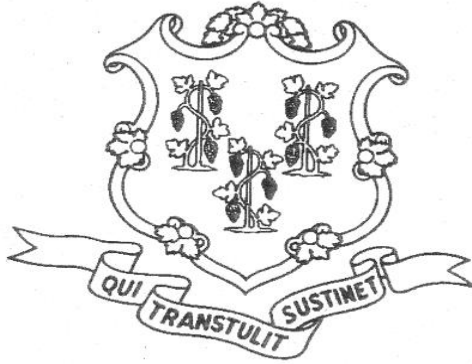


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Carolton Chronic and Convalescent Hospital, Inc.	
Address (No. & Street, City, State, Zip Code) 400 Mill Plain Road, Fairfield, CT 06824	
Type of Facility Chronic and Convalescent                      Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH)    (RHNS)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH 606-C	RHNS	(Specify)	Medicare Provider 07-5034
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Medicaid Provider Numbers:	CCNH 6064	RHNS	ICF-IID
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**For Department Use Only**

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

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### General Information

Name of Facility (as licensed) Carolton Chronic and Convalescent Hospital, Inc.	License No. 606-C	Report for Year Ended 9/30/2017	Page 1	of 37
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#### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Carolton Chronic and Convalescent Hospital, Inc. [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Dennis Kretzmer			Printed Name (Owner)		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Carolton Chronic and Convalescent Hospital, Inc.	Period Covered:	From 10/1/2016	To 9/30/2017	
Address of Facility 400 Mill Plain Road, Fairfield, CT 06824				
Report Prepared By PKF O'Connor, Davies, LLP	Phone Number 860-257-1870	Date 2/8/2018		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility 203-255-3573		Report for Year Ended 9/30/2017	Page 2	of 37
Name of Facility (as shown on license) Carolton Chronic and Convalescent Hospital, Inc.		Address (No. & Street, City, State, Zip) 400 Mill Plain Road, Fairfield, CT 06824		
License Numbers:	CCNH 606-C	RHNS	(Specify)	Medicare Provider No. 07-5034
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No                   If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator Dennis Kretzmer		Nursing Home Administrator's License No.:	939	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name N/A		License No.:		



**General Information and Questionnaire  
 Corporate Owners**

Name of Facility Carolton Chronic and Convalescent Hospital	License No. 606-C	Report for Year Ended 9/30/2017	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address		State(s) in Which Incorporated	
Carolton Chronic and Convalescent Hospital, Inc.	400 Mill Plain Road, Fairfield, CT 06824			
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Carmen A. Tortora	400 Mill Plain Road, Fairfield, CT 06824	President		
Michael Tortora	400 Mill Plain Road, Fairfield, CT 06824	Director		
Paul M. Tortora	400 Mill Plain Road, Fairfield, CT 06824	Director		
Russell J. Melita	400 Mill Plain Road, Fairfield, CT 06824	Director		
Names of Stockholders Owning at Least 10% of Shares				
Carmen A. and Agnes E. Tortora Dynasty Tr	400 Mill Plain Road, Fairfield, CT 06824			

### General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic and Convalescent Hospital, Inc.	606-C	9/30/2017	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

N/A



**General Information and Questionnaire  
Related Parties\***

Name of Facility Carolton Chronic and Convalescent Hospital, Inc.	License No. 606-C	Report for Year Ended 9/30/2017	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?  Yes  No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
CMF Realty (Tortora Family Trust)	Fairfield, CT	<input type="radio"/>	<input checked="" type="radio"/>		Rental of real estate and equipment.	22 9A	930,000	
Carmen A. & Agnes E. Tortora Dynasty (C)	Fairfield, CT	<input type="radio"/>	<input checked="" type="radio"/>		Rental of real estate and equipment.	22 9 A		
TTFT Management Associates	Fairfield, CT	<input type="radio"/>	<input checked="" type="radio"/>		Management services.	pg 16 M12	638,464	638,464
Peter Tortora, MD	Fairfield, CT	<input checked="" type="radio"/>	<input type="radio"/>		Assistant Medical Director	pg 13 B8a	30,000	30,000
Fairfield Medical Group	Fairfield CT	<input checked="" type="radio"/>	<input type="radio"/>		Employee Physicals	Pg 15a	125	125
Carmen Tortora Jr. - CAT	Fairfield CT	<input type="radio"/>	<input checked="" type="radio"/>		Loans	pg 34 b3	31,811	31,811
CAT Holdings	Fairfield CT	<input type="radio"/>	<input checked="" type="radio"/>		Management Services	Pg 31 A8\	1,338,742	1,338,742
TTFT Management Assoc.	Fairfiled CT	<input type="radio"/>	<input checked="" type="radio"/>		Laon	pg 31 A8	69,385	69,385
		<input type="radio"/>	<input type="radio"/>					

