Craig J. Lubitski Consulting LLC & CJLC LLC

CERTIFIED PUBLIC ACCOUNTANTS & ADVISORS

Mr. Chris LaVigne
CON & Reimbursement
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Chestelm

Mr. LaVigne:

This enclosed 2015 Medicaid Cost Report intentionally omits the following disallowances:

a. Administrator and Related Party salaries
b. Dues and Membership Fees to Professional Associations
c. Physical or Speech Therapy salaries or fees
d. Depreciation and/or interest expense related to capitalized items previously deemed unallowable by the Department

It is our understanding that the software utilized by the Department in the rate setting process computes the necessary disallowances for these areas and our intention is to eliminate the potential for a duplicate disallowance.

If you have any questions, please contact me at 860-610-9009.

Respectfully,

Craig J. Lubitski, CPA
Partner

225 Pitkin Street
East Hartford
Connecticut 06108

860.610.9009 (t)
860.610.9030 (f)

cjlc.com

State of Connecticut

Annual Report of Long-Term Care Facility
Cost Year 2015

Name of Facility (as licensed) Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center		
Address (No. & Street, City, State, Zip Code) 534 Town Street, Moodus, CT 06469		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☑ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015	

License Numbers:	CCNH 1029-C	RHNS 179RH	(Specify)	Medicare Provider 07-5307

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID

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

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Chestelm Health Care, Inc. d/b/a Chestelm Health & R	1029-C	9/30/2015	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 Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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
[signature]	2/15/16	[signature]	2-15-16
Printed Name (Administrator) Brenda Marinan		Printed Name (Owner) Brinton Epright	

Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires
Renee Lee Moreira	CT	2-15-16	[signature]	3/31/18

Address of Notary Public
20 SHAICOR Hill Rd Colchester Ct 06415

RENEE LEE MOREIRA
Notary Public, State of Connecticut
My Commission Expires 3/31/2018

(Notary Seal)

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State of Connecticut
Department of Social Services
25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center	Period Covered:		From 10/1/2014	To 9/30/2015
Address of Facility 534 Town Street, Moodus, CT 06469				
Report Prepared By Craig J. Lubitski Consulting LLC	Phone Number 860-610-9009		Date 2/12/2016	

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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-873-1455	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Ce	534 Town Street, Moodus, CT 06469

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	1029-C	179RH		07-5307

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.:
Brenda Marinan	00932

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chestelm Health & F	1029-C	9/30/2015	3	37

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

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
Chestelm Health Care, Inc. d/b/a Chestelm H	1029-C	9/30/2015	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
Chestelm Health Care, Inc.	534 Town Street, Moodus, CT 06469	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Brinton Epright	534 Town Street, Moodus, CT 06469	resident/Treasur	50
Evelyn Epright	534 Town Street, Moodus, CT 06469	VP/Secretary	50
Names of Stockholders Owning at Least 10% of Shares			
Brinton Epright	534 Town Street, Moodus, CT 06469	resident/Treasur	50
Evelyn Epright	534 Town Street, Moodus, CT 06469	VP/Secretary	50

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chestelm Health	1029-C	9/30/2015	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
Chestelm Health Care, Inc. d/b/a Chestelm Health & Re	1029-C	9/30/2015	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	%**				
Healthcare Holdings, LLC	534 Town Street, Moodus, CT 06469	○	⊙		Rent	Page 22/Line 9	672,191	672,191
Brenda Epright - Marinan	534 Town Street, Moodus, CT 06469	○	⊙		Administrator	Page 10/Line A2	102,971	102,971
Mark Epright	534 Town Street, Moodus, CT 06469	○	⊙		Chief Financial Officer	Page 10/LineA4	103,501	103,501
Chestelm Adult Day Services	534 Town Street, Moodus, CT 06469	○	⊙		Snow Plowing	Page 22/Line 6f	14,038	14,038
Chestelm Adult Day Services	534 Town Street, Moodus, CT 06469	○	⊙		Chestelm Adult Day Services purchased foo	Page 18/Line 2a1	(24,000)	(24,000)
		○	○					
		○	○					
		○	○					
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chestelm Hea	1029-C	9/30/2015	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
Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab	1029-C	9/30/2015	6	37

Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
GE Captial	○	⊙	Canon C7055	06/24/15	36 months	9,615	4,808
Marlin Leasing Corp	○	⊙	Phone System	06/30/15	36 months	15,648	1,304
Mercedes Benz Financial	○	○	Vehicle	Self Disallowed	Self Disallowed	29,116	29,116
GE Captial	○	○	Copier RC-51851	05/07/08	replaced with GE above	11,001	5,077
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total** *** 40,305

* 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.

GE Capital

Equipment Lease Agreement # 6799290006 IR

EQUIPMENT

Equipment MFG Model & Description	Serial Number	Accessories
Canon iR Adv - C7260		Booklet Finisher, Puncher, Fax

☐ See attached schedule for additional Equipment / Accessories

Billing Address: PO Box 719 Meadus CT 06469
Equipment Location: 534 Town St. Meadus CT 06469

SUPPLIER

Flo-Tech, LLC
Name
699 Middle St.
Address
Middletown CT 06457
City State Zip

TRANSACTION TERMS

Purchase Option: Fair Market Value
Lease Payment: $ 771.43 (plus applicable taxes)
Term: 36 (months) Billing Period: Monthly
The following additional payments are due on the date this Lease is signed by you:
Advance Payment: $ 0 (Plus Applicable Taxes) Applied to: ☐ First ☐ Last
Document Fee: $75.00 (included on first invoice)

YOU HAVE SELECTED THE EQUIPMENT. THE SUPPLIER AND ITS REPRESENTATIVES ARE NOT OUR AGENTS AND ARE NOT AUTHORIZED TO MODIFY THE TERMS OF THIS LEASE. YOU ARE AWARE OF THE NAME OF THE MANUFACTURER OF EACH ITEM OF EQUIPMENT AND YOU WILL CONTACT EACH MANUFACTURER FOR A DESCRIPTION OF YOUR WARRANTY RIGHTS. WE MAKE NO WARRANTIES TO YOU, EXPRESS OR IMPLIED, AS TO THE MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, SUITABILITY OR OTHERWISE. WE PROVIDE THE EQUIPMENT TO YOU AS-IS. YOU AGREE TO USE THE EQUIPMENT ONLY IN THE LAWFUL CONDUCT OF YOUR BUSINESS, AND NOT FOR PERSONAL, HOUSEHOLD OR FAMILY PURPOSES. WE SHALL NOT BE LIABLE FOR CONSEQUENTIAL OR SPECIAL DAMAGES. WE MAKE NO REPRESENTATION OR WARRANTY OF ANY KIND, EXPRESS OR IMPLIED, WITH RESPECT TO THE LEGAL, TAX OR ACCOUNTING TREATMENT OF THIS LEASE AND YOU ACKNOWLEDGE THAT WE ARE AN INDEPENDENT CONTRACTOR AND NOT A FIDUCIARY OF LESSEE. YOU WILL OBTAIN YOUR OWN LEGAL, TAX AND ACCOUNTING ADVICE RELATED TO THIS LEASE AND WILL MAKE YOUR OWN DETERMINATION OF THE PROPER LEASE TERM FOR ACCOUNTING PURPOSES.

YOUR PAYMENT OBLIGATIONS ARE ABSOLUTE AND UNCONDITIONAL AND ARE NOT SUBJECT TO CANCELLATION, REDUCTION OR SETOFF FOR ANY REASON WHATSOEVER. BOTH PARTIES AGREE TO WAIVE ALL RIGHTS TO A JURY TRIAL. THIS LEASE SHALL BE GOVERNED BY THE LAWS OF IOWA. YOU CONSENT TO THE JURISDICTION AND VENUE OF FEDERAL AND STATE COURTS IN IOWA.

