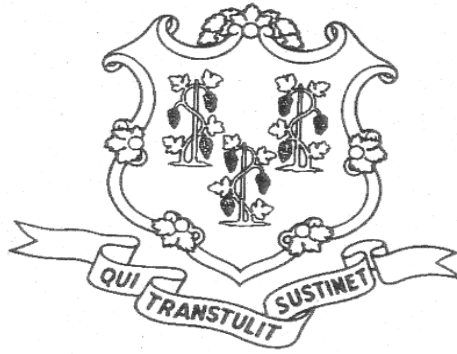


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2018

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 <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)	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

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

**General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Carolton Chronic and Convalescent Hospital, Inc.	606-C	9/30/2018	1	37

**Administrator's/Owner's Certification**

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Carolton Chronic and Convalescent Hospital, Inc. [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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)

# Table of Contents

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

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 10/1/2017	To 9/30/2018	
Address of Facility 400 Mill Plain Road, Fairfield, CT 06824				
Report Prepared By PKF O'Connor, Davies, LLP	Phone Number 860-257-1870	Date 2/11/2019		
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 9/30/2018	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 9/30/2018	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 Tru	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	9/30/2018	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

### Basis for Allocation of Costs

Name of Facility Carolton Chronic and Convalescent Hospital, Inc	License No. 606-C	Report for Year Ended 9/30/2018	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		License No.	Report for Year Ended			Page	of
Carolton Chronic and Convalescent Hospital, Inc.		606-C	9/30/2018			6	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	1,948	1,948
DeLange	<input type="radio"/>	<input checked="" type="radio"/>	Copy Machines	Monthly	Monthly	7,192	7,192
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?						<input type="radio"/> Yes	<input checked="" type="radio"/> No
<b>Total ***</b>						9,140	

\* 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 9/30/2018	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/Financial Statements/Tax Returns	\$ 32,875
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 32,875

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

- Yes     No    pg 15 1d

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 2 Jennifer Gable 3 Jackson Lewis 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 Collections (see pg 28)	\$ 2,100
2 Discrimination issue	\$ 20,890
3 Corporate (see pg 28)	\$ 435
4	\$
5	\$
	Charge for Services Provided
	\$ 23,425

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

- Yes     No    pg 15 e

### Schedule of Resident Statistics

Name of Facility Carolton Chronic and Convalescent Hospital, Inc.			License No. 606-C		Report for Year Ended 9/30/2018				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	165	165			165	165			148	148		
B. As of midnight of THIS report period	144	144			148	148			144	144		
3. Total Number of Days Care Provided During Period												
A. Medicare	9,620	9,620			7,359	7,359			2,261	2,261		
B. Medicaid (Conn.)	27,974	27,974			21,659	21,659			6,315	6,315		
C. Medicaid (other states)												
D. Private Pay	17,454	17,454			12,500	12,500			4,954	4,954		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	55,048	55,048			41,518	41,518			13,530	13,530		
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	271	271			234	234			37	37		
5. <b>Total Resident Days (3G + 4A + 4B)</b>	55,319	55,319			41,752	41,752			13,567	13,567		

**Annual Report of Long-Term Care Facility**

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

Name of Facility Carolton Chronic and Convalescent Hospital,			License No. 606-C			Report for Year Ended 9/30/2018			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input checked="" type="radio"/> Yes <input type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(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	RHNS	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR			
No. of Residents	23		66			55							
Per Diem Rate													
a. One bed rm.			251.85			500-560							
b. Two bed rms.						417-481							
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									1,629	1,629			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									1	1			
C. Other									17,415	17,415			
D. <b>Total Physical Therapy Treatments</b>									19,045	19,045			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									163	163			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments													
C. Other									1,501	1,501			
D. <b>Total Speech Therapy Treatments</b>									1,664	1,664			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									1,057	1,057			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									1	1			
C. Other									11,700	11,700			
D. <b>Total Occupational Therapy Treatments</b>									12,758	12,758			

## Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Carolton Chronic and Convalescent Hospital, Inc.	606-C	9/30/2018	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.)	724,781	32,324				
5. Dietary Service						
a. Head Dietitian	90,063	2,080				
b. Food Service Supervisor						
c. Dietary Workers	1,050,174	68,416				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	671,776	46,706				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	198,750	10,111				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	126,509	8,971				
9. Barber and Beautician Services	33,017	1,852				
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	179,942	4,004				
b. RN						
1. Direct Care	1,221,618	30,443				
2. Administrative**	304,102	8,037				
c. LPN						
1. Direct Care	2,639,246	82,812				
2. Administrative**	125,754	4,059				
d. Aides and Attendants	2,783,669	170,786				
e. Physical Therapists	1,337,918	44,786				
f. Speech Therapists						
g. Occupational Therapists	660,744	18,810				
h. Recreation Workers	224,890	122,350				
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	66,733	2,751				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	62,539	2,880				
A-13. Total Salary Expenditures	12,846,225	670,498				

\* 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	\$ 62,539	2,880				
<b>Total</b>	\$ 62,539	2,880	\$ -	-	\$ -	-

**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	9/30/2018				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 28a				President of Corp.	2,080	A1	TTFT Mgmt Co.	Pg28 Disal	

\* 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	9/30/2018			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		TTFT Mgmt. Co.	Pg28 Disal	
<b>Section IV - Assistant Administrators</b>										
Thomas J. Tortora	72,000				Ast. Admin.	2,080	A3	TTFT Mgmt. Co.	Pg28 Disal	
Kathleen Abrahamsen	72,000				Ast. Admin.	2,080	A3	TTFT Mgmt. Co.	Pg28 Disal	

\*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	9/30/2018	13	37		
<b>Total Cost and Hours</b>						
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)	30,000	300				
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) Ast. Medical Director - See pg 28	30,000	100				
9. Speech Therapist						
a. Resident Care	83,752	1,288				
b. Other	10,352	159				
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>173,598</b>	<b>1,943</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.



**Annual Report of Long-Term Care Facility**

CSP-15 Rev. 10/2005

**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	9/30/2018	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 582,393	582,393		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$			
4. Social Security (F.I.C.A.)	\$ 1,179,370	1,179,370		
5. Health Insurance	\$ 1,776,928	1,776,928		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 7,668	7,668		
8. Uniform Allowance	\$			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 32,875	32,875		
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 23,425	23,425		
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 252,110	252,110		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 29,813	29,813		
2. Cellular Phones	\$ 5,055	5,055		
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*	\$ 130,362	130,362		
2. Other ( <i>Specify</i> ) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 899,409	899,409		
<b>Subtotal</b>	\$ 4,919,408	4,919,408		

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

(Carry Subtotals forward to next page)



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

Name of Facility	License No.	Report for Year Ended		Page	of
Carolton Chronic and Convalescent Hospital, Inc.	606-C	9/30/2018		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>	4,919,408	4,919,408			
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$ 13,556	13,556			
4. Employee Travel	\$ 33,037	33,037			
5. Education Expenses Related to Seminars and Conventions	\$ 3,652	3,652			
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> )	\$ 3,078	3,078			
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 14,348	14,348			
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)***	\$ 312	312			
7. Postage	\$				
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 3,700	3,700			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 1,830	1,830			
10. Contributions*** See Attached Schedule	\$ 9,321	9,321			
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$				
12. Administrative Management Services**	\$ 626,491	626,491			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 37,671	37,671			
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 5,666,404	5,666,404			

\* 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	\$ 14,348		
<b>Total Other Advertising</b>	\$ 14,348	\$ -	\$ -

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 700		
Dues (See pg 28a)	\$ 3,000		
	\$ -		
<b>Total Dues</b>	\$ 3,700	\$ -	\$ -

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
See pg 28	\$ 9,321		
<b>Total Contributions</b>	\$ 9,321	\$ -	\$ -

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Director Fees (see pg 28)	\$ 12,000		
Penalties (See pg 28)	\$ 307		
Preemployment Physicals	\$ 17,800		
Permit	\$ 100		
Other (see pg 28)	\$ 7,464		
<b>Total Other Administrative and General</b>	\$ 37,671	\$ -	\$ -



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

Name of Facility	License No.	Report for Year Ended	Page of
Carolton Chronic and Convalescent Hosp	606-C	9/30/2018	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	626,491	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		License No.	Report for Year Ended		Page	of
Carolton Chronic and Convalescent Hospital, Inc.		606-C	9/30/2018		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1. Raw Food	\$	518,645	518,645			
2. Non-Food Supplies	\$	122,438	122,438			
3. Other (Specify) _____	\$					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Other (Specify) _____		\$				
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>		\$	641,083	641,083		
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.