\* Use additional sheets if necessary.

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

## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Carolton Chronic and Convalescent Hospital, Inc.	License No. 606-C	Report for Year Ended 9/30/2017	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

### General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Carolton Chronic and Convalescent Hospital, Inc.			License No. 606-C	Report for Year Ended 9/30/2017			Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Pitney Bowes	<input type="radio"/>	<input checked="" type="radio"/>	Stamp Machine	Monthly	Monthly	1,998	1,998	
DeLange	<input type="radio"/>	<input checked="" type="radio"/>	Copy Machines	Monthly	Monthly	7,267	7,267	
NEC	<input type="radio"/>	<input checked="" type="radio"/>	Telephone System	Monthly	Monthly	11,997	11,997	
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes	<input type="radio"/> No
							<b>Total ***</b>	21,262

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

\*\* Attach copies of newly acquired leases.

\*\*\* Amount should agree to Page 22, Line 6e.

## General Information and Questionnaire Accounting Basis

Name of Facility Carolton Chronic and Convalescent	License No. 606-C	Report for Year Ended 9/30/2017	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm 1 PKF O'Connor Davies, LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 100 Great Meadow Rd. Wethersfield CT
--	---

Services Provided by This Firm (*describe fully*)

1 Cost Report Prep/Financial Statements/Tax Returns	\$ 50,519
2	\$
3	\$
4	\$
<b>Charge for Services Provided</b>	
\$ 50,519	

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    Pg 15 L 1d

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 Jackson lewis 2 Charles Jankovsky 3 Murtha Cullina 4 Wiggen and Dana 5	Telephone Number
--	------------------

Address (*No. & Street, City, State, Zip Code*)  
 1  
 2  
 3  
 4  
 5

Services Provided by This Firm (*describe fully*)

1 Staff Discrimination Complaint	\$ 18,738
2 Collection - See pg 28	\$ 20,583
3 Medicaid Issue	\$ 1,025
4 Corporate - See pg 28	\$ 95
5	\$
<b>Charge for Services Provided</b>	
\$ 40,441	

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    pg 15 L 1e

### Schedule of Resident Statistics

Name of Facility Carolton Chronic and Convalescent Hospital, Inc.			License No. 606-C			Report for Year Ended 9/30/2017				Page 8	of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	229	229			229	229			229	229		
B. On last day of THIS report period	229	229			229	229			229	229		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	159	159			159	159			165	165		
B. As of midnight of THIS report period	165	165			165	165			165	165		
3. Total Number of Days Care Provided During Period												
A. Medicare	9,651	9,651			7,191	7,191			2,460	2,460		
B. Medicaid (Conn.)	31,360	31,360			23,853	23,853			7,507	7,507		
C. Medicaid (other states)												
D. Private Pay	17,611	17,611			13,098	13,098			4,513	4,513		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	58,622	58,622			44,142	44,142			14,480	14,480		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	109	109			92	92			17	17		
5. <b>Total Resident Days (3G + 4A + 4B)</b>	58,731	58,731			44,234	44,234			14,497	14,497		

**Schedule of Resident Statistics (Cont'd)**

Name of Facility Carolton Chronic and Convalescent Hospital,	License No. 606-C	Report for Year Ended 9/30/2017	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?  Yes  No  
 If "YES", provide the following information:

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

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

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	33	80		52				
Per Diem Rate								
a. One bed rm.	Var.	253.07		460-543				
b. Two bed rms.				411-475				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	1,126	1,126		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	14	14		
C. Other	17,596	17,596		
<b>D. Total Physical Therapy Treatments</b>	18,736	18,736		

