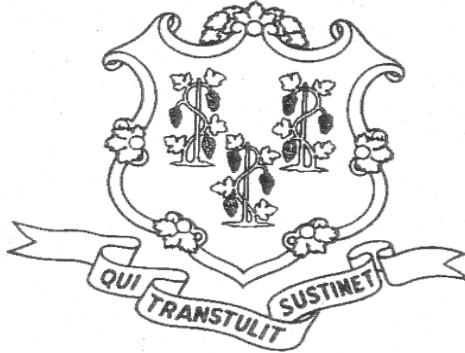


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2022

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 St. Moodus, CT 06469				
Type of Facility				
Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)		Rest Home with Nursing <input checked="" type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)		
Report for Year Beginning 10/1/2021		Report for Year Ending 9/30/2022		

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

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

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General Information

Name of Facility (as licensed) Chestelm Health Care, Inc. d/b/a Chestelm Health & R	License No. 1029-C	Report for Year Ended 9/30/2022	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)	Date	Signed (Owner)	Date
Printed Name (Administrator) Brenda Marinan		Printed Name (Owner) Brinton Epright	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)
Comm. Expires / /			
Address of Notary Public			

(Notary Seal)

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

Data Required for Real Wage Adjustment				Page 1A	of 37
Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center	Period Covered:	From 10/1/2021	To 9/30/2022		
Address of Facility 534 Town St. Moodus, CT 06469					
Report Prepared By CJLC LLC	Phone Number 860-610-9009	Date			
Item	Total	CCNH	RHNS	(Specify)	
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-873-1455	9/30/2022	2	37

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

Administrator

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

Name	License No.:

General Information and Questionnaire Partners/Members

General Information and Questionnaire

Corporate Owners

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3B Rev. 10/2005

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	9/30/2022	3B	37

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

Owner(s) of Facility

N/A

General Information and Questionnaire

Related Parties*

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm Health & Re		License No. 1029-C	Report for Year Ended 9/30/2022			Page 4	of 37	
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," provide the Name/Address and complete the information on Page 11 of the report.		
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," provide the following information:		
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Healthcare Holding Incorporated, LLC	534 Town St. Moodus, CT 06469	<input type="radio"/>	<input checked="" type="radio"/>		Rent	22/9	600,000	424,500
Brenda Marinan	534 Town St. Moodus, CT 06469	<input type="radio"/>	<input checked="" type="radio"/>		Administrator	10/A2	100,651	100,651
Mark Epright	534 Town St. Moodus, CT 06469	<input type="radio"/>	<input checked="" type="radio"/>		Chief Financial Officer	10/A4	100,592	100,592
Chestelm Adult Day Services	524 Town St. Moodus, CT 06469	<input type="radio"/>	<input checked="" type="radio"/>		Snow Removal	22/6f	4,117	4,117
Chestelm Adult Day Services	524 Town St. Moodus, CT 06469	<input type="radio"/>	<input checked="" type="radio"/>		Purchased Food	18/2a1	(24,000)	(24,000)
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm Hea	License No. 1029-C	Report for Year Ended 9/30/2022	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

General Information and Questionnaire Leases (Excluding Real Property)

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

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

○ No

Total ***

21,806

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.

General Information and Questionnaire

Accounting Basis

Name of Facility Chestelm Health Care, Inc. d/b/a CI	License No. 1029-C	Report for Year Ended 9/30/2022	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

⊕ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1	Medicaid Cost Report/CT Corp Tax Returns	\$	20,500
2	HHS Filing	\$	6,163
3		\$	
4		\$	
		Charge for Services Provided	
		\$	26,663

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

Yes No Pg 15/1d

Legal Services Information

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

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

Services Provided by This Firm (*describe fully*)

1	Resident Signing Agreement, 2567 & IDR Review	\$	487
2		\$	
3		\$	
4		\$	
5		\$	
		Charge for Services Provided	
		\$	487