TO HELP THE GOVERNMENT FIGHT THE FUNDING OF TERRORISM AND MONEY LAUNDERING ACTIVITIES, FEDERAL LAW REQUIRES ALL FINANCIAL INSTITUTIONS TO OBTAIN, VERIFY AND RECORD INFORMATION THAT IDENTIFIES EACH PERSON WHO OPENS AN ACCOUNT. WHAT THIS MEANS TO YOU: WHEN YOU OPEN AN ACCOUNT, WE WILL ASK FOR YOUR NAME, ADDRESS AND OTHER INFORMATION THAT WILL ALLOW US TO IDENTIFY YOU. WE MAY ALSO ASK TO SEE IDENTIFYING DOCUMENTS.

BY SIGNING THIS LEASE, YOU ACKNOWLEDGE RECEIPT OF PAGES 1 AND 2 OF THIS LEASE, AND AGREE TO THE TERMS ON BOTH PAGES 1 AND 2. ORAL AGREEMENTS OR COMMITMENTS TO LOAN MONEY, EXTEND CREDIT OR TO FORBEAR FROM ENFORCING REPAYMENT OF A DEBT INCLUDING PROMISES TO EXTEND OR RENEW SUCH DEBT ARE NOT ENFORCEABLE. TO PROTECT YOU AND US FROM MISUNDERSTANDING OR DISAPPOINTMENT, ANY AGREEMENTS WE REACH COVERING SUCH MATTERS ARE CONTAINED IN THIS WRITING, WHICH IS THE COMPLETE AND EXCLUSIVE STATEMENT OF THE AGREEMENT BETWEEN US. EXCEPT AS WE MAY LATER AGREE IN WRITING TO MODIFY IT.

TERMS AND CONDITIONS

1. **COMMENCEMENT OF LEASE.** Commencement of this Lease and acceptance of the Equipment shall occur upon delivery of the Equipment to you ("Commencement Date"). To the extent that the Equipment includes intangible property or associated services such as periodic software licenses and prepaid database subscription rights, such intangible property shall be referred to as "Software". You understand and agree that we have no right, title or interest in the Software and you will comply throughout the Term of this Lease with any license and/or other agreement ("Software License") entered into with the supplier of the Software ("Software Supplier"). You are responsible for entering into any Software License with the Software Supplier no later than the Commencement Date of this Lease. You agree to inspect the Equipment upon delivery and verify by telephone or in writing such information as we may require. If you signed a purchase order or similar agreement for the purchase of the Equipment, by signing this Lease you assign to us all of your rights, but none of your obligations under it. All attachments, accessories, replacements, replacement parts, substitutions, additions and repairs to the Equipment shall form part of the Equipment under this Lease.
2. **LEASE PAYMENTS.** You agree to remit to us the Lease Payment and all other sums when due and payable each Billing Period at the address we provide to you from time to time. You agree that you will remit payments to us in the form of company checks (or personal checks in the case of sole proprietorships), direct debit or wires only. You also agree cash and cash equivalents are not acceptable forms of payment for this Lease and that you will not remit such forms of payment to us. Payment in any other form may delay processing or be returned to you. Furthermore, only you or your authorized agent as approved by us will remit payments to us. Lease Payments will include any freight, delivery, installation and other expenses we finance on your behalf at your request. Lease Payments are due whether or not you receive an invoice. You authorize us to adjust the Lease Payments by not more than 15% to reflect any reconfiguration of the Equipment or adjustments to reflect applicable sales taxes or the cost of the Equipment by the manufacturer and/or Supplier. If the commencement of the Lease falls on any day other than the 20th day of a month, you agree to pay us interim rent from Commencement through, but not including, the 20th day of the month next following Commencement (the "Interim Rent Period") at a rate equal to 1/30th of the Lease Payment set forth hereon for each calendar day during the Interim Rent Period.
3. **LEASE CHARGES.** You agree to: (a) pay all costs and expenses associated with the use, maintenance, servicing, repair or replacement of the Equipment; (b) pay all fees, assessments, taxes and charges environmentally imposed upon Lessor's purchase, ownership, possession, leasing, renting, operation, control or use of the Equipment and pay all premiums and other costs of insuring the Equipment; (c) reimburse us for all costs and expenses incurred in enforcing this Lease; and (d) pay all other costs and expenses for which you are obligated under this Lease ((a) through (d) collectively referred to as "Lease Charges"). You agree at our discretion, to either (1) reimburse us for all personal property and other similar taxes and governmental charges associated with the ownership, possession or use of the Equipment when billed by the jurisdictions; or (2) remit us each Billing Period our estimate of the pro-rated equivalent of such taxes and

Continued on page 2.

LESSOR ("We", "Us")

General Electric Capital Corporation
By: X Caleb Wilson
Name TSS 6/24/15
Title Date

LESSEE ("You")

Chestelm Health Care Inc.
(Lessee Full Legal Name)
By: X
Mark W Enright 4 CFO
Name Title
5-29-15 06-1473863
Date Federal Tax ID

governmental) charges. In the event that the Billing Period sums includes a separately stated estimate of personal property and other similar taxes, you acknowledge and agree that such amount represents our estimate of such taxes that will be payable with respect to the Equipment during the Term. As compensation for our internal and external costs in the administration of taxes related to each unit of Equipment, you agree to pay us a "Tax Administrative Fee" equal to $12 per unit of Equipment per year during the Term, not to exceed the maximum permitted by applicable law. The Tax Administrative Fee, at our sole discretion, may be increased by an amount not exceeding 10% thereof for each subsequent year of the Term to reflect our increased cost of administration and we will notify you of any such increase by indicating such increased amount in the relevant invoice or in such other manner as we may deem appropriate. We may take on your behalf any action required under this Lease which you fail to take, and upon receipt of our invoice you will promptly pay our costs (including insurance premiums and other payments to affiliates), plus reasonable processing fees. Restrictive endorsements on checks you send to us will not reduce your obligations to us. We may charge you a return check or non-sufficient funds charge of $25 for any check which is returned by the bank for any reason (not to exceed the maximum amount permitted by law).

4. LATE CHARGES. For any payment which is not received within three (3) days of its due date, you agree to pay a late charge equal to the higher of 5% of the amount due or $35 (not to exceed the maximum amount permitted by law) as reasonable collection costs.

5. OWNERSHIP, USE, MAINTENANCE AND REPAIR. We own the Equipment and you have the right to use the Equipment under the terms of this Lease. If this Lease is deemed to be a secured transaction, you grant us a first priority security interest in the Equipment to secure all of your obligations under this Lease. We hereby assign to you all our rights under any manufacturer and/ or supplier warranties, so long as you are not in default hereunder. You must keep the Equipment free of liens. You may not remove the Equipment from the address indicated on page 1 of this Lease without first obtaining our approval. You agree to: (a) keep the Equipment in your exclusive control and possession; (b) use the Equipment in conformity with all insurance requirements, manufacturer's instructions and manuals; (c) keep the Equipment repaired and maintained in good working order and as required by the manufacturer's warranty, certification and standard full service maintenance contract; and (d) give us reasonable access to inspect the Equipment and its maintenance and other records.

6. INDEMNITY. You are responsible for all losses, damages, claims, infringement claims, injuries and attorneys' fees and costs, including, without limitation, those incurred in connection with responding to subpoenas, third party or otherwise ("Claims"), incurred or asserted by any person, in any manner relating to the Equipment, including its use, condition or possession. You agree to defend and indemnify us against all Claims, although we reserve the right to control the defense and to select or approve defense counsel. This indemnity continues beyond the termination of this Lease for acts or omissions which occurred during the Term of this Lease. You also agree that this Lease has been entered into on the assumption that we are the owner of the Equipment for U.S. federal income tax purposes and will be entitled to certain U.S. federal income tax benefits available to the owner of the Equipment. You agree to indemnify us for the loss of any U.S. federal income tax benefits resulting from the failure of any assumptions in this Lease to be correct or caused by your acts or omissions inconsistent with such assumption or this Lease. In the event of any such loss, we may increase the Lease Payments and other amounts due to offset any such adverse effect.