8. Total Number of Speech Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	158	158		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,637	1,637		
<b>D. Total Speech Therapy Treatments</b>	1,795	1,795		

9. Total Number of Occupational Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	675	675		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	23	23		
C. Other	10,890	10,890		
<b>D. Total Occupational Therapy Treatments</b>	11,588	11,588		

### Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Carolton Chronic and Convalescent Hospital, Inc.	606-C	9/30/2017	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)	100,000	2,080				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	100,000	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	144,000	4,160				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	752,079	37,164				
5. Dietary Service						
a. Head Dietitian	91,446	2,080				
b. Food Service Supervisor						
c. Dietary Workers	1,099,894	64,903				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	652,420	48,405				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	181,599	9,767				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	128,402	8,726				
9. Barber and Beautician Services	33,690	1,747				
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	160,963	3,418				
b. RN						
1. Direct Care	1,392,181	41,015				
2. Administrative**	320,581	8,210				
c. LPN						
1. Direct Care	2,713,209	81,939				
2. Administrative**	136,627	4,160				
d. Aides and Attendants	3,000,444	183,026				
e. Physical Therapists	1,270,034	41,881				
f. Speech Therapists						
g. Occupational Therapists	691,730	19,389				
h. Recreation Workers	243,624	12,523				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	96,441	4,148				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	63,314	2,849				
<i>A-13. Total Salary Expenditures</i>	<i>13,372,678</i>	<i>583,670</i>				

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

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

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

**Schedule of Other Salaries and Wages (Page 10)**

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Medical Records	\$ 63,314	2,849				
<b>Total</b>	\$ 63,314	2,849	\$ -	-	\$ -	-

**Schedule of Other Fees (Page 13)**

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
<b>Total</b>	\$ -	-	\$ -	-	\$ -	-



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

Name of Facility				License No.	Report for Year Ended				Page	of
Carolton Chronic and Convalescent Hospital, Inc.				606-C	9/30/2017				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										
Carmen A. Tortora Jr.	100000 - See pg 28				President of Corp.	2,080	A1	TTFT Mgmt Co.		Pg 28 Disallow

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended				Page	of
Carolton Chronic and Convalescent Hospital, Inc.				606-C	9/30/2017				12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Dennis Kretzmer	100,000				Administrator	2,080	A2	TTFT Mgmt Co.	Pg. 28 Dis	
<b>Section IV - Assistant Administrators</b>										
Thomas J. Tortora	72,000				Assistant Administrator	2,080	A3	TTFT Mgmt Co.	Pg. 28 Dia	
Kathern Abrahamsen	72,000				Assistant Administrator	2,080	A3	TTFT Mgmt Co.	Pg. 28 Dia	

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

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

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

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of		
Carolton Chronic and Convalescent Hospital, Inc.	606-C	9/30/2017	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian						
2. Dentist	19,494	96				
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	60,000	400				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	83,012	1,277				
b. Other	9,223	142				
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>171,729</b>	<b>1,915</b>				

\* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.  
 \*\* This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.  
 \*\*\* Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

Name of Facility		License No.	Report for Year Ended		Page	of
Carolton Chronic and Convalescent Hospital, Inc.		606-C	9/30/2017		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Healthdrive Dental, 25 Needham Street, Newton, MA 02461	Dental services.	<input type="radio"/>	<input checked="" type="radio"/>			
Stuart Miller MD, 39 Canterbury Lane, Trumbull, CT 06611	Medical director.	<input type="radio"/>	<input checked="" type="radio"/>			
Peter Tortora MD, 345 Old Oaks Drive, Fairfield, CT 06825	Assistant medical director.	<input checked="" type="radio"/>	<input type="radio"/>	Brother of operators.		
Fairfield Medical Group	Staff physicals (see pg 15	<input checked="" type="radio"/>	<input type="radio"/>	Brother of operators.		
Rehab Associates 411 Old Coach Rd Fairfield CT	Speech Therapy/OT	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			