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

Pg 15/1e

Schedule of Resident Statistics

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center			License No. 1029-C				Report for Year Ended 9/30/2022				Page 8		of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30					
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)		
1. Certified Bed Capacity					76	63	13							
A. On last day of PREVIOUS report period	76	63	13											
B. On last day of THIS report period	76	63	13							76	63	13		
2. Number of Residents					70	59	11		70	59	11			
A. As of midnight of PREVIOUS report period	70	59	11							66	55	11		
B. As of midnight of THIS report period	66	55	11											
3. Total Number of Days Care Provided During Period					2,130	2,130				709	709			
A. Medicare	2,839	2,839												
B. Medicaid (Conn.)	15,021	11,893	3,128		11,158	8,776	2,382			3,863	3,117	746		
C. Medicaid (other states)														
D. Private Pay	6,750	5,917	833		5,028	4,403	625			1,722	1,514	208		
E. State SSI for RCH														
F. Other (Specify) MM & MC	1,573	1,573			1,238	1,238				335	335			
G. Total Care Days During Period (3A thru F)	26,183	22,222	3,961		19,554	16,547	3,007			6,629	5,675	954		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds					29	29				3	3			
A. Medicaid Bed Reserve Days	32	32												
B. Other Bed Reserve Days	7	7			5	5				2	2			
5. Total Resident Days (3G + 4A + 4B)	26,222	22,261	3,961		19,588	16,581	3,007			6,634	5,680	954		

Schedule of Resident Statistics (Cont'd)

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm H			License No. 1029-C			Report for Year Ended 9/30/2022			Page 9	of 37				
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:														
Date of Change	Place of Change			Change in Beds				Capacity After Change			Reason for Change			
	CCNH	RHNS	(Specify)	Lost		Gained		CCNH	RHNS	(Specify)				
(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)						
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.														
Change in Resident Days											CCNH	RHNS	(Specify)	
1st change														
2nd change														
3rd change														
4th change														
6. Number of Residents and Rates on September 30 of Cost Year														
Item	Medicare		Medicaid		Self-Pay			Other State Assisted						
	CCNH	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR					
No. of Residents	7	34	7	14	4									
Per Diem Rate														
a. One bed rm.				450.00	300.00									
b. Two bed rms.				375.00	275.00									
c. Three or more bed rms.					260.00									
7. Total Number of Physical Therapy Treatments														
A. Medicare - Part B											TOTAL	CCNH	RHNS	(Specify)
											1,435	1,435		
B. Medicaid (Exclusive of Part B)														
1. Maintenance Treatments														
2. Restorative Treatments											6,343	6,343		
C. Other											1,142	1,142		
D. Total Physical Therapy Treatments											8,920	8,920		
8. Total Number of Speech Therapy Treatments														
A. Medicare - Part B											135	135		
B. Medicaid (Exclusive of Part B)														
1. Maintenance Treatments														
2. Restorative Treatments											1,730	1,730		
C. Other											86	86		
D. Total Speech Therapy Treatments											1,951	1,951		
9. Total Number of Occupational Therapy Treatments														
A. Medicare - Part B											1,272	1,272		
B. Medicaid (Exclusive of Part B)														
1. Maintenance Treatments														
2. Restorative Treatments											6,667	6,667		
C. Other											227	227		
D. Total Occupational Therapy Treatments											8,166	8,166		

Report of Expenditures - Salaries & Wages

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab	License No. 1029-C	Report for Year Ended 9/30/2022		Page 10	of 37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes		<input type="radio"/> No	
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	85,449	1,778	15,204	302	
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	306,220	10,092	54,487	1,713	
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor	63,257	1,685	11,256	286	
c. Dietary Workers	278,123	14,336	49,488	2,434	
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers	149,214	7,828	26,550	1,329	
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	69,939	1,966	12,445	334	
b. Other Maintenance Workers	102,944	5,058	18,317	859	
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	79,338	4,320	14,117	733	
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	148,878	3,475	26,491	590	
b. RN					
1. Direct Care	656,145	14,652	115,917	2,487	
2. Administrative**	151,349	1,990	26,930	338	
c. LPN					
1. Direct Care	294,487	8,519	49,995	1,446	
2. Administrative**					
d. Aides and Attendants	1,294,645	57,351	219,790	9,736	
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	109,594	6,773	19,501	1,150	
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	45,708	1,778	8,133	302	
n. Marketing					
o. Other (Specify)					
See Attached Schedule	38,689	1,724	6,884	293	
<i>A-13. Total Salary Expenditures</i>	3,873,979	143,324	675,504	24,332	