7. LOSS OR DAMAGE. If any item of Equipment is lost, stolen or damaged you will, at your option and cost, either: (a) repair the item or replace the item with a comparable item reasonably acceptable to us; or (b) pay us the sum of: (i) all past due and current Lease Payments and Lease Charges; (ii) the present value of all remaining Lease Payments and Lease Charges for the effected item(s) of Equipment, discounted at the rate of 6% per annum (or the lowest rate permitted by law, whichever is higher); and (iii) the Fair Market Value of the effected item(s) of Equipment. We will then transfer to you all our right, title and interest in the effected item(s) of Equipment AS IS AND WHERE IS, WITHOUT ANY WARRANTY AS TO CONDITION, TITLE OR VALUE. Insurance proceeds shall be applied toward repair, replacement or payment hereunder, as applicable. In this Lease, "Fair Market Value" of the Equipment means its fair market value at the end of the Term, assuming good order and condition (except for ordinary wear and tear from normal use), as estimated by us. No such loss or damage shall relieve you of your payment obligations under this Lease.

8. INSURANCE. You agree, at your cost, to: (a) keep the Equipment insured against all risks of physical loss or damage for its full replacement value, naming us as loss payee; and (b) maintain public liability insurance, covering personal injury and Equipment damage for not less than $300,000 per occurrance, naming us as additional insured. The policy must be issued by an insurance carrier acceptable to us, must provide us with not less than 15 days' prior written notice of cancellation, non-renewal or amendment, and must provide deductible amounts acceptable to us.

9. DEFAULT. You will be in default under this Lease if: (a) you fail to remit to us any payment within ten (10) days of the due date or breach any other obligation under this Lease, (b) a petition is filed by or against you or any guarantor under any bankruptcy or insolvency law; or (c) you default under any other agreement with us.

10. REMEDIES. If you default, we may do one or more of the following: (a) recover from you, AS LIQUIDATED DAMAGES FOR LOSS OF BARGAIN AND NOT AS A PENALTY, the sum of: (i) all past due and current Lease Payments and Lease Charges; (ii) the present value of all remaining Lease Payments and Lease Charges, discounted at the rate of 6% per annum (or the lowest rate permitted by law, whichever is higher); and (iii) the Fair Market Value of the Equipment; (b) declare any other agreements between us in default; (c) require you to return all of the Equipment in the manner outlined in Section 11, or take possession of the Equipment, in which case we shall not be held responsible for any losses directly or indirectly arising out of, or by reason of the presence and/or use of any and all proprietary information residing on or within the Equipment, and to lease or sell the Equipment or any portion thereof, and to apply the proceeds, less reasonable selling and administrative expenses, to the amounts due hereunder; (d) charge you interest on all amounts due to us from the due date until paid at the rate of 1-1/2% per month, but in no event more than the lawful maximum rate; and (e) charge you for expenses incurred in connection with the enforcement of our remedies including, without limitation, repossession, repair and collection costs, attorneys' fees and court costs. These remedies are cumulative, are in addition to any other remedies provided for by law, and may be exercised concurrently or separately. Any failure or delay by us to exercise any right shall not operate as a waiver of any other right or future right.

11. END OF TERM OPTIONS; RETURN OF EQUIPMENT. At the end of the Term and upon 30 days prior written notice to us, you shall either: (a) return all, but not less than all, of the Equipment; or (b) purchase all, but not less than all, of the Equipment AS IS AND WHERE IS, WITHOUT ANY WARRANTY AS TO CONDITION, TITLE OR VALUE, for the Fair Market Value, plus applicable sales and other taxes. If you do not provide us with such written notice and either return all of the Equipment or purchase all of the Equipment at the end of the Term, then this Lease will automatically renew on a month-to-month basis and all of the provisions of this Lease shall continue to apply, including, without limitation, your obligations to remit Lease Payments, Lease Charges and other charges, until all of the Equipment is either returned to us (either because we demand return of the Equipment or you decide to return the Equipment) or purchased by you for the applicable Fair Market Value, plus applicable sales and other taxes, in accordance with the terms hereof. If you are in default, or you do not purchase the Equipment at the end of the Term (or any month-to-month renewal term), you shall: (1) return all of the Equipment, freight and insurance prepaid at your cost and risk, to wherever we indicate in the continental United States, with all manuals and logs, in good order and condition (except for ordinary wear and tear from normal use), packed per the shipping company's specifications; and (2) securely remove all data from any and all disk drives or magnetic media prior to returning the Equipment (and you are solely responsible for selecting an appropriate removal standard that meets your business needs and complies with applicable laws). You will pay us for any loss in value resulting from the failure to maintain the Equipment in accordance with this Lease or for damages incurred in shipping and handling.

12. ASSIGNMENT. You may not assign or dispose of any rights or obligations under this Lease or sublease the Equipment without our prior written consent. We may, without notifying you, (a) assign all or any portion of this Lease or our interest in the Equipment; and (b) release information we have about you and this Lease to the manufacturer, Supplier or any prospective investor, participant or purchaser of this Lease. If we do make an assignment under subsection 12(a) above, our assignee will have all of our rights under this Lease, but none of our obligations. You agree not to assert against our assignee claims, offsets or defenses you may have against us.

13. MISCELLANEOUS. Notices must be in writing and will be deemed given five (5) days after mailing to your (or our) business address. You represent that: (a) you have authority to enter into this Lease and by so doing you will not violate any law or agreement; and (b) this Lease is signed by your authorized officer or agent. This Lease is the entire agreement between us, and cannot be modified except by another document signed by us. This Lease is binding on you and your successors and assigns. All financial information you have provided is true and a reasonable representation of your financial condition. You authorize us, our agent or our assignee to: (a) obtain credit reports and make credit inquiries; (b) furnish your information, including credit application, payment history and account information, to credit reporting agencies and our assignees, potential purchasers or investors or parties having an economic interest in this Lease or the Equipment, including, without limitation, the seller, Supplier or any manufacturer of the Equipment; and (c) you irrevocably grant us the power to prepare, sign on your behalf (if applicable), and file, electronically or otherwise Uniform Commercial Code ("UCC") financing statements and any amendments thereto or continuation thereof relating to the Equipment, and containing any other information required by the applicable UCC. Any claim you have against us must be made within two (2) years after the event which caused it. If a court finds any provision of this Lease to be unenforceable, all other terms shall remain in effect and enforceable. You authorize us to insert or correct missing information on this Lease, including your proper legal name, serial numbers and any other information describing the Equipment. If you so request, and we permit the early termination of this Lease, you agree to pay a fee for such privilege. THE PARTIES INTEND THIS TO BE A "FINANCE LEASE" UNDER ARTICLE 2A OF THE UCC. YOU WAIVE ALL RIGHTS AND REMEDIES CONFERRED UPON A LESSEE BY ARTICLE 2A OF THE UCC. YOU FURTHER HEREBY ACKNOWLEDGE AND AGREE THAT WE AND/OR SUPPLIER MAY MAKE A PROFIT ON ANY AND ALL FEES REFERENCED HEREIN AND, IN SO DOING WAIVE ANY AND ALL CLAIM WHICH YOU MAY HAVE FOR UNJUST ENRICHMENT. We may receive compensation from the manufacturer and/or Supplier of the Equipment in order to enable us to reduce the cost of this Lease below what we otherwise would charge. If we received such compensation, the reduction in the cost of this Lease is reflected in the Lease Payment.

