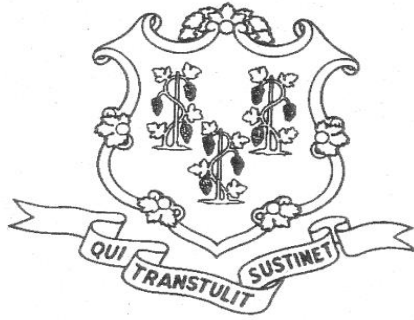


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2023

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 <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 606C	(Specify)	(Specify)	Medicare Provider 07-5034
------------------	---------------------	-----------	-----------	------------------------------

Medicaid Provider Numbers:	00000 6064	CCNH / RHNS	(Specify)	(Specify)
----------------------------	------------	-------------	-----------	-----------

General Information

Name of Facility (as licensed) Carolton Chronic and Convalescent Hospital, Inc.	License No. 606C	Report for Year Ended 9/30/2023	Page 1	of 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, 2022 and ending September 30, 2023, 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) Thomas J. Tortora			Printed Name (Owner) Kathryn Abrahamsen, President		
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 - Other Lines of Business	6
General Information and Questionnaire - Other Lines of Business (Continued)	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
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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Carolton Chronic and Convalescent Hospital, Inc.		Period Covered:	From 10/1/2022	To 9/30/2023
Address of Facility 400 Mill Plain Road Fairfield, CT 06824				
Report Prepared By Thomas O. Marien, CFO		Phone Number (203) 255-3573	Date 3/29/2024	
Item	Total	CCNH / RHNS	(Specify)	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility (203) 255-3573		Report for Year Ended 9/30/2023	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 / RHNS 606C	(Specify)	(Specify)	Medicare Provider No. 07-5034
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box) <input type="checkbox"/> Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> 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 N/A	Date Closed N/A	
Has there been any change in ownership or operation during this report year? <input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," explain fully.				
Carmen A. Tortora was replaced as President by Kathryn L. Abrahamsen and Dennis Kretzmer was replaced as Administrator by Thomas J. Tortora				
Administrator				
Name of Administrator Thomas J. Tortora		Nursing Home Administrator's License No.:	000753	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name None		License No.:		

General Information and Questionnaire
Corporate Owners

Name of Facility Carolton Chronic and Convalescent Hospital	License No. 606C	Report for Year Ended 9/30/2023	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 Incorporated	400 Mill Plain Road Fairfield, CT 06824	CT		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Kathryn L. Abrahamsen	400 Mill Plain Road Fairfield, CT 06824	President	None	
Michael Tortora	400 Mill Plain Road Fairfield, CT 06824	Director	None	
Paul M. Tortora	400 Mill Plain Road Fairfield, CT 06824	Director	None	
Russell J. Melita	400 Mill Plain Road Fairfield, CT 06824	Director	None	
Names of Stockholders Owning at Least 10% of Shares				
C.A.T. Holdings (a limited partnership) 100%	400 Mill Plain Road Fairfield, CT 06824	CT	120	

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic and Convalescent Hospital, Inc.	606C	9/30/2023	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. 606C	Report for Year Ended 9/30/2023	Page 4	of 37
--	---------------------	------------------------------------	-----------	----------

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	%**				
C.M.F. Realty	400 Mill Plain Road Fairfield CT 06824	<input type="radio"/>	<input checked="" type="radio"/>		Rental of Real Estate	22 9 A	930,000	
TTFT Management Associates	400 Mill Plain Road Fairfield CT 06824	<input type="radio"/>	<input checked="" type="radio"/>		Management	16 M 12 and pg 28	172,826	
Turtledove Home Infusion Nurses, LLC	411 Meadow Street Fairfield, CT 06824	<input checked="" type="radio"/>	<input type="radio"/>	99%	Blood Infusion Therapy	13 B 5	1,677	1,397
		<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"/>					

* 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. 606C	Report for Year Ended 9/30/2023	Page 5	of 37
--	---------------------	------------------------------------	-----------	----------

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (<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.