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center				License No. 1029-C		Report for Year Ended 9/30/2022			Page 11	of 37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
Mark Epright	85,397	15,195		Chief Financial Officer		1,440	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.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center				1029-C		9/30/2022			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	85,449	15,204			Administrator	2,080	A2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		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	13,447	301	2,393	51	
2. Dentist	1,377	15	245	5	
3. Pharmacist	8,512	148			
4. Podiatrist	5,255	54	935	10	
5. Physical Therapy					
a. Resident Care	228,596	2,564	17,910	435	
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	30,562	171	5,438	29	
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**					
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
Optometrist	350	5	62	1	
9. Speech Therapist					
a. Resident Care	101,013	1,801			
b. Other					
10. Occupational Therapist					
a. Resident Care	238,976	4,073			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	60,507	1,287	10,272	381	
2. Administrative***					
b. LPN					
1. Direct Care	41,566	595	7,057	101	
2. Administrative***					
c. Aides	121,427	3,236	20,614	549	
d. Other					
12. Other (Specify)					
See Attached Schedule					
B-13 Total Fees Paid in Lieu of Salaries	851,588	14,249	64,926	1,562	

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

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

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

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

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 155,005	132,509	22,496		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 39,099	33,425	5,674		
4. Social Security (F.I.C.A.)	\$ 334,179	283,700	50,480		
5. Health Insurance	\$ 433,313	370,426	62,887		
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 49,644	42,439	7,205		
8. Uniform Allowance	\$ 7,123	6,047	1,076		
9. Other (Specify) See Attached Schedule	\$ 44,587	38,116	6,471		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 1,500	1,273	227		
d. Accounting and Auditing	\$ 26,663	22,636	4,028		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 487	413	74		
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$ 47,484	40,311	7,173		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 9,079	7,707	1,371		
2. Cellular Phones	\$ 11,427	9,701	1,726		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 262	222	40		
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (Specify) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 465,254	394,975	70,280		
Subtotal	\$ 1,625,106	1,383,900	241,206		

* 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**

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Misc Employee Benefits	\$ 36,022	\$ 6,115	
Employee Physicals	\$ 2,094	\$ 356	
Total	\$ 38,116	\$ 6,471	\$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		16	37
Item		Total	CCNH	RHNS	(Specify)
	<i>Subtotals Brought Forward:</i>	1,625,106	1,383,900	241,206	
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$	2,976	2,526	449	
4. Employee Travel	\$	310	263	47	
5. Education Expenses Related to Seminars and Conventions	\$	13,705	11,635	2,070	
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	11,598	9,846	1,752	
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	29,882	25,368	4,514	
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	23,003	19,528	3,475	
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	\$	1,603	1,361	242	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	14,382	12,210	2,172	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	23,669	20,093	3,575	
10. Contributions*** See Attached Schedule	\$	4,402	3,737	665	
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	171,171	145,315	25,856	
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$	15,868	13,471	2,397	
<i>C-14 Total Administrative & General Expenditures</i>	\$	1,937,674	1,649,252	288,421	

* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising - Promo & Mktg	\$ 19,528	\$ 3,475	
Total Other Advertising	\$ 19,528	\$ 3,475	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Act Dues & Memberships	\$ 170	\$ 30	
Dues & Memberships - Nursing	\$ 634	\$ 113	
Dues & Memberships - Plant	\$ 110	\$ 19	
Dues & Memberships - General	\$ 11,296	\$ 2,010	
Total Dues	\$ 12,210	\$ 2,172	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Donations	\$ 3,737	\$ 665	
Total Contributions	\$ 3,737	\$ 665	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Licenses & Permits	\$ 1,651	\$ 294	
Service Charges - Bank	\$ 403	\$ 72	
Service Charges - Credit Card	\$ 18,404	\$ 3,275	
Purchases Discount	\$ (9,239)	\$ (1,644)	
Prior Period Adjustments	\$ 2,251	\$ 401	
Total Other Administrative and General	\$ 13,471	\$ 2,397	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm	License No. 1029-C	Report for Year Ended 9/30/2022	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
N/A			

