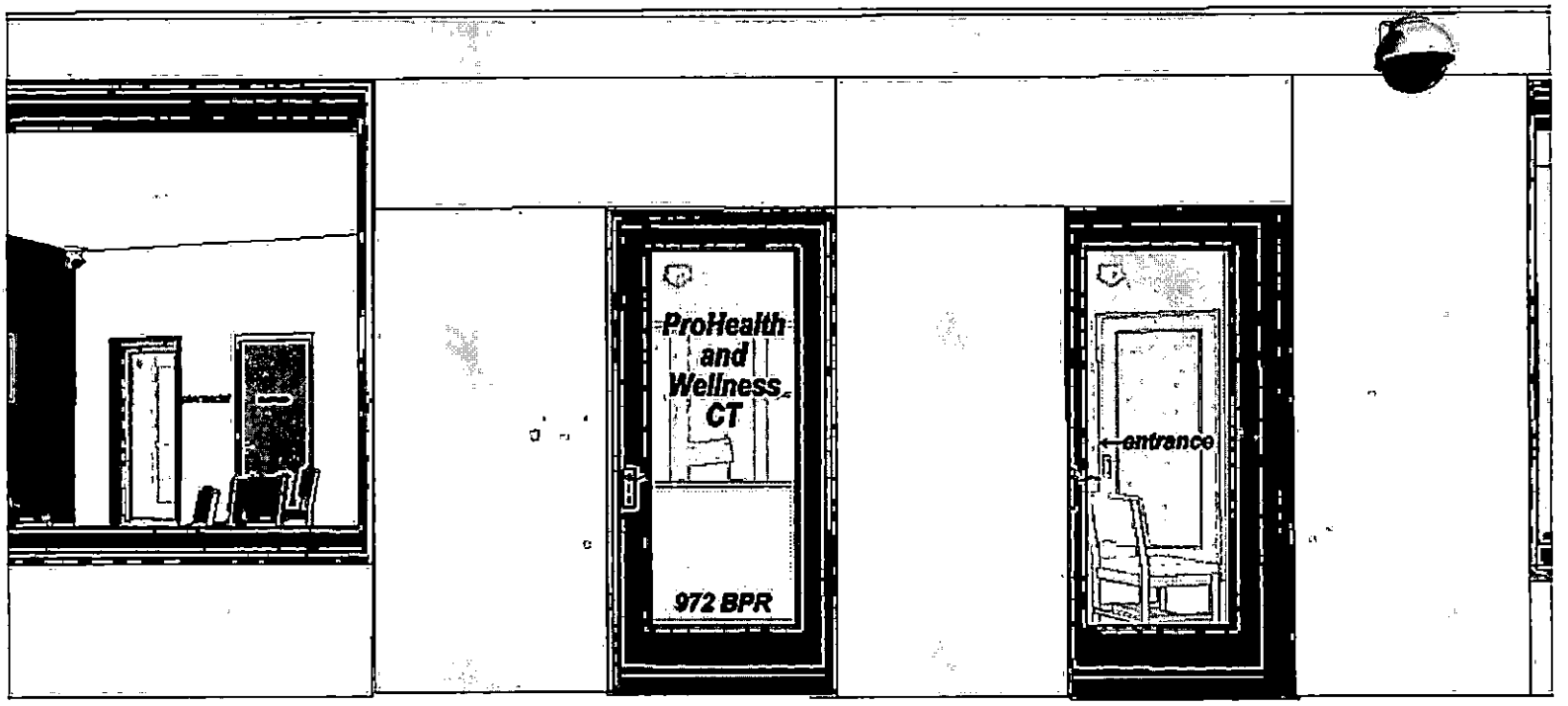
By:

Arnold Peck
Its Manager
Duly Authorized

B4

ProHealth and Wellness CT

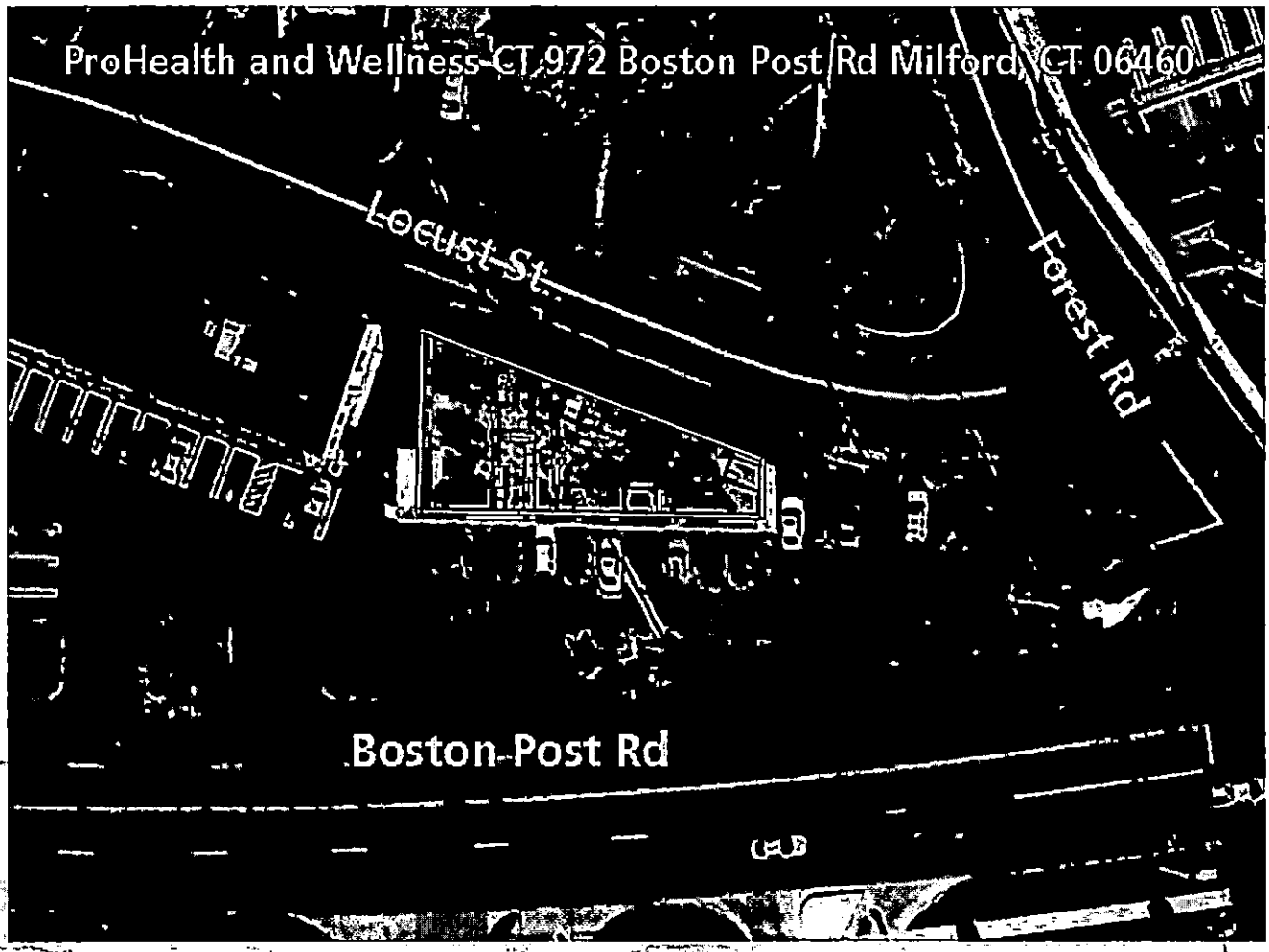
972 Boston Post Road
Milford, CT 06460
917 330-9233



B5a

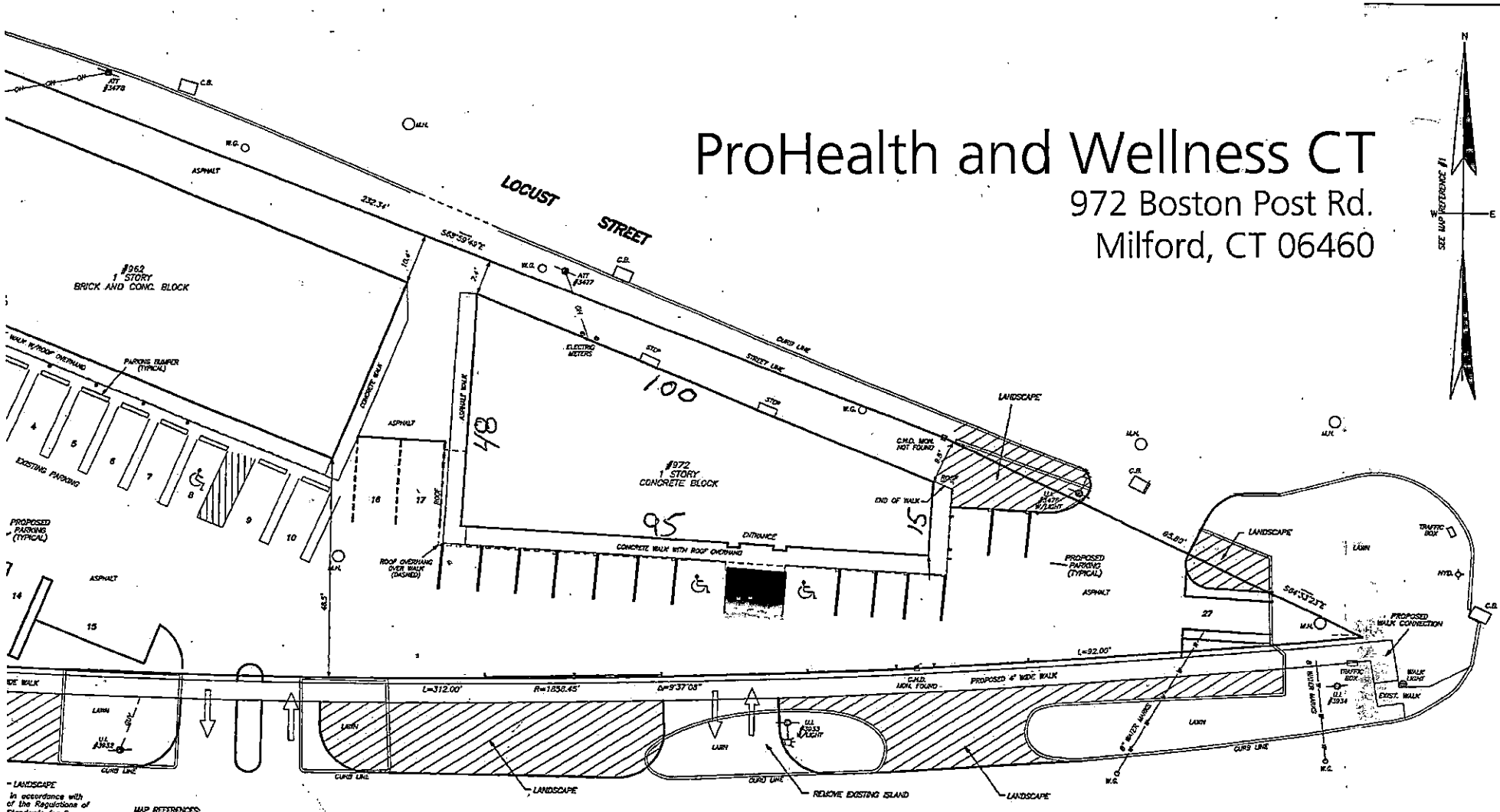
ProHealth and Wellness CT

972 Boston Post Road
Milford, CT 06460
917 330-9233



ProHealth and Wellness CT

972 Boston Post Rd.
Milford, CT 06460



- LANDSCAPE

In accordance with of the Regulations of Standards for Surveys adopted by the , Inc. The Boundary onforming to Horizontal

sign Development District 1

uary 11, 1980 and the Milford Land

y 14, 1978 and the Milford Land

uary 16, 1970 and the Milford Land

cted July 11, 1958 and the Milford Land

sanitary not shown

ream.

10. 15160

8-26-14.dwg 9/24/2014 3:33:24 PM EDT

MAP REFERENCES:

1. Property Boundary Dependent Resurvey Brooks, Torrey & Scott, Inc. Milford, Connecticut scale 1"=20' dated February 12, 2001 and revised August 23, 2001 by Clarke & Pearson, Associates, Inc. Not on File in the Milford Land Records.
2. Roller Family Division Property of Hugo Roller Et Als 952, 962 & 972 Boston Post Road Milford, Connecticut scale 1"=20' and dated July 16, 1993 by Clarke & Pearson, Associates, Inc. Milford Town Clerk Map No. A82053.
3. Compilation Map Town of Milford Map Showing Land Released to Hugo A. Roller Et Al by The State of Connecticut Locust St. at Boston Post Rd. U.S. 1 scale 1"=20' and dated December 9, 1993 Milford Town Clerk Map No. A82157.

PARCEL AREA:
22,995 S.F. = 0.5279 AC.

This map is not valid unless it has a live signature and embossed seal of Tracy H. Lewis.

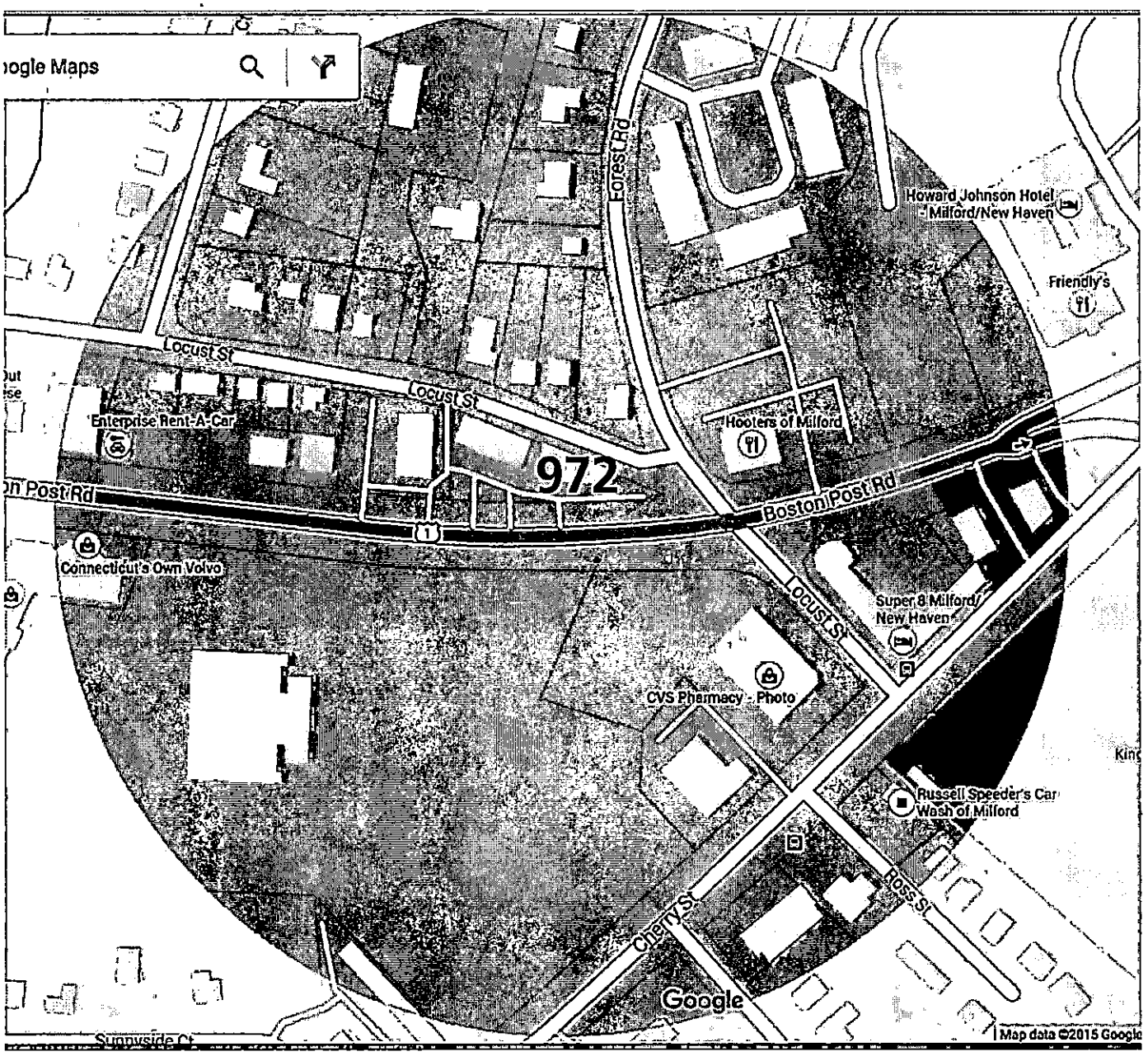
PREPARED FOR
MILFORD REALTY LLC
SCALE: 1"=10' DATE: 8-26-2014
SCALE IN FEET
10 0 10 20

LEWIS ASSOCIATES
LAND SURVEYING AND CIVIL ENGINEERING
260 MAIN STREET, MONROE, CONNECTICUT

B6

ProHealth and Wellness CT

972 Boston Post Road
Milford, CT 06460
917 330-9233

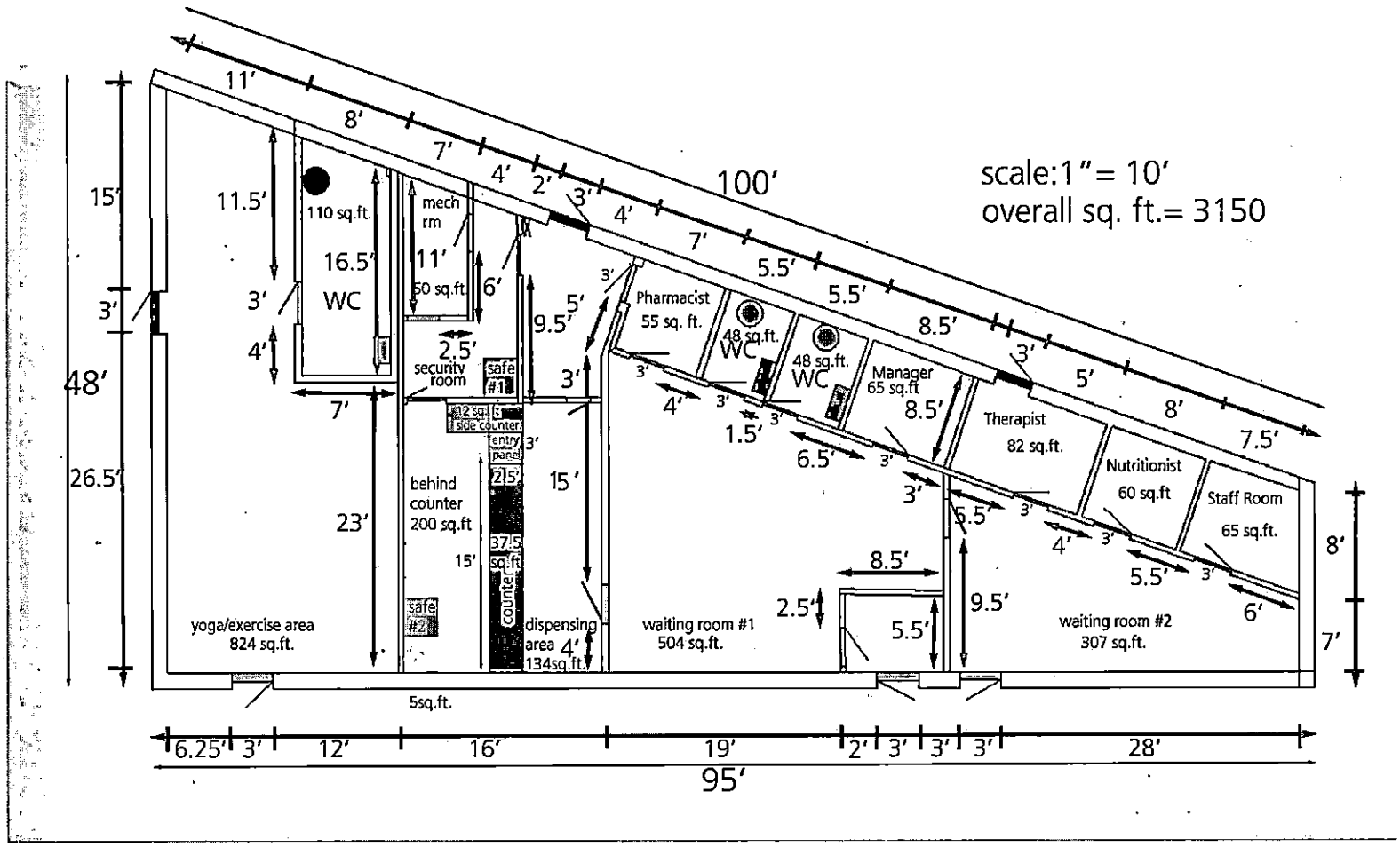


Boston Post Road in Milford, CT is a major business thoroughfare. Our location will have a positive effect on the neighborhood and there are no contrindicated business within 1000'

