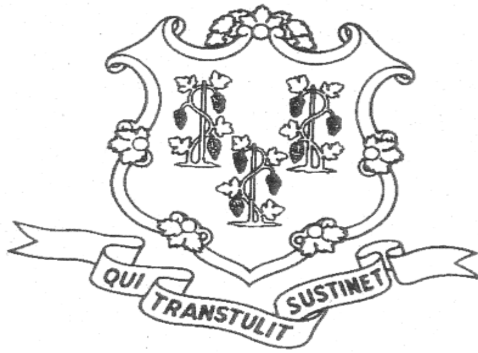
State of Connecticut



Annual Report of Long-Term Care Facility
Cost Year 2021

Name of Facility (as licensed)	
Carolton Chronic & Convalescent Hospital, Inc.	
Address (No. & Street, City, State, Zip Code) 400 Mill Plain Road Fairfield, CT 06824	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	00000 6064		

For Department Use Only

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

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Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	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 IMPRISIONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Carolton Chronic & Convalescent Hospital, Inc. [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, 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 Kretmer			Printed Name (Owner)	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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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 & Convalescent Hospital, Inc.		Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 400 Mill Plain Road Fairfield, CT 06824					
Report Prepared By PKF O'Connor, Davies LLP		Phone Number 860-257-1870		Date 2/14/2021	
Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$				
5. All other wages paid	$				
6. ***Total Wages Paid***	$				
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
(203) 255-3573	9/30/2021	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Carolton Chronic & Convalescent Hospital, Inc.	400 Mill Plain Road Fairfield, CT 06824

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	606-C			07 - 5034

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ⦿ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ⦿ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Dennis Kretzmer	939

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

Name	License No.:
N/A	

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Ir	606-C	9/30/2021	3A	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		

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	3B	37

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

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	4	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	%**				
CMF Realty (Tortora Family Trust)	Fairfield, CT	○	⦿		Rental of real estate and equipment.	22 9A	921,000	
TTFT Management Associates	Fairfield, CT	○	⦿		Management services.Assistant Medical Dire	pg 16 M12,pg 28	274,104	
		○	⦿					
		○	⦿					
		○	⦿					
		○	⦿					
		○	⦿					
		○	⦿					
		○	⦿					

* 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	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	5	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 (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	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	○	⊙	Stamp Machine	Monthly	Monthly		1,607
DeLange	○	⊙	Copy Machines	Monthly	Monthly		18,021
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 19,628

* 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	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent H	606-C	9/30/2021	7	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	Address (No. & Street, City, State, Zip Code)
1 PKF O'Connor Davies, LLP	100 Great Meadow Rd. Wethersfield CT
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Cost Report/Financial Statements/Tax Returns/Retirement Audit	$ 64,965
2		$
3		$
4		$
	Charge for Services Provided	$ 64,965

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

⦿ Yes ○ No Pg 15

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Jackson Lewis	
2 Wiggen Dana	
3	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Staff Matters	$ 1,483
2	Staff Matters	$ 247
3		$
4		$
5		$
	Charge for Services Provided	$ 1,730

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

⦿ Yes ○ No Pg 15

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	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	111	111			111	111						
B. As of midnight of THIS report period	106	106							106	106		
3. Total Number of Days Care Provided During Period												
A. Medicare	8,170	8,170			5,969	5,969			2,201	2,201		
B. Medicaid (Conn.)	17,770	17,770			13,166	13,166			4,604	4,604		
C. Medicaid (other states)												
D. Private Pay	10,824	10,824			7,888	7,888			2,936	2,936		
E. State SSI for RCH												
F. Other (Specify)	2,875	2,875			2,483	2,483			392	392		
G. Total Care Days During Period (3A thru F)	39,639	39,639			29,506	29,506			10,133	10,133		
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)**	39,639	39,639			29,506	29,506			10,133	10,133		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, In	606-C	9/30/2021	9	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)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	22	51		31				
Per Diem Rate								
a. One bed rm.		300.00		580.00				
b. Two bed rms.				480.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	2,043	2,043		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	15,793	15,793		
D. ***Total Physical Therapy Treatments***	17,836	17,836		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	137	137		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	829	829		
D. ***Total Speech Therapy Treatments***	966	966		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,498	1,498		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	10,255	10,255		
D. ***Total Occupational Therapy Treatments***	11,753	11,753		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	10	37