14. ELECTRONIC TRANSMISSION OF DOCUMENTATION. This Lease may be executed in counterparts. The executed counterpart which has our original signature and/or is in our possession shall constitute chattel paper as that term is defined in the UCC and shall constitute the original agreement for all purposes, including, without limitation: (i) any hearing, trial or proceeding with respect to this Lease; and (ii) any determination as to which version of this Lease constitutes the single true original item of chattel paper under the UCC. If you sign and transmit this Lease to us by facsimile or other electronic transmission, the transmitted copy shall be binding upon the parties. You agree that the facsimile or other similar electronic transmission of this Lease manually signed by us, when attached to the facsimile or other electronic copy signed by you, shall constitute the original agreement for all purposes. The parties further agree that, for purposes of executing this Lease, and subject to our prior approval and at our sole discretion: (a) a document signed and transmitted by facsimile or other electronic transmission shall be treated as an original document; (b) the signature of any party on such document shall be considered as an original signature; (c) the document transmitted shall have the same effect as a counterpart thereof containing original signature; and (d) at our request, you, who executed this Lease and transmitted its signature by facsimile or other electronic transmission shall provide the counterpart of this Lease containing your original manual signature to us. No party may raise as a defense to the enforcement of this Lease that a facsimile or other electronic transmission was used to transmit any signature of a party to this Lease.

Certificate of Acceptance

Re: Agreement / Contract / Account Schedule Number 6799290006 ("Contract")
Financial Services Provider: General Electric Capital Corporation ("FS Provider")
Lessee/ Customer: CHESTELM HEALTH CARE, INC. ("Customer")

This Certificate of Acceptance to the lease, loan or other form of financial services contract described above ("Contract") is by and between the FS Provider identified above and the Customer identified above.

Customer, through its authorized representative, hereby certifies to FS Provider and any assignee of FS Provider with respect to the Contract that:

1. The equipment ("Equipment") identified in the Contract, including in any equipment list attached to the Contract ("Contract Equipment List") has been delivered to the location where the Equipment will be used and which is the "Equipment location" identified in the Contract.

2. In the event of inconsistencies between the Contract Equipment List and the list of Equipment provided to FS Provider by the supplier of the Equipment, Customer authorizes FS Provider to correct the Contract Equipment List and substitute the Equipment identified in such corrected Contract Equipment List as the "Equipment" accepted under the Contract.

3. All of the Equipment has been inspected and is (a) complete, (b) properly installed, (c) fully functioning, and (d) in good working order.

4. The Equipment is of a capacity, size, design, and manufacture acceptable to Customer and is suitable for Customer's purposes.

5. Customer is not in default under the Contract and all of Customer 's statements and promises set forth in the Contract are true and correct.

6. The Equipment is accepted for all purposes under the Contract as of the Acceptance Date below.

IN WITNESS WHEREOF, Customer's duly authorized representatives has executed this Acceptance Certificate as of the Acceptance Date.

Customer: CHESTELM HEALTH CARE, INC.

By: _____

Title: CFO

Acceptance Date: 4/15/15

MARLIN

EQUIPMENT LEASE CONTRACT

Lessor ("We" or "Us"):
www.marlinleasing.com

☐ Marlin Leasing Corporation
300 Fellowship Road • Mt. Laurel, NJ 08054
phone: 888.479.9111 • fax: 888.479.1100

or

☐ Marlin Business Bank
2795 E. Cottonwood Pkwy, Ste 120 • Salt Lake City, UT 84121
phone: 801.453.1722

Processing Office
1500 JFK Blvd, Ste 330
Philadelphia, PA 19106

DESCRIPTION OF LEASED EQUIPMENT (Include quantity, make, model, serial number and accessories. Attach schedule if necessary.) *MUST BE COMPLETED*

#1052078

Phone System

LEASING CUSTOMER ("YOU")

Company Name (Exact business name): Chesterm Healthcare Inc. DBA Chesterm Health & Rehabilitation Center

Address: 534 Town Street (Street) Moodus (City) (County) CT (State) 06469 (Zip)

Phone: (860)873-1455 Fax: Email: ☒ Corp. ☐ LLC ☐ Partnership ☐ Prop.

Equipment Location: 534 Town Street Moodus, CT 06469 State of Incorporation/Organization: CT

Vendor: Address:

Lease Term (Mos.)	Total No. of Payments	Amount of Each Payment	Advance Rentals	Security Deposit	Payment Frequency	Equipment Purchase Option
36	36	$1,304.00 (plus applicable taxes)	$0.00 First 0 and Last 0 Mos.	$0.00	Monthly	Fair Market Value

TERMS OF LEASE

1. You (the customer) want to acquire the above equipment from the above vendor. You want the Lessor identified above to buy it and then lease it to you. This Lease will begin when the equipment is delivered to you and will continue for the entire Lease Term plus any interim rent period. You will unconditionally pay us all amounts due, without any right to set-off. If we do not receive your payment by its due date, there will be a late fee equal to 15% of the late amount (or, if less, the maximum amount allowable under law) which you agree is a reasonable estimate of the costs we incur with respect to late payments and is not a penalty. Upon your request, we will waive the first assessed late charge. We may charge you a partial payment (interim rent) for the time between delivery and the due date for the first regular payment. We may charge you a one-time documentation fee up to $149. You agree that we may adjust the payment amount above if the final equipment cost varies from the amount the payment was based upon. This Lease is not binding on us until we sign it. To expedite this Lease, you asked us to accept your faxed signature and have agreed it will be considered as good as your original signature and admissible in court as conclusive evidence of this Lease.

2. (a) You may purchase all of the equipment as indicated in the Equipment Purchase Option above. You will give us written notice by certified mail between 60 and 90 days before the expiration of the initial Lease Term (or any renewal term) of your intention to return the equipment or purchase the equipment. After you have (i) paid all amounts owing under the Lease and (ii) given us the proper and timely notice, then at the end of the Lease Term, you shall return the equipment pursuant to the instructions we provide to you. You agree to reimburse us for our costs to refurbish returned equipment for damage beyond normal wear and tear. You are solely responsible for removing all data/images stored on the equipment prior to its return. If you fail to notify us as provided herein, this Lease will extend on a month to month basis, until you have given at least 60 days written notice of your intention to return or purchase the equipment. (b) You agree the security deposit will not bear interest and that we may apply it to any amount owed to us, and should we do so, you agree to restore the security deposit to its original amount. You may request the return of the security deposit only after all of your obligations under this Lease have been met in full.

3. You alone selected the vendor and the equipment. You asked us to buy it. We are not related to the vendor and we cannot get a refund, nor is the vendor allowed to waive or modify any term of this Lease. Therefore, the Lease cannot be canceled by you for any reason, even if the equipment fails or is damaged and it is not your fault. We are leasing it to you "as is" and we disclaim all express and implied warranties, including any warranty of merchantability or fitness for a particular purpose. You are responsible for installation and all service. The vendor may have given you warranties. You may contact the vendor to get a statement of all warranties, if any. We assign to you any warranties the vendor may have given us. You shall settle any dispute regarding the equipment's performance directly with the vendor. You promise that the equipment will be used only for business and not for personal, family or household purposes. You will keep and use the equipment only at the above address and not move it or return it to us prior to the end of the Lease Term. Your payments may include amounts you owe to the vendor under a separate maintenance, service and/or supply arrangement. We may invoice such amounts on the vendor's behalf for your convenience. You agree that any claims related to maintenance, service or supplies will not impact your obligation to pay us the full amount due under this Lease.

4. If you do not pay us as agreed or fail to perform any other term of this Lease, you will be in default and you agree that we may (i) repossess or disable the equipment and/or (ii) directly debit (charge) your bank account(s) and/or sue you for all past due payments, fees, taxes, and all payments due in the future to the end of the Lease Term, plus our legal costs. If you are in default and/or do not meet your end of term obligations, we may also directly debit and/or sue you for the "residual" (end of term) equipment value. You agree to pay (i) a convenience fee of $10 for any payment you elect to make by telephone and (ii) a charge of $30 if any payment made by ACH or check is dishonored or returned. This Lease shall be governed by the laws of the Commonwealth of Pennsylvania (where we have an office and accepted this Lease). You agree that any suit relating to this Lease shall be brought only in a state or federal court in Pennsylvania. You irrevocably consent and submit to the jurisdiction of such courts, and you waive any claim that any such court is an inconvenient or improper forum. Each party waives any right to a jury trial. We will have title to the equipment at all times. This is a "true lease" and not a loan or installment sale. You grant us a first priority security interest in the equipment and authorize us to file Uniform Commercial Code ("UCC") financing statements (in case this is later determined not to be a "true lease"). You agree this is a "finance lease" under Article 2A of the UCC. You waive all UCC rights and remedies you may have, including those in Sections 2A-508 through 2A-522.