*** In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.**

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

Name of Facility	License No.	Report for Year Ended		Page of
Chestelm Health Care, Inc. d/b/a Chestelm Health & R		1029-C	9/30/2022	18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 257,023	218,198	38,825	
2. Non-Food Supplies	\$ 35,214	29,895	5,319	
3. Other (Specify) _____	\$ _____			
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 2,658	2,256	401	
c. Other (Specify) _____ Supplies	\$ 2,920	2,479	441	
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 297,815	252,828	44,987	
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No				
H. Did you receive revenue from employees? <input checked="" type="radio"/> Yes <input type="radio"/> No			If yes, specify amt.	\$647
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.	
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.	
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm Health & Rel	License No. 1029-C	Report for Year Ended 9/30/2022		Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry	Lbs.				
a. In-House Processing*					
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$	5,019	4,261	758	
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$				
c. Other (<i>Specify</i>) Supplies	\$	9,650	8,193	1,458	
3D. Total Laundry Expenditures (3a + b + c)	\$	14,669	12,453	2,216	
3E. Laundry Questionnaire					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
G. Did you receive revenue from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
H. Where is the revenue received reported in the Cost Report?					(Page/Line Item)
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
J. Did you receive revenue from these people?	<input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
K. Where is the revenue received reported in the Cost Report?					(Page/Line Item)

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm Hea	License No. 1029-C	Report for Year Ended 9/30/2022		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 30,225	25,659	4,566	
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 2,076	1,762	314	
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	32,301	27,422	4,879	
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	135,888	115,361	20,527	
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	65,098	55,265	9,833	
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	13,826	11,737	2,088	
f. X-rays and Related Radiological Procedures***	\$	6,059	5,143	915	
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	22,159	18,812	3,347	
i. Recreation	\$	10,083	8,560	1,523	
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	186,367	159,396	26,971	
5M. Total Resident Care Expenditures (5a - 5j)	\$	439,480	374,274	65,205	

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Nursing Purchase Service	\$ 6,796	\$ 1,083	
Nursing Equipment - Residents	\$ 641	\$ 114	
Nursing Station Supplies	\$ 1,798	\$ 320	
Resident Supplies	\$ 66,482	\$ 11,829	
Infection Control Expense	\$ 51,583	\$ 9,178	
Purchased Services - Nursing	\$ 14,111	\$ 2,511	
Supplies - OT	\$ 1,317		
Purchased Services - OT	\$ 212		
Supplies - ST	\$ 47		
IV Therapy Expense	\$ 7,025	\$ 1,250	
Respiratory Therapist	\$ 3,855	\$ 686	
Consolidated Billed Expenses	\$ 5,529		
Total Other Resident Care	\$ 159,396	\$ 26,971	\$ -

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

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center				License No. 1029-C	Report for Year Ended 9/30/2022				Page of 21 37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
CWPM, LLC	25 Norton Pl, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Trash Removal	18,679	3,324		22	6f
Point Click Care	Mississauga, Ontario, CA	<input type="radio"/>	<input checked="" type="radio"/>		Healthcare Software	42,741	7,605		16	m11
Paylocity	Arlington Heights, IL 60004	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Data Processing Fees	17,922	3,189		16	m11
IT Direct	67 Prospect Ave, W. Hartford, CT 06106	<input type="radio"/>	<input checked="" type="radio"/>		Software Maintenance	14,787	2,631		16	m11
OnShift	1621 Euclid Ave, Cleveland, OH 44115	<input type="radio"/>	<input checked="" type="radio"/>		EE Scheduling	13,724	2,442		16	m11
All American Healthcare	494 Broad St, Neward, NJ 07102	<input type="radio"/>	<input checked="" type="radio"/>		Temp Agency	30,210	5,331		13	B11a,
Maxim Healthcare	12558 Collection Ctr Dr, Chicago, IL 60693	<input type="radio"/>	<input checked="" type="radio"/>		Temp Agency	14,496	2,558		13	B11a,
HIBU	Cedar Rapid, IA 52406	<input type="radio"/>	<input checked="" type="radio"/>		Website Maint	14,171	2,522		16	m11
Flo-Tech	1801 W. Olympic Blvd, Pasadena, CA 91199	<input type="radio"/>	<input checked="" type="radio"/>		Copier Service	13,166	2,343		15	1g
IntelyCare	500 Ross St, Pittsburgh, PA 15262	<input type="radio"/>	<input checked="" type="radio"/>		Temp Agency	46,783	8,256		13	B11a,
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