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
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.)	655,413	25,271				
5. Dietary Service						
a. Head Dietitian	74,878	1,912				
b. Food Service Supervisor	74,575	2,136				
c. Dietary Workers	1,087,555	60,698				
6. Housekeeping Service						
a. Head Housekeeper	74,704	2,104				
b. Other Housekeeping Workers	707,220	44,464				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	107,043	5,192				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	83,473	5,743				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	168,467	3,509				
b. RN						
1. Direct Care	1,235,201	31,091				
2. Administrative**	257,715	6,321				
c. LPN						
1. Direct Care	2,410,859	71,968				
2. Administrative**	135,628	4,174				
d. Aides and Attendants	2,701,424	138,268				
e. Physical Therapists	1,070,578	28,734				
f. Speech Therapists						
g. Occupational Therapists	544,643	14,528				
h. Recreation Workers	168,377	8,230				
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	58,550	2,080				
n. Marketing						
o. Other (Specify) See Attached Schedule	61,703	2,485				
A-13. Total Salary Expenditures	12,022,007	467,228				

* 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)

	CCNH		RHNS		(Specify)	
Position	$	Hours	$	Hours	$	Hours
Med Records	$ 61,703	2,485				
Total	$ 61,703	2,485	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

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

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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 & Convalescent Hospital, Inc.	606-C	9/30/2021	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)							
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).										
Carmen A. Tortora Jr.	100,000 - See pg 28				Pres of Corp.	2,080	A1	TTFT Mgmt Co	Pg 28 Diall	

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

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

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Carolton Chronic & Convalescent Hospital, Inc.				606-C		9/30/2021			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)							
Section III - Administrators* **										
Dennis Kretzmer	100,000				Administrator	2,080	A2	TTFT Mgmt Co	Pg 28 Dial	
Section IV - Assistant Administrators										
Thomas J. Tortora	72,000				Asst. Administrator	2,080	A3	TTFT Mgmt Co	Pg 28 disal	
Kathleen Abrahamsen	72,000				Asst. Administrator	2,080	A3	TTFT Mgmt Co	Pg 28 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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.		Report for Year Ended		Page	of
Carolton Chronic & Convalescent Hospital, Inc.	606-C		9/30/2021		13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	9,450	236				
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)						
Assistant Medical Director (See pg 28)	30,000	100				
9. Speech Therapist						
a. Resident Care	65,527	1,008				
b. Other						
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-13 Total Fees Paid in Lieu of Salaries	154,471	1,740				

* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	14	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, Eye Exams	○	⦿	
Stuart Miller MD, 39 Canterbury Lane, Trumbull, CT 06611	Medical Director.	○	⦿	
Peter Tortora MD, 345 Old Oaks Drive, Fairfield, CT 06825	Assistant Medical Director. Pg 13 and 28a	○	⦿	Brother of operators.
Rehab Associates 411 Old Coach Rd Fairfield CT	Speech Therapy/OT	○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	205,410	205,410		
2. Disability Insurance	$				
3. Unemployment Insurance	$				
4. Social Security (F.I.C.A.)	$	1,013,472	1,013,472		
5. Health Insurance	$	1,589,828	1,589,828		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	8,047	8,047		
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	64,965	64,965		
e. Legal (*Services should be fully described on Page 7)*	$	1,730	1,730		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$	1,400	1,400		
g. Office Supplies	$	265,262	265,262		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	28,146	28,146		
2. Cellular Phones	$	6,167	6,167		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	(73,800)	(73,800)		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	615,465	615,465		
Subtotal	$	3,726,091	3,726,091		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,726,091	3,726,091		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	23,707	23,707		
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	540	540		
4. Employee Travel	$	28,204	28,204		
5. Education Expenses Related to Seminars and Conventions	$	1,962	1,962		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	6,477	6,477		
2. Advertising Telephone Directory (*all such expenses*)***	$	2,973	2,973		
3. Advertising Other (*Specify*)*** 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)***	$	6,261	6,261		
7. Postage	$				
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	13,799	13,799		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	19,894	19,894		
10. Contributions*** See Attached Schedule	$	7,500	7,500		
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	274,104	274,104		
13. Other (*Specify*) See Attached Schedule	$	25,759	25,759		
C-14 Total Administrative & General Expenditures	$	4,137,271	4,137,271		