B8 (details follow)

ProHealth and Wellness CT

972 Boston Post Road
Milford, CT 06460
917 330-9233



B8a

ProHealth and Wellness CT

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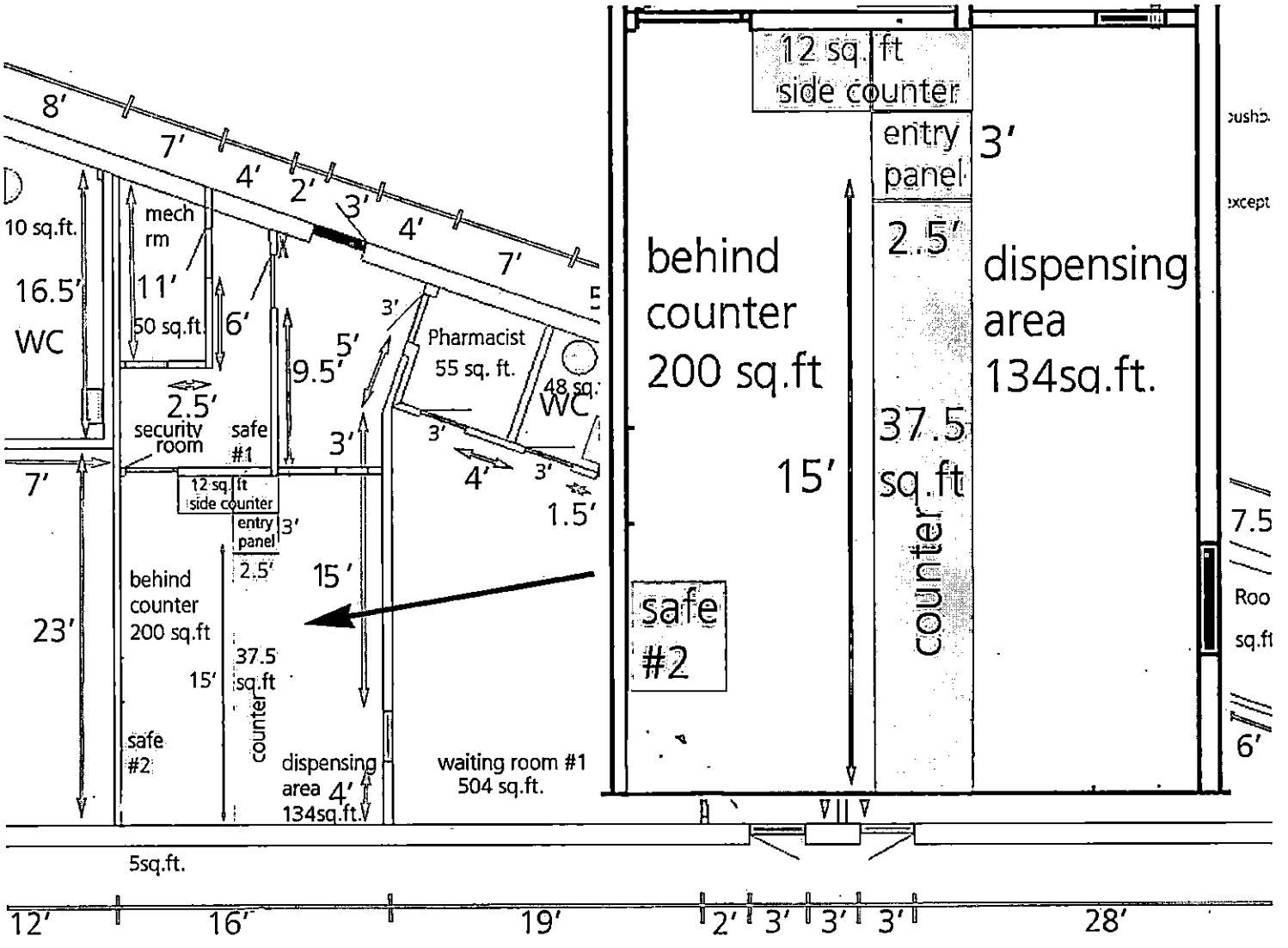

B8b

ProHealth and Wellness CT

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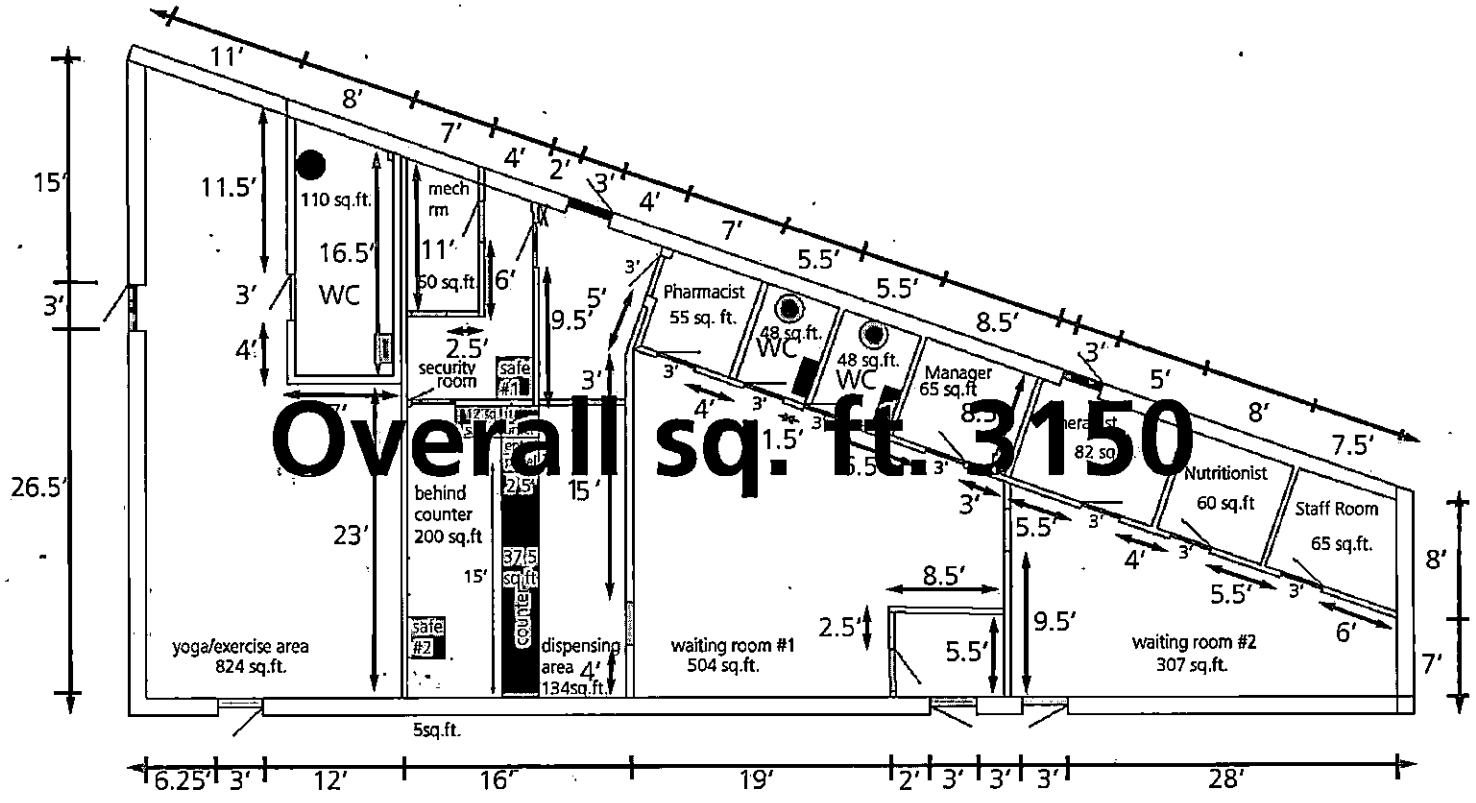
917 330-9233



B8c

ProHealth and Wellness CT

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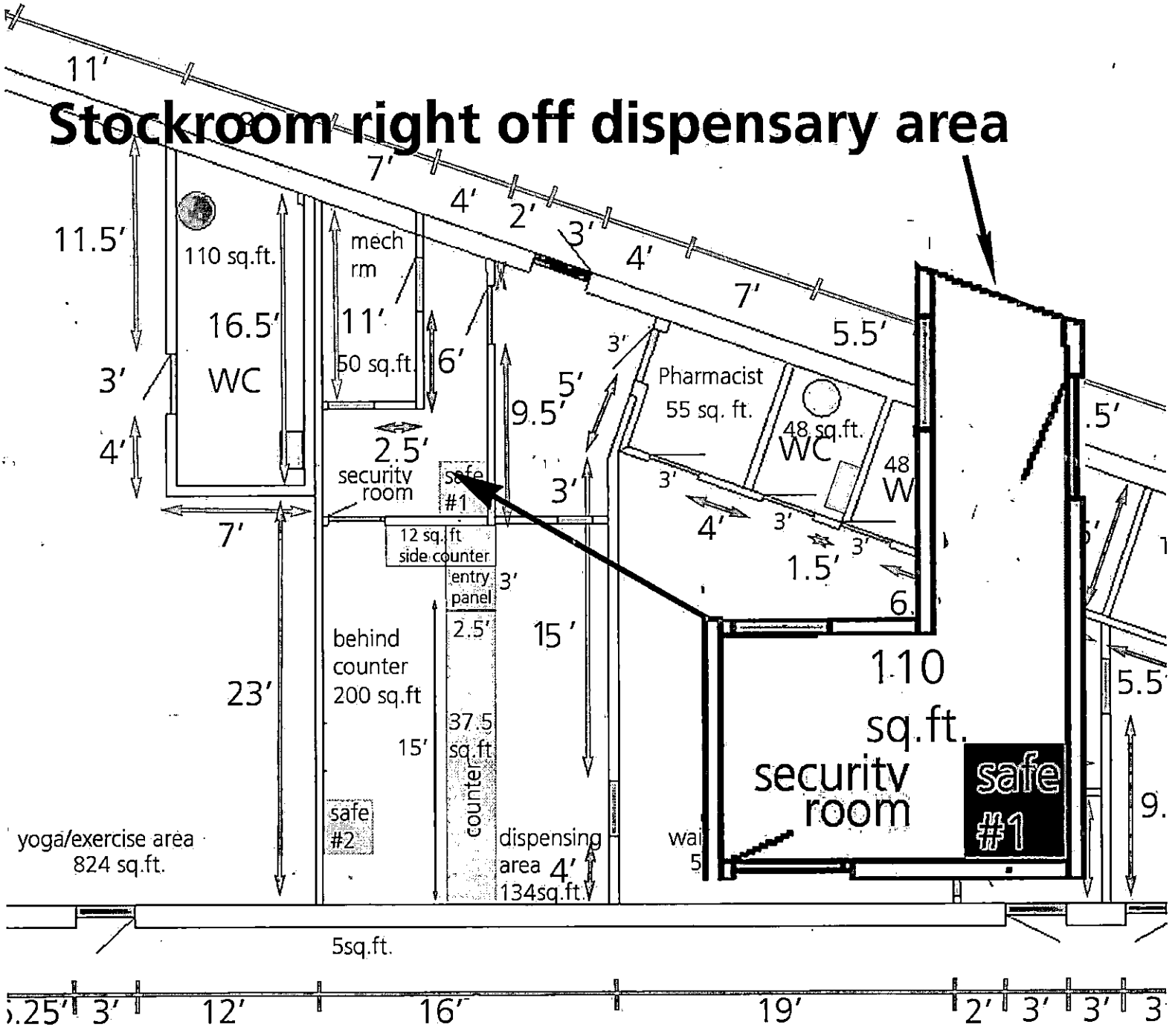

B8d

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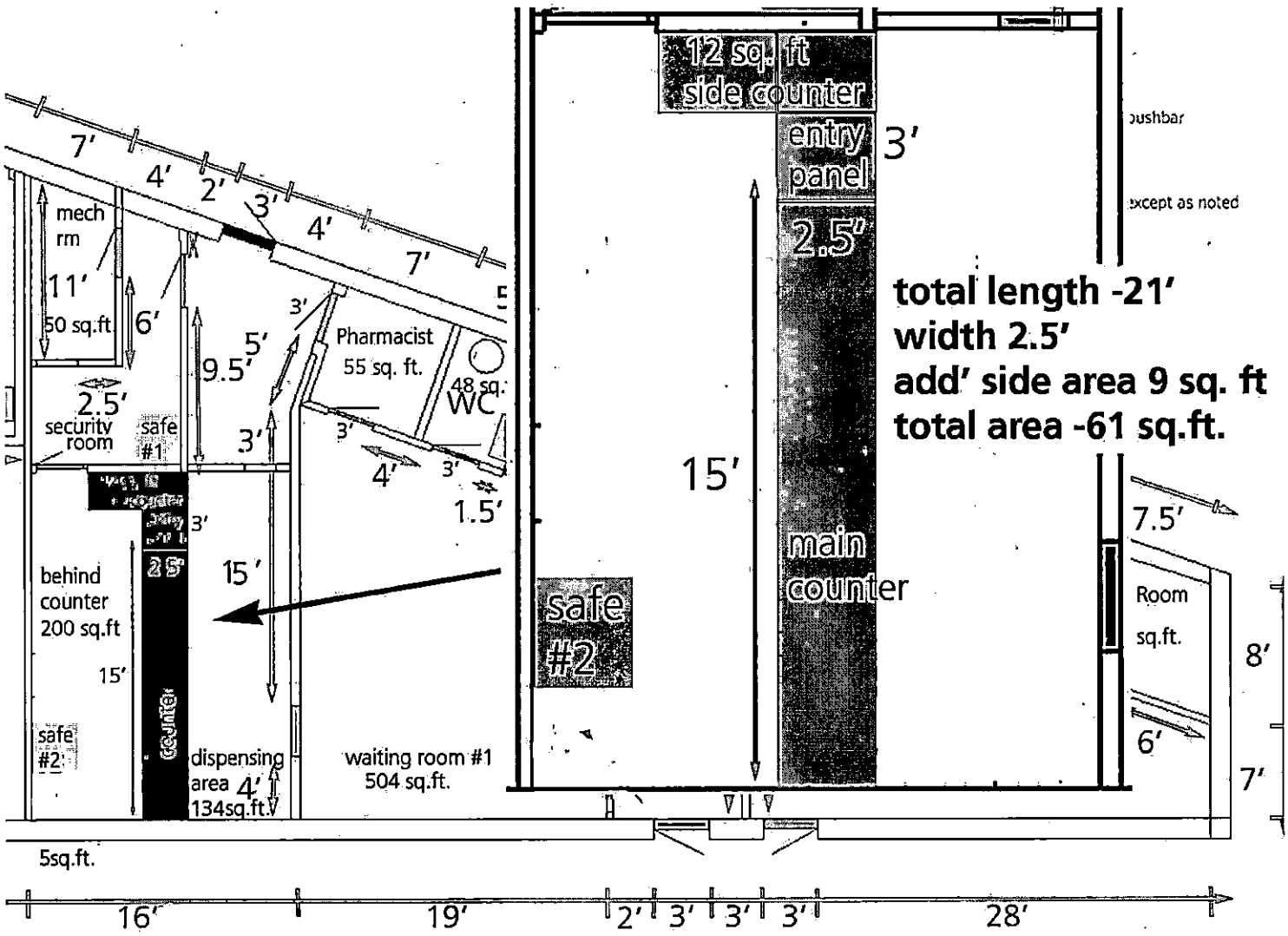
917 330-9233