N/A

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
Other Lines of Business

Name of Facility Carolton Chronic and Convalescent H	License No. 606C	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility.		99,103		
Outpatient Therapy				
Does the Facility provide outpatient therapy services?		Yes		
<i>If yes, please complete the following:</i>				
0		Square footage of therapy space.		
Meals on Wheels				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
		Square footage of kitchen		
		Number of meals served per week		
No		Are meals included in meals served on page 18 of the Annual Report?		
No		Are direct costs included in the Annual Report?		
<i>If yes, please state where costs are reported.</i>				
No		Are drivers for the program included in the facility's payroll?		
<i>If yes, please complete the following:</i>				
		Amount Reported		
		Annual Report page and line		
Please state the salary amounts of specific cooks and/or dietary aides				
Please state where the cooks and/or dietary aides are reported in the Annual Report				
Apartments, Independent Living, Assisted Living				
Does the facility have apartments, independent living, and/or assisted living?		Yes		
<i>If yes, please complete the following:</i>				
1,872		Square footage of apartments		
0		Square footage of independent living		
0		Square footage of assisted living		
Please identify the services provided:				

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility Carolton Chronic and	License No. 606C	Report for Year Ended 9/30/2023	Page 7	of 37
--	---------------------	------------------------------------	-----------	----------

Child Day Care

Does the Facility provide Child Day Care? No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care? No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

Schedule of Resident Statistics

Name of Facility Carolton Chronic and Convalescent Hospital, Inc.			License No. 606C		Report for Year Ended 9/30/2023				Page 8	of 37		
	Total All Levels	Total CCNH / RHNS Level	Total	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	229	229			229	229						
B. On last day of THIS report period	229	229							229	229		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	113	113			113	113						
B. As of midnight of THIS report period	113	113							113	113		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,446	5,446			4,394	4,394			1,052	1,052		
B. Medicaid (Conn.)	19,743	19,743			14,697	14,697			5,046	5,046		
C. Medicaid (other states)												
D. Private Pay	12,968	12,968			9,392	9,392			3,576	3,576		
E. State SSI for RCH												
F. Other (Specify) Hospice, Managed Care	3,862	3,862			2,785	2,785			1,077	1,077		
G. Total Care Days During Period (3A thru F)	42,019	42,019			31,268	31,268			10,751	10,751		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	42,019	42,019			31,268	31,268			10,751	10,751		

Schedule of Resident Statistics (Cont'd)

Name of Facility Carolton Chronic and Convalescent Hospital, Inc.	License No. 606C	Report for Year Ended 9/30/2023	Page 9	of 37
--	---------------------	------------------------------------	-----------	----------

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)	(Specify)	Lost			Gained			CCNH / RHNS	(Specify)	(Specify)		
	(1)	(2)	(3)	(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)	(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)	(Specify)	R.C.H.	ICF-MR
No. of Residents	12	53		44				
Per Diem Rate								
a. One bed rm.	700.00	#####		\$494 - \$597				
b. Two bed rms.				\$444 - \$508				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	7,745	3,571		4,174	
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments	142	142			
C. Other					
D. Total Physical Therapy Treatments	7,887	3,713		4,174	
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	350	350			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other					
D. Total Speech Therapy Treatments	350	350			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	3,602	2,747		855	
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other					
D. Total Occupational Therapy Treatments	3,602	2,747		855	

Report of Expenditures - Salaries & Wages

Name of Facility Carolton Chronic and Convalescent Hospital, Inc.	License No. 606C	Report for Year Ended 9/30/2023	Page 10	of 37
--	---------------------	------------------------------------	------------	----------