**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	9/30/2018		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. \$	60,642	60,642		
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 ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )		\$	2,726	2,726		
c. Other ( <i>Specify</i> ) Supplies		\$	26,354	26,354		
3D. <b>Total Laundry Expenditures</b> (3a + b + c)		\$	89,722	89,722		
3F. Laundry Questionnaire						
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				

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

All allocations should add to total recorded in 3E.

\*\*\* 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, In		606-C	9/30/2018		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. \$	86,539	86,539		
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.	Other ( <i>Specify</i> )	\$				
<b>4D.</b>	<b>Total Housekeeping Expenditures (4a + b + c)</b>	\$	86,539	86,539		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from	\$	398,726	398,726		
b.	Medicine Cabinet Drugs	\$				
c.	Medical and Therapeutic Supplies	\$	262,653	262,653		
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	38,593	38,593		
f.	X-rays and Related Radiological Procedures***	\$	29,045	29,045		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h.	Laboratory***	\$	85,639	85,639		
i.	Recreation	\$	16,176	16,176		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	154,418	154,418		
<b>5M.</b>	<b>Total Resident Care Expenditures (5a - 5j)</b>	\$	985,250	985,250		

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

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

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

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

**Schedule of Other Resident Care**

Description	CCNH	RHNS	(Specify)
IV - Medicare See pg 29	\$ 52,781		
IV - Managed Care - See pg 29	\$ 25,015		
Medical Supplies - Personal - See pg 29	\$ 38,193		
Physical Therapy Supplies	\$ 6,253		
Medical Supplies - Medicare	\$ 6,423		
Physicians Procedures-Med A- CB - see pg 29	\$ 22,007		
Medical Supplies - Mgd Care	\$ 3,746		
<b>Total Other Resident Care</b>	<b>\$ 154,418</b>	<b>\$ -</b>	<b>\$ -</b>

**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 9/30/2018	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
Call Peter		<input type="radio"/>	<input checked="" type="radio"/>		Trash Service	37,646			22	6f
Direct TV		<input type="radio"/>	<input checked="" type="radio"/>		TV	21,085			22	6f
D&M Landscaping		<input type="radio"/>	<input checked="" type="radio"/>		Landscaping/snow removal	40,220			22	6a,6f
Ray Flanagan		<input type="radio"/>	<input checked="" type="radio"/>		Plumbing	34,069			22	6a,6f
Precision Mechanicla		<input type="radio"/>	<input checked="" type="radio"/>		Sprinkler System	13,015			22	6f
Home Depot		<input type="radio"/>	<input checked="" type="radio"/>		Maint. Supplies	15,902			22	6a
Toth Mechanical		<input type="radio"/>	<input checked="" type="radio"/>		HVAC	35,468			22	6a,6f
Federal Electric		<input type="radio"/>	<input checked="" type="radio"/>		Electrical Contractor	16,175			22	6a,6f
ICS		<input type="radio"/>	<input checked="" type="radio"/>		Computer System	35,008			15	1g
Pointclick		<input type="radio"/>	<input checked="" type="radio"/>		Computer System	67,117			15	1g
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" 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	9/30/2018			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 161,859	161,859				
b. Heat	\$ 94,885	94,885				
c. Light & Power	\$ 218,233	218,233				
d. Water	\$ 46,116	46,116				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 9,140	9,140				
f. Other ( <i>itemize</i> )	\$ 231,762	231,762				
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	\$ 761,995	761,995				
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	\$ 50,536	50,536				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	\$ 191,863	191,863				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 96,395	96,395				
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	\$ 96,395	96,395				
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	\$ 266,817	266,817				
c. Personal property taxes	\$ 98,976	98,976				
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	\$ 1,584,051	1,584,051				

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

**Schedule of Other Repairs and Maintenance**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
Purchased services	\$ 231,762		
<b>Total Other Repairs and Maintenance</b>	\$ 231,762	\$ -	\$ -

