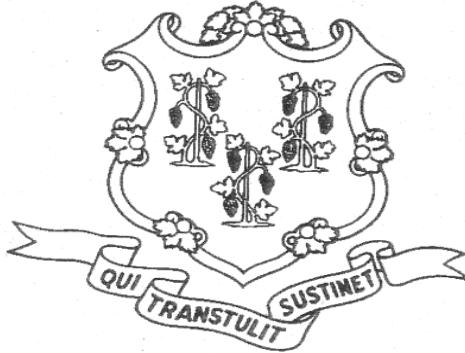


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab Center	
Address (No. & Street, City, State, Zip Code) 534 Town St. Moodus, CT 06469	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) Rest Home with Nursing <input checked="" type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 1029-C	RHNS 179RH	(Specify)	Medicare Provider 07-5307
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
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For Department Use Only

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

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General Information

Name of Facility (as licensed) Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rel	License No. 1029-C	Report for Year Ended 9/30/2021	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab Center [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) Brenda Marinan		Printed Name (Owner) Brinton Epright	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)
			Comm. Expires / /
Address of Notary Public			

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab Center	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 534 Town St. Moodus, CT 06469				
Report Prepared By CJLC LLC	Phone Number 860-610-9009	Date		
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
860-873-1455	9/30/2021	2	37

Name of Facility (as shown on license) Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab Cen		Address (No. & Street, City, State, Zip) 534 Town St. Moodus, CT 06469		
License Numbers:	CCNH 1029-C	RHNS 179RH	(Specify)	Medicare Provider No. 07-5307
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input checked="" type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes <input checked="" type="radio"/> No	If "Yes," explain fully.	

Administrator		
Name of Administrator Brenda Marinan	Nursing Home Administrator's License No.:	00932
Other Operators/Owners who are assistant administrators (full or part time) of this facility.		
Name	License No.:	

General Information and Questionnaire Partners/Members

General Information and Questionnaire

Corporate Owners

State of Connecticut

Annual Report of Long-Term Care Facility

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Heath Care, Inc. d/b/a Chestelm Heath &	1029-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

General Information and Questionnaire

Related Parties*

Name of Facility Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Reh	License No. 1029-C	Report for Year Ended 9/30/2021			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input checked="" type="radio"/> Yes <input type="radio"/> 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?				<input checked="" type="radio"/> Yes <input type="radio"/> 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	%**				
Heathcare Holding Incorporated, LLC	534 Town St. Moodus, CT 06469	<input type="radio"/>	<input checked="" type="radio"/>		Rent	22/9	600,000	600,000
Brenda Marinan	534 Town St. Moodus, CT 06469	<input type="radio"/>	<input checked="" type="radio"/>		Administrator	10/A2	100,651	100,651
Mark Epright	534 Town St. Moodus, CT 06469	<input type="radio"/>	<input checked="" type="radio"/>		Chief Financial Officer	10/A4	100,589	100,589
Chestelm Adult Day Services	524 Town St. Moodus, CT 06469	<input type="radio"/>	<input checked="" type="radio"/>		Snow Removal	22/6f	8,775	8,775
Chestelm Adult Day Services	524 Town St. Moodus, CT 06469	<input type="radio"/>	<input checked="" type="radio"/>		Purchased Food	18/2a1	(23,000)	(23,000)
		<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 Chestelm Heath Care, Inc. d/b/a Chestelm Heat	License No. 1029-C	Report for Year Ended 9/30/2021	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

General Information and Questionnaire Leases (Excluding Real Property)

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

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

○ No

Total ***

21,806

* 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 Chestelm Heath Care, Inc. d/b/a Ch	License No. 1029-C	Report for Year Ended 9/30/2021	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

⊕ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm 1 CJLC LLC 2 Marcum LLP 3 4	Address (No. & Street, City, State, Zip Code) 225 Pitkin Street, East Hartford, Ct 06108 555 Long Wharf Dr., 8th Fl., New Haven, CT 06511
---	---

Services Provided by This Firm (*describe fully*)

1	Medicaid Cost Report/CT Corp Tax Returns	\$	23,000
2	HHS Filing	\$	2,909
3		\$	
4		\$	
		Charge for Services Provided	
		\$	25,909

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

Yes No Pg 15/1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 State Marshall O'Toole	
2 CT Probate Court	
3	
4	
5	