5. You must pay us for all sales, use, property and other taxes relating to the Lease and the equipment. We may adjust this Lease and the payment above to finance for you any taxes and fees due at Lease inception. We may bill you based on our estimate of the taxes and fees. We may charge you an annual property tax administration fee up to $25. Unless we have given you a written option to buy the equipment at the end of the Lease Term for $1.00, we will be entitled to all tax benefits. If you do anything to disallow our getting these benefits, you will promptly indemnify (pay) us an equivalent amount. If we gave you a $1.00 purchase option, we may require you to file all personal property tax returns. You accept all risks of loss, injury or damage caused by the equipment and shall indemnify us for all suits and other liabilities arising from the same. This indemnity will continue even after the Lease has ended. You must maintain acceptable liability insurance naming us as "additional insured". You must keep the equipment insured against all risks of loss in an amount equal to the replacement cost and have us listed on the policy as "loss payee." If you do not give us proof of the required insurance within 30 days after the Lease commences, then depending on the original equipment cost we may, but are not obligated to, obtain insurance to cover our interests and charge you a fee for such coverage (including a monthly administration fee and a profit to us). You can cancel the insurance coverage fee at any time by delivering the required proof of insurance.

6. Since this Lease is based on your own credit rating, you may not assign the Lease to anyone else without our prior written approval. We may sell or transfer our interests to another entity, who will then have all of our rights but none of our obligations. Those obligations will continue to be ours. The rights we pass on to the new entity will not be subject to any defenses, claims or set-offs you may assert against us. All prior conversations, agreements and representations relating to this Lease or the equipment are integrated herein. None of the terms of this Lease shall be changed or modified except in writing duly executed by you and us. Any action by you against us must be commenced within one year after the cause of action arises or be forever barred.

ACCEPTANCE OF LEASE AGREEMENT THIS IS A BINDING CONTRACT. IT CANNOT BE CANCELED. READ IT CAREFULLY BEFORE SIGNING AND CALL US IF YOU HAVE ANY QUESTIONS.

X _____ Signature of Leasing Customer | _____ Print Name of Signer | _____ Title | _____ Date

Accepted and Signed by the Lessor Identified above | Print Name of Signer | Title | Date

USPA DISCLOSURE

TO HELP THE GOVERNMENT FIGHT THE FUNDING OF TERRORISM AND MONEY LAUNDERING ACTIVITIES, FEDERAL LAW REQUIRES ALL FINANCIAL INSTITUTIONS TO OBTAIN, VERIFY AND RECORD INFORMATION THAT IDENTIFIES EACH PERSON WHO OPENS AN ACCOUNT. WHAT THIS MEANS TO YOU: WHEN YOU OPEN AN ACCOUNT, WE WILL ASK YOU FOR YOUR NAME, ADDRESS, DATE OF BIRTH, AND OTHER INFORMATION THAT WILL ALLOW US TO IDENTIFY YOU. WE MAY ALSO ASK TO SEE YOUR DRIVER'S LICENSE OR OTHER IDENTIFYING DOCUMENTS. Federal Tax ID#: X 06 - 1473863

ACCEPTANCE OF DELIVERY

I AM AUTHORIZED TO SIGN THIS CERTIFICATE ON BEHALF OF THE LEASING CUSTOMER. I CERTIFY TO THE LESSOR THAT THE EQUIPMENT HAS BEEN DELIVERED AND IS FULLY INSTALLED AND WORKING PROPERLY. I AUTHORIZE THE LESSOR TO PAY THE VENDOR AND COMMENCE THE LEASE.

X _____ Authorized Signature | _____ Name and Title (Please Print) | _____ Equipment Delivery Date

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Cl	1029-C	9/30/2015	7	37

The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual O Cash O Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Saslow, Lufkin & Buggy	10 Tower Lane, Avon, CT 06001
2 Craig J. Lubitski Consulting LLC	225 Pitkin St., East Hartford, CT 06108
3	
4	

Services Provided by This Firm (*describe fully*)

1	CT Corp Tax Returns, Health CareHoldings Audit	$ 14,100
2	Preparation of Medicaid Cost Report	$ 7,500
3		$
4		$
		Charge for Services Provided $ 21,600

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

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha Cullina	
2	
3	
4	
5	

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

Services Provided by This Firm (*describe fully*)

1	Conservatorship application fee	$ 285
2		$
3		$
4		$
5		$
		Charge for Services Provided $ 285

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

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center	1029-C	9/30/2015	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30 Total	CCNH	RHNS	(Specify)	Period 7/1 Thru 9/30 Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
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	74	61	13		74	61	13		74	61	13	
B. As of midnight of THIS report period	66	54	12		74	61	13		66	54	12	
3. Total Number of Days Care Provided During Period												
A. Medicare	2,389	2,389			1,599	1,599			790	790		
B. Medicaid (Conn.)	14,507	10,597	3,910		10,948	7,992	2,956		3,559	2,605	954	
C. Medicaid (other states)												
D. Private Pay	6,707	6,047	660		5,416	4,940	476		1,291	1,107	184	
E. State SSI for RCH												
F. Other (Specify)	2,569	2,569			1,786	1,786			783	783		
G. Total Care Days During Period (3A thru F)	26,172	21,602	4,570		19,749	16,317	3,432		6,423	5,285	1,138	
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)**	26,172	21,602	4,570		19,749	16,317	3,432		6,423	5,285	1,138	

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chestelm H	1029-C	9/30/2015	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
				Lost			Gained						
	CCNH (1)	RHNS (2)	(Specify) (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-IID
No. of Residents	7	32	10	15	2			
Per Diem Rate								
a. One bed rm.				375.00	250.00			
b. Two bed rms.				325.00	225.00			
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	64,366	64,366		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	108,062	108,062		
C. Other	47,598	47,598		
D. ***Total Physical Therapy Treatments***	220,026	220,026		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	27,013	27,013		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	20,876	20,876		
2. Restorative Treatments				
C. Other	9,394	9,394		
D. ***Total Speech Therapy Treatments***	57,283	57,283		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	40,288	40,288		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	106,096	106,096		
C. Other	43,944	43,944		
D. ***Total Occupational Therapy Treatments***	190,328	190,328		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab (	1029-C	9/30/2015	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes O 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)	84,991	1,717	17,980	363		
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	280,356	10,206	59,311	2,159		
5. Dietary Service						
a. Head Dietitian	25,514	51	5,398	11		
b. Food Service Supervisor	50,003	1,719	10,578	364		
c. Dietary Workers	216,831	16,735	45,872	3,540		
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	88,382	6,998	18,698	1,480		
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	99,606	6,015	21,072	1,273		
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	49,275	3,714	10,424	786		
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	89,785	1,717	8,129	363		
b. RN						
1. Direct Care	588,843	13,911	53,312	2,943		
2. Administrative**	131,029	3,473	11,863	735		
c. LPN						
1. Direct Care	307,335	9,667	27,825	2,045		
2. Administrative**						
d. Aides and Attendants	1,044,067	62,684	94,526	13,261		
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	102,663	4,081	21,719	863		
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	52,576	1,717	11,123	363		
n. Marketing						
o. Other (Specify)						
See Attached Schedule	32,210	1,723	6,814	365		
A-13. Total Salary Expenditures	3,243,465	146,127	424,642	30,914		