Dispensing Department Counter size

B8e

ProHealth and Wellness CT

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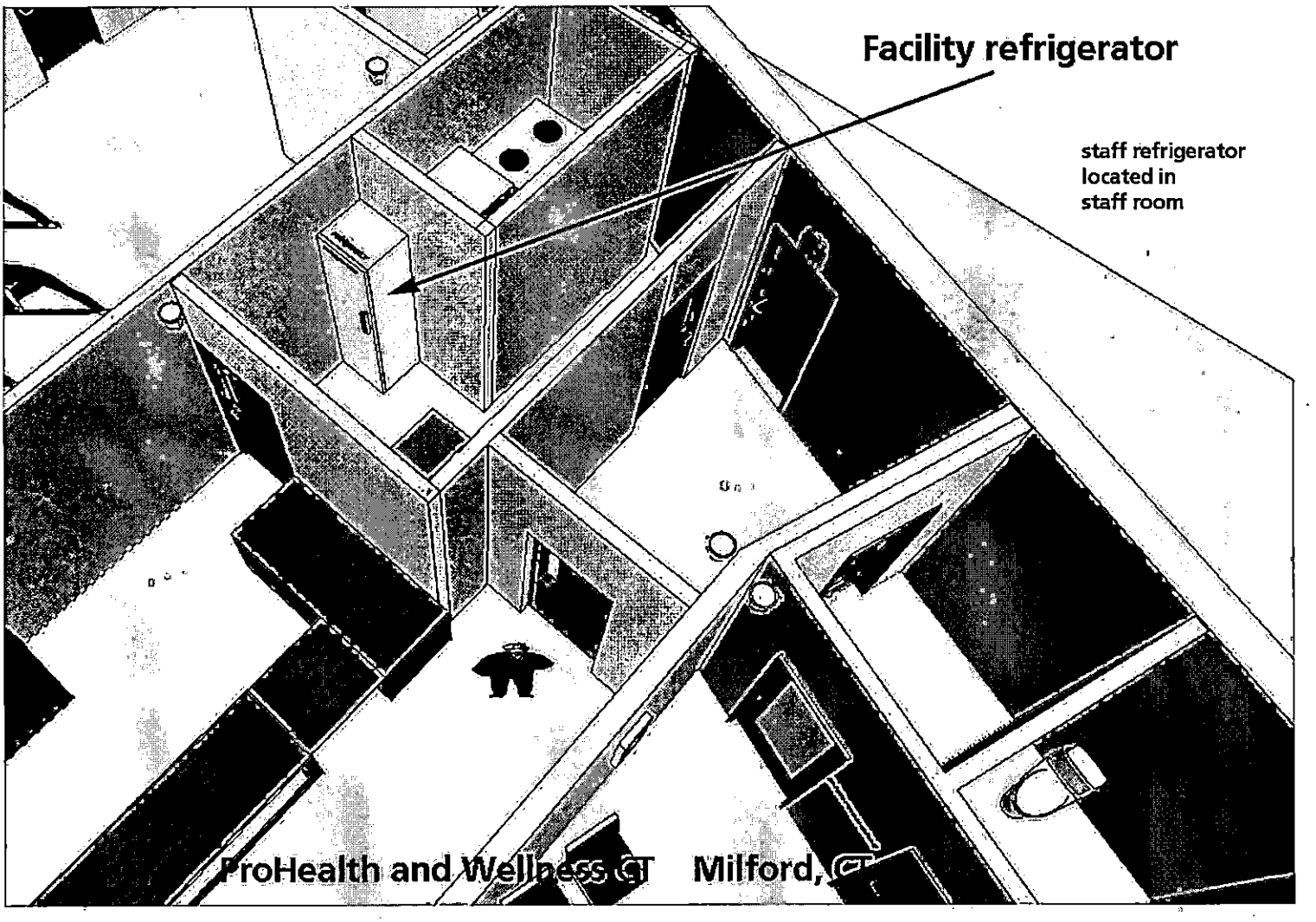

B8f

ProHealth and Wellness CT

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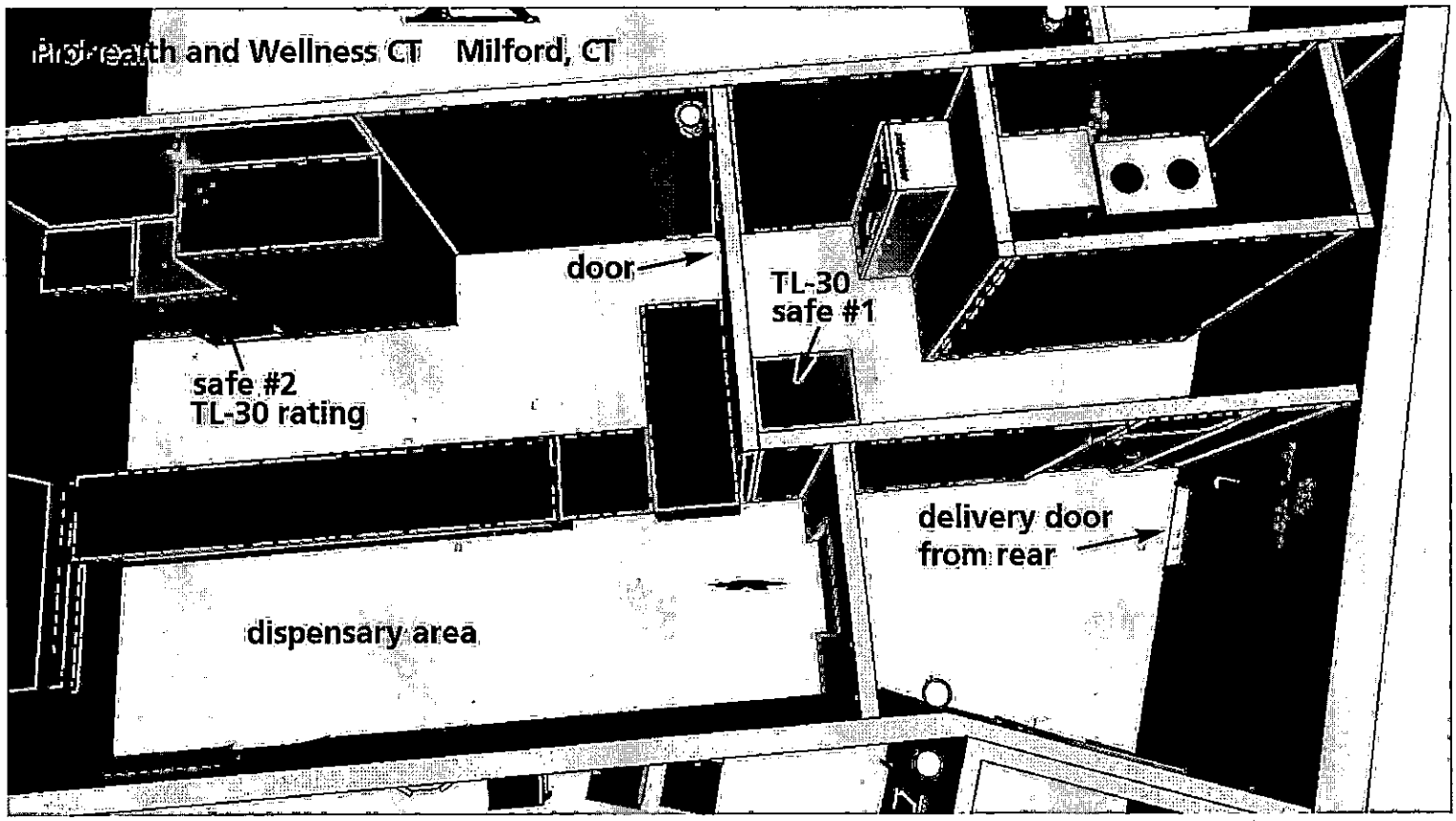

Location of two TL-30 approved safes

Dimensions:

Outside: 62H x 31W x 31.25D

Inside: 54.75H x 23.5W x 18D

B8g

ProHealth and Wellness CT

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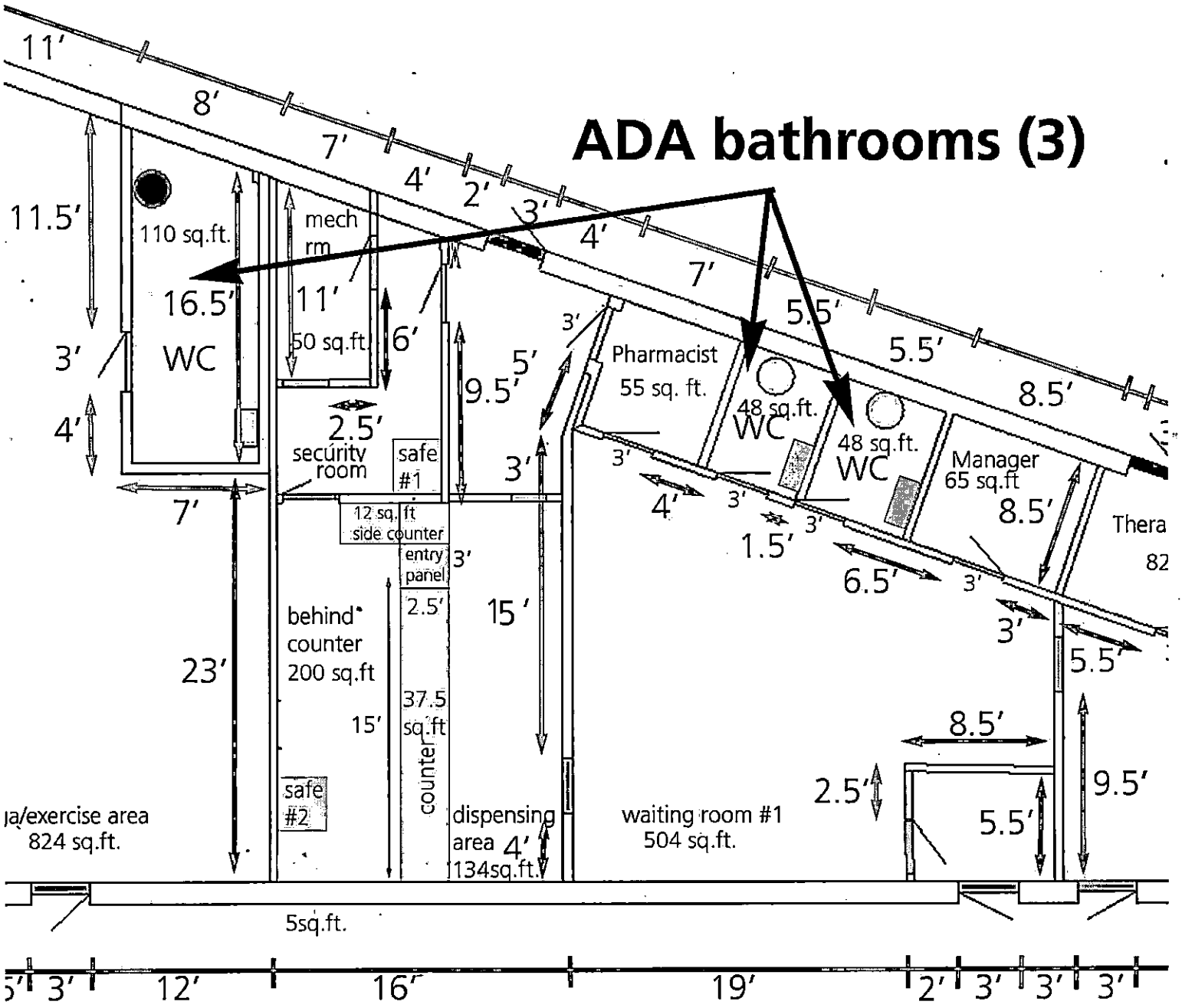

toilet facilities

B8h

ProHealth and Wellness CT

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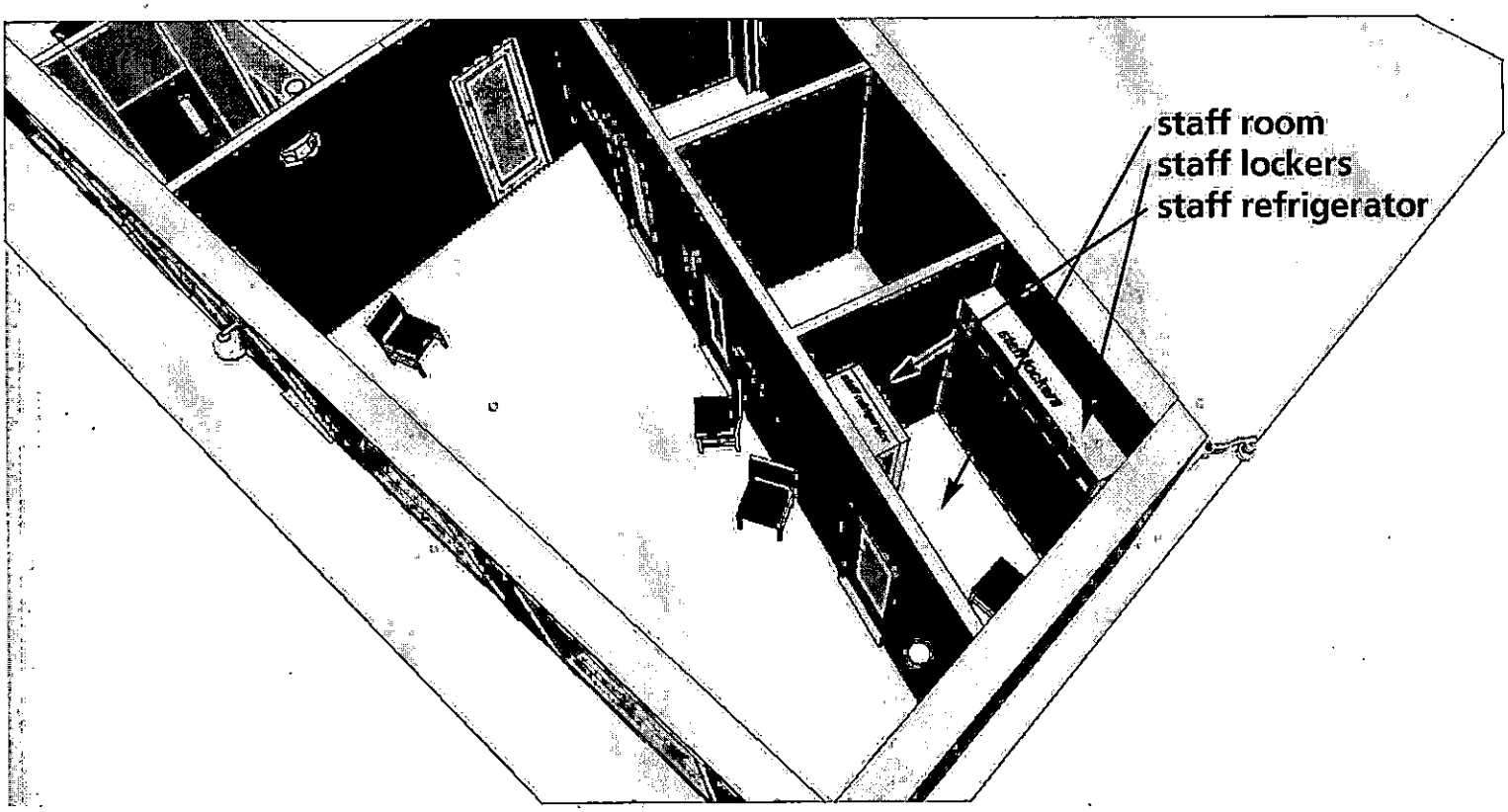

Staff break room and lockers

ProHealth and Wellness CT

972 Boston Post Road
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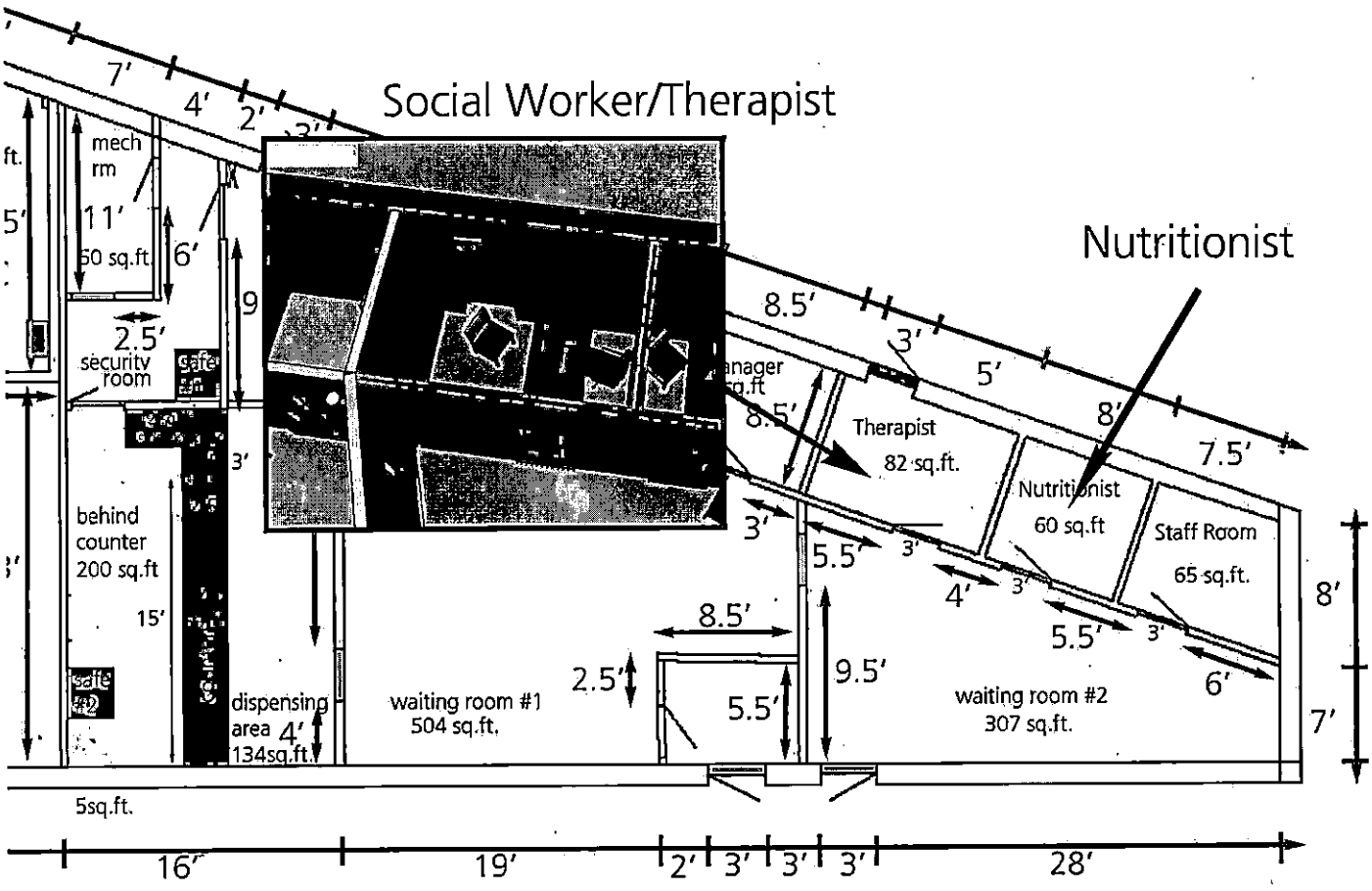

Social Worker/Therapy Office and Nutritionists office

B8k

ProHealth and Wellness CT

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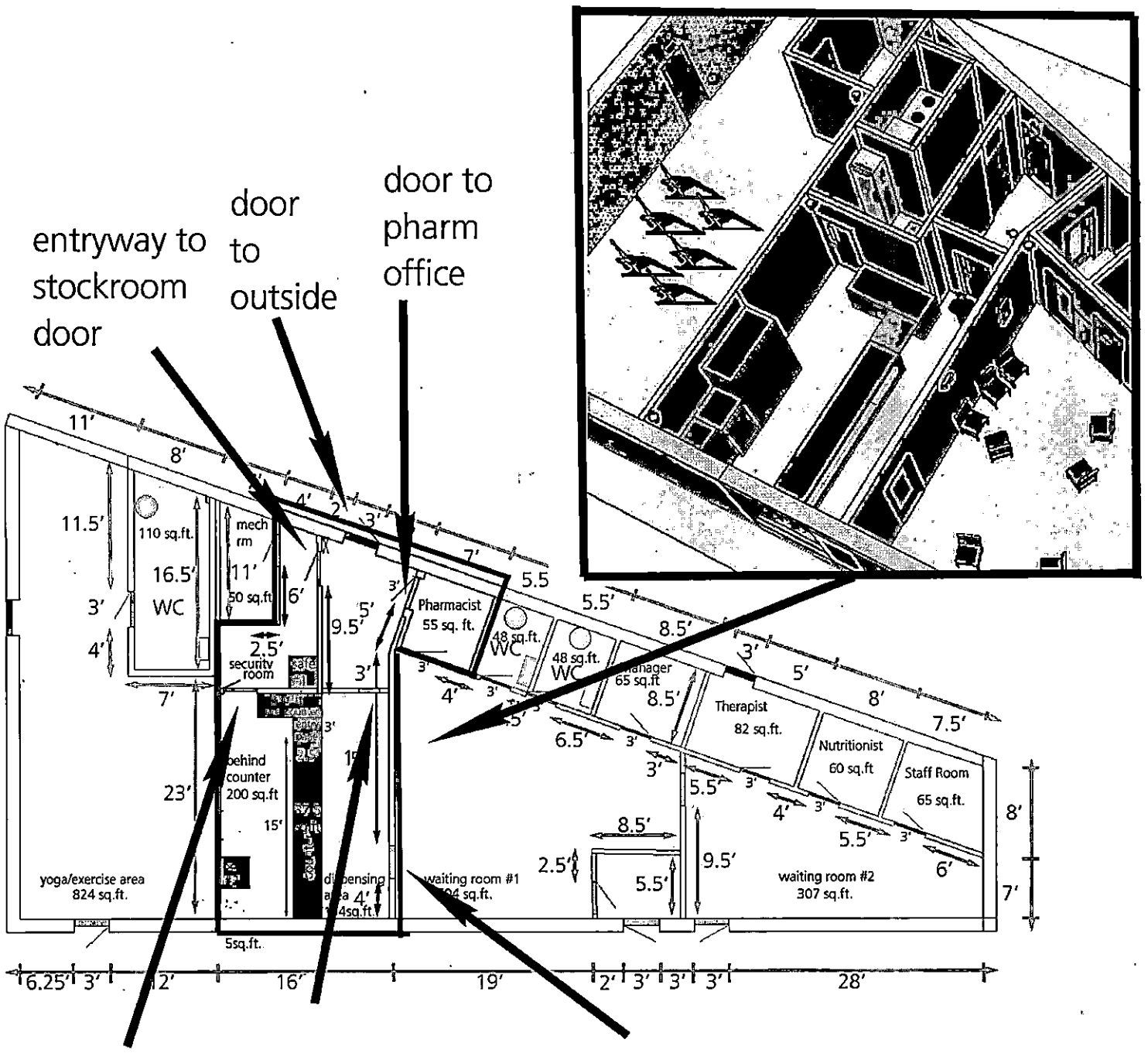