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

Services Provided by This Firm (*describe fully*)

1	Conservatorship	\$	85
2	Conservatorship	\$	290
3		\$	
4		\$	
5		\$	
		Charge for Services Provided	
		\$	375

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

Pg 15/1e

Schedule of Resident Statistics

Name of Facility Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab Center			License No. 1029-C				Report for Year Ended 9/30/2021				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					76	63	13		76	63	13	
A. On last day of PREVIOUS report period	76	63	13		76	63	13		76	63	13	
B. On last day of THIS report period	76	63	13		76	63	13		76	63	13	
2. Number of Residents												
A. As of midnight of PREVIOUS report period	68	56	12		68	56	12		65	54	11	
B. As of midnight of THIS report period	70	59	11		65	54	11		70	59	11	
3. Total Number of Days Care Provided During Period												
A. Medicare	3,192	3,192			2,410	2,410			782	782		
B. Medicaid (Conn.)	13,865	10,541	3,324		10,371	7,809	2,562		3,494	2,732	762	
C. Medicaid (other states)												
D. Private Pay	4,970	4,506	464		3,349	3,071	278		1,621	1,435	186	
E. State SSI for RCH												
F. Other (Specify) MM & MC	1,216	1,216			929	929			287	287		
G. Total Care Days During Period (3A thru F)	23,243	19,455	3,788		17,059	14,219	2,840		6,184	5,236	948	
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	124	124			105	105			19	19		
5. Total Resident Days (3G + 4A + 4B)	23,367	19,579	3,788		17,164	14,324	2,840		6,203	5,255	948	

Schedule of Resident Statistics (Cont'd)

Name of Facility Chestelm Heath Care, Inc. d/b/a Chestelm He			License No. 1029-C			Report for Year Ended 9/30/2021			Page 9	of 37	
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:											
Date of Change	Place of Change			Change in Beds				Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost		Gained		CCNH	RHNS	(Specify)	
(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)			
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.											
Change in Resident Days								CCNH	RHNS	(Specify)	
								1st change			
2nd change											
3rd change											
4th change											
6. Number of Residents and Rates on September 30 of Cost Year											
Item	Medicare		Medicaid		Self-Pay			Other State Assisted			
	CCNH	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR		
No. of Residents	9	34	8	16	3						
Per Diem Rate											
a. One bed rm.				425.00	300.00						
b. Two bed rms.				375.00	275.00						
c. Three or more bed rms.					260.00						
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)
								2,692	2,692		
A. Medicare - Part B											
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments											
2. Restorative Treatments								7,033	7,033		
C. Other								907	907		
D. Total Physical Therapy Treatments								10,632	10,632		
8. Total Number of Speech Therapy Treatments											
A. Medicare - Part B								187	187		
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments								1,387	1,387		
2. Restorative Treatments											
C. Other											
D. Total Speech Therapy Treatments								1,574	1,574		
9. Total Number of Occupational Therapy Treatments											
A. Medicare - Part B								1,254	1,254		
B. Medicaid (Exclusive of Part B)											
1. Maintenance Treatments											
2. Restorative Treatments								6,426	6,426		
C. Other								229	229		
D. Total Occupational Therapy Treatments								7,909	7,909		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of		
Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab Co.	1029-C	9/30/2021		10	37		
Are time records maintained by all individuals receiving compensation?	<input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours							
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours		
A. Salaries and Wages*							
1. Operators/Owners (Complete also Sec. I of Schedule A1)							
2. Administrator(s) (Complete also Sec. III of Schedule A1)	84,334	1,840	16,316	240			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)							
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	290,743	10,113	56,251	1,322			
5. Dietary Service							
a. Head Dietitian							
b. Food Service Supervisor	67,547	2,001	13,068	262			
c. Dietary Workers	251,704	14,378	48,698	1,880			
6. Housekeeping Service							
a. Head Housekeeper							
b. Other Housekeeping Workers	118,435	7,489	22,914	979			
7. Repairs & Maintenance Services							
a. Engineer or Chief of Maintenance	59,414	1,930	11,495	252			
b. Other Maintenance Workers	112,525	6,479	21,770	847			
8. Laundry Service							
a. Supervisor							
b. Other Laundry Workers	82,099	5,079	15,884	664			
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	154,229	3,698	29,839	483			
b. RN							
1. Direct Care	632,675	15,410	111,167	2,014			
2. Administrative**	102,056	2,381	19,745	311			
c. LPN							
1. Direct Care	370,610	10,740	33,554	1,404			
2. Administrative**							
d. Aides and Attendants	1,318,186	64,882	119,344	8,482			
e. Physical Therapists							
f. Speech Therapists							
g. Occupational Therapists							
h. Recreation Workers	113,482	5,331	21,956	697			
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	44,816	1,650	8,671	216			
n. Marketing							
o. Other (Specify)							
See Attached Schedule	37,129	1,815	7,183	237			
<i>A-13. Total Salary Expenditures</i>	3,839,983	155,215	557,854	20,290			