Are time records maintained by all individuals receiving compensation? Yes No

Item	Total Cost and Hours								
	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
A. Salaries and Wages*									
1. Operators/Owners (Complete also Sec. I of Schedule A1)									
2. Administrator(s) (Complete also Sec. III of Schedule A1)	156,000		2,080						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	123,552		2,080						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	879,238		29,330						
5. Dietary Service									
a. Head Dietitian	151,018		4,380						
b. Food Service Supervisor	81,974		2,516						
c. Dietary Workers	1,110,937		71,691						
6. Housekeeping Service									
a. Head Housekeeper	83,983	(932)	2,111						
b. Other Housekeeping Workers	785,073	(8,714)	52,904						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	49,948		1,953						
b. Other Maintenance Workers	73,545		5,777						
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers	111,049		8,785						
9. Barber and Beautician Services									
10. Protective Services									
11. Accounting Services									
a. Head Accountant	27,000		360						
b. Other Accountants									
12. Professional Care of Residents									
a. Directors and Assistant Director of Nurses	108,380		2,123						
b. RN									
1. Direct Care	1,333,230		34,686						
2. Administrative**									
c. LPN									
1. Direct Care	3,150,827		101,484						
2. Administrative**									
d. Aides and Attendants	2,536,239		144,826						
e. Physical Therapists	849,149	(457,667)	19,566						
f. Speech Therapists									
g. Occupational Therapists	481,069	(114,216)	11,624						
h. Recreation Workers	165,656		7,458						
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	219,386		6,343						
n. Marketing									
o. Other (Specify) See Attached Schedule	64,978		2,551						
<i>A-13. Total Salary Expenditures</i>	<i>12,542,231</i>	<i>(581,529)</i>	<i>514,628</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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
Medical Records	\$ 64,978		2,551						
Total	\$ 64,978	\$ -	2,551	\$ -	\$ -	-	\$ -	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
Blood Infusioin Therapy	\$ 1,677		6						
Private Duty Nursing	\$ 29,818	\$ (29,818)	1,491						
Assistant Medical Director	\$ 30,000	\$ (30,000)	50						
Total	\$ 61,495	\$ (59,818)	1,547	\$ -	\$ -	-	\$ -	\$ -	-

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.				606C	9/30/2023			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)	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
Kathryn L. Abrahamsen	143,000			Medical and Disability Insurance		2,080	10 A 4			

* 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.				606C	9/30/2023			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)	(Specify)							
Section III - Administrators***										
Dennis Kretzmer	156,000			Medical and Disability Insurance		2,080	10 A 2			
Section IV - Assistant Administrators										
Thomas J. Tortora	123,552			Medical and Disability Insurance		2,080	10 A 3			

*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.

Annual Report of Long-Term Care Facility

CSP-13 Rev. 3/2023

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended						Page	of
Carolton Chronic and Convalescent Hospital, Inc.	606C	9/30/2023						13	37
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)									
1. Dietitian	600		13						
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)	30,888		250						
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)									
Personal Physician	350	(350)	1						
9. Speech Therapist									
a. Resident Care	82,500		1,269						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	34,188		562						
2. Administrative***									
b. LPN									
1. Direct Care	19,783		314						
2. Administrative***									
c. Aides	428,068		12,094						
d. Other									
12. Other (Specify)									
See Attached Schedule	61,495	(59,818)	1,547						
B-13 Total Fees Paid in Lieu of Salaries	677,366	(60,168)	16,146						

* 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 in the Adjustment column.