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### Depreciation Schedule

Name of Facility Carolton Chronic and Convalescent Hospital, Inc.			License No. 606-C		Report for Year Ended 9/30/2018			Page 23	of 37				
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
<b>A. Land Improvements</b>													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
<b>A-4. Subtotal</b>													
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period			3,689,402		2,689,700	806,910			134,485				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
<b>B-4. Subtotal</b>										134,485			
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period			4,964,386		195,823	100,030			6,842				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
<b>C-4. Subtotal</b>										6,842			
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year								
<b>D. Movable Equipment</b>													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period						4,557,295		4,557,295	4,308,365			40,336	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						51,000		51,000				10,200	
<b>D-3. Subtotal</b>													50,536
<b>E. Total Depreciation</b>													191,863

Carolton Chronic and Convalescent Hospital, Inc.  
9/30/2018

**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 Improvement</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Land Improvement</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 Improvement</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Building Improvement</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>				
9/12/2018	Laptops	\$ 5,306	5	\$ 1,061
1/4/2018	Scales	\$ 11,168	5	\$ 2,234
10/18/2017	Mattresses	\$ 3,373	5	\$ 675
3/22/2018	Washers	\$ 10,200	5	\$ 2,040
3/16/2018	Scales	\$ 6,227	5	\$ 1,245
8/22/2018	Hydraulic Lift	\$ 6,884	5	\$ 1,377
8/22/2018	TV patient rooms	\$ 2,882	5	\$ 576
11/16/2017	PT equipment	\$ 4,960	5	\$ 992
<b>Total additions for Movable Equipmen</b>		\$ 51,000		\$ 10,200 *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipmen</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>				
12/17/2017	Roofing	\$ 9,061	20	\$ 453
6/12/2018	Spinkler	\$ 17,335	20	\$ 867
6/1/2018	Water heater	\$ 11,104	20	\$ 555
7/22/2018	Porch Repairs (rotted wood replacement)	\$ 3,222	20	\$ 161
8/21/2018	Water heater	\$ 5,876	20	\$ 294
<b>Total additions for Leasehold Improvemen</b>		\$ 46,598		\$ 2,330 *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvemen</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Annual Report of Long-Term Care Facility**

CSP-24 Rev. 10/2006

**Amortization Schedule\***

Name of Facility			License No.		Report for Year Ended			Page	of
Carolton Chronic and Convalescent Hospital, Inc.			606-C		9/30/2018			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<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				4,654,837	3,749,089			94,065	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				46,598				2,330	
C-4. Subtotal									96,395
<b>D. Total Amortization</b>									96,395

\* 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 9/30/2018	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 type="radio"/> Yes	<input checked="" 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	9/30/2018			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		9/30/2018			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)				\$	2,008	2,008		
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$	2,008	2,008		
14. Insurance								
a. Insurance on Property (buildings only)				\$	58,178	58,178		
b. Insurance on Automobiles				\$	209	209		
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)				\$	27,000	27,000		
2. Fire and Extended Coverage				\$				
3. Other (Specify) Gen. Liability				\$	134,529	134,529		
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$	219,916	219,916		
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$	23,056,791	23,056,791		

### 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	9/30/2018	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	\$ 882,494	882,494		
<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.			Accounting	\$			
10a.			Legal	\$ 2,535	2,535		
11.	15	1h1	Telephone	\$ 3,000	3,000		
12.	15	1h2	Cellular Telephone	\$ 3,255	3,255		
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	m3	Unallowable Advertising *	\$ 14,348	14,348		
19.	15	k1	Income Tax / Corporate Business Tax	\$ 130,362	130,362		
20.	16	m10	Fund Raising / Contributions	\$ 9,321	9,321		
21.	16	m12	Unallowable Management Fees	\$ 626,491	626,491		
22.	10, 16	a9, m6	Barber and Beauty	\$ 33,329	33,329		
23.			Other - See attached Schedule	\$ 201,144	201,144		
<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.			Housekeeping services to employees, guests and others who are not residents	\$ 8,427	8,427		
Subtotal (Items 1 - 26)				\$ 1,916,106	1,916,106		

\* 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	12e	Outpatient PT Wages	\$ 426,871		
		Outpatient PT Benefits 27.61% (see pg 29b)	\$ 117,859		
10	12f	Outpatient OT	\$ 256,572		
		Outpatient OT Benefits 27.61% (See pg 29b)	\$ 70,840		
13	9b	Outpatient Speech	\$ 10,352		
<b>Total Other Salaries Adjustment</b>			\$ 882,494	\$ -	\$ -