* 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)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab Center				License No. 1029-C		Report for Year Ended 9/30/2021			Page 11	of 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).										
Mark Epright	88,960	11,629		Chief Financial Officer		1,440	A4			
Paul Marinan	283	37		Groundskeeper		16	A7b			

* 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.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

**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
Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab Center				1029-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***										
Brenda Marinan	84,334	16,316			Administrator	2,080	A2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended		Page	of
	1029-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	12,405	292	2,400	38	
2. Dentist	1,746	Contract	338	Contract	
3. Pharmacist	6,417	Contract			
4. Podiatrist	4,322	Contract	836	Contract	
5. Physical Therapy					
a. Resident Care	270,339	3,875	17,618		
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	30,164	244	5,836		
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)					
Optometrist	393	5	76	1	
9. Speech Therapist					
a. Resident Care	93,828	1,585			
b. Other					
10. Occupational Therapist					
a. Resident Care	224,518	3,727			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	46,925	1,087	4,248	142	
2. Administrative***					
b. LPN					
1. Direct Care	6,683	53	605	7	
2. Administrative***					
c. Aides	23,799	788	4,605	103	
d. Other					
12. Other (Specify)					
See Attached Schedule					
B-13 Total Fees Paid in Lieu of Salaries	721,540	11,656	36,562	291	

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

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

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

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

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility Chestelm Heath Care, Inc. d/b/a Chestelm Heath	License No. 1029-C	Report for Year Ended 9/30/2021	Page 15	of 37	
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	155,422	137,429	17,993	
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	40,321	35,654	4,668	
4. Social Security (F.I.C.A.)	\$	322,728	270,411	52,317	
5. Health Insurance	\$	475,798	420,716	55,082	
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	33,402	29,536	3,867	
8. Uniform Allowance	\$	7,809	6,543	1,266	
9. Other (Specify) See Attached Schedule	\$	49,750	43,998	5,752	
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$				
d. Accounting and Auditing	\$	25,909	21,709	4,200	
e. Legal (<i>Services should be fully described on Page 7</i>)	\$	375	314	61	
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$	44,550	37,328	7,222	
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	6,686	5,602	1,084	
2. Cellular Phones	\$	11,026	9,239	1,787	
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$	94	79	15	
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (Specify) See Attached Schedule	\$				
3. Resident Day User Fee	\$	400,956	335,957	64,999	
Subtotal	\$	1,574,827	1,354,514	220,313	

* 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**

Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab Center
9/30/2021

Attachment Page 15

Schedule of Other Employee Benefits

Schedule of Other Taxes

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

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

Name of Facility Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Re	License No. 1029-C	Report for Year Ended 9/30/2021	Page 16	of 37
Item	Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>	1,574,827	1,354,514	220,313	
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$			
3. Gifts to Staff and Residents	\$	5,372	4,501	871
4. Employee Travel	\$	576	483	93
5. Education Expenses Related to Seminars and Conventions	\$	17,662	14,799	2,863
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	11,023	9,236	1,787
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	34,144	28,609	5,535
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)**** See Attached Schedule	\$	24,423	20,464	3,959
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	\$	3,132	2,625	508
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	12,577	10,538	2,039
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$	23,511	19,699	3,811
10. Contributions*** See Attached Schedule	\$	6,238	5,227	1,011
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	154,527	129,477	25,050
12. Administrative Management Services**	\$			
13. Other (<i>Specify</i>) See Attached Schedule	\$	7,173	6,010	1,163
<i>C-14 Total Administrative & General Expenditures</i>	\$	1,875,183	1,606,181	269,003