*** 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 Carolton Chronic and Convalescent Hospital, Inc.		License No. 606C		Report for Year Ended 9/30/2023		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship			
		Yes	No				
Healthdrive Dental, 5 Needham Street Newton MA 02461	Dental Services and Eye Exams	<input type="radio"/>	<input checked="" type="radio"/>				
Stuart Miller MD Inhouse MD LLC 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"/>	Beneficiary of Trust			
Rehab Associates, 411 Old Coach Road, Fairfield, CT	Speech Therapy	<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"/>				
		<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"/>				

* 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	606C	9/30/2023					15	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 190,355	199,612	(9,257)					
2. Disability Insurance	\$ 263,207	276,007	(12,800)					
3. Unemployment Insurance	\$							
4. Social Security (F.I.C.A.)	\$ 934,051	979,475	(45,424)					
5. Health Insurance	\$ 1,130,019	1,184,973	(54,954)					
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 15,049	15,781	(732)					
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*	\$	337,542	(337,542)					
d. Accounting and Auditing	\$ 70,158	70,158						
e. Legal (<i>Services should be fully described on Page 15b</i>)	\$	18,971	(18,971)					
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$							
g. Office Supplies	\$ 267,781	267,781						
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$ 24,122	24,122						
2. Cellular Phones	\$ 3,800	10,868	(7,068)					
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	\$							
3. Resident Day User Fee	\$ 700,112	700,112						
Subtotal	\$ 3,598,654	4,085,402	(486,748)					

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

General Information and Questionnaire
Accounting Basis

Name of Facility Carolton Chronic and Convalescent	License No. 606C	Report for Year Ended 9/30/2023	Page 15b	of 37
---	---------------------	------------------------------------	-------------	----------

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 Road Wethersfield CT 06109
--	--

Services Provided by This Firm (*describe fully*)

1 Financial Statements, Tax Returns, CARES Act Reporting	\$ 70,158
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 70,158

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

- Yes No

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Jackson Lewis LLP 2 Gregory and Adams, PC 3 4 5	Telephone Number (914) 514-6060 (203) 762-9000
---	--

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

1 One North Broadway White Plains NY
2 190 Old Ridgefield Road Wilton, CT
3
4
5

Services Provided by This Firm (*describe fully*)

1 Employment Matters	\$ 17,255
2 Consultaion to Board of Directors	\$ 1,716
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$ 18,971

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

- Yes No

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.	606C	9/30/2023				16	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:	3,598,654	4,085,402	(486,748)				
l. Travel and Entertainment							
1. Resident Travel and Entertainment \$							
2. Holiday Parties for Staff \$							
3. Gifts to Staff and Residents \$	2,127	2,127					
4. Employee Travel \$	3,192	3,192					
5. Education Expenses Related to Seminars and Conventions \$	4,229	4,229					
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>) \$	21,709	21,709					
2. Advertising Telephone Directory (<i>all such expenses</i>)*** \$							
3. Advertising Other (<i>Specify</i>)*** \$	230	230					
See Attached Schedule							
4. Fund-Raising*** \$							
5. Medical Records \$							
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)*** \$							
7. Postage \$							
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) \$	12,561	12,561					
See Attached Schedule							
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$							
9. Subscriptions \$	7,051	7,051					
10. Contributions*** \$							
See Attached Schedule							
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>) \$		19,221	(19,221)				
12. Administrative Management Services** \$		172,826	(172,826)				
13. Other (<i>Specify</i>) \$	29,795	98,332	(68,537)				
See Attached Schedule							
C-14 Total Administrative & General Expenditures	\$ 3,679,548	4,426,880	(747,332)				

* 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 in the Adjustment column.

Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Total Other Travel and Entertainment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Promotional	\$ 230					
Total Other Advertising	\$ 230	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Connecticut Association of Health Care Facilities	\$ 11,636					
Association of Long Term Care Financial Managers	\$ 80					
CT-Mutual Aid Plan	\$ 350					
Patient Administrative Costs	\$ 495					
Total Dues	\$ 12,561	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Total Contributions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Employee Onboarding Expense	\$ 26,097					
Directors Fees	\$ 10,000	\$ (10,000)				
Penalties	\$ 27,023	\$ (27,023)				
Bank charges	\$ 3,698					
Credit Card Processing Fees	\$ 31,514	\$ (31,514)				
Total Other Administrative and General	\$ 98,332	\$ (68,537)	\$ -	\$ -	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Carolton Chronic and Convalescent Hosp	License No. 606C	Report for Year Ended 9/30/2023	Page of 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 Mangement Associates, Fairfield CT	172,826	Mgt of Operations	P. 16 M 12 & 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
Carlton Chronic and Convalescent Hospital, Inc.		606C	9/30/2023				18	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 607,279	607,279						
2. Non-Food Supplies	\$ 120,676	120,676						
3. Other (Specify) _____	\$							
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$							
c. Other (Specify) _____	\$							
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 727,955	727,955						
2E. Dietary Questionnaire		Total	CCNH / RHNS		(Specify)	(Specify)		
F. Resident Meals:	Total no. of meals served per day:*							
G. Is cost of employee meals included in 2D?	<input checked="" type="radio"/> Yes <input type="radio"/> No							
H. Did you receive revenue from employees?	<input checked="" type="radio"/> Yes <input type="radio"/> No				If yes, specify amt.	9754		
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)						Pg. 30/ IV1		
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.			
K. Is any revenue collected 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)								
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.			
N. Is any revenue collected from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.			
O. 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.		606C	9/30/2023				19	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
3. Laundry								
a. In-House Processing*	Lbs.							
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$							
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.							
	Amt. \$							
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.							
	Amt. \$							
4. Repair and/or purchase of linens.***	Lbs.							
	Amt. \$	91,967	91,967					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	5,881	5,881					
c. Other (Specify) Supplies	\$	24,976	24,976					
3D. Total Laundry Expenditures (3a + b + c)	\$	122,824	122,824					
3E. Laundry Questionnaire								
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.					
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.					
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)							
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.					
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.					
K. 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 3D.

*** 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		606C	9/30/2023				20	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4.	Housekeeping							
a.	In-House Care	Sq. Ft. Serviced by Personnel						
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	76,309	78,414	(2,105)			
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>)	\$						
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	76,309	78,414	(2,105)			
5.	Resident Care (Supplies)**							
a.	Prescription Drugs***							
	1. Own Pharmacy	\$						
	2. Purchased from Omnicare	\$		357,807	(357,807)			
b.	Medicine Cabinet Drugs	\$	4,340	4,340				
c.	Medical and Therapeutic Supplies	\$	329,386	329,386				
d.	Ambulance/Limousine***	\$						
e.	Oxygen							
	1. For Emergency Use	\$						
	2. Other***	\$		42,767	(42,767)			
f.	X-rays and Related Radiological Procedures***	\$		28,968	(28,968)			
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$						
h.	Laboratory***	\$		95,541	(95,541)			
i.	Recreation	\$	27,326	27,326				
j.	Direct Management Services*	\$						
k.	Indirect Management Services*	\$						
l.	Cable TV	\$	7,200	50,834	(43,634)			
m.	Other (Specify)**** See Attached Schedule	\$	15,257	18,220	(2,963)			
n.	Physical Therapy Expense	\$						
o.	Speech Therapy Expense	\$						
5P.	Total Resident Care Expenditures (5a - 5o)	\$	383,509	955,189	(571,680)			

* 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 in the Adjustment column.
 **** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
IV Treatments	\$ 15,257					
Physicians and treatments Medicare A	\$ 2,963	\$ (2,963)				
Total Other Resident Care	\$ 18,220	\$ (2,963)	\$ -	\$ -	\$ -	\$ -

