

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2020

Name of Facility (as licensed) Apple Rehab Colchester	
Address (No. & Street, City, State, Zip Code) 36 Broadway Colchester CT 06415	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

License Numbers:	CCNH 1090 -C	RHNS	(Specify)	Medicare Provider 07-5231
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Medicaid Provider Numbers:	CCNH 10090	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

## General Information

Name of Facility (as licensed) Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020	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 Apple Rehab Colchester [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, 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) Courtney Peterson			Printed Name (Owner) Brian J. Foley	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Apple Rehab Colchester	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 36 Broadway Colchester CT 06415				
Report Prepared By Apple Health Care, Inc.	Phone Number (860) 678-9755	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	\$			
<b>6. Total Wages Paid</b>	<b>\$</b>			
7. Total salaries paid	\$			
<b>8. Total Wages and Salaries Paid (As per page 10 of Report)</b>	<b>\$</b>			

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 860-537-4606	Report for Year Ended 9/30/2020	Page 2
Name of Facility (as shown on license) Apple Rehab Colchester		Address (No. & Street, City, State, Zip ) 36 Broadway Colchester CT 06415	
License Numbers:	CCNH 1090 -C	RHNS	(Specify)
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing 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.
<b>Administrator</b>			
Name of Administrator Courtney Peterson		Nursing Home Administrator's License No.:	2114
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**

Name of Facility Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020	Page of 3A   37
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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	
Apple Rehab Colchester	36 Broadway Colchester CT 06415	Connecticut	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Brian J. Foley	21 Waterville Road Avon, CT 06001	President	100
Ryan Vess	21 Waterville Road Avon, CT 06001	Secretary	
Names of Stockholders Owning at Least 10% of Shares			
Brian J. Foley	21 Waterville Road Avon, CT 06001	President	100

# **General Information and Questionnaire**

## **Individual Proprietorship**

Name of Facility Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

## General Information and Questionnaire

### Related Parties\*

Name of Facility Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes <input checked="" 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			Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party	
		Yes	No	%**				Description of Goods/Services Provided
Brian J. Foley	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Real Estate Rental	Pg. 22 Line 9	341,949	341,949
Apple Heath Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Management & Accounting Services	Pg. 16 Line m12	266,060	266,060
Corporate Employees	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	99,315	99,315
Employees @ various Apple Facilities		<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	60,329	60,329
Apple Heath Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Pension Plan (401K)	Pg. 15 Line 1a7	24,934	24,934
Aetna	PO Box 88860 Chicago, IL 60695	<input checked="" type="radio"/>	<input type="radio"/>		Group Medical	Pg. 15 Line 1a5	190,725	
Metlife	PO Box 360229 Pittsburgh, PA 15251	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 1a5	13,827	
USI	PO Box 62937 Virginia Beach, VA 23466	<input checked="" type="radio"/>	<input type="radio"/>		Property, Liability, & Umbrella Insurance	Pg. 27 Line 14a	82,558	
Healthport	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	18,576	18,576

\* 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 Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020	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.

The costs incurred by Apple Health Care, Inc. (a related party) to provide accounting and managerial services to each facility owned by Brian J. Foley are allocated on a per bed basis.

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.

N/A

## **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
Apple Rehab Colchester		1090 -C		9/30/2020			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?		<input checked="" type="radio"/> Yes		<input type="radio"/> No		<b>Total ***</b>		

\* 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 Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020	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     Yes    If "No," explain.  
previous period?     No

#### Independent Accounting Firm

Name of Accounting Firm 1 Blum Shapiro & Co. PC 2 Brazee & Huban 3 Blum Shapiro & Co. PC 4	Address (No. & Street, City, State, Zip Code) 29 South Main St. West Hartford, CT 06127 35 Wendell Ave. Pittsfield, MA 10202 29 South Main St. West Hartford, CT 06127
--	---

Services Provided by This Firm (*describe fully*)

1 Preparation of audited financials (disallow Pg. 28)	\$ 1,961
2 Preparation of tax returns	\$ 1,791
3 Audit - 401K	\$ 864
4	\$
	Charge for Services Provided \$ 4,615