* 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)
Advertising - Promo & Mktg	\$ 20,464	\$ 3,959	
Total Other Advertising	\$ 20,464	\$ 3,959	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Act Dues & Memberships	\$ 530	\$ 102	
Dues & Memberships - Nursing	\$ 358	\$ 69	
Dues & Memberships - Dietary	\$ 557	\$ 108	
Dues & Memberships - Plant	\$ 108	\$ 21	
Dues & Memberships - General	\$ 8,985	\$ 1,738	
Total Dues	\$ 10,538	\$ 2,039	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Donations	\$ 5,227	\$ 1,011	
Total Contributions	\$ 5,227	\$ 1,011	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Licenses & Permits	\$ 2,573	\$ 498	
Service Charges - Bank	\$ 1,103	\$ 213	
Service Charges - Credit Card	\$ 7,359	\$ 1,424	
Bank Reconciliation Adjustment	\$ 25	\$ 5	
Purchases Discount	\$ (252)	\$ (49)	
Prior Period Adjustments	\$ (4,797)	\$ (928)	
Total Other Administrative and General	\$ 6,010	\$ 1,163	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Chestelm Heath Care, Inc. d/b/a Chestelm	License No. 1029-C	Report for Year Ended 9/30/2021	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 #
N/A			

*** 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 Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rel	License No. 1029-C	Report for Year Ended 9/30/2021		Page 18 of 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 206,165	172,744	33,421	
2. Non-Food Supplies	\$ 35,224	29,514	5,710	
3. Other (Specify) _____	\$ _____			
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 1,157	969	188	
c. Other (Specify) _____ Supplies	\$ 4,137	3,466	671	
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 246,683	206,694	39,990	
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
E. 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.	\$328
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?	<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 Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Reha	License No. 1029-C	Report for Year Ended 9/30/2021		Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry	Lbs.				
a. In-House Processing*					
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. \$	3,638	3,049	590	
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$				
c. Other (Specify) Supplies	\$	11,894	9,966	1,928	
3D. Total Laundry Expenditures (3a + b + c)	\$	15,532	13,014	2,518	
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 Chestelm Heath Care, Inc. d/b/a Chestelm Heat	License No. 1029-C	Report for Year Ended 9/30/2021		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 29,531	24,744	4,787	
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.)</i>					
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 1,305	1,093	212	
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	30,836	25,838	4,999	
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	119,933	110,811	9,122	
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	58,970	49,411	9,560	
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	13,458	11,276	2,182	
f. X-rays and Related Radiological Procedures***	\$	11,533	9,663	1,870	
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	31,895	26,724	5,170	
i. Recreation	\$	8,501	7,123	1,378	
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	165,622	139,664	25,958	
5M. Total Resident Care Expenditures (5a - 5j)	\$	409,912	354,672	55,239	

* 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)
Nursing Purchase Service	\$ 6,329	\$ 573	
Nursing Equipment - Residents	\$ 718	\$ 139	
Nursing Station Supplies	\$ 6,142	\$ 1,188	
Resident Supplies	\$ 72,061	\$ 13,942	
Infection Control Expense	\$ 34,712	\$ 6,716	
Purchased Services - Nursing	\$ 6,133	\$ 1,187	
Supplies - PT	\$ 759	\$ -	
Equipment - OT	\$ 780	\$ -	
Supplies - OT	\$ 587	\$ -	
IV Therapy Expense	\$ 6,817	\$ 1,319	
Respiratory Therapist	\$ 691	\$ 134	
Consolidated Billed Expenses	\$ 3,934	\$ 761	
Total Other Resident Care	\$ 139,664	\$ 25,958	\$ -