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

**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended		Page	of
Carolton Chronic and Convalescent Hospital, Inc	606-C	9/30/2017		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 709,908	709,908			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 1,156,102	1,156,102			
5. Health Insurance	\$ 1,637,969	1,637,969			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 9,215	9,215			
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 125	125			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$				
d. Accounting and Auditing	\$ 50,519	50,519			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 40,441	40,441			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 238,515	238,515			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 35,858	35,858			
2. Cellular Phones	\$ 4,003	4,003			
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$				
k. Other Taxes ( <i>Not related to property - See Page 22</i> )					
1. Income*	\$				
2. Other ( <i>Specify</i> ) See Attached Schedule	\$ 52,531	52,531			
3. Resident Day User Fee	\$ 1,000,566	1,000,566			
<b>Subtotal</b>	\$ 4,935,752	4,935,752			

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

(Carry Subtotals forward to next page)

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

Carolton Chronic and Convalescent Hospital, Inc.  
9/30/2017

Attachment Page 15

**Schedule of Other Employee Benefits**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
Employee Physicals	\$ 125		
<b>Total</b>	\$ 125	\$ -	\$ -

-----  
**Schedule of Other Taxes**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
Federal Tax	\$ 41,000		
State Tax	\$ 12,000		
Deferred Income Tax	\$ (469)		
<b>Total</b>	\$ 52,531	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic and Convalescent Hospital, Inc.	606-C	9/30/2017	16	37
Item	Total	CCNH	RHNS	(Specify)
<b>Subtotals Brought Forward:</b>	4,935,752	4,935,752		
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$			
3. Gifts to Staff and Residents	\$ 13,250	13,250		
4. Employee Travel	\$ 29,992	29,992		
5. Education Expenses Related to Seminars and Conventions	\$ 1,855	1,855		
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$			
7. Other ( <i>Specify</i> )	\$			
See Attached Schedule				
m. Other Administrative and General Expenses				
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 3,175	3,175		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$			
3. Advertising Other ( <i>Specify</i> )***	\$ 58,903	58,903		
See Attached Schedule				
4. Fund-Raising***	\$			
5. Medical Records	\$			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$ 738	738		
7. Postage	\$			
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> )	\$			
See Attached Schedule				
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$ 5,154	5,154		
10. Contributions***	\$ 9,400	9,400		
See Attached Schedule				
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$			
12. Administrative Management Services**	\$ 638,464	638,464		
13. Other ( <i>Specify</i> )	\$ 45,396	45,396		
See Attached Schedule				
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 5,742,079	5,742,079		

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

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

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

**Schedule of Other Travel and Entertainment**

Description	CCNH	RHNS	(Specify)
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Advertising see pg 28	\$ 58,903		
<b>Total Other Advertising</b>	\$ 58,903	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
	\$ -		
<b>Total Dues</b>	\$ -	\$ -	\$ -

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
See pg 28	\$ 9,400		
<b>Total Contributions</b>	\$ 9,400	\$ -	\$ -

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
BOD - See pg 28	\$ 6,000		
Consulting	\$ 2,229		
Penalties - See pg 28	\$ 19,451		
State of CT license	\$ 1,585		
Preemployment Physicals	\$ 15,956		
Town of Fairfield Kitchen Permits	\$ 175		
<b>Total Other Administrative and General</b>	\$ 45,396	\$ -	\$ -



**Schedule C-1 - Management Services\***

Name of Facility	License No.	Report for Year Ended	Page of
Carolton Chronic and Convalescent Hosp	606-C	9/30/2017	17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
TTFT Management Associates, Fairfield, CT	638,464	Overall Management of facility	P. 16/ m12 & pg. 28

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

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

Name of Facility Carolton Chronic and Convalescent Hospital, Inc.	License No. 606-C	Report for Year Ended 9/30/2017	Page 18	of 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 515,659	515,659		
2. Non-Food Supplies	\$ 120,656	120,656		
3. Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$			
c. Management Services**	\$			
d. Other (Specify) _____	\$			
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 636,315</b>	<b>636,315</b>		
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*				
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input checked="" type="radio"/> Yes <input type="radio"/> No                      If yes, specify amt.				
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify cost.				
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.				
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify cost.				
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No                      If yes, specify amt.				
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility		License No.	Report for Year Ended	Page	of
Carolton Chronic and Convalescent Hospital, Inc.		606-C	9/30/2017	19	37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	64,948	64,948		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	3,933	3,933		
c. Management Services**	\$				
d. Other (Specify) Supplies	\$	26,510	26,510		
<b>3E. Total Laundry Expenditures (3a + b + c + d)</b>	<b>\$</b>	<b>95,391</b>	<b>95,391</b>		
<b>3F. Laundry Questionnaire</b>					
G. Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

\* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3E.