**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	L 5	Education	\$ 1,730		
27	12D	Interest Expense	\$ 2,008		
Pg 16a		Dues	\$ 3,000		
30a		Interest Income	\$ 8		
16	L4	Travel/Entertainment	\$ 32,333		
16 A		Directors Fees	\$ 12,000		
29B		Outpatient Therapy	\$ 6,392		
13	8e	Med Dir Related Party	\$ 30,000		
16A		Penalties	\$ 307		
27	14b	Auto Insurance	\$ 209		
16a		Other	\$ 7,464		
16	L3	Gifts	\$ 5,693		
10 A1		Owner Wages	\$ 100,000		
<b>Total Other A&amp;G Adjustments</b>			\$ 201,144	\$ -	\$ -

**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	9/30/2018	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,916,106	1,916,106		
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$ 398,726	398,726		
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$ 29,045	29,045		
30.			Laboratory	\$ 85,639	85,639		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$ 38,593	38,593		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 137,996	137,996		
<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	\$ 9,811	9,811		
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$ 5,600	5,600		
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 2,621,516	2,621,516		

\*\*\* 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.  
9/30/2018

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20a		IV Therapy	\$ 77,796		
20a		Personal Supplies	\$ 38,193		
20a		Physician Services	\$ 22,007		
<b>Total Other Ancillary Costs</b>			\$ 137,996	\$ -	\$ -

**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	\$ 2,902		
29C		Apartment Disallowance	\$ 6,909		
<b>Total Other Property Adjustments</b>			\$ 9,811	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30A		Rental Income	\$ 5,600		
<b>Total Other Adjustments</b>			\$ 5,600	\$ -	\$ -

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 Hospi	606-C	9/30/2018		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> )	\$ 12,773,031	12,773,031			
b. Medicaid Room and Board Contractual Allowance **	\$ (5,849,850)	(5,849,850)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 6,626,553	6,626,553			
b. Medicare Room and Board Contractual Allowance **	\$ (2,781,119)	(2,781,119)			
4. a. Private-Pay Residents and Other	\$ 9,705,568	9,705,568			
b. Private-Pay Room and Board Contractual Allowance **	\$ (1,427,103)	(1,427,103)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 326,934	326,934			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$ (340)	(340)			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2. a. Medical Supplies - Medicare	\$ 6,107	6,107			
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$ 31,396	31,396			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 1,019,128	1,019,128			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 193,768	193,768			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$				
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 125,990	125,990			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 1,116,712	1,116,712			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 211,916	211,916			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 100,851	100,851			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 944,749	944,749			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 23,124,291	23,124,291			
<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> )	\$ 8	8			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 89,053	89,053			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 89,061	89,061			
<b>VI. Total All Revenue</b> (III +V)	\$ 23,213,352	23,213,352			

\* 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	\$ 62,218		
	Xray	\$ 18,529		
	Oxygen	\$ 20,104		
<b>Total Other Resident Revenue - Medicare</b>		\$ 100,851	\$ -	\$ -

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

**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
	IV	\$ (3)		
	Outpatient	\$ 664,846		
	Lab	\$ 5,104		
	IV	\$ (1,273)		
	therapy	\$ 276,075		
<b>Total Other Resident Revenue</b>		\$ 944,749	\$ -	\$ -

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income see pg 29		\$ 8		
<b>Total Interest Income</b>			\$ 8	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
	Cafeteria Net- Revenue \$38,298, Food Exp -\$24,898 Café wages - \$29,163	\$ (15,763)		
	Private Duty Nursing Net - Revenue = \$52,104 Wages - \$49,154	\$ 2,950		
	Hairdresser & Barber	\$ 20,599		
	Personal Items	\$ 78,401		
	Personal Items	\$ (2,734)		
	Rent Income (see pg 29)	\$ 5,600		
<b>Total Other Revenue</b>		\$ 89,053	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic and Convalescent Hos	606-C	9/30/2018	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	438,499
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	3,387,957
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	56,567
5. Prepaid Expenses			\$	5,600
a. In-house MD	5,600			
b. _____				
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	1,720,004
TIFT Mgmt	73,676			
CAT holdings	1,639,051			
Loans to Employees	4,959			
See Schedule	2,318			
<b>A-9. Total Current Assets (Lines A1 thru 8)</b>			<b>\$</b>	<b>5,608,627</b>
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>3,862,238</u>		\$	415,372
	Accum. Depreciation <u>3,446,866</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>4,608,295</u>		\$	249,394
	Accum. Depreciation <u>4,358,901</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	1,099,890
CR vs FS Depr.	1,099,890			
See Schedule				
<b>B-10. Total Fixed Assets (Lines B1 thru 9)</b>			<b>\$</b>	<b>1,764,656</b>