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		(Specify)	
	$	Hours	$	Hours	$	Hours
Medical Records	$ 32,210	$ 1,723	$ 6,814	$ 365		
Total	$ 32,210	1,723	$ 6,814	365	$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	$	Hours	$	Hours	$	Hours
Physician Services	$ 33	1	$ 7	1		
Optometrist	$ 44	1	$ 9	1		
Physiatrist	$ 990	$ 7	$ 210	$ 1		
Respiratory Therapist	$ 5,980	Contract	$ 1,265	Contract		
Total	$ 7,047	9	$ 1,491	3	$ -	-

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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
Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center	1029-C	9/30/2015	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).										
Mark Epright (10/1/14 - 9/30/15)	85,428	18,073		Standard Package	Chief Financial Officer	2,080	A4			

* 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
Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center	1029-C	9/30/2015	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 (10/1/14 - 9/30/15)	84,991	17,980		Standard Package	Facility 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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chestelm Health &	1029-C	9/30/2015	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						
2. Dentist	9,083	Contract	1,922	Contract		
3. Pharmacist	4,599	Contract	973	Contract		
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	253,759	4,561				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	26,165	325	5,535	69		
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)						
Medical Staff Meeting	103	1	22	1		
9. Speech Therapist						
a. Resident Care	67,468	1,231				
b. Other						
10. Occupational Therapist						
a. Resident Care	205,554	4,147				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	26,123	326				
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	7,047	9	1,491	3		
B-13 Total Fees Paid in Lieu of Salaries	599,900	10,600	9,943	73		

* 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
Chestelm Health Care, Inc. d/b/a Chestelm Health & Re	1029-C	9/30/2015	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Joseph Anquillare, MD	Medical Director	○	⊙	
Elmo Villanueva, MD	Assistant Medical Director	○	⊙	
Mustapha Kernal	Physiatrist	○	⊙	
Khybery Kasem	Medical Staff Meetings	○	⊙	
Health Drive Medical	Dentist	○	⊙	
Health Drive Podiatry Group	Podiatrist	○	⊙	
Action Nursing	Nursing Pool	○	⊙	
Partners Pharmacy	Pharmacist	○	⊙	
Nurse Network	Nursing Pool	○	⊙	
Preferred Therapy	PT,OT,ST	○	⊙	
Ready Nurse Staffing	Nursing Pool	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

* 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
Chestelm Health Care, Inc. d/b/a Chestelm Healt	1029-C	9/30/2015	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	147,812	130,701	17,112	
2. Disability Insurance	$				
3. Unemployment Insurance	$	69,794	61,714	8,080	
4. Social Security (F.I.C.A.)	$	272,139	240,634	31,504	
5. Health Insurance	$	275,044	243,204	31,841	
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	21,647	19,141	2,506	
(not-owners and not-operators)					
8. Uniform Allowance	$	12,365	10,206	2,159	
9. Other (*Specify*)	$	32,323	26,679	5,644	
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	21,600	17,828	3,772	
e. Legal (*Services should be fully described on Page 7*)	$	285	235	50	
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	47,145	38,913	8,232	
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	8,694	7,176	1,518	
2. Cellular Phones	$	12,464	10,288	2,176	
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22*)					
1. Income*	$				
2. Other (*Specify*)	$	16	13	3	
See Attached Schedule					
3. Resident Day User Fee	$	491,444	405,631	85,813	
Subtotal	$	1,412,772	1,212,362	200,410	

* 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)
Misc Employee Benefits	$ 22,287	$ 4,715	
Employee Physicals	$ 4,392	$ 929	
Total	$ 26,679	$ 5,644	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Tax - Sales & Use	$ 13	$ 3	
Total	$ 13	$ 3	$ -

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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
Chestelm Health Care, Inc. d/b/a Chestelm Health & I	1029-C	9/30/2015	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,412,772	1,212,362	200,410	
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	1,367	1,129	239	
4. Employee Travel	$	4,843	3,997	846	
5. Education Expenses Related to Seminars and Conventions	$	4,543	3,749	793	
6. Automobile Expense (*not purchase or depreciation*)	$	2,216	1,829	387	
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	5,044	4,163	881	
2. Advertising Telephone Directory (*all such expenses*)***	$	2,620	2,162	457	
3. Advertising Other (*Specify*)*** See Attached Schedule	$	36,796	30,371	6,425	
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	$	5,740	4,737	1,002	
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	6,864	5,666	1,199	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	280	231	49	
9. Subscriptions	$	12,675	10,462	2,213	
10. Contributions*** See Attached Schedule	$	3,075	2,538	537	
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual*)	$	90,957	75,075	15,882	
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	11,355	9,372	1,983	
C-14 Total Administrative & General Expenditures	$	1,601,147	1,367,844	233,303	

* 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)
Promotional	$ 30,371	$ 6,425	
Total Other Advertising	$ 30,371	$ 6,425	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Alzheimer's Association	$ 165	$ 35	
ICNC Membership	$ 31	$ 7	
AANAC - Annual Membership	$ 669	$ 141	
CAHCF	$ 4,281	$ 906	
ALTCFM	$ 264	$ 56	
ACHCA - Annual Membership	$ 256	$ 54	
Total Dues	$ 5,666	$ 1,199	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Donations	$ 2,538	$ 537	
Total Contributions	$ 2,538	$ 537	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Licenses & Permits	$ 3,606	$ 763	
Service Charges - Bank	$ 379	$ 80	
Service Charges - Credit Card	$ 5,141	$ 1,088	
Bank Reconciliation	$ (62)	$ (13)	
Purchases Discount	$ (13)	$ (3)	
Prior Period Adjustments	$ 321	$ 68	
Total Other Administrative and General	$ 9,372	$ 1,983	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chesteln	1029-C	9/30/2015	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.**

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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
Chestelm Health Care, Inc. d/b/a Chestelm Health & R	1029-C	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	224,742	185,499	39,243	
2. Non-Food Supplies	$	22,262	18,375	3,887	
3. Other (*Specify*) _____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	2,872	2,371	502	
c. Management Services**	$				
d. Other (*Specify*) _____ Small Equipment	$	1,375	1,135	240	
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	251,252	207,380	43,872	

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	3	3		

H.	Is cost of employee meals included in 2E?	⊙ Yes	○ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	⊙ Yes	○ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

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

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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
Chestelm Health Care, Inc. d/b/a Chestelm Health & Rel	1029-C	9/30/2015	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. $				
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. $	2,523	2,082	441	
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*) Supplies	$	6,728	5,553	1,175	
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	9,251	7,635	1,615	

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	O Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	O Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	O Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	O Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3E.

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

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

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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
Chestelm Health Care, Inc. d/b/a Chestelm Hea	1029-C	9/30/2015	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.	$	37,425	30,890	6,535	
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	1,915	1,581	334	
c. Management Services*		$				
d. Other (*Specify*) Supplies		$	2,608	2,152	455	
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	41,947	34,623	7,325	
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Value Health		$	152,354	152,354		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	86,024	71,003	15,021	
d. Ambulance/Limousine***		$	3,499	2,888	611	
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	22,448	18,528	3,920	
f. X-rays and Related Radiological Procedures***		$	13,472	11,119	2,352	
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	11,569	9,549	2,020	
i. Recreation		$	14,781	12,200	2,581	
j. Other (Specify)**** See Attached Schedule		$	75,195	62,065	13,130	
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	379,341	339,706	39,635	

* 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)
Supplies - Soc Svc	$ 598	$ 126	
Nursing Equipment- Stations	$ 2,156	$ 456	
Nursing Equipment - Residents	$ 2,620	$ 554	
Nursing Station Supplies	$ 1,797	$ 380	
Nursing Purchase Service	$ 21,110	$ 4,466	
Resident Supplies	$ 7,609	$ 1,610	
Supplies (Non-Medical) — RFL. sche.	$ 960	$ 203	
Small Equipment Purchased	$ 728	$ 154	
Equipment - PT	$ 4,112	$ 870	
Supplies - PT	$ 5,582	$ 1,181	
Equipment - OT — self-dis	$ 3,632	$ 768	
Supplies - OT	$ 554	$ 117	
IV Therapy Expense — self-dis	$ 10,563	$ 2,235	
Consolidated Billed Expenses — self-dis	$ 45	$ 9	
Total Other Resident Care	$ 62,065	$ 13,130	$ -