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of	
Carolton Chronic and Convalescent Hospital, I	606-C	9/30/2017	20	37	
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care					
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	75,385	75,385		
b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	Sq. Ft. Serviced by Personnel				
	Amt. \$				
c. Management Services*		\$			
d. Other ( <i>Specify</i> )		\$			
<b>4E. Total Housekeeping Expenditures</b> (4a + b + c + d)		\$ 75,385	75,385		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	530,981	530,981		
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	237,907	237,907		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	48,220	48,220		
f. X-rays and Related Radiological Procedures***	\$	28,732	28,732		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	68,450	68,450		
i. Recreation	\$	16,991	16,991		
j. Other (Specify)**** See Attached Schedule	\$	147,694	147,694		
<b>5K. Total Resident Care Expenditures</b> (5a - 5j)		\$ 1,078,975	1,078,975		

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

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

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

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



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

Name of Facility Carolton Chronic and Convalescent Hospital, Inc.			License No. 606-C	Report for Year Ended 9/30/2017	Page 21	of 37				
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
D & M Landscaping	131 Carlynn Rd Fairfield CT	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping/snowplowing	37,613			22	6a & 1
Federal Electric		<input type="radio"/>	<input type="radio"/>		Electrical	27,532			22	6 a &
Ray Flanagan	Fairfiled CT	<input type="radio"/>	<input checked="" type="radio"/>		Plumbing	44,650			22	6 a &
Precision Mechanical		<input type="radio"/>	<input type="radio"/>		Sprinkers	14,096			22	6 a &
Call Peter	East Windsor CT	<input type="radio"/>	<input checked="" type="radio"/>		Dumpsters/Garbage	39,277			22	6f
Home Depot		<input type="radio"/>	<input type="radio"/>		Materials	14,236			22	6a
Direct TV	PO Box 5392 Miami FL 33152	<input type="radio"/>	<input checked="" type="radio"/>		Satellite TV	19,164			22	6f
Toth Mechanical	Shelton CT	<input type="radio"/>	<input checked="" type="radio"/>		Maintenance	23,399			22	6 a &
		<input type="radio"/>	<input checked="" type="radio"/>							6f
		<input type="radio"/>	<input type="radio"/>							
Surburban		<input type="radio"/>	<input type="radio"/>		Office Supplies	32,136			15	1g
ICS		<input type="radio"/>	<input checked="" type="radio"/>		Computer System	42,663			15	1g
Pointclick Care Tech		<input type="radio"/>	<input checked="" type="radio"/>		Computer System	72,010			15	1g
		<input type="radio"/>	<input type="radio"/>							

\* List all contracted services over \$10,000. Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

\*\*\* Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended			Page	of
Carolton Chronic and Convalescent Hospital,	606-C	9/30/2017			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 132,870	132,870				
b. Heat	\$ 96,676	96,676				
c. Light & Power	\$ 218,430	218,430				
d. Water	\$ 42,235	42,235				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 21,262	21,262				
f. Other ( <i>itemize</i> )	\$ 242,067	242,067				
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 753,540</b>	<b>753,540</b>				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 134,485	134,485				
c. Non-Movable Equipment	\$ 6,842	6,842				
d. Movable Equipment	\$ 58,298	58,298				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 199,625</b>	<b>199,625</b>				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 99,107	99,107				
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 99,107</b>	<b>99,107</b>				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 930,000	930,000				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 180,107	180,107				
c. Personal property taxes	\$ 86,128	86,128				
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 1,494,967</b>	<b>1,494,967</b>				