* List all contracted services over \$10,000. Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	87,455	74,244	13,211		
b. Heat	\$	91,939	78,051	13,888		
c. Light & Power	\$	63,224	53,674	9,550		
d. Water	\$	8,428	7,155	1,273		
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$	21,651	18,380	3,271		
f. Other (<i>itemize</i>)	\$	77,466	65,764	11,702		
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	350,162	297,268	52,894		
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$	1,279	1,086	193		
d. Movable Equipment	\$	48,847	41,469	7,379		
*7e. Total Depreciation Costs (7a + b + c + d)	\$	50,126	42,554	7,572		
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	88,638	75,249	13,389		
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$	88,638	75,249	13,389		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	600,000	509,366	90,634		
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	66,530	56,480	10,050		
c. Personal property taxes	\$	10,660	9,050	1,610		
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	815,955	692,700	123,255		

* 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)
Trash Removal	\$ 18,214	\$ 3,241	
Purchased Services - Plant &	\$ 33,647	\$ 5,987	
Snow Plowing - Plant & Maint	\$ 4,117	\$ 733	
Grounds Maintenance	\$ 1,806	\$ 321	
Grounds Landscaping	\$ 7,981	\$ 1,420	
Total Other Repairs and Maintenance	\$ 65,764	\$ 11,702	\$ -

Depreciation Schedule

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Center				License No. 1029-C			Report for Year Ended 9/30/2022				Page 23	of 37	
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
A. Land Improvements													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
B. Building and Building Improvements													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal													
C. Non-Movable Equipment													
1. Acquired prior to this report period				67,661		67,661	61,022		10	1,279			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal													
D. Movable Equipment	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
	Yes	No	Month	Year									
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a. Ford F-150	X		2	2016	28,135		28,135	28,135	SL	5			
b. 2015 Mercedes Benz S550	X		6	2018	76,762		76,762	52,454	SL	5	15,352		
c. 2019 Ford Transit T350	X		6	2021	18,569		18,569	3,714	SL	5	3,714		
d. Range Rover					Never Claimed		Removed	Removed					
2. Movable Equipment													
a. Acquired prior to this report period													
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative													
d. Standard Resident													
e. Specialized Resident													
Total Acquired during this report period													
D-3. Subtotal													
E. Total Depreciation													
												48,847	
												50,126	

Schedule of Land Improvements Acquired during this report period

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful	Depreciation
		Movable Category		Life	
Additions:		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipment			\$ -		\$ -
Deletions:					
9/30/2022	Range Rover (Never claimed for reimbursement)				
9/30/2022	Deletions		\$ (40,931)		
Total deletions for Movable Equipment			\$ (40,931)		\$ -

*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	Depreciation
			Life	
Additions:				
Total additions for Leasehold Improvement		\$ -		\$ -
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ -

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab C			License No. 1029-C		Report for Year Ended 9/30/2022			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	Var	Var	Var	2,920,676	2,286,132			88,638	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									88,638
D. Total Amortization									88,638

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Chestelm Health Care, Inc. d/b/a Ches	License No. 1029-C	Report for Year Ended 9/30/2022	Page 25	of 37
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11. Property Questionnaire

Part A

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

Yes

No

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

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

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase	04/01/83			
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	76			
6. Square Footage	31,196			
7. Acquisition Cost				
a. Land				
b. Building				

Part B - Owner and Related Parties

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	05/20/98			
c. Interest Rate for the Cost Year	8.00%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	4,365,200			
f. Principal balance outstanding as of				

Complete if Mortgage was Refinanced During Current Cost Year

g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount		\$				
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$				

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended			Page	of
		9/30/2022			27	37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$	8,430	7,156	1,273	
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$	8,430	7,156	1,273	
14. Insurance						
a. Insurance on Property (buildings only)		\$	105,365	89,449	15,916	
b. Insurance on Automobiles		\$	5,515	4,682	833	
c. Insurance other than Property (as specified above)						
1. Umbrella (<i>Blanket Coverage</i>)		\$				
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$				
14d. Total Insurance Expenditures (14a + b + c)		\$	110,881	94,131	16,749	
15. Total All Expenditures (A-13 thru C-14)		\$	9,473,364	8,133,053	1,340,311	

D. Adjustments to Statement of Expenditures

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm Health & Rehab Cen			License No. 1029-C	Report for Year Ended 9/30/2022		Page 28	of 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	B10a	Occupational Therapy	\$ 238,976	238,976		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 1,500	1,273	227	
10.			Accounting	\$			
10a.			Legal	\$ 487	413	74	
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 8,626	7,323	1,303	
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.	16	16	Automobile Expense (e.g. personal use)	\$ 11,598	9,846	1,752	
18.	16	m3	Unallowable Advertising *	\$ 23,003	19,528	3,475	
19.	15	1j	Income Tax / Corporate Business Tax	\$ 12	10	2	
20.	16	m10	Fund Raising / Contributions	\$ 4,402	3,737	665	
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 2,652	2,251	401	
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)			\$ 291,256	283,358	7,898		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Prior Period Adjustments	\$ 2,251	\$ 401	
Total Other A&G Adjustments			\$ 2,251	\$ 401	\$ -