Location of all areas that may contain marijuana

ProHealth and Wellness CT

972 Boston Post Road
Milford, CT 06460
917 330-9233

c. Proposed Business Plan

1. Business will dispense medical marijuana according to CT state law and offer a variety of products for its consumption and use including products for safer consumption such as vaporizers. In another area we will offer a small selection of vitamins and supplements as per client needs. See ad. B8j

2. **Social worker, nutritionist and physical therapist on staff/premises**

   - **Social Worker on Premises 3 days/ week** providing free counseling and referral for individuals with medical issues (referred by their physician), substance abuse issues, and family concerns. There will be an emphasis on *mindfullness*. PHWCT **has secured a $150,000.00 grant from 291 Foundation** to support this program along with a related study for three years. Sole trustee of the foundation is a psychotherapist and has a personal interest in this issue. See letter attached.

   - **Nutritionist** on premises 2 days/week to assist people with proper nutrition and necessary supplements supported and referred by their physician and on a personal level.

   - **Physical Therapist** 1 day/week (increasing as needed) **and Exercise Room** to address various weight loss issues in conjunction with their physicians including cachexia. Cost effective services offered on a sliding scale.

3. Security Plan

- All areas in the facility are separated and secured by steel doors.
- Primary access to facility is through a single front door. Client's CT---MM card is viewed by CCTV outside the door by the receptionist, then "buzzed" into an enclosed protected area where their card is verified and logged in before they are "buzzed" into the waiting area.
- Clients and staff will be on video constantly, held internally (hidden) and on still cameras that send images offsite for safety.
- Product delivery will be at a rear secured door leading into a secured internal area. There are video cameras on the outside of the building covering all doorways. Area is well lighted but discreet.
- video cameras on the exterior and on the interior
- still cameras sending images offsite a floor safe with a "stuff hole" will be used during the day.
- afes will allow one to always remain closed. Safes are separated for safety

4. Disability efforts

- Three restrooms, two in dispensary, one in exercise area, will all be ADA compliant. All public entrances to the facility will have a regulation complying ramp and entry. Disabled individuals will have access to every part of the facility and someone on staff will be available to assist folks with any difficulties.

5. Air Treatment

- Building is a freestanding facility located at 972 Boston Post Rd. Product is prepackaged and creates minimal significant odor. To minimize any possibility a fresh air ventilation exchange system will be part of the HVAC and will introduce fresh air continually to exchange air and maintain a healthy environment in the facility.

6. delivery process and protocols to avoid diversion, theft or loss.

- Growers are responsible for delivery to dispensaries. Deliveries will be accepted through a rear door with immediate access to one of our tw TL--30 rated safes.
- Multiple exterior video cameras, will be directed at the door and delivery vehicle. Additional cameras will monitor the door activity from the inside.
- cameras around the facility will record to a digital recorder on the facility that is secreted and under a secure locking system.
- In addition to video recording, motion activated still images from additional cameras are sent off site where they are not vulnerable to theft of recording equipment.
- TL---30 large safes will minimize exposure to product. One safe is located inside the door in an area accessible only to staff members, noted on illustration and the other in the dispensary area. We are also investigating a wall "pass through" safe but have not found one large enough yet.

7. Staff training and continuing ed.

- Our pharmacist Jill Bebey has been ramping up her educational and informational activities since August 2015 and has 15 years of experience.
- We will encourage and pay for our staff to attend seminars, talks and professional gatherings.
- Staff will be encouraged to exchange information from all areas.
- We will join the other dispensaries in their educational and information activities

8. Tracking of controlled product.

Software from Proteus 420 will be used to track all aspects of ordering, fulfilling and tracking of clients. Software will produce extremely detailed real time reports. Our site is operational and connected to Proteus and their servers. See compliance letter attached. See attached C8a and C8b from Proteus

- **Proteus 420**
  In addition to our video and still images, and the safes we are already running Protues420 software that tracks all aspects of our business. Described below:

  Proteus420 is the leader and ONLY full functioning dispensary management solution on the market.

- **Proteus420's web based benefits include, but are not limited to:**

- Being the first and ONLY full functioning web-based dispensary management solution
- Enjoy all the benefits and flexibility of a globally accessible solution
- Full access and real time data information anywhere, anytime
- Utilizing ONLY the highest standards in data back-up and security
- **Proteus420 Convenience and Reliability:**

- Cloud based management solution means you always have access to your crucial business data -- when and where you need it
- No Expensive software upgrades or maintenance costs
- Reliably forecast IT expenditures with a subscription based pricing model
- A Real-time, Web-based business solution for you at your fingertips

PROTEUS420 Security and Back-up:

- Self controlled hosting environment
- 2048 Bit SSL Encryption
- IP restrictions
- SSAE 16 Type II certified data center
- On-Site Security experts monitoring and updating security protocols 24/7/365
- We currently have a presence in multiple top tier datacenters worldwide. We only utilize quality bandwidth providers and the most up to date power, cooling, and security technologies

  NOC 1: San Diego,
  CA NOC 2: Lenoir,
  NC NOC 3: Hong
  Kong

REVOLUTIONIZING CHANGE

PROTEUS 420

PROTEUS Business Solutions, Inc is dedicated to providing the most secure and compliant processes involving all our healthcare providers and/or patient information. PROTEUS and it's 420 System, is a 100% HIPAA, (Health Insurance Portability and Accountability Act.) compliant cloud based system that meets or exceeds the requirements of the storage and access of patient verification used to verify medical cannabis patients.

Patient verification systems are a cornerstone of the medical cannabis healthcare movement. Like other patient databases, they may store sensitive patient data, such as medical record numbers, patient addresses, patient contact details, diagnoses codes and driver's license numbers.

PROTEUS and its 420 System is encrypted utilizing the most advanced security standards set for data transmission, encryption and storage. Our 256-bit SSL encryption and can be verified by the padlock and https:// in the address set for each Dispensary or Businessness Location. This security and use of SSL encryption meets HIPAA's data transmission security requirements. This ensures all data transacted from the database to end-user is protected. Sensitive Patient information is also encrypted in our databases using a hash based encryption method.

All PROTEUS Data is submitted utilizing a double encryption in and out methodolgy and all data is being securely transmitted by one of our our SSAE 16 certified data centers. Each Data Center is systmatically certified every year by a third party security company and provided upon request by our Data Centers for viewing. These confidential records confirm HIPAA protocols in proper security control and 24/7 monitoring by trained security personnel.

PROTEUS backs up all data and replicates it every __ minutes by utilizing our Data Center locations, Load Balancing and proper security and back-up protocols 24 hours a day, 7 days a week.

Keep in mind that Medical Marijuana while still not Federally Mandated HIPAA policies, PROTEUS still agrees your patient and healthcare information should be compliant and ensures the proper and compliant HIPAA standards for your business and patient saftey.

*The consequences of violating HIPAA security regulations are serious and often include fines for violators. If you believe that a covered entity violated your (or someone else's) health information privacy rights or committed another violation of the Privacy or Security Rule, you may file a complaint with the OCR (Office for Civil Rights).

SSAE 16 CERTIFIED TYPE II

PCI

HIPAA

PROTEUS BUSINESS SOLUTIONS, INC., 350 W 9TH AVE, SUITE 106, ESCONDIDO, CA 92025

PROTEUSERP.COM

Compliance Report

Executive Summary

Merchant	Proteus Business Solutions
Today's Date	September 04, 2015
Compliance Status	Compliant
Questionnaire Status	Passing - SAQ D 3.0
Questionnaire Date	February 25, 2015
Scan Status	Passing
Scan Date	August 13, 2015
Next Scheduled Scan	November 13, 2015

This certificate is valid for NO MORE THAN 3 MONTHS from the scan date shown above, or 1 YEAR from the questionnaire date above, whichever comes first.

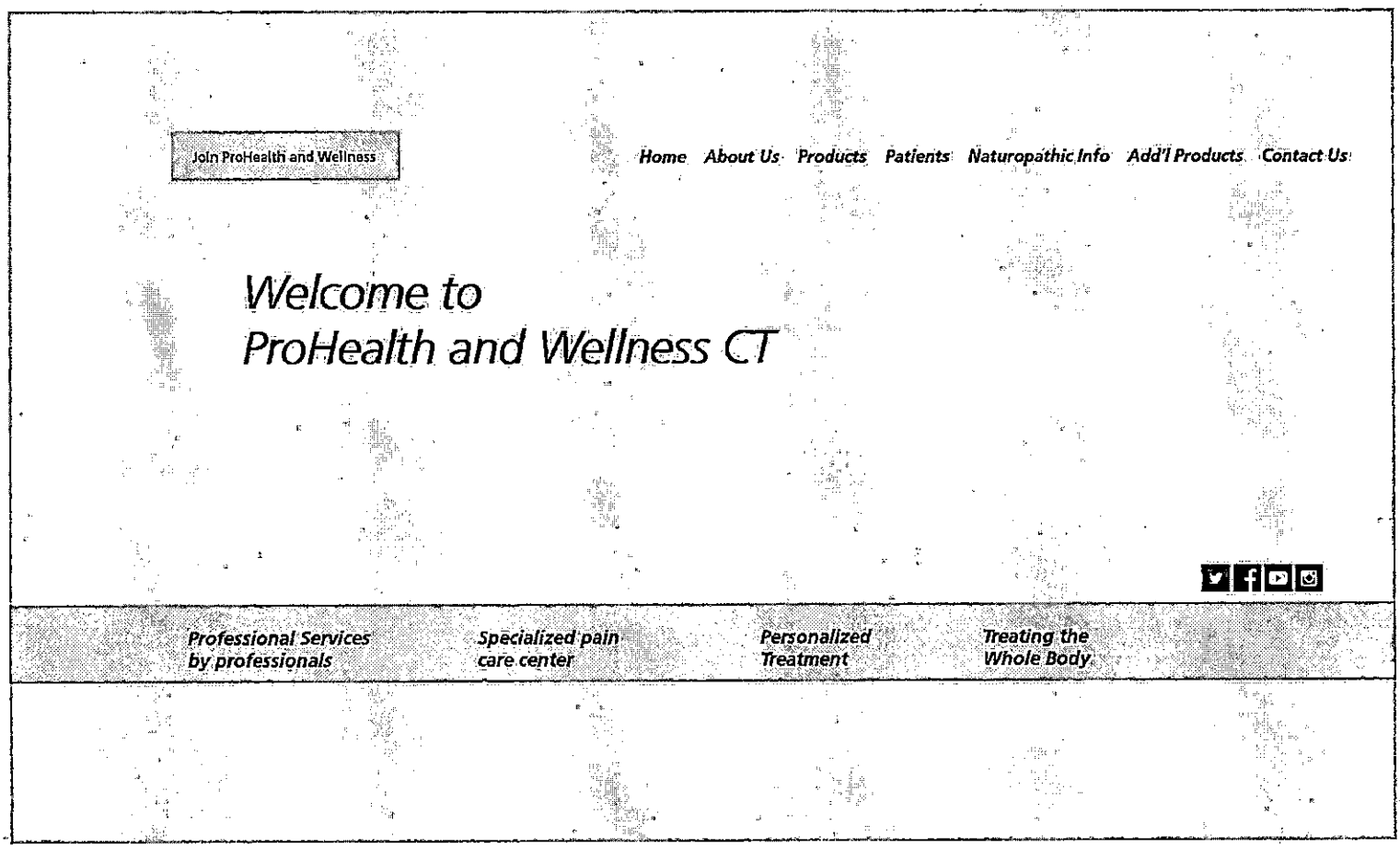
CONFIDENTIAL

securityMETRICS®

D1a

ProHealth and Wellness CT

972 Boston Post Road
Milford, CT 06460
917 330-9233

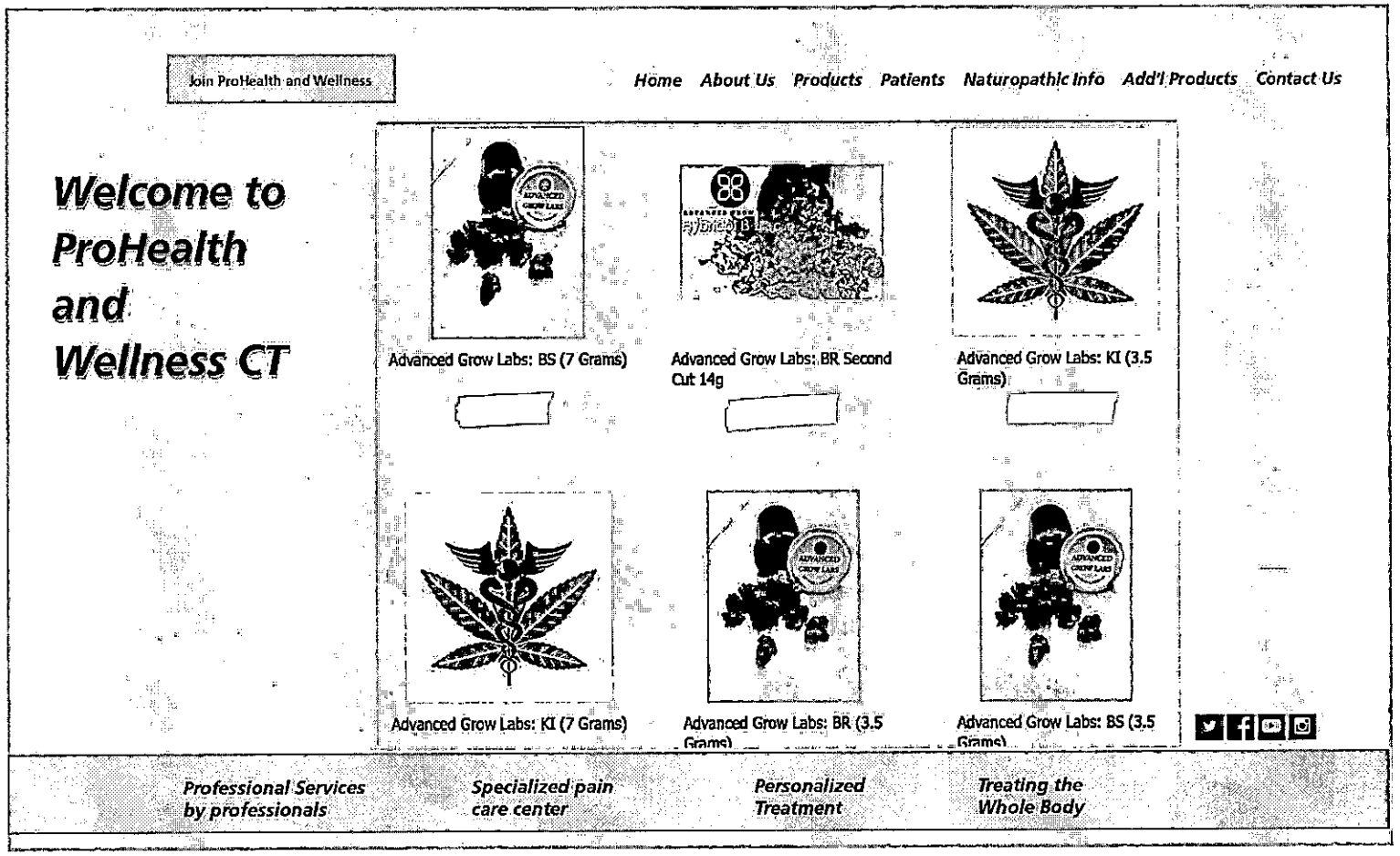


website image

D1b

ProHealth and Wellness CT

972 Boston Post Road
Milford, CT 06460
917 330-9233



website image

ProHealth and Wellness CT

972 Boston Post Road
Milford, CT 06460
917 330-9233

E. Financial Statements and Organizational Structure

1. LLC documents attached. As E1

2. Organization
   - **ProHealth and Wellness CT** is an LLC corporation registered in the State of Connecticut on Sept. 2 2015 by Steven Rand. It is wholly owned and financially secured by the applicant.
   - Organizational structure:
     - **Steven Rand** – owner – business operations, general oversight and compliance
     - **Jill Bebey** – Pharmacist and manager – prescribe and dispense medical marijuana as per regulation and oversee general operations in conjunction with owner

3. Steven Rand (owner) will be responsible for all information security requirements. Please see compliance certificate from *Proteus* our tracking software provider. All information is held off-site on Proteus certified compliant servers. See C8a and C8b

4.Compensation for pharmacist will total [redacted] per year initially and will include med. Insurance and a matching IRA ([redacted] per annum) Staff will get complimentary therapist, nutrition and physical training services. All staff gets [redacted] weeks and [redacted] floating days of paid vacation per year. Business will subsidize Affordable Care Act healthcare (approx. [redacted]/mo.) for all staff members after 3 mos.