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







Carolton Chronic and Convalescent Hospital, Inc.  
9/30/2017

Schedule of Land Improvements Acquired during this report period

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

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
Oct - Jan 2017	Computer Equipment	\$ 11,955	5	\$ 2,391
<b>Total additions for Movable Equipment</b>		\$ 11,955		\$ 2,391 *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

## Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
8/1/2017	Air Conditioner	\$ 7,500	20	\$ 375
1/22/2017	Alarm System	\$ 12,698	10	\$ 1,270
<b>Total additions for Leasehold Improvement</b>		\$ 20,198		\$ 1,645 *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility Carolton Chronic and Convalescent Hospital, Inc.			License No. 606-C		Report for Year Ended 9/30/2017			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period				4,634,639	3,649,982			97,462	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				20,198				1,645	
C-4. Subtotal									99,107
<b>D. Total Amortization</b>									99,107

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

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

Name of Facility Carolton Chronic and Convalescent Hc	License No. 606-C	Report for Year Ended 9/30/2017	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description	Total			
1. Date Land Purchased	1956			
2. Date Structure Completed	1956			
3. If <b>NOT</b> Original Owner, Date of Purchase	05/09/05			
4. Date of Initial Licensure	05/09/05			
5. Total Licensed Bed Capacity	2.29			
6. Square Footage				
7. Acquisition Cost				
a. Land	139,648			
b. Building	66,176			
<b>Part B - Owner and Related Parties</b>	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	07/01/03			
c. Interest Rate for the Cost Year	5.90%			
d. Term of Mortgage (number of years)	20			
e. Amount of Principal Borrowed	9,000,000			
f. Principal balance outstanding as of _____				
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
Carolton Chronic and Convalescent H		606-C	9/30/2017			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$					

*(Carry Subtotals forward to next page )*

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

Name of Facility		License No.		Report for Year Ended		Page of	
Carolton Chronic and Convalescent		606-C		9/30/2017		27   37	
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify)				\$ 22,174	22,174		
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)				\$ 22,174	22,174		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 59,973	59,973		
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)			\$ 32,552	32,552			
2. Fire and Extended Coverage			\$				
3. Other (Specify)			\$ 137,220	137,220			
General Liability							
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$ 229,745	229,745		
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$ 23,672,978	23,672,978		

### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Carolton Chronic and Convalescent Hospital, Inc.				606-C	9/30/2017	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 426,369	426,369		
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.	15	1 e	Accounting & Legal	\$ 20,678	20,678		
11.	15	1 h1	Telephone	\$ 3,000	3,000		
12.			Cellular Telephone	\$			
13.	15	1 a 5	Life insurance premiums on the life of Owners, Partners, Operators	\$ 1,400	1,400		
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m 3	Unallowable Advertising *	\$ 58,903	58,903		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m 10	Fund Raising / Contributions	\$ 9,400	9,400		
21.	16	m 12	Unallowable Management Fees	\$ 638,464	638,464		
22.	16 &		Barber and Beauty	\$ 34,428	34,428		
23.			Other - See attached Schedule	\$ 199,250	199,250		
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.	29B		Housekeeping services to employees, guests and others who are not residents	\$ 8,479	8,479		
Subtotal (Items 1 - 26)				\$ 1,400,371	1,400,371		

\* All except "Help Wanted".

(Carry Subtotal forward to next page)

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



**Schedule of Other Salaries Adjustment**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	12 e	Outpatient PT	\$ 373,088		
10	12 g	Outpatient OT	\$ 53,281		
<b>Total Other Salaries Adjustment</b>			\$ 426,369	\$ -	\$ -

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Fees Adjustments</b>			\$ -	\$ -	\$ -