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

Name of Facility Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab Center				License No. 1029-C	Report for Year Ended 9/30/2021				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)	Pg	Line
CWPM, LLC	25 Norton Pl, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Trash Removal	18,436	3,567		22	6a
Point Click Care	Mississauga, Ontario, CA	<input type="radio"/>	<input checked="" type="radio"/>		Healthcare Software	42,185	8,162		16	m11
Paylocity	Arlington Heights, IL 60004	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Data Processing Fees	17,689	3,422		16	m11
IT Direct	67 Prospect Ave, W. Hartford, CT 06106	<input type="radio"/>	<input checked="" type="radio"/>		Software Maintenance	14,595	2,824		16	m11
OnShift	1621 Euclid Ave, Cleveland, OH 44115	<input type="radio"/>	<input checked="" type="radio"/>		EE Scheduling	13,545	2,621		16	m11
All American Healthcare	494 Broad St, Neward, NJ 07102	<input type="radio"/>	<input checked="" type="radio"/>		Temp Agency	37,452	7,246		13	B11a]
Maxim Healthcare	12558 Collection Ctr Dr, Chicago, IL 60693	<input type="radio"/>	<input checked="" type="radio"/>		Temp Agency	21,463	4,153		13	B11a]
HIBU	Cedar Rapid, IA 52406	<input type="radio"/>	<input checked="" type="radio"/>		Website Maint	13,987	2,706		16	m11
Indeed, Inc.	PO Box 660.67, Dallas, TX 75266-0367	<input type="radio"/>	<input checked="" type="radio"/>		Employment Ad	28,609	5,535		16	m1
		<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 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	90,924	76,184	14,740		
b. Heat	\$	58,321	48,866	9,454		
c. Light & Power	\$	53,050	44,450	8,600		
d. Water	\$	3,132	2,624	508		
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$	21,806	18,271	3,535		
f. Other (<i>itemize</i>)	\$	54,334	45,526	8,808		
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	281,566	235,922	45,644		
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$	1,334	1,118	216		
d. Movable Equipment	\$	81,802	68,541	13,261		
*7e. Total Depreciation Costs (7a + b + c + d)	\$	83,136	69,659	13,477		
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	90,777	76,061	14,716		
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$	90,777	76,061	14,716		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	600,000	502,735	97,265		
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	62,072	52,010	10,062		
c. Personal property taxes	\$	9,240	7,742	1,498		
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	845,226	708,207	137,019		

* 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

Depreciation Schedule

Name of Facility Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab Center				License No. 1029-C			Report for Year Ended 9/30/2021				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. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal													
C. Non-Movable Equipment				60,962		60,962	59,688		10	664			
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)				6,700						670			
C-4. Subtotal													
	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		
	Yes	No	Month	Year									
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a. Ford F-150	X	2	2016	28,135		28,135	25,790	SL	5	2,345			
b. 2015 Mercedes Benz S550	X	6	2018	76,762		76,762	37,101	SL	5	15,352			
c. 2018 Range Rover	X	9	2018	101,433		101,433	40,574	SL	5	20,287			
d. 2019 Ford Transit T350	X	6	2021	18,569		18,569		SL	5	3,714			
2. Movable Equipment													
a. Acquired prior to this report period													
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)													
D-3. Subtotal													
E. Total Depreciation													
												81,802	83,136

Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab Center
9/30/2021

Schedule of Land Improvements Acquired during this report period

***Ties to Page 23, Line A3**

****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
4/21/2021	Beds, Head/Foot Boards/Side Rails	\$ 7,892	5	\$ 1,578
9/7/2021	ThinkPad	\$ 4,005	5	\$ 801
Total additions for Movable Equipment		\$ 11,897		\$ 2,379 *
Deletions:				
9/30/2021	Moveable Equipment (DRYER)	\$ 5,449		
9/30/2021	ELECTRIC BEDS	\$ 1,488		
9/30/2021	ELECTRIC BEDS	\$ 1,516		
9/30/2021	Gator	\$ 3,000		
9/30/2021	Over Bed Tables	\$ 3,004		
9/30/2021	Robo Coup	\$ 2,952		
9/30/2021	Dell - Computer HR	\$ 1,031		
9/30/2021	(3) Dell - Optiplex 3020 Minitower	\$ 2,262		
9/30/2021	(2) Lenovo ThinkCentre M73 - Computer	\$ 2,106		
9/30/2021	(2) Lenovo	\$ 4,483		
Total deletions for Movable Equipment		\$ (27,290)		\$ - **

*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
Additions:				
10/15/2020	Trane RTU Installation	\$ 11,983	15	\$ 799
Total additions for Leasehold Improvement		\$ 11,983		\$ 799 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab Ce			License No. 1029-C		Report for Year Ended 9/30/2021			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	Var	Var	Var	2,908,693	2,195,355	SL		89,978	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				11,983		SL		799	
C-4. Subtotal									90,777
D. Total Amortization									90,777

* 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 Chestelm Heath Care, Inc. d/b/a Chest	License No. 1029-C	Report for Year Ended 9/30/2021	Page 25	of 37
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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				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase	04/01/83			
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	76			
6. Square Footage	31,196			
7. Acquisition Cost				
a. Land				
b. Building				

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	05/20/98			
c. Interest Rate for the Cost Year	7.65%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	4,365,200			
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.