5. ProHealth and Wellness CT has no indebtedness or obligations whatsoever.

6. certified financial statement attached as E6

7. pro forma financial

Build out		**125,000. 35/sq.ft**
POS terminals 3		REDACTED
safes		REDACTED
Cameras, recorders, phones		REDACTED
Furnishings		
Pharmacist retainer-2016		
Attorney services		
Location retainer-2016		
Monthly Costs		
Security/monitoring		
Liability insurance		
web/marketing/internet		
pharmacist		
staff		
proteus		
Rent (nnn)		
Taxes F.I.C.A/ workman's comp	REDACTED	
Utilities/mo.	REDACTED	
total	REDACTED	
Anticipated product cost per mo. First year	**Approx.**	REDACTED
Anticipated gross sales		REDACTED
Anticipated net profit		REDACTED

8. tax returns and other financial support documents attached as E8a-p

SECRETARY OF THE STATE OF CONNECTICUT

MAILING ADDRESS: COMMERCIAL RECORDING DIVISION, CONNECTICUT SECRETARY OF THE STATE, P.O. BOX 150470, HARTFORD, CT 06115-0470
DELIVERY ADDRESS: COMMERCIAL RECORDING DIVISION, CONNECTICUT SECRETARY OF THE STATE, 30 TRINITY STREET, HARTFORD, CT 06106
PHONE: 860-509-6003 WEBSITE: www.concord-sots.ct.gov

ARTICLES OF ORGANIZATION

LIMITED LIABILITY COMPANY - DOMESTIC

C.G.S. §§34-120; 34-121

USE INK. COMPLETE ALL SECTIONS. PRINT OR TYPE. ATTACH 81/2 X 11 SHEETS IF NECESSARY.

FILING PARTY *(CONFIRMATION WILL BE SENT TO THIS ADDRESS)*:
NAME: James J. D'Esposito; Bleckner P.C.
ADDRESS: 350 Fifth Avenue, Suite 6440
CITY: New York
STATE: NY ZIP: 10118

FILING FEE: $120
MAKE CHECKS PAYABLE TO "SECRETARY OF THE STATE"

1. NAME OF LIMITED LIABILITY COMPANY - REQUIRED: (MUST INCLUDE BUSINESS DESIGNATION I.E. LLC, L.L.C., ETC.)
ProHealth and Wellness CT LLC

2. DESCRIPTION OF BUSINESS TO BE TRANSACTED OR PURPOSE TO BE PROMOTED - REQUIRED:
ATTACH 81/2 X 11 SHEETS IF NECESSARY.
See Attachment

3. LLC'S PRINCIPAL OFFICE ADDRESS - REQUIRED: *(NO P.O. BOX)* PROVIDE FULL ADDRESS. "SAME AS ABOVE" NOT ACCEPTABLE.
ADDRESS: 39 Flag Swamp Road
CITY: Roxbury
STATE: CT ZIP: 06783

4. MAILING ADDRESS, IF DIFFERENT THAN #3: PROVIDE FULL ADDRESS. "SAME AS ABOVE" NOT ACCEPTABLE.
ADDRESS:
CITY:
STATE: ZIP:

5. APPOINTMENT OF STATUTORY AGENT FOR SERVICE OF PROCESS - REQUIRED: *(COMPLETE A OR B NOT BOTH)*
☒ **A. IF AGENT IS AN INDIVIDUAL.**
PRINT OR TYPE FULL LEGAL NAME:
Steven Rand

BUSINESS ADDRESS *(P.O. BOX NOT ACCEPTABLE) IF NONE, MUST STATE "NONE"*	**CONNECTICUT RESIDENCE ADDRESS** *(P.O. BOX NOT ACCEPTABLE)*
ADDRESS: 39 Flag Swamp Road	ADDRESS: 39 Flag Swamp Road
CITY: Roxbury	CITY: Roxbury
STATE: CT	STATE: CT
ZIP: 06783	ZIP: 06783

SIGNATURE ACCEPTING APPOINTMENT: Digitally signed by com.apple.idms.appleid.prd.546b4e4d6c466d75537059363 65a1465693866506d513d3d DN: cn=com.apple.idms.appleid.prd.546b4e4d6c466d75537059363653465693866506d513d3d Date: 2015.09.01 21:54:27 -05'00'

FORM LC-1-1.0
Rev. 1/1/2015

☐ **B. IF AGENT IS A BUSINESS:**
PRINT OR TYPE NAME OF BUSINESS AS IT APPEARS ON OUR RECORDS:

CT BUSINESS ADDRESS *(P.O.BOX UNACCEPTABLE)*

ADDRESS:

CITY:

STATE: ZIP:

SIGNATURE ACCEPTING APPOINTMENT ON BEHALF OF AGENT:

PRINT NAME & TITLE OF PERSON SIGNING:

6. MANAGER OR MEMBER INFORMATION-*REQUIRED:* *(MUST LIST AT LEAST ONE MANAGER OR MEMBER OF THE LLC.) ATTACH 81/2 X 11 SHEETS IF NECESSARY.*

NAME	TITLE	BUSINESS ADDRESS (No. P.O Box) *IF NONE, MUST STATE "NONE"*	RESIDENCE ADDRESS: (No. P.O Box)
Steven Rand	Manager	See Attached	See Attached

7. MANAGEMENT - PLACE A CHECK NEXT TO THE FOLLOWING STATEMENT ONLY IF IT APPLIES

☐ MANAGEMENT OF THE LIMITED LIABILITY COMPANY SHALL BE VESTED IN A MANAGER OR MANAGERS

8. ENTITY EMAIL ADDRESS-REQUIRED: *(IF NONE, MUST STATE "NONE.")*

Info@prohealthandwellnessct.com

9. EXECUTION: ***(SUBJECT TO PENALTY OF FALSE STATEMENT)***

DATED THIS 1st **DAY OF** September **, 20** 15

NAME OF ORGANIZER (PRINT OR TYPE)	SIGNATURE
James J. D'Esposito	

AN ANNUAL REPORT WILL BE DUE YEARLY IN THE ANNIVERSARY MONTH THAT THE ENTITY WAS FORMED/REGISTERED AND CAN BE EASILY FILED ONLINE @ www.concord-sots.ct.gov
CONTACT YOUR TAX ADVISOR OR THE TAXPAYER SERVICE CENTER AT THE DEPARTMENT OF REVENUE SERVICES AS TO ANY POTENTIAL TAX LIABILITY RELATING TO YOUR BUSINESS, INCLUDING QUESTIONS ABOUT THE BUSINESS ENTITY TAX.
TAX PAYER SERVICE CENTER: (800) 382-9463 OR (860) 297-5962 OR GO TO www.ct.gov/drs

ATTACHMENT TO ARTICLES OF ORGANIZATION

PROHEALTH AND WELLNESS CT LLC

2. DESCRIPTION OF BUSINESS TO BE TRANSACTED OR PURPOSE TO BE PROMOTED –

The purpose of the limited liability company is to engage in any lawful act or activity for which a limited liability company may be formed under the Connecticut Limited Liability Company Act.

6. MANAGER OR MEMBER INFORMATION –

Steven Rand, Manager

BUSINESS ADDRESS

39 Flag Swamp Road, Roxbury, CT 06783

RESIDENCE ADDRESS

39 Flag Swamp Road, Roxbury, CT 06783

ProHealth and Wellness CT

972 Boston Post Road
Milford, CT 06460
917 330-9233

Financial statements Pharmacist resume E2a

Jill Bebey, RPH
606 Cascade Drive Fairfield, CT 06825
Cellular: 203.520.4856 Email: jillbebey@gmail.com

Highly Experienced Registered Pharmacist with Specialty in Retail Settings

Summary of Qualifications

- Registered pharmacist with over 25 years' experience in all facets of retail pharmacy.
- Experienced retail salesperson known for exemplary customer service and team player mindset.
- Strong interpersonal skills and a commitment to a customer's positive sales experience.
- Focused and accomplished in up-selling and associated sales with all customer transactions.
- Experienced pharmacy educator with medical professionals and in community college, hospital and retail settings.
- Thorough knowledge of computerized drug-distribution systems, drug-utilization, evaluation, complex equipment and delivery systems, emerging medications, inventory management and regulations governing pharmacy services.
- Highly effective liaison between the healthcare team and the patient community to improve drug usage and therapeutic outcomes.
- Experienced patient counselor relied upon to develop close interpersonal and professional relationships.
- Managerial skills developed as staff supervisor and scheduler.
- Diabetes, respiratory and lactation educator.
- Skilled in compounding, narcotic prescription management, product reclamation and recall skills.
- Experienced in insurance processing, troubleshooting, reimbursement and audits, inventory control, durable medical equipment, supply chain and warehouse purchases.
- Key relationships with pharmaceutical community within a large professional network.
- Proven organizational and time management skills.
- Strong PC skills.

Professional Experience

Grieb's Pharmacy, Darien, CT 2001-present

Staff Pharmacist

Responsible for managing an independent retail community pharmacy, and ensuring effective and efficient operations.
Courteously greet customers and ensure the safe and accurate preparation of pharmaceutical sales, within busy, fast-paced pharmacy environment.
Build and maintain customer relationships.
Provide counsel and advice on prescription medicine compliancy, side effects and interactions.
Communicate with health care professionals, hospitals, long term care facilities and insurance companies regarding patient care and proper medication.
Monitor prescriptions through State of Connecticut PMP.
Detail monthly controlled substance reports.
Supervise the preparation and accountability of retail store physical inventory.

Consultant
USA Rx is a pharmacy discount card company.
Provide expertise and knowledge on various projects such as compiling the top medications per individual healthcare specialties throughout the USA.
Supply prescription drug price comparisons and overall pharmaceutical industry knowledge to USA Rx to enhance sales revenue.

Wilton Pharmacy, Wilton, CT
1997-2001
Staff Pharmacist
Managed retail pharmacy with a staff of 5 pharmacists and similar duties to above position at Grieb's Pharmacy.
Responsible for instituting breast pump rental, lactation support, The Flavor Rx program in addition to professional duties.

Arrow Prescription Center, Cos Cob, CT 1995-1997
Pharmacy Manager
Responsible for front store inventory and accounting, including bank deposits, and all managerial duties in addition to general pharmacist duties.

Greenwich Drug, Greenwich, CT
1993-1995
Staff Pharmacist

Palmer Professional Pharmacy, Greenwich, CT 1992-1993
Staff Pharmacist

Walgreens Pharmacy, Westport, CT 1990-1992
Staff Pharmacist
Recruited out of college by Walgreens Corporate to join Westport, CT retail pharmacy team.

Education

University of Rhode Island, Kingston, RI
Bachelor of Science, Pharmacy, 1990

Indiana University of Pennsylvania, Indiana, PA
Undergraduate Study, Pre-Pharmacy, 1985-1987

Continuing Education

University of Rhode Island, Kingston, RI
School of Pharmacy
Seminar by the Sea (on-going, yearly)
Update to all aspects of pharmacy industry

University of Connecticut, Storrs, CT
School of Pharmacy

Medical College
Advanced Nutrition Science and Education

Professional Organizations

APhA

CT Pharmacists Association

Greater Bridgeport Pharmacy Association

Northeast Pharmacy Corporation

Lambda Chi Alpha Pharmacy Sorority

ProHealth and Wellness CT

972 Boston Post Road
Milford, CT 06460
917 330-9233

Financial statements-Owner's resume **E3a**

1974 B.A. University of Buffalo
1976 M.A University of Arizona Tucson
1976-2007 artist, working with galleries in New York, Germany, Argentina, China

1985- 2000 owned company that did work for museums and art galleries- nine employees

1991- 2008 residential homes designer/builder

1994- present Executive Director Apexart Programs 291 Church Street a not-for profit educational organization with programs in more than 12 countries (primary funder) Lectures internationally.

2013- present Board member of ACE an economic development organizing rehabilitating disadvantaged men and women through training programs and educational opportunities. Annual donation of $20,000.

Supports many social service organizations through substantial donations.

ProHealth and Wellness CT

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Financial statements **E4a**

- ProHealth and Wellness CT will pay Jill Bebey, our pharmacist [redacted] per year. This will include her carrying her own E&O insurance and all other costs associated with her employment excluding F.I.C.A. and workman's comp.
- We provide a matching [redacted] per annum 401k
- Two weeks vacation with five paid personal/sick days
- After one year we will offer a profit sharing opportunity to Ms. Bebey

- There are no other agreements in place with anyone.

ProHealth and Wellness CT

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Financial statements **E5a**

- There are no debts, loans, bonds, deeds, pledges, lines of credit or any similar encumbrance regarding the applicant or this business venture.

- There are no other agreements in place with anyone regarding this business.

PROHEALTH AND WELLNESS CT LLC

FINANCIAL STATEMENTS

SEPTEMBER 13, 2015

PROHEALTH AND WELLNESS CT LLC

SEPTEMBER 13, 2015

TABLE OF CONTENTS

HOWARD SIMOWITZ
Certified Public Accountant
12330 Cascade Valley Lane
Boynton Beach, FL 33434
Tel. (561) 739-3617/ Fax (561) 336-2984

ACCOUNTANT'S REPORT

September 13, 2015

Member
Prohealth and Wellness CT LLC

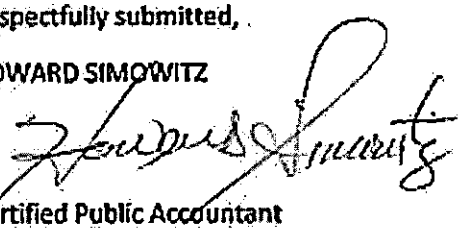
I have audited the accompanying balance sheet of Prohealth and Wellness CT LLC as of September 13, 2015 and the related statement of cash flows for the period then ended. These financial statements are the responsibility of the company's management. My responsibility is to express and opinion on these financial statements based on my audit.

I conducted the audit in accordance with generally accepted auditing standards generally accepted in the United States of America. Those standards require that I plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. I believe that my audit provides a reasonable basis for my opinion.

In my opinion, the financial statements referred to above present fairly in all material respects, the financial position of Prohealth and Wellness CT LLC. as of September 13, 2015 and the results of its cash flows for the period then ended in conformity with generally accounting principles generally accepted in the United States of America.

Respectfully submitted,

HOWARD SIMOWITZ



Certified Public Accountant
HS:lb

PROHEALTH AND WELLNESS CT LLC
BALANCE SHEET
SEPTEMBER 13, 2015

ASSETS

Cash In Bank	
TOTAL ASSETS	

LIABILITIES

None	-
MEMBER'S EQUITY	

The accompanying Accountant's Report and Notes are an intergarl part of these Financial Statements

PROHEALTH AND WELLNESS CT LLC
STATEMENT OF CASH FLOWS
FROM INCEPTION SEPTEMBER 2, 2015 TO SEPTEMBER 13, 2015

CASH FLOWS FOR OPERATING ACTIVITIES	
Net Income	-
NET CASH PROVIDED BY OPERATING ACTIVITIES	-
CASH FLOWS PROVIDED BY FINANCING ACTIVITIES	
Increase in Member's Equity	-
NET CASH PROVIDED BY FINANCING ACTIVITIES	-
NET INCREASE IN CASH	-
CASH AT INCEPTION- SEPTEMBER 2, 2015	-
CASH-SEPTEMBER 13, 2015	-

The accompanying Accountant's Report and Notes are an intergarl part of these Financial Statements

PROHEALTH AND WELLNESS CT LLC

NOTES TO FINANCIAL STATEMENTS

SEPTEMBER 13, 2015

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Business Activity – Prohealth and Wellness CT LLC was formed under the Laws of Connecticut on September 2, 2015 for the sole purpose of retail sales of medical marijuana.

Income Taxes – The LLC will file its tax return as part of the individual's income tax return on its 100% member owner.

Operations-There have been no business operations from its inception on September 2, 2015 to September 13, 2015, the date of these financial statements.

ProHealth and Wellness CT

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Milford, CT 06460
917 330-9233

E7. Pro forma financials

1. LLC documents attached. As E1

2. Organization
   - **ProHealth and Wellness CT** is an LLC corporation registered in the State of Connecticut on Sept. 2 2015 by Steven Rand. It is wholly owned and financially secured by the applicant.
   - Organizational structure:
     - **Steven Rand** – owner – business operations, general oversight and compliance
     - **Jill Bebey** – Pharmacist and manager – prescribe and dispense medical marijuana as per regulation and oversee general operations in conjunction with owner

3. Steven Rand (owner) will be responsible for all information security requirements. Please see compliance certificate from *Proteus* our tracking software provider. All information is held off-site on Proteus certified compliant servers. See C8a and C8b

4.Compensation for pharmacist will total [redacted] per year initially and will include med. Insurance and a matching IRA [redacted] per annum) Staff will get complimentary therapist, nutrition and physical training services. All staff gets [redacted] weeks and [redacted] floating days of paid vacation per year. Business will subsidize Affordable Care Act healthcare (approx. [redacted]) for all staff members after 3 mos.

5. ProHealth and Wellness CT has no indebtedness or obligations whatsoever.

6. certified financial statement attached as E6

7. pro forma financial

Build out		**125,000. 35/sq.ft**
POS terminals 3		REDACTED REDACTED REDACTED
safes		
Cameras, recorders, phones		
Furnishings		
Pharmacist retainer-2016		
Attorney services		
Location retainer-2016		
Monthly Costs		
Security/monitoring	REDACTED REDACTED REDACTED	
Liability insurance		
web/marketing/internet		
pharmacist		
staff		
proteus		
Rent (nnn)		
Taxes F.I.C.A/ workman's comp		
Utilities/mo.		
total		REDACTED
		REDACTED
Anticipated product cost per mo. First year	**Approx. 90,000./mo**	REDACTED
Anticipated gross sales		REDACTED
Anticipated net profit		REDACTED
		REDACTED

8. tax returns and other financial support documents attached as E8a-p

ProHealth and Wellness CT

972 Boston Post Road
Milford, CT 06460
917 330-9233

Note regarding Assets of Steven Rand **E6**

- Tax returns for the previous 3 years 2012,13,and 14 are attached but are not indicative of my assets.
- Net assets are approx.
- Substantiated by attached real estate holdings and two of my brokerage accounts holding more than in liquid assets.
- Salary is from not-for profit organization applicant founded in 1994 by me and is necessary for me to qualify for medical insurance through the organization. It is a token salary.
- My assets more than qualify me to run the organization with no chance of compromise.
- My accountant is available for any questions regarding the above: Howard Simowitz 973 223-1003 (mobile) or 561 336-2984
  I am also available at 917 330-9233 to answer any questions.

Form **1040** U.S. Individual Income Tax Return (99) **2012** OMB No. 1545-0074 IRS Use Only - Do not write or staple in this space.

For the year Jan. 1-Dec. 31, 2012, or other tax year beginning , 2012, ending , 20 See separate instructions.

Your first name and initial	Last name	Your social security number
STEVEN J.	RAND	[redacted]
If a joint return, spouse's first name and initial	Last name	Spouse's social security number

Home address (number and street). If you have a P.O. box, see instructions. Apt. no.
291 CHURCH STREET

Make sure the SSN(s) above and on line 6c are correct.