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16 A		Directors Fees	\$ 6,000		
16	L4	Entertainment	\$ 29,992		
16	L3	Gifts to staff	\$ 350		
29B		Outpatient Therapy	\$ 6,707		
16A		Penalties	\$ 19,451		
10	A1	Owner Wages	\$ 100,000		
13	8a	Med Dir - Related Party	\$ 30,000		
16	l5	Education Expense	\$ 1,596		
16	m9	Subscriptions	\$ 5,154		
<b>Total Other A&amp;G Adjustments</b>			\$ 199,250	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Carolton Chronic and Convalescent Hospital, Inc.			606-C	9/30/2017	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,400,371	1,400,371		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5a2	Prescription Drugs	\$ 530,981	530,981		
28.			Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 28,732	28,732		
30.	20	5g	Laboratory	\$ 68,450	68,450		
31.			Medical Supplies	\$			
32.	20	500	Oxygen (non emergency)	\$ 48,220	48,220		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 129,033	129,033		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 7,551	7,551		
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.	30A		Interest Income on Accounts Rec	\$ 5,617	5,617		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$ 9,542	9,542		
<b>Not For Profit Providers Only</b>							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	<b>Total Amount of Decrease (Items 1 - 50)</b>			\$ 2,228,497	2,228,497		

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

Carolton Chronic and Convalescent Hospital, Inc.  
9/30/2017

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20		IV Therapy	\$ 64,105		
20		Med Supply Personal	\$ 43,799		
20		Physician Procedures	\$ 21,129		
<b>Total Other Ancillary Costs</b>			\$ 129,033	\$ -	\$ -

**Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ -

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
29B		Outpatient Services	\$ 2,264		
29C		Apartment Disallowances	\$ 5,287		
<b>Total Other Property Adjustments</b>			\$ 7,551	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30A		Rental Income	\$ 9,542		
<b>Total Other Adjustments</b>			\$ 9,542	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

### F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Carolton Chronic and Convalescent Hosp 606-C		9/30/2017		30	37
Item	Total	CCNH	RHNS	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 15,102,792	15,102,792			
b. Medicaid Room and Board Contractual Allowance **	\$ (6,508,853)	(6,508,853)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 6,600,957	6,600,957			
b. Medicare Room and Board Contractual Allowance **	\$ (2,827,382)	(2,827,382)			
4. a. Private-Pay Residents and Other	\$ 8,579,270	8,579,270			
b. Private-Pay Room and Board Contractual Allowance **	\$ (1,371,756)	(1,371,756)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 353,146	353,146			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$ (867)	(867)			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2. a. Medical Supplies - Medicare	\$ 6,780	6,780			
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$ 13,438	13,438			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 1,035,437	1,035,437			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 171,278	171,278			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$				
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 154,830	154,830			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 1,089,746	1,089,746			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 159,039	159,039			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 94,409	94,409			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 894,250	894,250			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 23,546,514	23,546,514			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$ 5,617	5,617			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 61,247	61,247			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 66,864	66,864			
<b>VI. Total All Revenue</b> (III +V)	\$ 23,613,378	23,613,378			

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

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

**Schedule of Other Resident Revenue - Medicare**

**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
	Lab	\$ 49,880		
	Xray	\$ 20,421		
	Oxygen	\$ 24,108		
<b>Total Other Resident Revenue - Medicare</b>		\$ 94,409	\$ -	\$ -

**Schedule of Other Non-Medicare Resident Revenue**

**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
	OP Therapy	\$ 892,587		
	Lab	\$ 1,324		
	Oxygen	\$ 339		
	IV			
<b>Total Other Resident Revenue</b>		\$ 894,250	\$ -	\$ -

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income - See pg 29		\$ 5,617		
<b>Total Interest Income</b>			\$ 5,617	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
	Cafeteria - Dietary Rev \$47,197 Food Exp \$29,672, Salary Expense \$30,968	\$ (13,443)		
	Private Duty Nursing Rev \$170,548 Exp \$159,610	\$ 10,938		
	Barber Revenue	\$ 26,937		
	Personal Items Rev. \$36,249 Exp. \$8,976	\$ 27,273		
	Rent Income (See pg 28)	\$ 9,542		
<b>Total Other Revenue</b>		\$ 61,247	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic and Convalescent Ho	606-C	9/30/2017	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	150,690
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	3,373,525
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	59,451
5. Prepaid Expenses			\$	6,673
a. Prepaid Med Dir Fee	6,673			
b. _____				
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	1,424,697
Loan - Advances Employees	16,570			
CAT Holdings	1,338,742			
TTFT Management Assoc.	69,385			
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	5,015,036
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>3,815,640</u>		\$	423,209
	Accum. Depreciation <u>3,392,431</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>58,977</u>		\$	
	Accum. Depreciation <u>58,977</u>	Net		
6. Movable Equipment	*Historical Cost <u>4,557,295</u>		\$	248,930
	Accum. Depreciation <u>4,308,365</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	1,143,417
CR Dep vs. FS Dep	1,143,417			
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	1,815,556