\* 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	9/30/2018	32	37
Account			Amount	
Total Brought Forward:			\$	7,373,283
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	3,528,898		
	Accum. Depreciation	1,340,013	Net	\$ 2,188,885
4. Non-Movable Equipment				
	*Historical Cost	136,846		
	Accum. Depreciation	47,896	Net	\$ 88,950
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>			<b>\$</b>	<b>2,277,835</b>
D. Investment and Other Assets				
1. Deferred Deposits				\$
2. Escrow Deposits				\$
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)				\$
5. Investments Related to Resident Care <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			(2,573,656)	\$ (2,573,656)
See Schedule				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			<b>\$</b>	<b>(2,573,656)</b>
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			<b>\$</b>	<b>7,077,462</b>

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



Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
<b>Total Prepaid Expenses</b>			\$ -

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref	Line Ref	Description	
		Loans & Advances CAT Jr. Related Party	\$ 2,318
<b>Total Other Current Assets (Itemize)</b>			\$ 2,318

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref	Line Ref	Description	
<b>Total Other Other Fixed Assets (Itemize)</b>			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
<b>Total Other Assets</b>			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			\$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

Schedule of Other Long-Term Liabilities (itemize) Page 34 Line B4

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

**Annual Report of Long-Term Care Facility**

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

Name of Facility Carolton Chronic and Convalescent Hospital,		License No. 606-C	Report for Year Ended 9/30/2018	Page 33	of 37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	470,333
2. Notes Payable ( <i>itemize</i> )				\$	
_____					
_____					
See Schedule					
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> )				\$	247,525
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	106,308
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*				\$	88,000
12. Other Current Liabilities ( <i>itemize</i> )				\$	504,038
CT Bus. Tax		29,000	Employee 401K Loans P	30,334	
Accrued Prop Tax		200,113	Due to State of CT	216,506	
Property Escrow		(45,802)	Deferred Fed Income Ta:	71,100	
Employee Garnishment		2,787	See Schedule		
A-13. <b>Total Current Liabilities</b> (Lines A1 thru 12)				\$	1,416,204

\* 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 9/30/2018	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,416,204	
<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> )				\$ 31,425	
Name and Address of Lender	Amount	Loan Date			
Loan CAT	31,425				
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$	
_____					
_____					
See Schedule					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 31,425	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 1,447,629	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic and Convalescent Ho	606-C	9/30/2018	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			\$	2,277,835
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			\$	2,277,835
<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			\$	3,577,677
6. Gain or Loss for Period			\$	296,321
	10/1/2017	thru	9/30/2018	
7. Total Net Worth			\$	3,351,998
<b>C. Total Reserves and Net Worth</b>			\$	5,629,833
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	7,077,462

### H. Changes in Total Net Worth

Name of Facility Carolton Chronic and Convalescent Hos	License No. 606-C	Report for Year Ended 9/30/2018	Page 36	of 37		
Account			Amount			
A. Balance at End of Prior Period as shown on Report of 09/30/2017			\$	3,577,677		
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	23,213,352		
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	23,056,791		
D. Net Income or Deficit			\$	156,561		
E. Balance			\$	3,734,238		
F. Additions						
1. Additional Capital Contributed <i>(itemize)</i>						
CR vs FS Depreciation	139,760					
2. Other <i>(itemize)</i>						
F-3. Total Additions					\$	139,760
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>			\$		3,873,998	
				09/30/18		

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

Name of Facility Carolton Chronic and Convalescent	License No. 606-C	Report for Year Ended 9/30/2018	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 Address			Phone Number	
100 Great Meadow Rd. Wethersfield, CT 06109			860-257-1870	
Annual Report Contact			Phone Number	
Annual Report Contact Email Address				