State of Connecticut

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

Name of Facility			License No.	Report for Year Ended		Page	of
Item No.	Page No.	Line No.		1029-C	9/30/2022	29	37
						Total Amount of Decrease	
						CCNH	RHNS
						(Specify)	
			Subtotals Brought Forward			\$ 291,256	283,358
							7,898
Page 20 - Resident Care Supplies***							
27.	20	5a	Prescription Drugs	\$ 135,888	115,361	20,527	
28.			Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 6,059	5,143	915	
30.	20	5h	Laboratory	\$ 22,159	18,812	3,347	
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 13,826	11,737	2,088	
33.	20	5j	Occupational Therapy	\$ 1,529	1,529		
34.			Other - See Attached Schedule	\$ 18,345	16,409	1,936	
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation	\$			
			See Attached Schedule	\$			
36.	22	7d	Depreciation on Unallowable Motor Vehicles	\$ 11,638	9,880	1,758	
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.	27	14b	Property Insurance	\$ 5,515	4,682	833	
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 4,000	4,000		
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation	\$			
			Unallowable Building Interest -	\$			
			See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)						\$ 510,214	470,912
							39,303

*** 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.

Schedule of Other Ancillary Costs

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 30	of 37
		Item	Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 4,863,790	4,164,217	699,573			
b. Medicaid Room and Board Contractual Allowance **	\$ (905,359)	(898,986)	(6,372)			
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,538,923	1,374,912	164,011			
b. Medicare Room and Board Contractual Allowance **	\$ (971,907)	(971,907)				
4. a. Private-Pay Residents and Other	\$ 2,474,755	2,264,155	210,600			
b. Private-Pay Room and Board Contractual Allowance **	\$ (5,210)	(5,210)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 102,678	102,678				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 12,786	12,786				
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	\$ 434,698	434,698				
b. Physical Therapy - Medicare Contractual Allowance **	\$ 117,797	117,797				
c. Physical Therapy - Non-Medicare	\$ 131,282	131,282				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 204,499	204,499				
b. Speech Therapy - Medicare Contractual Allowance **	\$ 60,369	60,369				
c. Speech Therapy - Non-Medicare	\$ 66,736	66,736				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 476,256	476,256				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ 53,775	53,775				
c. Occupational Therapy - Non-Medicare	\$ 182,259	182,259				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$ 888,995	888,995				
b. Other (<i>Specify</i>) - Non-Medicare	\$ (275,109)	(275,109)				
III. Total Resident Revenue (Section I. thru Section II.)		\$ 9,452,012	8,384,200	1,067,812		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$ 4,000	4,000				
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 722	613	109			
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 26,461	22,464	3,997			
V. Total Other Revenue (1 thru 8)		\$ 31,183	27,077	4,106		
VI. Total All Revenue (III +V)		\$ 9,483,195	8,411,277	1,071,918		