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

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 26	of 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)

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

Name of Facility	License No.	Report for Year Ended			Page	of
		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)	\$	8,768	7,347	1,421		
13. Total All Interest Expense (12B7 + 12C3 + 12D)	\$	8,768	7,347	1,421		
14. Insurance						
a. Insurance on Property (buildings only)	\$	86,315	72,322	13,992		
b. Insurance on Automobiles	\$	7,793	6,530	1,263		
c. Insurance other than Property (as specified above)						
1. Umbrella (<i>Blanket Coverage</i>)	\$					
2. Fire and Extended Coverage	\$					
3. Other (Specify)	\$					
14d. Total Insurance Expenditures (14a + b + c)	\$	94,108	78,852	15,256		
15. Total All Expenditures (A-13 thru C-14)	\$	8,963,755	7,798,250	1,165,505		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		1029-C	9/30/2021	28 37	
			Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<i>Page 10 - Salaries and Wages</i>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<i>Page 13 - Professional Fees</i>							
5.			Resident Care Physicians **	\$			
6.	13	b10a	Occupational Therapy	\$	224,518	224,518	
7.			Other - See attached Schedule	\$			
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.			Accounting	\$			
10a.			Legal	\$	375	314	61
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$	8,226	6,892	1,334
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.	16	16	Automobile Expense (e.g. personal use)	\$	11,023	9,236	1,787
18.	16	m3	Unallowable Advertising *	\$	24,423	20,464	3,959
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$	6,238	5,227	1,011
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$	(5,725)	(4,797)	(928)
<i>Page 18 - Dietary Expenditures</i>							
24.	30	IV1	Meals to employees, guests and others who are not residents	\$	660	553	107
<i>Page 19 - Laundry Expenditures</i>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<i>Page 20 - Housekeeping Expenditures</i>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$	269,738	262,407	7,331	

* 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)
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Prior Period Adjustments	\$ (4,797)	\$ (928)	
Total Other A&G Adjustments			\$ (4,797)	\$ (928)	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-29 Rev. 10/2006

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

Name of Facility				License No.	Report for Year Ended		Page	of
Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab C				1029-C	9/30/2021		29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)	
				Subtotals Brought Forward	\$ 269,738	262,407	7,331	
Page 20 - Resident Care Supplies***								
27.	20	5a	Prescription Drugs	\$ 119,933	110,811	9,122		
28.			Ambulance/Limousine	\$				
29.	20	5f	X-rays, etc	\$ 11,533	9,663	1,870		
30.	20	5h	Laboratory	\$ 31,895	26,724	5,170		
31.			Medical Supplies	\$				
32.	20	e2	Oxygen (non emergency)	\$ 13,458	11,276	2,182		
33.	20	5j	Occupational Therapy	\$ 1,367	1,367			
34.			Other - See Attached Schedule	\$ 13,656	11,442	2,214		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation	\$				
	See Attached Schedule			\$				
36.	22	7d	Depreciation on Unallowable Motor Vehicles	\$ 37,983	31,826	6,157		
37.			Unallowable Property and Real Estate Taxes	\$				
38.			Rental of Building Space or Rooms	\$				
39.			Other - See Attached Schedule	\$ 7,793	6,530	1,263		
Page 27 - Insurance								
40.			Mortgage Insurance	\$				
41.			Property Insurance	\$				
Other - Miscellaneous								
42.			Other - Indirect	\$				
43.			Interest Income on Account Rec.	\$				
44.	30	IV3	Other - Miscellaneous Administrative	\$ 3,000	2,514	486		
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)			\$ 510,356	474,561	35,795		