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

Yes     No

#### Legal Services Information

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

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

1 2 3 4 5	
-----------------------	--

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided \$

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

Yes     No

## Schedule of Resident Statistics

Name of Facility Apple Rehab Colchester			License No. 1090 -C				Report for Year Ended 9/30/2020				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					60	60								
A. On last day of PREVIOUS report period	60	60												
B. On last day of THIS report period	60	60								60	60			
2. Number of Residents					53	53								
A. As of midnight of PREVIOUS report period	53	53												
B. As of midnight of THIS report period	49	49								49	49			
3. Total Number of Days Care Provided During Period					2,166	2,166				467	467			
A. Medicare	2,633	2,633												
B. Medicaid (Conn.)	14,738	14,738			11,314	11,314				3,424	3,424			
C. Medicaid (other states)														
D. Private Pay	1,918	1,918			1,212	1,212				706	706			
E. State SSI for RCH														
F. Other (Specify)														
G. Total Care Days During Period (3A thru F)	19,289	19,289			14,692	14,692				4,597	4,597			
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. <b>Total Resident Days (3G + 4A + 4B)</b>	<b>19,289</b>	<b>19,289</b>			<b>14,692</b>	<b>14,692</b>				<b>4,597</b>	<b>4,597</b>			

**Schedule of Resident Statistics (Cont'd)**

Name of Facility Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?

 Yes No

If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change	
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)		
				(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.

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	5	36		8				
Per Diem Rate								
a. One bed rm.				440.00				
b. Two bed rms.	RUGS	226.70		410.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		2,366	2,366		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		6,135	6,135		
D. <b>Total Physical Therapy Treatments</b>		8,501	8,501		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		185	185	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other		372	372	
D. <b>Total Speech Therapy Treatments</b>		557	557	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		1,794	1,794	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other		5,632	5,632	
D. <b>Total Occupational Therapy Treatments</b>		7,426	7,426	

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		1090 -C	9/30/2020	10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No			
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)	88,410	2,143			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	36,397	2,170			
5. Dietary Service					
a. Head Dietitian	3,050	84			
b. Food Service Supervisor	48,477	1,873			
c. Dietary Workers	177,969	12,282			
6. Housekeeping Service					
a. Head Housekeeper	50,229	2,236			
b. Other Housekeeping Workers	101,520	6,462			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance					
b. Other Maintenance Workers	52,396	2,258			
8. Laundry Service					
a. Supervisor	42,163	2,108			
b. Other Laundry Workers	1,922	116			
9. Barber and Beautician Services					
10. Protective Services					
11. Accounting Services					
a. Head Accountant					
b. Other Accountants	69,550	2,226			
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	212,482	4,568			
b. RN					
1. Direct Care	609,593	15,424			
2. Administrative**	121,218	2,776			
c. LPN					
1. Direct Care	190,236	6,422			
2. Administrative**					
d. Aides and Attendants	777,271	45,896			
e. Physical Therapists	170,977	4,260			
f. Speech Therapists	16,933	430			
g. Occupational Therapists	131,832	3,383			
h. Recreation Workers	84,296	4,334			
i. Physicians					
1. Medical Director					
2. Utilization Review					
3. Resident Care***					
j. Dentists					
k. Pharmacists					
l. Podiatrists					
m. Social Workers/Case Management	64,330	2,111			
n. Marketing					
o. Other (Specify) See Attached Schedule					
<i>A-13. Total Salary Expenditures</i>	3,051,251	123,562			

\* 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 Apple Rehab Colchester			License No. 1090 -C		Report for Year Ended 9/30/2020			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)							
<b>Section I - Operators/Owners</b>										
<b>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).</b>										

\* 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
Apple Rehab Colchester				1090 -C		9/30/2020			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)							
<b>Section III - Administrators***</b>										
Sarah Theide	3,195				Admin 10/1/19 - 10/16/19	80	A2	Middletown	1,906	96,821
Courtney Peterson	85,215				Admin 10/17/19 - 9/30/20	2,063	A2	Orchard Grove	48	1,615
<b>Section IV - Assistant Administrators</b>										

\*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 Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020		Page 13	of 37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist	6,942	93			
3. Pharmacist	6,486	86			
4. Podiatrist	5	1			
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	18,000	45			
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) Healthdrive Eyecare Group	24	1			
9. Speech Therapist					
a. Resident Care	1,080	14			
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care					
2. Administrative***					
b. LPN					
1. Direct Care					
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify) See Attached Schedule	3,920	78			
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	36,457	319			