* 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)
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

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

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Connecticut Association of Health Care Facilities	$ 13,799		
Total Dues	$ 13,799	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Donations (See Page 28)	$ 7,500		
Total Contributions	$ 7,500	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Directors fees (see pg 28)	$ 12,000		
Penalties (See pg 28)	$ 3,387		
Other expenses (see pg 28)	$ 10,372		
Total Other Administrative and General	$ 25,759	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Carolton Chronic & Convalescent Hospita	606-C	9/30/2021	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	274,104	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 & Convalescent Hospital, Inc.	606-C	9/30/2021	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	451,895	451,895		
2. Non-Food Supplies	$	111,269	111,269		
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)	$	563,164	563,164		

2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				

	Question	Yes	No	
G.	Is cost of employee meals included in 2D?	○ Yes	⊙ No	
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	○ Yes	⊙ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⊙ 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 & Convalescent Hospital, Inc.	606-C	9/30/2021	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.				
	Amt. $	49,028	49,028		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	11,249	11,249		
c. Other (*Specify*) Supplies	$	39,632	39,632		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	99,909	99,909		

3E. Laundry Questionnaire			
F. Is cost of employee laundry included in 3D?	○ Yes	⦿ No	If yes, specify cost.
G. Did you receive revenue from employees?	○ Yes	⦿ 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?	○ Yes	⦿ No	If yes, specify cost.
J. Did you receive revenue from these people?	○ Yes	⦿ 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Inc	606-C	9/30/2021	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	118,040	118,040		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	118,040	118,040		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	319,100	319,100		
b. Medicine Cabinet Drugs		$	4,463	4,463		
c. Medical and Therapeutic Supplies		$	221,890	221,890		
d. Ambulance/Limousine***		$	604	604		
e. Oxygen						
1. For Emergency Use		$	48,702	48,702		
2. Other***		$				
f. X-rays and Related Radiological Procedures***		$	39,177	39,177		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	106,946	106,946		
i. Recreation		$	9,471	9,471		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	231,874	231,874		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	982,225	982,225		

* 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	$ 11,614		
IV - Managed Care	$ 2,777		
Medical Supplies - Personal	$ 49,048		
Physical Therapy Supplies	$ 267		
Medical Supplies - Medicare	$ 3,337		
Physicians Procedures-Med A- CB	$ 12,982		
Medical Supplies - Mgd Care	$ 1,819		
COVID	$ 150,029		
Total Other Resident Care	$ 231,874	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
All American Waste		○	⦿		Garbage Removal	36,502			22	6f
Direct TV		○	⦿		Cable TV	23,727			22	6f
DM Landscaping		○	⦿		Landscaping	38,615			22	fa,6f
Westport Plumbing		○	⦿		Plumbing	16,668			22	6a,6f
Precision Mechanicals		○	⦿		Sprinkler system	17,204			22	6f
The Home Depot		○	⦿		Maintenance supplies	11,192			22	6f
Toth Mechanical		○	⦿		HVAC	18,346			22	6a,6f
Federal Electric		○	⦿		Electrial Contractor	10,256			22	6a,6f
Hill Rom		○	⦿		Bed Rentals	7,294			22	6a,6f
		○	⦿							
		○	⦿							
		○	⦿							
		○	⦿							
		○	⦿							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Carolton Chronic & Convalescent Hospital, In	606-C	9/30/2021	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	79,634	79,634		
b. Heat	$	101,660	101,660		
c. Light & Power	$	236,050	236,050		
d. Water	$	45,061	45,061		
e. Equipment Lease (*Provide detail on page 6*)	$	19,628	19,628		
f. Other (*itemize*)	$	299,215	299,215		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	781,248	781,248		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	134,485	134,485		
c. Non-Movable Equipment	$	6,843	6,843		
d. Movable Equipment	$	63,566	63,566		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	204,894	204,894		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	104,476	104,476		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	104,476	104,476		
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	$	132,735	132,735		
c. Personal property taxes	$	42,771	42,771		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,414,875	1,414,875		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Purchased Services	$ 232,721		
Sewer tax	$ 66,494		
Total Other Repairs and Maintenance	$ 299,215	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	23	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		2,689,700	1,210,365	SL	20 Years	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		195,823	120,557	SL	20 Years	6,843	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								6,843