*** 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.

Chestelm Heath Care, Inc. d/b/a Chestelm Heath & Rehab Center
9/30/2021

Schedule of Other Ancillary Costs

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 30	of 37
		Item	Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 4,622,636	4,622,636				
b. Medicaid Room and Board Contractual Allowance **	\$ (1,240,109)	(960,771)	(279,339)			
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,671,121	1,024,586	646,535			
b. Medicare Room and Board Contractual Allowance **	\$ (1,120,334)	(1,120,334)				
4. a. Private-Pay Residents and Other	\$ 1,665,444	1,665,444				
b. Private-Pay Room and Board Contractual Allowance **	\$ 22,657	22,657				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 96,550	96,550				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 5,104	5,104				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 617,255	617,255				
b. Physical Therapy - Medicare Contractual Allowance **	\$ 48,439	48,439				
c. Physical Therapy - Non-Medicare	\$ 84,155	84,155				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 238,801	238,801				
b. Speech Therapy - Medicare Contractual Allowance **	\$ 48,920	48,920				
c. Speech Therapy - Non-Medicare	\$ 45,700	45,700				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 535,458	535,458				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ 41,814	41,814				
c. Occupational Therapy - Non-Medicare	\$ 70,722	70,722				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$ 891,415	891,415				
b. Other (<i>Specify</i>) - Non-Medicare	\$ (277,591)	(277,665)	74			
III. Total Resident Revenue (Section I. thru Section II.)		\$ 8,068,156	7,700,886	367,270		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$ 660	553	107			
2. Rental of rooms to non-residents	\$					
3. Telephone	\$ 3,000	3,000				
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 566	474	92			
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 16,857	14,124	2,733			
V. Total Other Revenue (1 thru 8)		\$ 21,083	18,151	2,932		
VI. Total All Revenue (III +V)		\$ 8,089,239	7,719,037	370,202		

* 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)
30/II6a	Medicare A - NTA C/A	\$ 417,150		
30/II6a	Medicare A - Nursing C/A	\$ 649,792		
30/II6a	Medicare A - Oxygen	\$ 11,676		
30/II6a	Medicare A - X-Ray	\$ 9,509		
30/II6a	Medicare A - Lab	\$ 25,799		
30/II6a	Medicare A - Contractual Adju	\$ (309,171)		
30/II6a	Medicare A - Sequestration	\$ (45)		
30/II6a	Medicare A - Gram	\$ 195,667		
30/II6a	Medicare A - Prior Year Adju	\$ (2)		
30/II6a	Managed Medicare - NTA C/A	\$ 86,254		
30/II6a	Managed Medicare - Nursing C/A	\$ 124,047		
30/II6a	Managed Medicare - Oxygen	\$ 1,240		
30/II6a	Managed Medicare - X-Ray	\$ 1,019		
30/II6a	Managed Medicare - Lab	\$ 3,189		
30/II6a	Managed Medicare - Ancillary	\$ (134,796)		
30/II6a	Managed Medicare - Prior Year	\$ (1,909)		
30/II6a	Medicare B - Lab	\$ 902		
30/II6a	Medicare B - Contractual Adju	\$ (188,625)		
30/II6a	Medicare B - Sequestration	\$ (280)		
Total Other Resident Revenue - Medicare		\$ 891,415	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6b	Private SNF - Lab	\$ 72		
30/II6b	Private SNF - Prior Year Adju	\$ (75,081)		
30/II6b	Medicaid SNF - Prior Year Adj	\$ (72,473)		
30/II6b	Medicaid ICF - Prior Year Adj		\$ 74	
30/II6b	Managed Care - Oxygen	\$ 552		
30/II6b	Managed Care - X-Ray	\$ 736		
30/II6b	Managed Care - Lab	\$ 883		
30/II6b	Managed Care - Contractual Ad	\$ (33,000)		
30/II6b	Blue Cross Contractual Adj	\$ (702)		
30/II6b	Hospice XIX - Prior Year Adju	\$ (14,376)		
30/II6b	Managed Care B - Contractual	\$ (1,834)		
30/II6b	Managed Care B - Prior Year A	\$ (911)		
30/II6b	Outpatient - Contractual Adju	\$ (90,214)		
30/II6b	Outpatient - Prior Year Adju	\$ (6,017)		
30/II6b	Outpatient Part B ? Physical	\$ 26,896		
30/II6b	Outpatient Part B OT	\$ 7,213		
30/II6b	Outpatient -Part B Cont Adj	\$ (19,411)		
Total Other Resident Revenue		\$ (277,665)	\$ 74	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30/IV5	Interest income	\$ 474	\$ 92		
Total Interest Income		\$ 474	\$ 92	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30/IV8	Transportation	\$ 6,252	\$ 1,210	
30/IV8	Charitable Donations	\$ 168	\$ 32	
30/IV8	Misc. Income	\$ 7,704	\$ 1,491	
Total Other Revenue		\$ 14,124	\$ 2,733	\$ -