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

Name of Facility Carolton Chronic and Convalescent Hospital, Inc.			License No. 606C	Report for Year Ended 9/30/2023	Page of 21 37					
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	(Specify)	Pg	Line
		<input checked="" type="radio"/>	<input type="radio"/>						10	A 4
		<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"/>							
		<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, I	606C	9/30/2023					22	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$ 94,075	98,583	(4,508)					
b. Heat	\$ 114,252	119,727	(5,475)					
c. Light & Power	\$ 229,197	240,180	(10,983)					
d. Water	\$ 33,297	34,893	(1,596)					
e. Equipment Lease (<i>Provide detail on page 22b</i>)	\$ 18,501	18,501						
f. Other (<i>itemize</i>)	\$ 296,303	308,068	(11,765)					
See Attached Schedule								
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 785,625	819,952	(34,327)					
7. Depreciation (<i>complete schedule page 23*</i>)								
a. Land Improvements	\$							
b. Building & Building Improvements	\$ 134,485	134,485						
c. Non-Movable Equipment	\$ 5,844	5,844						
d. Movable Equipment	\$ 40,985	40,985						
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 181,314	181,314						
8. Amortization (<i>Complete att. Schedule Page 24*</i>)								
a. Organization Expense	\$							
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$ 88,566	88,566						
d. Other (<i>Specify</i>)	\$							
*8e. Total Amortization Costs (8a + b + c + d)	\$ 88,566	88,566						
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	\$ (6,168)	134,874	(6,168)					
c. Personal property taxes	\$ 43,179	43,179						
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,371,765	1,377,933	(6,168)					

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

Schedule of Other Repairs and Maintenance

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Purchased Services - Plant	\$ 251,626	\$ (11,507)				
Sewer Tax	\$ 56,442	\$ (258)				
Total Other Repairs and Maintenance	\$ 308,068	\$ (11,765)	\$ -	\$ -	\$ -	\$ -

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. 606C		Report for Year Ended 9/30/2023		Page 22b	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						
De Lage Landen P.O. Box 41602 Philadelphia PA 19101	<input type="radio"/>	<input checked="" type="radio"/>	Copy Machines	Monthly	Monthly		18,501	
	<input checked="" type="radio"/>	<input 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 type="radio"/> No	Total ***
							18,501	

* 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.

Depreciation Schedule

Name of Facility Carolton Chronic and Convalescent Hospital, Inc.			License No. 606C		Report for Year Ended 9/30/2023			Page 23	of 37				
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
A. Land Improvements													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
B. Building and Building Improvements													
1. Acquired prior to this report period			2,689,700			1,479,335	SL	20	134,485				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal										134,485			
C. Non-Movable Equipment													
1. Acquired prior to this report period			195,823			134,243	SL	20	5,844				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal										5,844			
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year								
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period						4,711,000			4,510,997	SL	10	39,640	
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative													
d. Standard Resident						13,465						1,345	
e. Specialized Resident													
Total Acquired during this report period						13,465						1,345	
D-3. Subtotal													40,985
E. Total Depreciation													181,314

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
3/21/2023	Manitowoc Undercounter Ice Maker	Standard Resident	\$ 4,254	10	\$ 425
4/12/2023	Manitowoc Undercounter Ice Maker	Standard Resident	\$ 4,254	10	\$ 425
6/12/2023	Manitowoc Koolair Ice Maker	Standard Resident	\$ 4,957	10	\$ 495
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipment			\$ 13,465		\$ 1,345 *
Deletions:					
Total deletions for Movable Equipment			\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
12/20/2022	2 - 8000 Btu Units HVAC	\$ 1,864	20	\$ 93
12/20/2022	2 - 12,000 Btu Units HVAC	\$ 2,795	20	\$ 140
1/23/2023	2 - Honeywell hilimit controls	\$ 3,965	20	198
2/24/2023	AO Smith 50 Gallon gas fired hot water heater	\$ 2,951	20	148
5/31/2023	B & G 1/2 HP 208 Volt 3 Phase Circulator	\$ 4,321	20	216
Total additions for Leasehold Improvement		\$ 15,896		\$ 795 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*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. 606C		Report for Year Ended 9/30/2023			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							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period				4,922,459	4,215,369	4,922,459	5	87,771	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				15,896		15,897	5	795	
C-4. Subtotal									88,566
D. Total Amortization									88,566