	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					4,679,690		4,679,690	4,392,852	SL	5 - 20 Yea	60,640	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					23,558						2,926	
D-3. Subtotal												63,566
E. ***Total Depreciation***												204,894

Schedule of Land Improvements Acquired during this report period

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

***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 Improvement		$ -		$ -	*
Deletions:					
Total deletions for Building Improvement		$ -		$ -	**

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report peri

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

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
	Computer Equipment - Wireless Access Point	$ 949	5	$ 190	
	Computer Equipment - Wireless Access Point	$ 949	5	$ 190	
	Computer Equipment - Wireless Access Point	$ 949	5	190	
	Computer Equipment - Wireless Access Point	$ 949	5	190	
	Computer Equipment - Wireless Access Point	$ 949	5	190	
	Computer Equipment - Wireless Access Point	$ 949	5	190	
	Departmental Equipment - Roll In Refrigerator	$ 8,932	10	893	
	Departmental Equipment - Roll In Refrigerator	$ 8,932	10	893	
Total additions for Movable Equipmen		$ 23,558		$ 2,926	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
	Building Services Equipment - 1510e 5hp pump	$ 9,157	15	$ 610	
	Building Services Equipment - 1510e 5hp pump	$ 9,157	15	$ 610	
	Building Services Equipment - Hot water heater	$ 8,045	10	$ 805	
	Building Services Equipment - Generator	$ 11,299	25	$ 452	
	Building Services Equipment - Roof Top Unit	$ 15,950	10	$ 1,595	
	Building Services Equipment- Cured in place pipeline	$ 11,468	20	$ 573	
	Building Services Equipment- Backflow preventor	$ 4,677	20	$ 234	
	Building Services Equipment- Gas fired rooftop unit	$ 9,300	5	$ 1,860	
Total additions for Leasehold Improvemer		$ 79,053		$ 6,739	*
Deletions:					
Total deletions for Leasehold Improvemer		$ -		$ -	**

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	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							
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				4,838,551	4,021,682	SL		97,737	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				79,053		SL		6,739	
C-4. Subtotal									104,476
D. ***Total Amortization***									104,476

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Carolton Chronic & Convalescent Hos	606-C	9/30/2021	25 | 37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?*

⦿ Yes   ○ No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total
1. Date Land Purchased	1956
2. Date Structure Completed	1956
3. If **NOT** Original Owner, Date of Purchase	05/09/05
4. Date of Initial Licensure	05/09/05
5. Total Licensed Bed Capacity	229
6. Square Footage	
7. Acquisition Cost	
a. Land	139,648
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)	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 ___________				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Carolton Chronic & Convalescent Ho	606-C	9/30/2021	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage	$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage	$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)	$				