RFL — schedul

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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
Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center	1029-C	9/30/2015	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		○	⊙		Trash Removal	13,831	2,854		22	6f
MDI Achieve		○	⊙		Software Maintenance	30,279	6,406		16	m11
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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
Chestelm Health Care, Inc. d/b/a Chestelm He	1029-C	9/30/2015			22 | 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	86,309	71,238	15,071	
b. Heat	$	64,930	53,593	11,338	
c. Light & Power	$	55,144	45,515	9,629	
d. Water	$	5,279	4,358	922	
e. Equipment Lease (*Provide detail on page 6*)	$	40,035	33,045	6,991	
f. Other (*itemize*)	$	49,730	41,046	8,684	
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	301,428	248,795	52,634	
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	1,670	1,379	292	
d. Movable Equipment	$	47,381	39,108	8,273	
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	49,051	40,486	8,565	
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	92,079	76,001	16,078	
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	92,079	76,001	16,078	
9. Rental payments on leased real property less real estate taxes included in item 10b	$	726,000	599,230	126,770	
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	53,809	44,413	9,396	
c. Personal property taxes	$	7,975	6,582	1,393	
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	928,914	766,712	162,201	

* 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	$ 13,772	$ 2,913	
Snow Plowing	$ 11,587	$ 2,451	
Grounds Maintenance	$ 2,824	$ 597	
Grounds Landscaping	$ 5,717	$ 1,210	
Small Equipment Purchase	$ 7,147	$ 1,512	
Total Other Repairs and Maintenance	$ 41,046	$ 8,684	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center	1029-C	9/30/2015	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. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	60,962		60,962	55,682			1,670	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								1,670

	Is a mileage logbook maintained?		Date of Acquisition								
	Yes	No	Month	Year	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
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. 2008 Ford F250		X	11	2007	47,996		47,996	33,199			4,800	
b.												
c.												
d.												
2. M e Equipment												
ired prior to this report period					1,262,658		1,262,658	1,037,594			41,223	
sals (attach schedule)												
ed during this report period schedule)					4,833						1,358	
												47,381
tion												49,051

Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center
9/30/2015

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3
**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
4/14/2015	2 Laptop computers/MDS	$ 2,933	3	$ 978	
5/5/2015	Photographs matted, framed and hung	782	5	$ 156	
6/29/2015	Photographs - North wing	1,118	5	$ 224	
Total additions for Movable Equipment		$ 4,833		$ 1,358	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/20/2015	Installation of vinyl floor	$ 3,095	10	$ 310	
10/21/2015	Added/replaced outlets	4,714	10	$ 471	
1/13/2015	Installation of vinyl strip marble	5,204	10	$ 520	
2/7/2015	Wing renovation	7,375	10	$ 738	
3/19/2015	Installation of new floors	3,682	10	$ 368	
4/10/2015	Heat zone for front offices	3,467	10	$ 347	
7/24/2015	Down payment for Awning replacement	550	10	$ 55	
9/29/2015	Fire escape awning cover	1,104	10	$ 110	
Total additions for Leasehold Improvement		$ 29,191		$ 2,919	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

*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
Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab C	1029-C	9/30/2015	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	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
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				2,733,593	1,650,887			89,160	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				29,191				2,919	
C-4. Subtotal									92,079
D. ***Total Amortization***									92,079

* 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
Chestelm Health Care, Inc. d/b/a Ches	1029-C	9/30/2015	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	
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 9/30/2014	4,164,116			
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
Chestelm Health Care, Inc. d/b/a Ches	1029-C	9/30/2015	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
Chestelm Health Care, Inc. d/b/a C	1029-C	9/30/2015	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*) $ Interest Expense	247	204	43	
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	247	204	43	
14. Insurance a. Insurance on Property (buildings only) $				
b. Insurance on Automobiles $	8,558	7,064	1,494	
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $ Insurance - General	46,334	38,243	8,091	
14d. ***Total Insurance Expenditures (14a + b + c)*** $	54,892	45,307	9,585	
15. ***Total All Expenditures (A-13 thru C-14)*** $	7,846,370	6,861,572	984,798	

Adj. the remain

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Ce	1029-C	9/30/2015	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 $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	10a	Occupational Therapy $	205,554	205,554		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.	15	1e	Accounting & Legal $	285	235	50	
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	11,384	9,396	1,988	
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	L6	Automobile Expense (e.g. personal use) $	2,216	1,829	387	
18.	16	m2/3	Unallowable Advertising * $	39,416	32,533	6,883	
19.			Income Tax / Corporate Business Tax $				
20.	16	m10	Fund Raising / Contributions $	3,075	2,538	537	
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	280	231	49	
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 $				
			Subtotal (Items 1 - 26) $	262,210	252,317	9,893	

* 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	m8a	Chamber of Commerce Dues	$ 231	$ 49	
Total Other A&G Adjustments			$ 231	$ 49	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab (	1029-C	9/30/2015	29	37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	262,210	252,317	9,893	
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	152,354	152,354		
28.	20	5d	Ambulance/Limousine $	3,499	2,888	611	
29.	20	5f	X-rays, etc $	13,472	11,120	2,352	
30.	20	5h	Laboratory $	11,569	9,549	2,020	
31.			Medical Supplies $				
32.	20	5e2	Oxygen (non emergency) $	22,448	18,528	3,920	
33.	20	5j	Occupational Therapy $	5,071	4,186	885	
34.			Other - See Attached Schedule $	12,852	10,608	2,244	
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.	22	6e	Depreciation on Unallowable Motor Vehicles $	29,116	24,032	5,084	
37.	22	10c	Unallowable Property and Real Estate Taxes $	1,161	958	203	
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.	27	14b	Property Insurance $	6,301	5,201	1,100	
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.	30	IV3	Radio and Television Revenue $	1,907	1,574	333	
44.			Vending Machine Revenue $				
45.	30	IV8	Purchase Discounts and Allowances $	2,822	2,329	493	
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $				
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			***Total Amount of Decrease (Items 1 - 50)*** $	524,782	495,643	29,139	

*** 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 Health Care, Inc. d/b/a Chestelm Health & Rehab Center
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Consolidated Billing Expenses	$ 45	$ 9	
20	5j	IV Therapy	$ 10,563	$ 2,235	
Total Other Ancillary Costs			$ 10,608	$ 2,244	$ -