City, town or post office, state, and ZIP code. If you have a foreign address, also complete spaces below.
NEW YORK, NY 10013

Presidential Election Campaign
Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund.
☐ You ☐ Spouse

Foreign country name | Foreign province/state/county | Foreign postal code

Filing Status Check only one box.
1 [X] Single
2 [ ] Married filing jointly (even if only one had income)
3 [ ] Married filing separately. Enter spouse's SSN above and full name here. ▶
4 [ ] Head of household (with qualifying person). If the qualifying person is a child but not your dependent, enter this child's name here. ▶
5 [ ] Qualifying widow(er) with dependent child

Exemptions
6a [X] Yourself. If someone can claim you as a dependent, do not check box 6a
b [ ] Spouse
Boxes checked on 6a and 6b: 1
No. of children on 6c who:
• lived with you
• did not live with you due to divorce or separation (see instructions)
Dependents on 6c not entered above
Add numbers on lines above ▶: 1

c Dependents:

(1) First name / Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) ✓ if child under age 17 qualifying for child tax credit

If more than four dependents, see instructions and check here ▶ ☐

d Total number of exemptions claimed: 1

Income
Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.
If you did not get a W-2, see instructions.
Enclose, but do not attach, any payment. Also, please use Form 1040-V.

7	Wages, salaries, tips, etc. Attach Form(s) W-2		7	
8a	Taxable interest. Attach Schedule B if required		8a	
b	Tax-exempt interest. Do not include on line 8a	8b		
9a	Ordinary dividends. Attach Schedule B if required		9a	
b	Qualified dividends	9b		
10	Taxable refunds, credits, or offsets of state and local income taxes		10	
11	Alimony received		11	
12	Business income or (loss). Attach Schedule C or C-EZ		12	
13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ ☐		13	
14	Other gains or (losses). Attach Form 4797		14	
15a	IRA distributions 15a	b Taxable amount	15b	
16a	Pensions and annuities 16a	b Taxable amount	16b	
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E		17	
18	Farm income or (loss). Attach Schedule F		18	
19	Unemployment compensation		19	
20a	Social security benefits 20a	b Taxable amount	20b	
21	Other income. List type and amount		21	
22	Combine the amounts in the far right column for lines 7 through 21. This is your total income ▶		22	

Adjusted Gross Income

23	Educator expenses	23		
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24		
25	Health savings account deduction. Attach Form 8889	25		
26	Moving expenses. Attach Form 3903	26		
27	Deductible part of self-employment tax. Attach Schedule SE	27		
28	Self-employed SEP, SIMPLE, and qualified plans	28		
29	Self-employed health insurance deduction	29		
30	Penalty on early withdrawal of savings	30		
31a	Alimony paid b Recipient's SSN ▶	31a		
32	IRA deduction	32		
33	Student loan interest deduction	33		
34	Tuition and fees. Attach Form 8917	34		
35	Domestic production activities deduction. Attach Form 8903	35		
36	Add lines 23 through 35		36	
37	Subtract line 36 from line 22. This is your adjusted gross income ▶		37	

Tax and Credits	38	Amount from line 37 (adjusted gross income)		38
Standard Deduction for - • People who check any box on line 39a or 39b or who can be claimed as a dependent. • All others: Single or Married filing separately, $5,950 Married filing jointly or Qualifying widow(er), $11,900 Head of household, $8,700	39a	Check { ☐ You were born before January 2, 1948, ☐ Blind. ☐ Spouse was born before January 2, 1948, ☐ Blind. } Total boxes checked ▶ 39a		
	b	If your spouse itemizes on a separate return or you were a dual-status alien, check here ▶ 39b ☐		
	40	Itemized deductions (from Schedule A) or your standard deduction (see left margin)		40
	41	Subtract line 40 from line 38		41
	42	Exemptions. Multiply $3,800 by the number on line 6d		42
	43	Taxable income. Subtract line 42 from line 41. If line 42 is more than line 41, enter -0-		43
	44	Tax. Check if any from: a ☐ Form(s) 8814 b ☐ Form 4972 c ☐ 962 election		44
	45	Alternative minimum tax. Attach Form 6251		45
	46	Add lines 44 and 45 ▶		46
	47	Foreign tax credit. Attach Form 1116 if required	47	
	48	Credit for child and dependent care expenses. Attach Form 2441	48	
	49	Education credits from Form 8863, line 19	49	
	50	Retirement savings contributions credit. Attach Form 8880	50	
	51	Child tax credit. Attach Schedule 8812, if required	51	
	52	Residential energy credits. Attach Form 5695	52	
	53	Other credits from Form: a ☐ 3800 b ☐ 8801 c ☐	53	
	54	Add lines 47 through 53. These are your total credits		54
	55	Subtract line 54 from line 46. If line 54 is more than line 46, enter -0- ▶		55
Other Taxes	56	Self-employment tax. Attach Schedule SE		56
	57	Unreported social security and Medicare tax from Form: a ☐ 4137 b ☐ 8919		57
	58	Additional tax on IRAs, other qualified retirement plans, etc. Attach Form 5329 if required		58
	59a	Household employment taxes from Schedule H		59a
	b	First-time homebuyer credit repayment. Attach Form 5405 if required		59b
	60	Other taxes. Enter code(s) from instructions		60
	61	Add lines 55 through 60. This is your total tax ▶		61
Payments	62	Federal income tax withheld from Forms W-2 and 1099	62	
	63	2012 estimated tax payments and amount applied from 2011 return	63	
If you have a qualifying child, attach Schedule EIC.	64a	Earned income credit (EIC)	64a	
	b	Nontaxable combat pay election 64b		
	65	Additional child tax credit. Attach Schedule 8812	65	
	66	American opportunity credit from Form 8863, line 8	66	
	67	Reserved	67	
	68	Amount paid with request for extension to file	68	
	69	Excess social security and tier 1 RRTA tax withheld	69	
	70	Credit for federal tax on fuels. Attach Form 4136	70	
	71	Credits from Form: a ☐ 2439 b ☐ Reserved c ☐ 8801 d ☐ 8885	71	
	72	Add lines 62, 63, 64a, and 65 through 71. These are your total payments ▶		72
Refund	73	If line 72 is more than line 61, subtract line 61 from line 72. This is the amount you overpaid		73
	74a	Amount of line 73 you want refunded to you. If Form 8888 is attached, check here ▶ ☐		74a
Direct deposit? See instructions. ▶	b	Routing number [redacted] ▶ c Type: ☐ Checking ☐ Savings ▶ d Account number [redacted]		
	75	Amount of line 73 you want applied to your 2013 estimated tax ▶	75	
Amount You Owe	76	Amount you owe. Subtract line 72 from line 61. For details on how to pay, see instructions ▶		76
	77	Estimated tax penalty (see instructions)	77	

Third Party Designee Do you want to allow another person to discuss this return with the IRS (see instructions)? [X] Yes. Complete below. ☐ No

Designee's name ▶ HOWARD SIMOWITZ Phone no. ▶ Personal identification number (PIN) ▶

Sign Here Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Joint return? See instructions. Keep a copy for your records.

Your signature	Date	Your occupation	Daytime phone number
Spouse's signature. If a joint return, both must sign.	Date	Spouse's occupation	If the IRS sent you an Identity Protection PIN, enter it here

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check [X] if self-employed	PTIN
HOWARD SIMOWITZ		03/22/13		

Firm's name ▶ HOWARD SIMOWITZ CPA Firm's EIN ▶

Firm's address ▶ 20742 NW 29TH AVENUE BOCA RATON, FL 33434 Phone no.

2012

New York State Department of Taxation and Finance

Resident Income Tax Return

New York State • New York City • Yonkers

IT-201

For the full year January 1, 2012, through December 31, 2012, or fiscal year beginning ...
and ending ...

For help completing your return, see the instructions, Form IT-201-I.

Your first name and middle initial	Your last name (for a joint return, enter spouse's name on line below)	Your date of birth (mm-dd-yyyy)	Your social security number
STEVEN J	RAND		[redacted]
Spouse's first name and middle initial	Spouse's last name	Spouse's date of birth (mm-dd-yyyy)	Spouse's social security number

Mailing address (see instructions, page 12) (number and street or rural route)	Apartment number	New York State county of residence
291 CHURCH STREET		NY
City, village, or post office	**State ZIP code** / **Country (if not United States)**	**School district name**
NEW YORK	NY 10013	MANHATTAN

Permanent home address (see instructions, page 12) (number and street or rural route) — Apartment number — School district code number

City, village, or post office — State: NY — ZIP code — Decedent information — Taxpayer's date of death — Spouse's date of death

A Filing status (mark an X in one box):

1. [X] Single — NEW
2. [ ] Married filing joint return (enter spouse's social security number above)
3. [ ] Married filing separate return (enter spouse's social security number above)
4. [ ] Head of household (with qualifying person)
5. [ ] Qualifying widow(er) with dependent child

B Did you itemize your deductions on your 2012 federal income tax return? ..... Yes [X] No [ ]

C Can you be claimed as a dependent on another taxpayer's federal return? ..... Yes [ ] No [X]

D Did you have a financial account located in a foreign country? *(see page 13)* ... Yes [ ] No [X]

E (1) Did you or your spouse maintain living quarters in NYC during 2012? *(see pg 13)* ... Yes [ ] No [ ]

(2) Enter the number of days spent in NYC in 2012 *(any part of a day spent in NYC is considered a day)*

F NYC residents and NYC part-year residents only *(see page 13)*:

(1) Number of months you lived in NYC in 2012 .....

(2) Number of months your spouse lived in NYC in 2012 .....

G Enter your 2-character special condition code if applicable *(see page 13)* .....

If applicable, also enter your second 2-character special condition code .....

H Dependent exemption information *(see page 14)*

First name and middle initial	Last name	Relationship	Social security number	Date of birth (mm-dd-yyyy)

COPY

If more than 9 dependents, mark an X in the box. [ ]

201001121019

Your social security number [redacted]

Federal income and adjustments *(see page 14)*

Whole dollars only

1	Wages, salaries, tips, etc.	1
2	Taxable interest income	2
3	Ordinary dividends	3
4	Taxable refunds, credits, or offsets of state and local income taxes *(also enter on line 25)*	4
5	Alimony received	5
6	Business income or loss *(submit a copy of federal Schedule C or C-EZ, Form 1040)*	6
7	Capital gain or loss *(if required, submit a copy of federal Schedule D, Form 1040)*	7
8	Other gains or losses *(submit a copy of federal Form 4797)*	8
9	Taxable amount of IRA distributions. If received as a beneficiary, mark an X in the box ☐	9
10	Taxable amount of pensions and annuities. If received as a beneficiary, mark an X in the box ☐	10
11	Rental real estate, royalties, partnerships, S corporations, trusts, etc. (submit copy of federal Schedule E, Form 1040)	11
12	Rental real estate included in line 11 — 12	
13	Farm income or loss *(submit a copy of federal Schedule F, Form 1040)*	13
14	Unemployment compensation	14
15	Taxable amount of social security benefits *(also enter on line 27)*	15
16	Other income *(see page 14) Identify:*	16
17	Add lines 1 through 11 and 13 through 16	17
18	Total federal adjustments to income *(see page 14) Identify:*	18
19	Federal adjusted gross income *(subtract line 18 from line 17)*	19

New York additions *(see page 14)*

20	Interest income on state and local bonds and obligations (but not those of NYS or its local governments)	20
21	Public employee 414(h) retirement contributions from your wage and tax statements *(see page 15)*	21
22	New York's 529 college savings program distributions *(see page 15)*	22
23	Other *(see page 16) Identify:*	23
24	Add lines 19 through 23	24

New York subtractions *(see page 19)*

25	Taxable refunds, credits, or offsets of state and local income taxes (from line 4)	25
26	Pensions of NYS and local governments and the federal government *(see page 19)*	26
27	Taxable amount of social security benefits *(from line 15)*	27
28	Interest income on U.S. government bonds	28
29	Pension and annuity income exclusion *(see page 19)*	29
30	New York's 529 college savings program deduction/earnings	30
31	Other *(see page 20) Identify:*	31
32	Add lines 25 through 31	32
33	New York adjusted gross income *(subtract line 32 from line 24)*	33

Standard deduction or itemized deduction *(see page 24)*

34	Enter your standard deduction *(table on page 24)* or your itemized deduction *(from Form IT-201-D)* Mark an X in the appropriate box: ☐ Standard - or - ☒ Itemized	34
35	Subtract line 34 from line 33 *(if line 34 is more than line 33, leave blank)*	35
36	Dependent exemptions *(not the same as total federal exemptions; see page 24)*	36
37	Taxable income *(subtract line 36 from line 35)*	37

201002121019

1040 U.S. Individual Income Tax Return 2013

OMB No. 1545-0074 | IRS Use Only - Do not write or staple in this space.

For the year Jan. 1-Dec. 31, 2013, or other tax year beginning , 2013, ending , 20 | See separate instructions.

Your first name and initial: STEVEN J.	Last name: RAND
Your social security number: [redacted]	
If a joint return, spouse's first name and initial	Last name
Spouse's social security number	
Home address (number and street). If you have a P.O. box, see instructions. 291 CHURCH STREET	Apt. no.
Make sure the SSN(s) above and on line 6c are correct.	
City, town or post office, state, and ZIP code. If you have a foreign address, also complete spaces below. NEW YORK, NY 10013	Presidential Election Campaign: Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund. ☐ You ☐ Spouse
Foreign country name / Foreign province/state/county / Foreign postal code	

Filing Status Check only one box.

1 [X] Single
2 [ ] Married filing jointly (even if only one had income)
3 [ ] Married filing separately. Enter spouse's SSN above and full name here. ▶
4 [ ] Head of household (with qualifying person). If the qualifying person is a child but not your dependent, enter this child's name here. ▶
5 [ ] Qualifying widow(er) with dependent child

Exemptions

6a [X] Yourself. If someone can claim you as a dependent, do not check box 6a. Boxes checked on 6a and 6b: No. of children on 6c who:
b [ ] Spouse
c Dependents:

(1) First name / Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) ✓ if child under 17 qualifying for child tax credit (see instructions)

If more than four dependents, see instructions and check here ▶ [ ]

COPY

- lived with you
- did not live with you due to divorce or separation (see instructions)

Dependents on 6c not entered above:

Add numbers on lines above ▶

d Total number of exemptions claimed

Income

Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.

If you did not get a W-2, see instructions.

7	Wages, salaries, tips, etc. Attach Form(s) W-2			7	
8a	Taxable interest. Attach Schedule B if required			8a	
b	Tax-exempt interest. Do not include on line 8a	8b			
9a	Ordinary dividends. Attach Schedule B if required			9a	
b	Qualified dividends	9b			
10	Taxable refunds, credits, or offsets of state and local income taxes			10	
11	Alimony received			11	
12	Business income or (loss). Attach Schedule C or C-EZ			12	
13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ [ ]			13	
14	Other gains or (losses). Attach Form 4797			14	
15a	IRA distributions	15a	b Taxable amount	15b	
16a	Pensions and annuities	16a	b Taxable amount	16b	
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E			17	
18	Farm income or (loss). Attach Schedule F			18	
19	Unemployment compensation			19	
20a	Social security benefits	20a	b Taxable amount	20b	
21	Other income. List type and amount			21	
22	Combine the amounts in the far right column for lines 7 through 21. This is your total income ▶			22	

Adjusted Gross Income

23	Educator expenses	23	
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24	
25	Health savings account deduction. Attach Form 8889	25	
26	Moving expenses. Attach Form 3903	26	
27	Deductible part of self-employment tax. Attach Schedule SE	27	
28	Self-employed SEP, SIMPLE, and qualified plans	28	
29	Self-employed health insurance deduction	29	
30	Penalty on early withdrawal of savings	30	
31a	Alimony paid b Recipient's SSN ▶	31a	
32	IRA deduction	32	
33	Student loan interest deduction	33	
34	Tuition and fees. Attach Form 8917	34	
35	Domestic production activities deduction. Attach Form 8903	35	
36	Add lines 23 through 35		36
37	Subtract line 36 from line 22. This is your adjusted gross income ▶		37

Form 1040 (2013) STEVEN J. RAND [redacted] Page 2

Tax and Credits	38	Amount from line 37 (adjusted gross income)		38	
Standard Deduction for— • People who check any box on line 39a or 39b or who can be claimed as a dependent, see instructions. • All others: Single or Married filing separately, $6,100 Married filing jointly or Qualifying widow(er), $12,200 Head of household, $8,950	39a	Check { ☐ You were born before January 2, 1949, ☐ Blind. ☐ Spouse was born before January 2, 1949, ☐ Blind. } Total boxes checked ▶ 39a			
	b	If your spouse itemizes on a separate return or you were a dual-status alien, check here ▶ 39b ☐			
	40	Itemized deductions (from Schedule A) or your standard deduction (see left margin)		40	
	41	Subtract line 40 from line 38		41	
	42	Exemptions. If line 38 is $150,000 or less, multiply $3,900 by the number on line 6d. Otherwise, see inst.		42	
	43	Taxable income. Subtract line 42 from line 41. If line 42 is more than line 41, enter -0-		43	
	44	Tax. Check if any from: a ☐ Form(s) 8814 b ☐ Form 4972 c ☐		44	
	45	Alternative minimum tax. Attach Form 6251		45	
	46	Add lines 44 and 45 ▶		46	
	47	Foreign tax credit. Attach Form 1116 if required	47		
	48	Credit for child and dependent care expenses. Attach Form 2441	48		
	49	Education credits from Form 8863, line 19	49		
	50	Retirement savings contributions credit. Attach Form 8880	50		
	51	Child tax credit. Attach Schedule 8812, if required	51		
	52	Residential energy credits. Attach Form 5695	52		
	53	Other credits from Form: a ☐ 3800 b ☐ 8801 c ☐	53		
	54	Add lines 47 through 53. These are your total credits		54	
	55	Subtract line 54 from line 46. If line 54 is more than line 46, enter -0- ▶		55	
Other Taxes	56	Self-employment tax. Attach Schedule SE		56	
	57	Unreported social security and Medicare tax from Form: a ☐ 4137 b ☐ 8919		57	
	58	Additional tax on IRAs, other qualified retirement plans, etc. Attach Form 5329 if required		58	
	59a	Household employment taxes from Schedule H		59a	
	b	First-time homebuyer credit repayment. Attach Form 5405 if required		59b	
	60	Taxes from: a ☐ Form 8959 b ☐ Form 8960 c ☐ Inst; enter code(s)		60	
	61	Add lines 55 through 60. This is your total tax ▶		61	
Payments	62	Federal income tax withheld from Forms W-2 and 1099	62		
	63	2013 estimated tax payments and amount applied from 2012 return	63		
If you have a qualifying child, attach Schedule EIC.	64a	Earned income credit (EIC)	64a		
	b	Nontaxable combat pay election 64b			
	65	Additional child tax credit. Attach Schedule 8812	65		
	66	American opportunity credit from Form 8863, line 8	66		
	67	Reserved	67		
	68	Amount paid with request for extension to file	68		
	69	Excess social security and tier 1 RRTA tax withheld	69		
	70	Credit for federal tax on fuels. Attach Form 4136	70		
	71	Credits from Form: a ☐ 2439 b ☐ Reserved ☐ 8885 d ☐	71		
	72	Add lines 62, 63, 64a, and 65 through 71. These are your total payments ▶		72	
Refund	73	If line 72 is more than line 61, subtract line 61 from line 72. This is the amount you overpaid		73	
	74a	Amount of line 73 you want refunded to you. If Form 8888 is attached, check here ▶ ☐		74a	
Direct deposit? See instructions. ▶	b	Routing number ▶ c Type: ☐ Checking ☐ Savings ▶ d Account number			
	75	Amount of line 73 you want applied to your 2014 estimated tax ▶	75		
Amount You Owe	76	Amount you owe. Subtract line 72 from line 61. For details on how to pay, see instructions ▶		76	
	77	Estimated tax penalty (see instructions)	77		

Third Party Designee Do you want to allow another person to discuss this return with the IRS (see instructions)? [X] Yes. Complete below. ☐ No

Designee's name ▶ HOWARD SIMOWITZ Phone no. ▶ Personal identification number (PIN) ▶

Sign Here Joint return? See instructions. Keep a copy for your records.

Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Your signature	Date	Your occupation	Daytime phone number
Spouse's signature. If a joint return, both must sign.	Date	Spouse's occupation	If the IRS sent you an Identity Protection PIN, enter it here

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check [X] if self-employed	PTIN
HOWARD SIMOWITZ		04/07/14		

Firm's name ▶ HOWARD SIMOWITZ CPA Firm's EIN

Firm's address ▶ 20742 NW 29TH AVENUE BOCA RATON, FL 33434 Phone

Form 1040 (2013)

New York State Department of Taxation and Finance

2013 Resident Income Tax Return

New York State • New York City • Yonkers

IT-201

For the full year January 1, 2013, through December 31, 2013, or fiscal year beginning ____ and ending ____

For help completing your return, see the instructions, Form IT-201-I.

Your first name and middle initial	Your last name (for a joint return, enter spouse's name on line below)	Your date of birth (mm-dd-yyyy)	Your social security number
STEVEN J	RAND		[redacted]
Spouse's first name and middle initial	Spouse's last name	Spouse's date of birth (mm-dd-yyyy)	Spouse's social security number

Mailing address (see instructions, page 12) (number and street or rural route)	Apartment number	New York State county of residence
291 CHURCH STREET		NY

City, village, or post office	State	ZIP code	Country (if not United States)	School district name
NEW YORK	NY	10013		MANHATTAN

Taxpayer's permanent home address (see instructions, page 12) (number and street or rural route)	Apartment number	School district code number

City, village, or post office	State	ZIP code	Decedent (deceased)	Taxpayer's date of death	Spouse's date of death
	NY				

A Filing status (mark an X in one box)

1. [X] Single
2. [ ] Married filing joint return (enter spouse's social security number above)
3. [ ] Married filing separate return (enter spouse's social security number above)
4. [ ] Head of household (with qualifying person)
5. [ ] Qualifying widow(er) with dependent child

B Did you itemize your deductions on your 2013 federal income tax return? ..... Yes [X] No [ ]

C Can you be claimed as a dependent on another taxpayer's federal return? ..... Yes [ ] No [X]

D Did you have a financial account located in a foreign country? (see page 13) ... Yes [ ] No [X]

E (1) Did you or your spouse maintain living quarters in NYC during 2013? (see pg 13) ... Yes [ ] No [ ]

(2) Enter the number of days spent in NYC in 2013 (any part of a day spent in NYC is considered a day) [ ]

F NYC residents and NYC part-year residents only (see page 13):

(1) Number of months you lived in NYC in 2013 ..... [ ]

(2) Number of months your spouse lived in NYC in 2013 ..... [ ]

G Enter your 2-character special condition code if applicable (see page 13) ..... [ ]

If applicable, also enter your second 2-character special condition code ..... [ ]

H Dependent exemption information (see page 14)

First name and middle initial	Last name	Relationship	Social security number	Date of birth (mm-dd-yyyy)

If more than 9 dependents, mark an X in the box. [ ]

Your social security number [redacted]

Federal income and adjustments *(see page 14)*

Whole dollars only

1	Wages, salaries, tips, etc.	1	
2	Taxable interest income	2	
3	Ordinary dividends	3	
4	Taxable refunds, credits, or offsets of state and local income taxes *(also enter on line 25)*	4	
5	Alimony received	5	
6	Business income or loss *(submit a copy of federal Schedule C or C-EZ, Form 1040)*	6	
7	Capital gain or loss *(if required, submit a copy of federal Schedule D, Form 1040)*	7	
8	Other gains or losses *(submit a copy of federal Form 4797)*	8	
9	Taxable amount of IRA distributions. If received as a beneficiary, mark an X in the box	9	
10	Taxable amount of pensions and annuities. If received as a beneficiary, mark an X in the box	10	
11	Rental real estate, royalties, partnerships, S corporations, trusts, etc. *(submit copy of federal Schedule E, Form 1040)*	11	
12	Rental real estate included in line 11	12	
13	Farm income or loss *(submit a copy of federal Schedule F, Form 1040)*	13	
14	Unemployment compensation	14	
15	Taxable amount of social security benefits *(also enter on line 27)*	15	
16	Other income *(see page 14)* Identify:	16	
17	Add lines 1 through 11 and 13 through 16	17	
18	Total federal adjustments to income *(see page 14)* Identify:	18	
19	Federal adjusted gross income *(subtract line 18 from line 17)*	19	

New York additions *(see page 14)*

20	Interest income on state and local bonds and obligations (but not those of NYS or its local governments)	20	
21	Public employee 414(h) retirement contributions from your wage and tax statements *(see page 15)*	21	
22	New York's 529 college savings program distributions *(see page 15)*	22	
23	Other *(see page 16)* Identify:	23	
24	Add lines 19 through 23	24	

New York subtractions *(see page 19)*

25	Taxable refunds, credits, or offsets of state and local income taxes (from line 4)	25		
26	Pensions of NYS and local governments and the federal government *(see page 19)*	26		
27	Taxable amount of social security benefits *(from line 15)*	27		
28	Interest income on U.S. government bonds	28		
29	Pension and annuity income exclusion *(see page 19)*	29		
30	New York's 529 college savings program deduction/earnings	30		
31	Other *(see page 20)* Identify:	31		
32	Add lines 25 through 31		32	
33	New York adjusted gross income *(subtract line 32 from line 24)*		33	

Standard deduction or itemized deduction *(see page 24)*

34	Enter your standard deduction *(table on page 24)* or your itemized deduction *(from Form IT-201-D)* Mark an X in the appropriate box: ☐ Standard - or - ☒ Itemized	34	
35	Subtract line 34 from line 33 *(if line 34 is more than line 33, leave blank)*	35	
36	Dependent exemptions *(not the same as total federal exemptions; see page 24)*	36	
37	Taxable income *(subtract line 36 from line 35)*	37	

Form **1040** U.S. Individual Income Tax Return (99) **2014** OMB No. 1545-0074 IRS Use Only - Do not write or staple in this space.

For the year Jan. 1-Dec. 31, 2014, or other tax year beginning , 2014, ending , 20 See separate instructions.

Your first name and initial	Last name	Your social security number
STEVEN J.	RAND	[redacted]
If a joint return, spouse's first name and initial	Last name	Spouse's social security number

Home address (number and street). If you have a P.O. box, see instructions. Apt. no.
291 CHURCH STREET

▲ Make sure the SSN(s) above and on line 6c are correct.

City, town or post office, state, and ZIP code. If you have a foreign address, also complete spaces below.
NEW YORK, NY 10013

Foreign country name | Foreign province/state/county | Foreign postal code

Presidential Election Campaign
Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund.
☐ You ☐ Spouse

Filing Status Check only one box.
1 [X] Single
2 [ ] Married filing jointly (even if only one had income)
3 [ ] Married filing separately. Enter spouse's SSN above and full name here. ▶
4 [ ] Head of household (with qualifying person). If the qualifying person is a child but not your dependent, enter this child's name here. ▶
5 [ ] Qualifying widow(er) with dependent child

Exemptions
6a [X] Yourself. If someone can claim you as a dependent, do not check box 6a. Boxes checked on 6a and 6b
b [ ] Spouse No. of children on 6c who:
c Dependents:

(1) First name / Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) ✓ if child qualifying for child tax credit (see instructions)

• lived with you
• did not live with you due to divorce or separation (see instructions)
Dependents on 6c not entered above
Add numbers on lines above ▶
If more than four dependents, see instructions and check here ▶ [ ]
d Total number of exemptions claimed.

COPY

Income
Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.
If you did not get a W-2, see instructions.

7	Wages, salaries, tips, etc. Attach Form(s) W-2			7
8a	Taxable interest. Attach Schedule B if required			8a
b	Tax-exempt interest. Do not include on line 8a	8b		
9a	Ordinary dividends. Attach Schedule B if required			9a
b	Qualified dividends	9b		
10	Taxable refunds, credits, or offsets of state and local income taxes			10
11	Alimony received			11
12	Business income or (loss). Attach Schedule C or C-EZ			12
13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ [ ]			13
14	Other gains or (losses). Attach Form 4797			14
15a	IRA distributions 15a		b Taxable amount	15b
16a	Pensions and annuities 16a		b Taxable amount	16b
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E			17
18	Farm income or (loss). Attach Schedule F			18
19	Unemployment compensation			19
20a	Social security benefits 20a		b Taxable amount	20b
21	Other income. List type and amount			21
22	Combine the amounts in the far right column for lines 7 through 21. This is your total income ▶			22

Adjusted Gross Income

23	Educator expenses	23	
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24	
25	Health savings account deduction. Attach Form 8889	25	
26	Moving expenses. Attach Form 3903	26	
27	Deductible part of self-employment tax. Attach Schedule SE	27	
28	Self-employed SEP, SIMPLE, and qualified plans	28	
29	Self-employed health insurance deduction	29	
30	Penalty on early withdrawal of savings	30	
31a	Alimony paid b Recipient's SSN ▶	31a	
32	IRA deduction	32	
33	Student loan interest deduction	33	
34	Tuition and fees. Attach Form 8917	34	
35	Domestic production activities deduction. Attach Form 8903	35	
36	Add lines 23 through 35		36
37	Subtract line 36 from line 22. This is your adjusted gross income ▶		37

410001
12-31-14

Form 1040 (2014) STEVEN J. RAND [redacted] Page 2

Tax and Credits

Standard Deduction for -
- People who check any box on line 39a or 39b or who can be claimed as a dependent, see instructions.
- All others: Single or Married filing separately, $6,200 Married filing jointly or Qualifying widow(er), $12,400 Head of household, $9,100

38	Amount from line 37 (adjusted gross income)			38
39a	Check if: ☐ You were born before January 2, 1950, ☐ Blind. ☐ Spouse was born before January 2, 1950, ☐ Blind.	Total boxes checked ▶ 39a		
b	If your spouse itemizes on a separate return or you were a dual-status alien, check here ▶ 39b ☐			
40	Itemized deductions (from Schedule A) or your standard deduction (see left margin)			40
41	Subtract line 40 from line 38			41
42	Exemptions. If line 38 is $152,525 or less, multiply $3,950 by the number on line 6d. Otherwise, see inst.			42
43	Taxable income. Subtract line 42 from line 41. If line 42 is more than line 41, enter -0-			43
44	Tax. Check if any from: a ☐ Form(s) 8814 b ☐ Form 4972 c ☐			44
45	Alternative minimum tax. Attach Form 6251			45
46	Excess advance premium tax credit repayment. Attach Form 8962			46
47	Add lines 44, 45, and 46		▶	47
48	Foreign tax credit. Attach Form 1116 if required	48		
49	Credit for child and dependent care expenses. Attach Form 2441	49		
50	Education credits from Form 8863, line 19	50		
51	Retirement savings contributions credit. Attach Form 8880	51		
52	Child tax credit. Attach Schedule 8812, if required	52		
53	Residential energy credits. Attach Form 5695	53		
54	Other credits from Form: a ☐ 3800 b ☐ 8801 c ☐	54		
55	Add lines 48 through 54. These are your total credits			55
56	Subtract line 55 from line 47. If line 55 is more than line 47, enter -0-		▶	56

Other Taxes

57	Self-employment tax. Attach Schedule SE		57
58	Unreported social security and Medicare tax from Form: a ☐ 4137 b ☐ 8919		58
59	Additional tax on IRAs, other qualified retirement plans, etc. Attach Form 5329 if required		59
60a	Household employment taxes from Schedule H		60a
b	First-time homebuyer credit repayment. Attach Form 5405 if required		60b
61	Health care: individual responsibility (see instructions) Full-year coverage [X]		61
62	Taxes from: a ☐ Form 8959 b ☐ Form 8960 c ☐ Inst; enter code(s)		62
63	Add lines 56 through 62. This is your total tax	▶	63

Payments

If you have a qualifying child, attach Schedule EIC.

64	Federal income tax withheld from Forms W-2 and 1099	64		
65	2014 estimated tax payments and amount applied from 2013 return	65		
66a	Earned income credit (EIC)	66a		
b	Nontaxable combat pay election 66b			
67	Additional child tax credit. Attach Schedule 8812	67		
68	American opportunity credit from Form 8863, line 8	68		
69	Net premium tax credit. Attach Form 8962	69		
70	Amount paid with request for extension to file	70		
71	Excess social security and tier 1 RRTA tax withheld	71		
72	Credit for federal tax on fuels. Attach Form 4136	72		
73	Credits from Form: a ☐ 2439 b ☐ Reserved c ☐ Reserved ☐	73		
74	Add lines 64, 65, 66a, and 67 through 73. These are your total payments		▶	74

Refund

Direct deposit? See instructions.

75	If line 74 is more than line 63, subtract line 63 from line 74. This is the amount you overpaid			75
76a	Amount of line 75 you want refunded to you. If Form 8888 is attached, check here ▶ ☐			76a
b	Routing number ▶ c Type: ☐ Checking ☐ Savings ▶ d Account number			
77	Amount of line 75 you want applied to your 2015 estimated tax ▶	77		

Amount You Owe

78	Amount you owe. Subtract line 74 from line 63. For details on how to pay, see instructions		▶	78
79	Estimated tax penalty (see instructions)	79		

Third Party Designee

Do you want to allow another person to discuss this return with the IRS (see instructions)? [X] Yes. Complete below. ☐ No

Designee's name ▶ HOWARD SIMOWITZ Phone no. Personal identification number (PIN)

Sign Here

Joint return? See instructions. Keep a copy for your records.

Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Your signature	Date	Your occupation	Daytime phone number
Spouse's signature. If a joint return, both must sign.	Date	Spouse's occupation	If the IRS sent you an Identity Protection PIN, enter it here

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check [X] if self-employed	PTIN
HOWARD SIMOWITZ		03/29/15		

Firm's name ▶ HOWARD SIMOWITZ CPA Firm's EIN

Firm's address ▶ 20742 NW 29TH AVENUE BOCA RATON, FL 33434 Phone no.

410002 12-31-14

New York State Department of Taxation and Finance

2014 Resident Income Tax Return

New York State • New York City • Yonkers

IT-201

For the full year January 1, 2014, through December 31, 2014, or fiscal year beginning ... and ending ...

For help completing your return, see the instructions, Form IT-201-I.

Your first name	MI	Your last name (for a joint return, enter spouse's name on line below)	Your date of birth (mmddyyyy)	Your social security number
STEVEN	J	RAND		[redacted]
Spouse's first name	MI	Spouse's last name	Spouse's date of birth (mmddyyyy)	Spouse's social security number

Mailing address (see instructions, page 12) (number and street or PO Box)	Apartment number	New York State county of residence
291 CHURCH STREET		NY

City, village, or post office	State	ZIP code	County (if not United States)	School district name
NEW YORK	NY	10013		MANHATTAN

Taxpayer's permanent home address (see instructions, page 12) (number and street or rural route)	Apartment number	School district code number

City, village, or post office	State	ZIP code	Taxpayer's date of death (mmddyyyy)	Spouse's date of death (mmddyyyy)
	NY		Decedent filing status	

A Filing status (mark an X in one box):

1. [X] Single
2. [ ] Married filing joint return (enter spouse's social security number above)
3. [ ] Married filing separate return (enter spouse's social security number above)
4. [ ] Head of household (with qualifying person)
5. [ ] Qualifying widow(er) with dependent child

B Did you itemize your deductions on your 2014 federal income tax return? ... Yes [X] No [ ]

C Can you be claimed as a dependent on another taxpayer's federal return? ... Yes [ ] No [X]

D1 Did you have a financial account located in a foreign country? (see page 13) Yes [ ] No [X]

D2 Yonkers residents and Yonkers part-year residents only:

(1) Did you receive a property tax freeze credit? (see page 13) ... Yes [ ] No [ ]

(2) If Yes, enter the amount ... .00

D3 Did you receive a family tax relief credit? (see page 13) ... Yes [ ] No [X]

E (1) Did you or your spouse maintain living quarters in NYC during 2014? (see pg 13) Yes [ ] No [ ]

(2) Enter the number of days spent in NYC in 2014 (any part of a day spent in NYC is considered a day) ...

F NYC residents and NYC part-year residents only (see page 13):

(1) Number of months you lived in NYC in 2014 ...

(2) Number of months your spouse lived in NYC in 2014 ...

G Enter your 2-character special condition code if applicable (see page 13) ...

If applicable, also enter your second 2-character special condition code ...

H Dependent exemption information (see page 14)

First name	MI	Last name	Relationship	Social security number	Date of birth (mmddyyyy)

COPY

If more than 7 dependents, mark an X in the box. [ ]

201001141019

For office use only

4580101
10-27-14

Your social security number [redacted]

Federal income and adjustments *(see page 14)*

Whole dollars only

1	Wages, salaries, tips, etc.	1	
2	Taxable interest income	2	00
3	Ordinary dividends	3	
4	Taxable refunds, credits, or offsets of state and local income taxes *(also enter on line 25)*	4	00
5	Alimony received	5	00
6	Business income or loss *(submit a copy of federal Schedule C or C-EZ, Form 1040)*	6	00
7	Capital gain or loss *(if required, submit a copy of federal Schedule D, Form 1040)*	7	
8	Other gains or losses *(submit a copy of federal Form 4797)*	8	00
9	Taxable amount of IRA distributions. If received as a beneficiary, mark an X in the box ☐	9	00
10	Taxable amount of pensions and annuities. If received as a beneficiary, mark an X in the box ☐	10	00
11	Rental real estate, royalties, partnerships, S corporations, trusts, etc. *(submit copy of federal Schedule E, Form 1040)*	11	00
12	Rental real estate included in line 11	12	00
13	Farm income or loss *(submit a copy of federal Schedule F, Form 1040)*	13	00
14	Unemployment compensation	14	00
15	Taxable amount of social security benefits *(also enter on line 27)*	15	00
16	Other income *(see page 14)* Identify:	16	00
17	Add lines 1 through 11 and 13 through 16	17	
18	Total federal adjustments to income *(see page 14)* Identify:	18	00
19	Federal adjusted gross income *(subtract line 18 from line 17)*	19	

New York additions *(see page 15)*

20	Interest income on state and local bonds and obligations (but not those of NYS or its local governments)	20	00
21	Public employee 414(h) retirement contributions from your wage and tax statements *(see page 15)*	21	00
22	New York's 529 college savings program distributions *(see page 15)*	22	00
23	Other *(Form IT-225, line 9)*	23	00
24	Add lines 19 through 23	24	

New York subtractions *(see page 16)*

25	Taxable refunds, credits, or offsets of state and local income taxes (from line 4)	25	00
26	Pensions of NYS and local governments and the federal government *(see page 16)*	26	00
27	Taxable amount of social security benefits *(from line 15)*	27	00
28	Interest income on U.S. government bonds	28	00
29	Pension and annuity income exclusion *(see page 16)*	29	00
30	New York's 529 college savings program deduction/earnings	30	00
31	Other *(Form IT-225, line 18)*	31	00
32	Add lines 25 through 31	32	00
33	New York adjusted gross income *(subtract line 32 from line 24)*	33	

Standard deduction or itemized deduction *(see page 18)*

34	Enter your standard deduction *(table on page 18)* or your itemized deduction *(from Form IT-201-D)* Mark an X in the appropriate box: ☐ Standard - or - ☒ Itemized	34	
35	Subtract line 34 from line 33 *(if line 34 is more than line 33, leave blank)*	35	
36	Dependent exemptions *(enter the number of dependents listed in item H; see page 18)*	36	
37	Taxable income *(subtract line 36 from line 35)*	37	

201002141019

Your Property Information

"A Business & Taxpayer Resource"

NYCProperty E8

Need Help ?
Select a BBL
Search by REUC Ident
Statements List
NYCProperty Home Page
Change Mail Address
Tax Reduction

The Statements List displays information currently available for the Parcel you selected.