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Carolton Chronic & Convalescent H	606-C	9/30/2021	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*) See pg 28			$	3,384	3,384		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	3,384	3,384		
14. Insurance a. Insurance on Property (buildings only)			$	56,006	56,006		
b. Insurance on Automobiles			$				
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*)			$	26,598	26,598		
2. Fire and Extended Coverage			$				
3. Other (*Specify*) Prof. Liab, Directors/officers, cyber			$	139,657	139,657		
14d. ***Total Insurance Expenditures (14a + b + c)***			$	222,261	222,261		
15. ***Total All Expenditures (A-13 thru C-14)***			$	20,498,855	20,498,855		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	28 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages								
1.			Outpatient Service Costs	$				
2.			Salaries not related to Resident Care	$				
3.			Occupational Therapy	$				
4.			Other - See attached Schedule	$	408,508	408,508		
Page 13 - Professional Fees								
5.			Resident Care Physicians **	$				
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$	30,000	30,000		
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.			Bad Debts	$				
10.			Accounting	$				
10a.			Legal	$				
11.			Telephone	$	3,000	3,000		
12.			Cellular Telephone	$	6,167	6,167		
13.			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	$	249	249		
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.			Unallowable Advertising *	$	2,973	2,973		
19.			Income Tax / Corporate Business Tax	$	(114,800)	(114,800)		
20.			Fund Raising / Contributions	$	7,500	7,500		
21.			Unallowable Management Fees	$	274,104	274,104		
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	275,909	275,909		
Page 18 - Dietary Expenditures								
24.			Meals to employees, guests and others who are not residents	$				
Page 19 - Laundry Expenditures								
25.			Laundry services to employees, guests and others who are not residents	$				
Page 20 - Housekeeping Expenditures								
26.			Housekeeping services to employees, guests and others who are not residents	$	1,795	1,795		
			Subtotal (Items 1 - 26)	$	896,805	896,805		

* 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)
		Outpatient Service Costs	$ 396,616		
		Other Houskeeping - Outpatient Therapy Overhead	$ 11,892		
Total Other Salaries Adjustment			$ 408,508	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	8 e	Asst. Medical Director	$ 30,000		
Total Other Fees Adjustments			$ 30,000	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15		Benefits - Wage Adjustments	$ 95,770		
16	L 3	Gifts	$ 540		
16	L 4	Travel	$ 24,088		
10	A1	Owner wages	$ 100,000		
27	12D	Interest Expense	$ 3,384		
22	6f	Cable TV	$ 20,107		
16a		Director Fees	$ 12,000		
16a		Penalties	$ 3,387		
16a		Other Expenses	$ 10,372		
16M		Barber and Beauty Supplies	$ 6,261		
Total Other A&G Adjustments			$ 275,909	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Carolton Chronic & Convalescent Hospital, Inc.	606-C	9/30/2021	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	896,805	896,805		
Page 20 - Resident Care Supplies*								
27.			Prescription Drugs	$	319,100	319,100		
28.			Ambulance/Limousine	$	604	604		
29.			X-rays, etc	$	39,177	39,177		
30.			Laboratory	$	106,946	106,946		
31.			Medical Supplies	$				
32.			Oxygen (non emergency)	$				
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	29,192	29,192		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$				
36.			Depreciation on Unallowable Motor Vehicles	$				
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$	23,680	23,680		
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
Other - Miscellaneous								
42.			Other - Indirect	$				
43.			Interest Income on Account Rec.	$				
44.			Other - Miscellaneous Administrative	$				
45.			Management Fees Direct	$				
46.			Management Fees Indirect	$				
47.			Other - Direct	$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
49.			***Total Amount of Decrease (Items 1 - 48)***	$	1,415,504	1,415,504		

*** 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.

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20A		IV Therapy	$ 14,391		
20A		Physician Procedures	$ 12,982		
20A		Medical Supplies Mgd Care	$ 1,819		
Total Other Ancillary Costs			$ 29,192	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22		Outpatient Therapy Real Estate Expenses	$ 2,019		
10573		Outpatient Therapy Property Expenses	$ 10,573		
29C		Apartment Real Estate Expense	$ 2,059		
29C		Apartment Property Expense	$ 1,921		
30A		Rental Income	$ 7,108		
Total Other Property Adjustments			$ 23,680	$ -	$ -