G. Balance Sheet

Name of Facility Chestelm Heath Care, Inc. d/b/a Chestel	License No. 1029-C	Report for Year Ended 9/30/2021	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	439,355
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,569,659
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	2,400
5. Prepaid Expenses			\$	249,850
a. _____				
b. _____				
c. _____				
d. See Schedule		249,850		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,261,265
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	Net		
3. Buildings	*Historical Cost	_____	\$	
	Accum. Depreciation	Net		
4. Leasehold Improvements	*Historical Cost	2,920,676	\$	634,544
	Accum. Depreciation	2,286,132 Net		
5. Non-Movable Equipment	*Historical Cost	67,662	\$	6,640
	Accum. Depreciation	61,022 Net		
6. Movable Equipment	*Historical Cost	1,363,755	\$	98,675
	Accum. Depreciation	1,265,081 Net		
7. Motor Vehicles	*Historical Cost	224,898	\$	79,736
	Accum. Depreciation	145,162 Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	186,007
See Schedule		186,007		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,005,602

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Chestelm Heath Care, Inc. d/b/a Chesteste	License No. 1029-C	Report for Year Ended 9/30/2021	Page 32	of 37
Account		Amount		
		Total Brought Forward:		
		\$ 3,266,866		
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>)			\$ 401,585	
See Schedule	401,585			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 401,585	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 3,668,452	

* 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
Chestelm Heath Care, Inc. d/b/a Chestelm Hea	1029-C	9/30/2021	33	37
Liabilities	Account	Amount		
A. Current Liabilities				
1. Trade Accounts Payable		\$ 1,169,423		
2. Notes Payable (<i>itemize</i>)		\$ 1,815,386		
See Schedule		1,815,386		
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>)		\$ 180,169		
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)		\$		
6. Accrued Payroll Taxes Payable		\$ 38,510		
7. Medicare Final Settlement Payable		\$ 1,646		
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*		\$		
12. Other Current Liabilities (<i>itemize</i>)		\$ 213,135		
See Schedule		213,135		
A-13. Total Current Liabilities (Lines A1 thru 12)		\$ 3,418,269		

* 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 Chestelm Heath Care, Inc. d/b/a Chestelm H	License No. 1029-C	Report for Year Ended 9/30/2021	Page 34	of 37
Account				Amount
Total Brought Forward:				\$ 3,418,269
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>)				\$ 252,027
Name and Address of Lender	Amount	Loan Date		
Due to Related Parties	252,027			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 252,027
C. Total All Liabilities (Lines A-13 + B-5)				\$ 3,670,297

G. Balance Sheet (cont'd)

Reserves and Net Worth

Name of Facility Chestelm Heath Care, Inc. d/b/a Chest	License No. 1029-C	Report for Year Ended 9/30/2021	Page 35	of 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 (<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				\$
B. Net Worth				
1. Owner's Capital				\$
2. Capital Stock				\$
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ 869,672
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ (874,516)
7. Total Net Worth				\$ (4,844)
C. Total Reserves and Net Worth				\$ (4,844)
D. Total Liabilities, Reserves, and Net Worth				\$ 3,665,453

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Heath Care, Inc. d/b/a Chestelm	1029-C	9/30/2021	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ (1,115,193)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 8,089,239
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 8,963,755
D. Net Income or Deficit				\$ (874,516)
E. Balance				\$ (1,989,709)
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 (No., City, State, Zip)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)				\$
Purpose		Amount		
3. Total Deductions				\$
H. Balance at End of Period				\$ (1,989,709)

I. Preparer's/Reviewer's Certification

Name of Facility Chestelm Heath Care, Inc. d/b/a Chestelm	License No. 1029-C	Report for Year Ended 9/30/2021	Page 37	of 37
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Check appropriate category

<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)
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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

CJLC LLC

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