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)
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other 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
Chestelm Health Care, Inc. d/b/a Chesteln 1029-C	9/30/2015			30 | 37
Item	Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue				
1. a. Medicaid Residents (*CT only*)	$ 4,782,822	3,844,912	937,910	
b. Medicaid Room and Board Contractual Allowance **	$ (1,334,152)	(1,075,543)	(258,610)	
2. a. Medicaid (*All other states*)	$			
b. Other States Room and Board Contractual Allowance **	$			
3. a. Medicare Residents *(all inclusive)*	$ 1,014,220	1,014,220		
b. Medicare Room and Board Contractual Allowance **	$ 589,032	589,032		
4. a. Private-Pay Residents and Other	$ 2,238,960	2,077,350	161,610	
b. Private-Pay Room and Board Contractual Allowance **	$ (3,096)	(3,096)		
II. Other Resident Revenue				
1. a. Prescription Drugs - Medicare	$ 113,267	113,267		
b. Prescription Drugs - Medicare Contractual Allowance **	$			
c. Prescription Drugs - Non-Medicare	$ 24,719	24,719		
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	$ 695,751	695,751		
b. Physical Therapy - Medicare Contractual Allowance **	$			
c. Physical Therapy - Non-Medicare	$ 4,303	4,303		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$			
4. a. Speech Therapy - Medicare	$ 209,157	209,157		
b. Speech Therapy - Medicare Contractual Allowance **	$			
c. Speech Therapy - Non-Medicare	$ 1,953	1,953		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$			
5. a. Occupational Therapy - Medicare	$ 674,577	674,577		
b. Occupational Therapy - Medicare Contractual Allowance **	$			
c. Occupational Therapy - Non-Medicare	$ 137,458	137,458		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$			
6. a. Other *(Specify)* - Medicare	$ (1,592,411)	(1,592,411)		
b. Other *(Specify)* - Non-Medicare	$ (30,285)	(30,285)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$ 7,526,277	6,685,367	840,910	
IV. Other Revenue*				
1. Meals sold to guests, employees & others	$			
2. Rental of rooms to non-residents	$			
3. Telephone	$ 1,907	1,574	333	
4. Rental of Television and Cable Services	$			
5. Interest Income *(Specify)*	$ 157	129	27	
6. Private Duty Nurses' Fees	$			
7. Barber, Coffee, Beauty and Gift shops	$			
8. Other (*Specify*)	$ 3,807	3,142	665	
V. Total Other Revenue (1 thru 8)	$ 5,871	4,846	1,025	
VI. Total All Revenue (III +V)	$ 7,532,148	6,690,213	841,936	

* *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 - Oxygen	$ 10,363		
30/II6a	Medicare A - X-Ray	$ 9,151		
30/II6a	Medicare A - Physician Care	$ (1,346)		
30/II6a	Medicare A - Lab	$ 7,402		
30/II6a	Medicare A - Contractual Adju	$ (1,112,219)		
30/II6a	Medicare A - Sequestration	$ (23,372)		
30/II6a	Managed Medicare - Oxygen	$ 3,823		
30/II6a	Managed Medicare - X-Ray	$ 1,444		
30/II6a	Manged Medicare - Lab	$ 1,748		
30/II6a	Managed Medicare - Ancillary	$ (258,824)		
30/II6a	Managed Medicare - Prior Year	$ (2,176)		
30/II6a	Medicare B - Lab	$ 4,466		
30/II6a	Medicare B - Contractual Adju	$ (224,505)		
30/II6a	Medicare B - Sequestration	$ (3,540)		
30/II6a	Medicare B - Prior Year Adjus	$ 231		
30/II6a	Managed Care B - Respiratory	$ 850		
30/II6a	Managed Care B - Contractual	$ (5,501)		
30/II6a	Managed Care B - Prior Year A	$ (404)		
Total Other Resident Revenue - Medicare		$ (1,592,411)	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6b	Private SNF - Lab	$ 34		
30/II6b	Private SNF - Prior Year Adju	$ 21,515		
30/II6b	Medicaid SNF - Lab	$ 11		
30/II6b	Medicaid SNF - Prior Year Adj	$ (19,707)		
30/II6b	Managed Care - Oxygen	$ 552		
30/II6b	Managed Care - X-Ray	$ 1,437		
30/II6b	Managed Care - Lab	$ 1,389		
30/II6b	Managed Care - Contractual Ad	$ (171,557)		
30/II6b	Blue Cross Contractual Adj	$ (1,627)		
30/II6b	Outpatient - Physical Therapy	$ 77,071		
30/II6b	Outpatient - Occupational The	$ 54,967		
30/II6b	Outpatient - Speech Therapy	$ 14,309		
30/II6b	Outpatient - Contractual Adju	$ (53,964)		
30/II6b	Outpatient - Prior Year Adjus	$ 2,338		
30/II6b	Outpatient Part B ? Physical	$ 79,226		
30/II6b	Outpatient Part B OT	$ 21,111		
30/II6b	Outpatient Part B- Speech Th	$ 21,328		
30/II6b	Outpatient -Part B Cont Adj	$ (69,751)		
30/II6b	Outpatient - Prior Year Adju	$ 629		
30/II6b	Outpatient Private- Contract	$ (7,762)		
30/II6b	Outpatient Private - Prior Yr	$ (1,834)		
Total Other Resident Revenue		$ (30,285)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
31/A1	Interest Income		$ 129	$ 27	
Total Interest Income			$ 129	$ 27	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30/IV8	Charitable Donations	$ 813	$ 172	
30/IV8	Discounts	$ 2,329	$ 493	
Total Other Revenue		$ 3,142	$ 665	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Cheste	1029-C	9/30/2015	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 300,059
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 855,977
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 2,400
5. Prepaid Expenses				$ 196,922
a. Deposits - Form 8752		9,160		
b. Prepaid - Insurance- Mortgage		90,463		
c. Prepaid - Insurance - Other		97,300		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,355,359
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	2,762,784		$ 1,019,819
	Accum. Depreciation	1,742,966	Net	
5. Non-Movable Equipment	*Historical Cost	60,962		$ 3,610
	Accum. Depreciation	57,352	Net	
6. Movable Equipment	*Historical Cost	1,267,491		$ 187,316
	Accum. Depreciation	1,080,175	Net	
7. Motor Vehicles	*Historical Cost	47,996		$ 9,997
	Accum. Depreciation	37,999	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 296,054
Construction in Progress		89,599		
Book vs Cost		206,455		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,516,796

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chesto	1029-C	9/30/2015	32	37

Account				Amount
			Total Brought Forward:	$ 2,872,154
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*)				$ (99,127)
Deposits Escrow		56,284		
Goodwill / Escrows /Reserves		(104,976)		
Due From Related Parties		(50,436)		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (99,127)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 2,773,027

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chestelm He	1029-C	9/30/2015	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 2,990,946
2. Notes Payable (*itemize*)				$ 44,652
Ford	27,650			
Merc R350	4,481			
CL&P	12,521			
3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 147,849
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 165
7. Medicare Final Settlement Payable				$ (9,463)
8. Medicare Current Financing Payable				$
9. Mortgage Payable (*Current Portion*)				$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 96,686
Payroll Clearing	4,474	Accrued User Tax	(1,675)	
Accrued Pension	31,112	Accrued Back Taxes	20,213	
Employee 401K Plan Withholding	34,670	Due to Medicaid	(10,579)	
Accrued Accounting	20,100	Resident Refunds	(1,629)	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 3,270,834

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chestelm	1029-C	9/30/2015	34	37

Account	Amount
Total Brought Forward:	3,270,834
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*)	$ 120,126

Name and Address of Lender	Amount	Loan Date
Due to Related Parties	120,126	

4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 120,126
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 3,390,961

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

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Ches	1029-C	9/30/2015	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	$
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	$ (303,713)
6. Gain or Loss for Period 10/1/2014 thru 9/30/2015	$ (314,221)
7. Total Net Worth	$ (617,934)
C. ***Total Reserves and Net Worth***	$ (617,934)
D. ***Total Liabilities, Reserves, and Net Worth***	$ 2,773,027

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chestel	1029-C	9/30/2015	36	37

Account	Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2014	$ (516,768)
B. Total Revenue (*From Statement of Revenue Page 30*)	$ 7,532,148
C. Total Expenditures (*From Statement of Expenditures Page 27*)	$ 7,846,370
D. Net Income or Deficit	$ (314,221)
E. Balance	$ (830,989)
F. Additions	
1. Additional Capital Contributed (*itemize*)	
2. Other (*itemize*)	
F-3. Total Additions	$
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***	09/30/15	$ (830,989)

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I. Preparer's/Reviewer's Certification

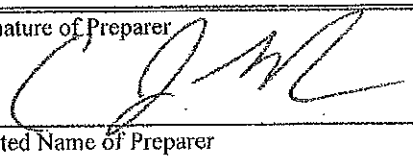
Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chestelm	1029-C	9/30/2015	37	37

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
	Partner	2-15-16

Printed Name of Preparer

Craig J. Lubitski Consulting LLC

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