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Carolton Chronic & Convalescent Hospita	606-C	9/30/2021	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	8,777,322	8,777,322		
b. Medicaid Room and Board Contractual Allowance **	$	(3,960,916)	(3,960,916)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	5,976,966	5,976,966		
b. Medicare Room and Board Contractual Allowance **	$	(1,534,390)	(1,534,390)		
4. a. Private-Pay Residents and Other	$	7,948,518	7,948,518		
b. Private-Pay Room and Board Contractual Allowance **	$	(760,987)	(760,987)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	209,324	209,324		
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$	(1,178)	(1,178)		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$	592	592		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	35,825	35,825		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	528,388	528,388		
b. Physical Therapy - Medicare Contractual Allowance **	$				
c. Physical Therapy - Non-Medicare	$	2,992	2,992		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$				
4. a. Speech Therapy - Medicare	$				
b. Speech Therapy - Medicare Contractual Allowance **	$				
c. Speech Therapy - Non-Medicare	$	64,463	64,463		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$				
5. a. Occupational Therapy - Medicare	$	643,473	643,473		
b. Occupational Therapy - Medicare Contractual Allowance **	$				
c. Occupational Therapy - Non-Medicare	$	4,603	4,603		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$				
6. a. Other *(Specify)* - Medicare	$	86,640	86,640		
b. Other *(Specify)* - Non-Medicare	$	547,141	547,141		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	18,568,776	18,568,776		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$	7,108	7,108		
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	6,212	6,212		
6. Private Duty Nurses' Fees	$	(1,260)	(1,260)		
7. Barber, Coffee, Beauty and Gift shops	$	4,712	4,712		
8. Other (*Specify*)	$	4,116,002	4,116,002		
V. Total Other Revenue (1 thru 8)	$	4,132,774	4,132,774		
VI. Total All Revenue (III +V)	$	22,701,550	22,701,550		

* *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)
	Laboratory	$ 43,093		
	Xray	$ 26,535		
	Oxygen	$ 17,012		
Total Other Resident Revenue - Medicare		$ 86,640	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Outpatient Therapy	$ 1,469		
	Therapy - Agency	$ 160,059		
	Therapy - Other Receipt	$ 385,614		
Total Other Resident Revenue		$ 547,141	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
	Interest Income (see pg 28)		$ 6,212		
Total Interest Income			$ 6,212	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Personal Items	$ 3,107		
	Personal Items	$ (2,134)		
	Covid Relief Funds Earned	$ 110,412		
	Provider Relief Funds Earned	$ 1,075,817		
	Forgiveness Paycheck Protection Loan	$ 2,928,800		
Total Other Revenue		$ 4,116,002	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page of
Carolton Chronic & Convalescent Hosp	606-C	9/30/2021	31 | 37

Account			Amount
Assets			
A. Current Assets			
1. Cash (*on hand and in banks*)			$ 2,861,658
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			$ 2,342,035
3. Other Accounts Receivable (Excluding Owners or Related Parties)			$
4 Inventories			$ 75,493
5. Prepaid Expenses			$ 12,108
a. In-House MD		12,108	
b.			
c.			
d. See Schedule			
6. Interest Receivable			$
7. Medicare Final Settlement Receivable			$
8. Other Current Assets (*itemize*)			$ 93,191
Loan and Advances- Employees		8,946	
Income tax refund		40,000	
Property Tax Escrow		44,245	
See Schedule			
A-9. ***Total Current Assets*** (Lines A1 thru 8)			$ 5,384,485
B. Fixed Assets			
1. Land			$
2. Land Improvements	*Historical Cost		$
	Accum. Depreciation	Net	
3. Buildings	*Historical Cost	2,689,700	$ 1,344,850
	Accum. Depreciation	1,344,850 Net	
4. Leasehold Improvements	*Historical Cost	4,917,604	$ 791,446
	Accum. Depreciation	4,126,158 Net	
5. Non-Movable Equipment	*Historical Cost	195,823	$ 68,423
	Accum. Depreciation	127,400 Net	
6. Movable Equipment	*Historical Cost	4,703,248	$ 246,830
	Accum. Depreciation	4,456,418 Net	
7. Motor Vehicles	*Historical Cost		$
	Accum. Depreciation	Net	
8. Minor Equipment-Not Depreciable			$
9. Other Fixed Assets (*itemize*)			$
See Schedule			
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)			$ 2,451,549