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6a	Medicare A - NTA C/A	\$ 371,100		
30/II6a	Medicare A - Nursing C/A	\$ 578,586		
30/II6a	Medicare - Oxygen	\$ 2,959		
30/II6a	Medicare - X-Ray	\$ 4,801		
30/II6a	Medicare - Lab	\$ 14,592		
30/II6a	Medicare - Contractual Adju	\$ (266,725)		
30/II6a	Medicare A - Sequestration	\$ (11,686)		
30/II6a	Medicare A - Grant	\$ 285,411		
30/II6a	Medicare A - Prior Year Adju	\$ (14,530)		
30/II6a	Managed Medicare - NTA C/A	\$ 64,057		
30/II6a	Managed Medicare - Nursing C/A	\$ 113,487		
30/II6a	Managed Medicare - Oxygen	\$ 276		
30/II6a	Managed Medicare - X-Ray	\$ 769		
30/II6a	Managed Medicare - Lab	\$ 3,524		
30/II6a	Managed Medicare - Ancillary	\$ (177,277)		
30/II6a	Managed Medicare - Prior Year	\$ 34,803		
30/II6a	Medicare B - Lab	\$ 1,210		
30/II6a	Medicare B - Contractual Adju	\$ (115,822)		
30/II6a	Medicare B - Sequestration	\$ (540)		
Total Other Resident Revenue - Medicare		\$ 888,995	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
30/II6b	Private SNF - X-Ray	\$ 140		
30/II6b	Private SNF - Prior Year Adju	\$ (62,136)		
30/II6b	Medicaid SNF - Prior Year Adj	\$ 38,883		
30/II6b	Managed Care - Oxygen	\$ 276		
30/II6b	Managed Care - X-Ray	\$ 371		
30/II6b	Managed Care - Lab	\$ 1,847		
30/II6b	Managed Care - Contractual Ad	\$ (129,162)		
30/II6b	Blue Cross Contractual Adju	\$ (974)		
30/II6b	Managed Care B - Contractual	\$ (5,570)		
30/II6b	Managed Care B - Prior Year A	\$ (1,160)		
30/II6b	Outpatient - Contractual Adju	\$ (140,331)		
30/II6b	Outpatient - Prior Year Adju	\$ (2,177)		
30/II6b	Outpatient Part B ? Physical	\$ 35,552		
30/II6b	Outpatient Part B OT	\$ 6,647		
30/II6b	Outpatient Part B- Speech Th	\$ 15,024		
30/II6b	Outpatient -Part B Cont Adju	\$ (32,339)		
Total Other Resident Revenue		\$ (275,109)	\$ -	\$ -

Interest Income

Page Ref	Account	Account	CCNH	RHNS	(Specify)
30/IV5	Interest Income		\$ 613	\$ 109	
Total Interest Income			\$ 613	\$ 109	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30/IV8	Transportation	\$ 2,960	\$ 527	
30/IV8	Charitable Donations	\$ 412	\$ 73	
30/IV8	Misc. Income	\$ 18,992	\$ 3,379	
30/IV8	Discounts	\$ 100	\$ 18	
Total Other Revenue		\$ 22,464	\$ 3,997	\$ -

G. Balance Sheet

Name of Facility Chestelm Health Care, Inc. d/b/a Chestel	License No. 1029-C	Report for Year Ended 9/30/2022	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	238,745
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,930,612
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	2,400
5. Prepaid Expenses			\$	265,356
a. _____				
b. _____				
c. _____				
d. See Schedule		265,356		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,437,112
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	Net		
3. Buildings	*Historical Cost	_____	\$	
	Accum. Depreciation	Net		
4. Leasehold Improvements	*Historical Cost	2,920,676	\$	545,906
	Accum. Depreciation	2,374,770 Net		
5. Non-Movable Equipment	*Historical Cost	67,662	\$	5,361
	Accum. Depreciation	62,301 Net		
6. Movable Equipment	*Historical Cost	1,322,825	\$	51,747
	Accum. Depreciation	1,271,078 Net		
7. Motor Vehicles	*Historical Cost	123,465	\$	20,097
	Accum. Depreciation	103,368 Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	196,686
See Schedule		196,686		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	819,797

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Chestelm Health Care, Inc. d/b/a Chestel	License No. 1029-C	Report for Year Ended 9/30/2022	Page 32	of 37
Account		Amount		
Total Brought Forward:			\$	3,256,909
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements	*Historical Cost Accum. Depreciation	Net	\$	
3. Buildings	*Historical Cost Accum. Depreciation	Net	\$	
4. Non-Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
5. Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
6. Motor Vehicles	*Historical Cost Accum. Depreciation	Net	\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense	*Historical Cost Accum. Depreciation	Net	\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	494,089
See Schedule	494,089			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	494,089
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	3,750,998

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Deposits - Form 8752	\$ 9,160
31	A5	Prepaid - Insurance - Mortgage	\$ 90,463
31	A5	Prepaid - Insurance - Other	\$ 116,665
31	A5	Prepaid - Health Insurance	\$ 49,068
Total Prepaid Expenses			\$ 265,356

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

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

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

Page Ref	Line Ref	Description	
31	B9	Construction in Progress	\$ 89,599
31	B9	Book vs. Cost	\$ 107,087
Total Other Other Fixed Assets (Itemize)			\$ 196,686