* 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. 606C	Report for Year Ended 9/30/2023	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description	Total			
1. Date Land Purchased	05/09/55			
2. Date Structure Completed	05/09/55			
3. If NOT Original Owner, Date of Purchase	05/09/55			
4. Date of Initial Licensure	05/09/55			
5. Total Licensed Bed Capacity	229			
6. Square Footage	99,103			
7. Acquisition Cost				
a. Land	139,176			
b. Building	66,176			
Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Variable			
b. Date Mortgage Obtained	12/01/07			
c. Interest Rate for the Cost Year	288.00%			
d. Term of Mortgage (number of years)	35			
e. Amount of Principal Borrowed	9,000,000			
f. Principal balance outstanding as of _____	4,338,535			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility		License No.	Report for Year Ended				Page	of
Carolton Chronic and Convalescent H		606C	9/30/2023				26	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
12. Interest								
A. Building, Land Improvement & Non-Movable Equipment								
1. First Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
2. Second Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
3. Third Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
4. Fourth Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
B. CHEFA Loan Information								
1. Original Loan Amount		\$						
2. Loan Origination Date								
3. Interest Rate %								
4. Term								
5. CHEFA Interest Expense								
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$						

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended				Page	of	
Carolton Chronic and Convalescen		606C		9/30/2023				27	37	
Item				Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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) Credit Card				\$		257	(257)			
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$		257	(257)			
14. Insurance										
a. Insurance on Property (buildings only)				\$	59,569	62,424	(2,855)			
b. Insurance on Automobiles				\$						
c. Insurance other than Property (as specified above)										
1. Umbrella (Blanket Coverage)				\$	99,154	103,906	(4,752)			
2. Fire and Extended Coverage				\$						
3. Other (Specify) Cyber, Directors and Officers, Bond				\$	35,993	35,993				
14d. Total Insurance Expenditures (14a + b + c)				\$	194,716	202,323	(7,607)			
15. Total All Expenditures (A-13 thru C-14)				\$	19,920,151	21,931,324	(2,011,173)			

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Carolton Chronic and Convalescent Hosp 606C		9/30/2023		30	37
Item	Total	CCNH / RHNS	(Specify)	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 9,850,611	9,850,611			
b. Medicaid Room and Board Contractual Allowance **	\$ (4,499,883)	(4,499,883)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 3,915,846	3,915,846			
b. Medicare Room and Board Contractual Allowance **	\$ (1,155,018)	(1,155,018)			
4. a. Private-Pay Residents and Other	\$ 8,910,525	8,910,525			
b. Private-Pay Room and Board Contractual Allowance **	\$ (971,176)	(971,176)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 190,222	190,222			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2. a. Medical Supplies - Medicare	\$ 46	46			
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$ 32,445	32,445			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 382,777	382,777			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 5,262	5,262			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 58,010	58,010			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 466,518	466,518			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 1,668	1,668			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other (<i>Specify</i>) - Medicare	\$ 48,176	48,176			
b. Other (<i>Specify</i>) - Non-Medicare	\$ 706,133	706,133			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 17,942,162	17,942,162			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$ 9,754	9,754			
2. Rental of rooms to non-residents	\$ 7,432	7,432			
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 448	448			
6. Private Duty Nurses' Fees	\$ 18,141	18,141			
7. Barber, Coffee, Beauty and Gift shops	\$ 15,793	15,793			
8. Other (<i>Specify</i>)	\$ 2,616,128	2,616,128			
V. Total Other Revenue (1 thru 8)	\$ 2,667,696	2,667,696			
VI. Total All Revenue (III +V)	\$ 20,609,858	20,609,858			