* 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)			$ -

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Carolton Chronic & Convalescent Hosp	606-C	9/30/2021	32 | 37

Account				Amount
			Total Brought Forward:	$ 7,836,034
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 (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 632,000
Deferred Tax Asset		632,000		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 632,000
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 8,468,034

* 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	License No.	Report for Year Ended	Page of
Carolton Chronic & Convalescent Hospital, In	606-C	9/30/2021	33 | 37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 681,508
2. Notes Payable (*itemize*)	$
See Schedule	
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)	$ 439,591
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$ 124,289
7. Medicare Final Settlement Payable	$
8. Medicare Current Financing Payable	$
9. Mortgage Payable (*Current Portion*)	$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)	$
11. Accrued Income Taxes*	$ 4,540
12. Other Current Liabilities (*itemize*)	$ 99,551
Accrued Property Tax 99,551	
See Schedule	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 1,349,479

* 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	License No.	Report for Year Ended	Page of
Carolton Chronic & Convalescent Hospital, I	606-C	9/30/2021	34 | 37

Account				Amount
			Total Brought Forward:	1,349,479
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$ 953,160
Name and Address of Lender	Amount	Loan Date		
	953,160			
4. Other Long-Term Liabilities (*itemize*)				$ 1,077,447
Medicare Advance Account		796,287		
Due to State of CT - Medicaid		161,160		
Advance DSS Medicaid March and April 2020		120,000		
See Schedule				
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 2,030,607
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 3,380,086

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

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hos[p]	606-C	9/30/2021	35	37

Account				Amount
A. **Reserves**				
1. Reserve for value of leased land				$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				$
3. Reserve for depreciation value of leased personal property (*Equity)*				$
4. Reserve for leasehold real properties on which fair rental value is based				$ 807,816
5. Reserve for funds set aside as donor restricted				$
6. Total Reserves				$ 807,816
B. **Net Worth**				
1. Owner's Capital				$
2. Capital Stock				$ 18,000
3. Paid-in Surplus				$
4. Treasury Stock				$ (540,000)
5. Cumulated Earnings				$ 2,599,437
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	$ 2,202,695
7. Total Net Worth				$ 4,280,132
C. ***Total Reserves and Net Worth***				$ 5,087,948
D. ***Total Liabilities, Reserves, and Net Worth***				$ 8,468,034

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page of
Carolton Chronic & Convalescent Hospi	606-C	9/30/2021	36 | 37

	Account			Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2020			$ 2,462,279
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 22,701,550
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 20,498,855
D.	Net Income or Deficit			$ 2,202,695
E.	Balance			$ 4,280,132
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
	Depreciation Difference Cost Report Fixed Asset	137,157		
	Fair Rent Balance Sheet Adjustments posted incorreclty on prior year	(521,999)		
F-3.	Total Additions			$ (384,842)
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings (*Specify*)			$
	Purpose	Amount		
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/21			$ 3,895,290

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Carolton Chronic & Convalescent Hospital,	606-C	9/30/2021	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer	
Thomas O. Marien, CPA, MBA, CVA	
Addres Address	Phone Number
100 Great Meadow Rd. Wethersfield CT 06109	(860) 419-3401
Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Dennis Kretzmer	203-255-3573
Contact Email Address	