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
	32 D7	Escrow Deposits	\$ (2,708)
	32 D7	Reserve Realty	\$ (51,494)
	32 D7	Reserve Realty-Realty	\$ 47,249
	32 D7	Tax Escrow	\$ (51,045)
	32 D7	Insurance Escrow	\$ 57,116
	32 D7	Goodwill	\$ 1,086
	32 D7	Due from Related Parties	\$ 66,329
	32 D7	Due from Employees	\$ 2,430
	32 D7	Due from CADS	\$ 425,126
Total Other Assets			\$ 494,089

Schedule of Notes Payable (Itemize) Page 33 Line A2

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

Page Ref	Line Ref	Description	
	33 A12	Payroll Clearing	\$ (258.25)
	33 A12	Accrued Accounting	\$ 18,260.00
	33 A12	Accrued User Tax	\$ 118,511.00
	33 A12	Accrued Property Tax	\$ 31,036.08
	33 A12	Accrued State Back Taxes	\$ (1,675.00)
	33 A12	Accrued Federal Back Taxes	\$ 20,213.01
	33 A12	Due to Medicaid	\$ (8,442.95)
	33 A12	Due to Medicaid A/1	\$ (726.84)
	33 A12	Resident Refunds	\$ (12,309.10)
	33 A12	Resident Trust	\$ (2,865.14)
Total Other Current Liabilities (Itemize)			\$ 161,743

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

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Chestelm Health Care, Inc. d/b/a Chestelm He	1029-C	9/30/2022	33	37
Liabilities	Account	Amount		
A. Current Liabilities				
1. Trade Accounts Payable		\$ 1,339,234		
2. Notes Payable (<i>itemize</i>)		\$ 1,775,000		
See Schedule		1,775,000		
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)		\$		
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)		\$ 189,376		
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)		\$		
6. Accrued Payroll Taxes Payable		\$ 48,666		
7. Medicare Final Settlement Payable		\$ (9,463)		
8. Medicare Current Financing Payable		\$		
9. Mortgage Payable (<i>Current Portion</i>)		\$		
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)		\$		
11. Accrued Income Taxes*		\$		
12. Other Current Liabilities (<i>itemize</i>)		\$ 161,743		
See Schedule		161,743		
A-13. Total Current Liabilities (Lines A1 thru 12)		\$ 3,504,557		

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm	License No. 1029-C	Report for Year Ended 9/30/2022	Page 34	of 37
Account				Amount
Total Brought Forward:				\$ 3,504,557
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$ 238,452
Name and Address of Lender	Amount	Loan Date		
	238,452			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 238,452
C. Total All Liabilities (Lines A-13 + B-5)				\$ 3,743,009

G. Balance Sheet (cont'd)

Reserves and Net Worth

Name of Facility Chestelm Health Care, Inc. d/b/a Ches	License No. 1029-C	Report for Year Ended 9/30/2022	Page 35	of 37
Account				Amount
A. Reserves				
1. Reserve for value of leased land				\$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				\$
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)				\$
4. Reserve for leasehold real properties on which fair rental value is based				\$
5. Reserve for funds set aside as donor restricted				\$
6. Total Reserves				\$
B. Net Worth				
1. Owner's Capital				\$
2. Capital Stock				\$
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ (1,845)
6. Gain or Loss for Period	10/1/2021	thru	9/30/2022	\$ 9,831
7. Total Net Worth				\$ 7,986
C. Total Reserves and Net Worth				\$ 7,986
D. Total Liabilities, Reserves, and Net Worth				\$ 3,750,995

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	9/30/2022	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ (1,989,709)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 9,483,195
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 9,473,364
D. Net Income or Deficit				\$ 9,831
E. Balance				\$ (1,979,878)
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions				\$
G. Deductions				\$
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$
Name and Address (No., City, State, Zip)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)				\$
Purpose		Amount		
3. Total Deductions				\$
H. Balance at End of Period				\$ (1,979,878)

I. Preparer's/Reviewer's Certification

Name of Facility Chestelm Health Care, Inc. d/b/a Chestelm	License No. 1029-C	Report for Year Ended 9/30/2022	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input checked="" type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer CJLC LLC		
Address 225 Pitkin St., East Hartford, CT 06108	Phone Number 860-610-9009	
Contacted Person Regarding Additional Information Needed Regarding This Report CJLC	Phone Number 860-610-9009	
Contact Email Address annualreports@cjlc.com		