Parcel (BBL): 1-193-18
Owner(s): RAND STEVEN J
Property Address: 289 CHURCH STREET

Statements List for Parcel 1-193-18

September 14, 2015 - Account History
August 21, 2015 - Quarterly Property Tax Bill
June 5, 2015 - Quarterly Property Tax Bill
May 25, 2015 - Market Value History
May 25, 2015 - Final Assessment Roll
February 20, 2015 - Quarterly Property Tax Bill
January 15, 2015 - Market Value History
January 15, 2015 - Tentative Assessment Roll
January 15, 2015 - Notice of Property Value
November 21, 2014 - Quarterly Property Tax Bill
August 22, 2014 - Quarterly Property Tax Bill
June 6, 2014 - Quarterly Property Tax Bill
May 25, 2014 - Market Value History
May 25, 2014 - Final Assessment Roll
February 21, 2014 - Quarterly Property Tax Bill
January 15, 2014 - Market Value History
January 15, 2014 - Notice of Property Value
January 15, 2014 - Tentative Assessment Roll
November 22, 2013 - Quarterly Property Tax Bill
August 23, 2013 - Quarterly Property Tax Bill
June 7, 2013 - Quarterly Property Tax Bill
May 25, 2013 - Market Value History
May 25, 2013 - Final Assessment Roll

Town of Roxbury

Town of Roxbury
PO BOX 153
ROXBURY, CT 06783
(860) - 354 - 6484

Payment Details

Tax Payer Information	
Bill #:	
Unique ID:	
District & Flag:	
Name:	RAND STEVE J & NANCY L
Address:	
Property Location:	69 FLAG SWAMP RD 15/88 LT3 24 024
Volume:	
Page:	
Town Benefit:	
Elderly Benefit (C):	

Bill Information as of 09/14/2015	
Due 1:	
Due 2:	
Due 3:	
Due 4:	
Assessment	
Exempt	
Net	
To Pay This Bill in Full:	

Payment History

Pay Date	Type	Tax/Principal	Interest	Lien	Fee	Total
07/01/2014	PAY					

Total Payments made to taxes in 2014:

This is not a tax form, contact your financial advisor for information regarding tax reporting.

Date Generated: 09/14/2015

Town of Roxbury

Town of Roxbury
PO BOX 153
ROXBURY, CT 06783
(860) - 354 - 6484

Payment Details

Tax Payer Information	
Bill #:	
Unique ID:	
District & Flag:	
Name:	RAND STEVEN J & WENDER NANCY L
Address:	
Property Location:	43 FLAG SWAMP RD 15/88 LT 2 15 017
Volume:	
Page:	
Town Benefit:	
Elderly Benefit (C):	

Bill Information as of 09/14/2015			
Due 1:	07/01/2015	**Inst1**	
Due 2:	01/01/2015	**Inst2**	
Due 3:		**Inst3**	
Due 4:		**Inst4**	
Assessment		**Tota**	
Exempt		**Tota Adju**	
Net		**Mill Rate**	
To Pay This Bill in Full:			

Payment History						
Pay Date	*Type*	*Tax/Principal*	*Interest*	*Lien*	*Fee*	*Total*
07/01/2014	PAY					

Total Payments made to taxes in 2014:

This is not a tax form, contact your financial advisor for information regarding tax reporting.

Date Generated: 09/14/2015

Town of Roxbury

SHOPPING CART Account info last updated on Sep 4, 2015

0 BILL(S)

Home › Shopping Cart › Checkout

TAX BILLS

SEARCH BY
NAME
See Example

Enter the search criteria below:
rand s
Search
(Last Name then 1st Initial) or Business Name (No comma, & or -)

◉ All ○ Due Now ○ Balance Due

01 - REAL ESTATE 02 - PERSONAL PROPERTY 03 - MOTOR VEHICLE 04 - MOTOR VEHICLE SUPP

BILL #	NAME/ADDRESS	PROPERTY/VEHICLE	PAID	OUTSTANDING	OPTIONS	PAY
(REAL ESTATE)	RAND STEVE J & NANCY L	69 FLAG SWAMP RD 15/88 LT3 24 024				
(REAL ESTATE)	RAND STEVE J & NANCY L	69 FLAG SWAMP RD 15/88 LT3 24 024				
(MOTOR VEHICLE)	RAND STEVEN	2011 11 CHANG 90154				
(MOTOR VEHICLE)	RAND STEVEN	2011 11 CHANG 90154				
(MOTOR VEHICLE)	RAND STEVEN	2012 1 JEEP WRANGLER				
(MOTOR VEHICLE)	RAND STEVEN	2012 1 JEEP WRANGLER				
(REAL ESTATE)	RAND STEVEN J & WENDER NANCY L	43 FLAG SWAMP RD 15/88 LT 2 15 017				
(REAL ESTATE)	RAND STEVEN J & WENDER NANCY L	43 FLAG SWAMP RD 15/88 LT 2 15 017				
(REAL ESTATE)	RAND STEVEN J & WENDER NANCY L	39 FLAG SWAMP RD 15/88 LT1 15 015				
(REAL ESTATE)	RAND STEVEN J & WENDER NANCY L	39 FLAG SWAMP RD 15/88 LT1 15 015				
(MOTOR VEHICLE)	RAND STEVEN JAY	1965 1 MORGA PLUS4				
(MOTOR VEHICLE)	RAND STEVEN JAY	1965 1 MORGA PLUS4				

TD Ameritrade

Statement Reporting Period:
08/01/15 - 08/31/15

800-669-3900
TD AMERITRADE
DIVISION OF TD AMERITRADE INC
PO BOX 2209
OMAHA, NE 68103-2209
TD Ameritrade Clearing, Inc., Member SIPC

Statement for Account # [redacted]
STEVEN JAY RAND
291 CHURCH ST
NEW YORK, NY 10013-2403

Announcements:
EDUCATION THAT'S ON YOUR CLOCK. FROM QUICK-HIT VIDEOS TO FULL-ON COURSES, THE EDUCATION CENTER MAKES IT EASY TO FIT LEARNING INTO YOUR DAY. CHECK IT OUT NOW AT TDAMERITRADE.COM/EDCENTER

Portfolio Summary

Investment	Current Value	Prior Value	Period Change	% Change	Estimated Income	Estimated Yield	Portfolio Allocation
Cash							
Insrd Dep Acct (IDA)							
Money Market							
Short Balance							
Stocks							
Short Stocks							
Fixed Income							
Options							
Short Options							
Mutual Funds							
Other							
Total							

Cash Activity Summary

	Current	YTD
Opening Balance		
Securities Purchased		
Securities Sold		
Funds Deposited		
Funds Disbursed		
Income		
Expense		
Other		
Closing Balance		

Income & Expense Summary

	Reportable	Non Reportable	YTD
		-	
		-	-
		-	-
		-	-
		-	

Performance Summary

Cost Basis As Of - 08/31/15 **	
Unrealized Gains	
Unrealized Losses	
Funds Deposited/(Disbursed)YTD	-
Income/(Expense)YTD	
Securities Received/(Delivered)YTD	

**For cost-basis information, refer to www.tdameritrade.com

E8

Current balances | Balances over time | Balances compared to year-end | Balances by date

Text size: A A A

Steven J. Rand Registration details

Buy and sell | Order status | Transaction history | Cost basis | More

As of 04/28/2015, the expense ratio on your Vanguard Small-Cap Index Fund Admiral Shares has changed from 0.10% to 0.09%.
Find out what causes expense ratios to change

Symbol	Name	Expense ratio	Fund & account	Quantity	Price as of 09/14/2015	Change	Current balance	
VSMAX	Vanguard Small-Cap Index Fund Admiral Shares	[redacted]						Buy | Sell | Exch

Total

Add another account →

Outside Investments

Outside investments allows you to view your non-Vanguard investments on your Balances and holdings page. Learn more about this service.

Intraday prices are generally provided for stocks, ETFs, and options on a delayed basis during market hours. Prices are delayed at least 20 minutes. If an intraday price is not available, the price displayed will reflect the previous business day's close. For mutual funds and fixed income holdings, the prices displayed are generally the previous business day's closing price.

Market information is provided by Thomson Reuters. Disclaimer

Additional information about prices for other products and Outside Investments.

ProHealth and Wellness CT

972 Boston Post Road
Milford, CT 06460
917 330-9233

F.Bonus Points

1. **Employee working environment.**
   - Staff will have access to a private secure room with individual lockers and a refrigerator and an outer area that is separated from the client waiting area. See floor layout.
   - They will have access to the therapist, the nutritionist and the execise/yoga area at no cost.
   - Each staff member is entitled to [redacted] weeks vacation and [redacted] personal/sick days
   - Each staff member will after one (1) year will be entitled to a 401k with [redacted]/annum matching

2. **Compassionate Care Plan**
   - Free Social worker/therapy sesiciansions provided by 291 Foundation for three years
   - Nutritionist and physical therapist services- inexpensive sessions and a sliding scale to zero with physician referral
   - Up to [redacted] year in free product to clients with physician referral

3. **ProHealth and Wellness CT Research Plan**

In an effort to support ProHealth and Wellness CT's mission of wellness and treatment of the whole person, the facility wants to undertake one of more studies that will qualify and quantify the effects of Medical Marijuana and tailor dosing to meet these needs, along with the inclusion of programs to support health and well-being.

Issues for Study

Being cognizant of the many factors that contribute and support the goal of wellness in our population served, we are interested in focusing our attention on the use of nutrition, psychotherapy, mindfulness and exercise in conjunction with THC to treat cachexia and wasting syndrome. Particularly important to those suffering with cancer and its many devastating symptoms, our facility will be unique in offering an integrated, comprehensive approach to pain reduction, improved health and mood.

Methodology of the Study

pharmacist, exercise trainer, nutritionist and mental health professional, among other professionals in the community.

In consultation with the referral source, generally being the patient's medical doctor, our pharmacist will assess the physical, pain threshold issues and emotional needs of the patient suffering from cachexia and wasting syndrome and begin to put a coordinated plan in motion to address these concerns.

1. Exercise Trainer. Our trainer on staff will develop a tailored exercise regimen that will be measurable and quantifiable. Goals will include increasing muscle mass and strength. The trainer will develop this plan in collaboration with the patient and prepare a written documentation of these measures, and body mass will be checked and recorded regularly.

2. Nutritionist. A staff nutritionist, in consultation with the trainer, pharmacist and staff therapist, will meet with each patient and construct an integrated food plan, so that the work of the trainer in the strengthening area can be supported. Proper nutrition is integral to increasing appetite and weight gain, thus adding to the patient's strength and quality of life. Regular meetings will be set up between the patient and nutritionist to track the progress. The patient out-of-session will be asked to record his/her daily food intake in diary form and will bring the diary to the meetings. The nutritionist may also set up an e-mail form to be filled out by the patient on a daily basis, thus being able to track progress in real time and spot any potential adjustments that are needed.

3. Staff Therapist. The therapist on staff will also meet with the patients regularly and will start with a baseline questionnaire on mood, family relationships and functionality. Emotional issues are vastly important to track, as the synergy between pain management via THC dosages, exercise and proper nutrition cannot be overstated. Via daily journal entries, the patients can track their mood in relation to their use of THC and the other resources provided to them at the Center and in the community.

In addition, a questionnaire will be developed to help track the progress of the patient. Our hypothesis to be proven is that patients will report improvement in daily living, experience less pain, notice better concentration at work and benefit from improved mood.

Family members will be integral in helping the patient be supported in all facets of his or her life. They will provide input via a questionnaire answering questions about their family menbers' baseline level of mood, improvements, what they observe and progress over time.

4. Mindfulness Training. Should our staff therapist be a practioner of mindfulness, he/she will be able to integrate the practice of mindfulness into the wellness

mindfulness to aid with alleviating pain, stress and human suffering. Alternatively, a therapist from the community skilled in the practice of mindfulness may come to the Center on a weekly basis to lead a few classes. Whichever treatment therapist leads this effort, our patients' progress will be tracked to measure the efficacy as additive to the total improved well-being of the patients.

Important to consider is the value of holding mindfulness classes in a group setting. This modality will further promote the importance of feeling supported and being among other patients dealing with similar issues. Not being alone is healing and will promote connection, when the tendency may be to isolate and deal with thoughts, feelings and physical ailments on one's own. Group work may also help defuse depressive symptoms and add to one's improved sense of well-being.

Community Involvement

ProHealth and Wellness endeavors to work with one of the local universities to further rigorous study on the effects of THC for the medical reasons cited above. Through a three-year foundation grant referenced in the application, the Center will communicate with the local medical schools or hospitals to determine an appropriate partner to help design and participate in a study, using the information gathered on-site. Preliminary overtures to Quinnipiac College and Southern Connecticut State University, among others, will be fine-tuned to determine interest and involvement.

Intended Use of the Study Results

The patients referred to the Center for use of THC for treatment of cachexia and wasting syndrome provide a viable sample for the study mentioned above. Our pharmacist will be available to speak at conferences to advocate for the use of THC and to highlight the proven results derived from our comprehensive care model. The goal, in addition to patient care, is to move the agenda forward and provide a stronger case for the efficacy of Medical Marijuana.

Mission and Goals of ProHealth and Wellness CT

"Our main mission at ProHealth and Wellness is collaborative and comprehensive care. We plan to not only provide expert analysis, advice and care, but also to treat

system, but only one piece of the puzzle. We strive for a team approach engaging all parts of the collaboration.

Our goal is wellness. We identify that many factors contribute to wellness: good nutrition, healthy environment, increased activity and psychological and physiological balance. We also know that with disease comes a cascade of events including depression, loss of normal function, weight issues and possible substance abuse. We aim to facilitate life improvements, by recommending positive lifestyle changes including nutrition advice, exercise and psychological services as a holistic approach to treating the patient along with the disease at hand. We will have a pharmacist, nutritionist, trainer and social worker/psychotherapist on staff. Our facility will be unique in that it is multifaceted offering services that will not only provide palliative care, but also will provide alternative techniques to improve wellness and ultimately quality of life.

We hope to be an integral part of this innovative therapy by providing quantifying data and feedback to all persons involved, including physicians, patients caretakers, production facilities and department of consumer protection.

4. Community benefits Plan –Donations of at least $2000,00 to each or the organizations below. Applicant currently donates more than $30,000 to various humanitarian organizations, hospitals and social service organizations and is firmly committed to giving back to the community.

- http://www.accessinct.org/ Access Independence 80 Ferry Blvd., Suite 205 Stratford, CT 06615
- http://www.rapecrisisctr.org/
- 70 West River Street
  Milford, CT 06460
  203-874-8712 (Office)
- https://www.unitedwayofmilford.org/

5. Substance Abuse Prevention Plan

As noted ProHealth and Wellness CT will have a social worker/therapist on staff three days per week to provide free counseling regarding abuse. The therapist will also work with social welfare organization to help provide inclusive care to those in need. This is an area we will take very seriously.

CPA CONNECTICUT PHARMACISTS ASSOCIATION

September 8, 2015

To Whom It May Concern:

The purpose of this letter is to inform the State of Connecticut Department of Consumer Protection(DCP) that the **Connecticut Pharmacists Association (CPA),** a 501(c)6 professional organization representing pharmacists in the State of Connecticut since 1876, will be conducting a Research Monitoring Program in the State of Connecticut related to the medicinal use of cannabis.

It is the intent of the CPA to partner with the **Yale University School of Medicine** in order to conduct this proposed research monitoring program with the marijuana growers and dispensaries that receive licenses from the State of Connecticut. In addition, CPA will continue to collaborate with the Canadian Consortium on (CCIC), a federally registered Canadian nonprofit organization of basic and clinical researchers and health care professionals established to promote evidence-based research and education concerning the endocannabinoid system and therapeutic applications of endocannabinoid and cannabinoid agents.

Please note that **Pro Health and Wellness CT,** the applicant, has committed to the CPA that it fully supports and will cooperate in the data collection efforts that are needed to support this Research Plan, the accompanying financial commitment, and the study initiative if their company is selected by the State of Connecticut to dispense medical cannabis.

The Research Plan will be designed independently by CPA and Yale University School of Medicine. The main objective of the research is to ensure the safety and efficacy of the product that patients use. In this study we will track all cannabinoid strengths in regard to patient benefits, effectiveness, and adverse events (AEs) as well as to differentiate benefits across the therapeutic disease states. We will also look to quantify doses and modes of cannabis administration as well as documenting any noted drug interactions. All information will be uploaded into a highly-secure electronic database - **Research Electronic Data Capture** (REDCap) which has been designed exclusively to support data capture for research studies.

It is our estimation that the results and data gleaned from the estimated 2 year study period will be used to inform policy-makers and regulatory agencies about safety aspects of medical cannabis; clinicians will be better informed about best practice guidelines and safety issues, and the medical cannabis producers will receive beneficial information about the efficacy of their products in real world situations. Most importantly, due to how the Connecticut regulations are written, the pharmacists, who are an integral

piece to both the data collection and dispensing activities, will have a comprehensive and data driven approach when educating patients about their medical use of cannabis.

The CPA has a strong and positive history of working with state agencies, universities and the pharmacists we represent in programs that involve both pharmacists and patient outcomes. It is due to this synergy and focus that the CPA feels that it is well-positioned to be the critical component to ensure that the Research Plan reflects the highest quality evidence-based "best practices" and continuing education for all those involved in this, emerging sector of patient care in Connecticut.

Sincerely,

Margherita R. Giuliano

Margherita R. Giuliano, RPh
Executive Vice President
Connecticut Pharmacists Association

F4

291 FOUNDATION

291 CHURCH STREET, NEW YORK, NEW YORK 10013

The 291 Foundation pledges a grant of $50,000 yearly for three years to be awarded to a local university's graduate social work department and/or medical school. This $150,000 grant (with other monies to be provided when necessary) will focus on collaboration of the design and implementation of one or more studies conceived, designed and implemented at ProHealth and Wellness (Wellness Center).

The Foundation is invested in furthering the interdisclinary approach to research and practice in the burgeoning field of Medical Marijuana, to add the Wellness Center's voice in support of the efficacy and policy advancement of its use and to provide health and well-being for its population served. It believes that this collaboration of the university, scientific community and the Wellness Center's pharmacist, along with the inclusion of a psychotherapist, will advance learning in this important, growing field and further attest to the value of Medical Marijuana for assisting with pain management, among other medical areas of consideration.

Nancy L. Wender
Trustee, 291 Foundation
September 6, 2015