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

(Carry Total forward to next page)

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic and Convalescent Ho	606-C	9/30/2017	32	37
<b>Account</b>			<b>Amount</b>	
Total Brought Forward:			\$	6,830,592
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
1. Land				
\$				
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	3,528,898		
	Accum. Depreciation	1,163,568	Net	\$ 2,365,330
4. Non-Movable Equipment				
	*Historical Cost	136,846		
	Accum. Depreciation	41,054	Net	\$ 95,792
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable				
\$				
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	2,461,122
<b>D. Investment and Other Assets</b>				
1. Deferred Deposits				
\$				
2. Escrow Deposits				
\$				
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)				
\$				
5. Investments Related to Resident Care ( <i>itemize</i> )				
\$				
6. Loans to Owners or Related Parties ( <i>itemize</i> )				
\$				
Name and Address		Amount	Loan Date	
7. Other Assets ( <i>itemize</i> )				
Due from CMF Realty - Related Party			(2,523,903)	\$ (2,523,903)
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)				
			\$	(2,523,903)
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)				
			\$	6,767,811

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



**G. Balance Sheet (cont'd)**

Name of Facility Carolton Chronic and Convalescent Hospital,		License No. 606-C	Report for Year Ended 9/30/2017	Page 33	of 37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	420,520
2. Notes Payable ( <i>itemize</i> )				\$	
_____					
_____					
_____					
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$	246,625
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	84,559
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable ( <i>Current Portion</i> )				\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$	
11. Accrued Income Taxes*				\$	41,000
12. Other Current Liabilities ( <i>itemize</i> )				\$	426,497
Accrued Prop Tax/Prop Tax Escrow		79,211	Deferred Fed Income Tax	64,000	
Employee Garnishment		2,198	CT Bus. Tax Payable	12,000	
Employee 401K Loan Payments		29,292			
Due to State of CT		239,796			
A-13. <b>Total Current Liabilities</b> (Lines A1 thru 12)				\$	1,219,201

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

(Carry Total forward to next page)

### G. Balance Sheet (cont'd)

Name of Facility Carolton Chronic and Convalescent Hospital	License No. 606-C	Report for Year Ended 9/30/2017	Page 34	of 37
Account			Amount	
Total Brought Forward:			1,219,201	
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				
				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$ 31,811
Name and Address of Lender	Amount	Loan Date		
Loan CAT	31,811			
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 31,811
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 1,251,012

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

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic and Convalescent H	606-C	9/30/2017	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	2,461,122
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	2,461,122
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	18,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	(540,000)
5. Cumulated Earnings			\$	3,484,872
6. Gain or Loss for Period			\$	92,805
	10/1/2016	thru	9/30/2017	
7. Total Net Worth			\$	3,055,677
<b>C. Total Reserves and Net Worth</b>			\$	5,516,799
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	6,767,811

### H. Changes in Total Net Worth

Name of Facility Carolton Chronic and Convalescent Hos	License No. 606-C	Report for Year Ended 9/30/2017	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	2,962,872
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	23,613,378
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	23,672,978
D. Net Income or Deficit			\$	(59,600)
E. Balance			\$	2,903,272
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
CR Dep Vs. FS	152,405			
2. Other ( <i>itemize</i> )				
F-3. Total Additions			\$	152,405
G. Deductions				
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )			\$	
Name and Address ( <i>No., City, State, Zip</i> )		Title	Amount	
2. Other Withdrawings ( <i>Specify</i> )			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	3,055,677
				09/30/17

### I. Preparer's/Reviewer's Certification

Name of Facility Carolton Chronic and Convalescent	License No. 606-C	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
PKF O'Connor, Davies, LLP				
Address			Phone Number	
100 Great Meadow Rd. Wethersfield, CT 06109			860-257-1870	