* 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)	(Specify)
	Laboratory - Meicare	\$ 28,928		
	X-Ray - Medicare	\$ 19,248		
	Total Other Resident Revenue - Medicare	\$ 48,176	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	Laboratory - Self Pay	\$ 64		
	Oxygen - Medicaid	\$ 12,483		
	I.V. Therapy	\$ 45		
	Managed Care Therapies	\$ 620,914		
	Other Therapy	\$ 377		
	Optum-UNC Nursing Home Plan	\$ 72,250		
	Total Other Resident Revenue	\$ 706,133	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
	Interest		\$ 448		
	Total Interest Income		\$ 448	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	Outpatient Therapies	\$ 1,248,073		
	Personal items	\$ 7,806		
	Employee Retention Credit	\$ 1,360,249		
	Total Other Revenue	\$ 2,616,128	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic and Convalescent Ho	606C	9/30/2023	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	157,869
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	3,790,716
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	160,614
4. Inventories			\$	94,155
5. Prepaid Expenses			\$	49,904
a. Prepaid insurance	42,404			
b. Deposit on asset acquisition	7,500			
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	1,363,810
Employee Retention Credit	1,360,249			
Advances to employees	3,561			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	5,617,068
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost 2,689,700		\$	1,075,880
	Accum. Depreciation 1,613,820	Net		
4. Leasehold Improvements	*Historical Cost 4,938,355		\$	634,420
	Accum. Depreciation 4,303,935	Net		
5. Non-Movable Equipment	*Historical Cost 195,823		\$	55,736
	Accum. Depreciation 140,087	Net		
6. Movable Equipment	*Historical Cost 4,724,465		\$	172,483
	Accum. Depreciation 4,551,982	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,938,519

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			\$ -

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

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			\$ -

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

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			\$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			\$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic and Convalescent Ho	606C	9/30/2023	32	37
Account			Amount	
Total Brought Forward:			\$	7,555,587
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	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>)			\$	679,000
Deferred Tax Asset	679,000			
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	679,000
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	8,234,587

* 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. 606C	Report for Year Ended 9/30/2023	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	854,029
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>)				\$	244,050
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	
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*				\$	14,497
12. Other Current Liabilities (<i>itemize</i>)				\$	1,855,522
Accrued expenses		65,654			
Accrued property tax		234,984			
Employee Group Health Plan		1,023,163			
Accrued Provider Use Fee		531,721	See Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	2,968,098

* 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. 606C	Report for Year Ended 9/30/2023		Page 34	of 37
Account				Amount	
Total Brought Forward:				2,968,098	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
				\$	
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$ 1,620,587	
Name and Address of Lender	Amount	Loan Date			
	1,620,587				
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 47,000	
Deferred Federal Income Tax		47,000			
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 1,667,587	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 4,635,685	

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	606C	9/30/2023	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	649,294
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	649,294
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	18,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	(540,000)
5. Cumulated Earnings			\$	4,793,074
6. Gain or Loss for Period	10/1/2022	thru	9/30/2023	\$ align="right">(1,321,466)
7. Total Net Worth			\$	2,949,608
C. Total Reserves and Net Worth			\$	3,598,902
D. Total Liabilities, Reserves, and Net Worth			\$	8,234,587

H. Changes in Total Net Worth

Name of Facility Carolton Chronic and Convalescent Hosp	License No. 606C	Report for Year Ended 9/30/2023	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	4,793,074
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	20,609,858
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	21,931,324
D. Net Income or Deficit			\$	(1,321,466)
E. Balance			\$	3,471,608
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	3,471,608
				09/30/23

I. Preparer's/Reviewer's Certification

Name of Facility Carolton Chronic and Convalescent	License No. 606C	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> Home (CCNH) & RHNS Combined	<input type="checkbox"/> (Specify)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report in the Adjustments columns. 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				
Thomas O. Marien				
Address Address		Phone Number		
400 Mill Plain Road Fairfield, CT 06824		(203) 255-3573 Extension: 210		
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number		
Thomas O. Marien		(203) 255-3573 Extension: 210		
Contact Email Address				
Thomas.Marien@thecarolton.com				