\* 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
		9/30/2020		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 77,530	77,530			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 34,355	34,355			
4. Social Security (F.I.C.A.)	\$ 212,153	212,153			
5. Health Insurance	\$ 132,945	132,945			
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 22,836	22,836			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 24,934	24,934			
8. Uniform Allowance	\$				
9. Other (Specify) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 16,083	16,083			
d. Accounting and Auditing	\$ 4,615	4,615			
e. Legal (Services should be fully described on Page 7)	\$				
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$ 6,419	6,419			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 16,522	16,522			
2. Cellular Phones	\$				
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*	\$ (14,324)	(14,324)			
2. Other (Specify) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 347,925	347,925			
<b>Subtotal</b>	\$ 881,994	881,994			

\* 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**

### Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
<b>Total</b>	\$ -	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended		Page	of
	1090 -C	9/30/2020		16	37
Item		Total	CCNH	RHNS	(Specify)
	<b><i>Subtotals Brought Forward:</i></b>	881,994	881,994		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 3,875	3,875			
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$ 815	815			
4. Employee Travel	\$ 8,586	8,586			
5. Education Expenses Related to Seminars and Conventions	\$ 1,612	1,612			
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$				
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$				
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 2,322	2,322			
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 3,395	3,395			
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 5,044	5,044			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 90	90			
9. Subscriptions	\$ 406	406			
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$				
12. Administrative Management Services**	\$ 266,060	266,060			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 122,537	122,537			
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$ 1,296,737	1,296,737			

\* 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)
<b>Total Other Travel and Entertainment</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Advertising - Public Relations	\$ 2,322		
<b>Total Other Advertising</b>	<b>\$ 2,322</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 4,444		
American Health Care Assoc	\$ 600		
<b>Total Dues</b>	<b>\$ 5,044</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
	\$ -		
<b>Total Contributions</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Corporate Fees - Non Reimburable	\$ 41,387		
Licenses & Fees	\$ 1,430		
Pr Employment Screenings	\$ 10,195		
System License & Subscription Fees	\$ 21,762		
Bank Service Charges	\$ 11,367		
Legal Fees - Collection/Probate	\$ 321		
IT Service Fees	\$ 1,278		
Internet & Cable/Satellite TV	\$ 13,616		
Survey Fines & Citations	\$ -		
Healthport Indirect	\$ 7,060		
Settlement	\$ 6,250		
Resident Expenses	\$ -		
Gemino Finance Expense	\$ 5,153		
Prior Period Adj/Account W/O	\$ 2,718		
<b>Total Other Administrative and General</b>	<b>\$ 122,537</b>	<b>\$ -</b>	<b>\$ -</b>

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-17 Rev. 10/97

**Schedule C-1 - Management Services\***

Name of Facility	License No.	Report for Year Ended	Page of
Apple Rehab Colchester	1090 -C	9/30/2020	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 #
Apple Health Care Inc	266,060	Accounting & Management Services	Pg 16 m 12

**\* 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
	1090 -C	9/30/2020		18   37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 141,257	141,257		
2. Non-Food Supplies	\$ 12,865	12,865		
3. Other (Specify) _____	\$ _____			
b. Purchased Services (by contract other than through Management Services) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 1,303	1,303		
c. Other (Specify) _____	\$ _____			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 155,425</b>	<b>155,425</b>		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	159	159		
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <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 Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020		Page of 19   37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	5,097	5,097	
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. \$	8,272	8,272	
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$	14,857	14,857	
c. Other (Specify)	\$			
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	28,226	28,226	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.
G. Did you receive revenue from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.
H. Where is the revenue received reported in the Cost Report?				(Page/Line Item)
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.
J. Did you receive revenue from these people?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.
K. Where is the revenue received reported in the Cost Report?				(Page/Line Item)

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
	1090 -C	9/30/2020		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 16,488	16,488		
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 154	154		
C. Other ( <i>Specify</i> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>16,641</b>	<b>16,641</b>		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Neighbors	\$	106,996	106,996		
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	164,731	164,731		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	7,632	7,632		
f. X-rays and Related Radiological Procedures***	\$	6,822	6,822		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	17,180	17,180		
i. Recreation	\$	4,362	4,362		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other ( <i>Specify</i> )**** <i>See Attached Schedule</i>	\$	17,225	17,225		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>324,948</b>	<b>324,948</b>		

\* 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**

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

\* 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 Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	86,711	86,711			
b. Heat	\$	62,697	62,697			
c. Light & Power	\$	54,348	54,348			
d. Water	\$	25,803	25,803			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$					
f. Other <i>(itemize)</i>	\$	15,000	15,000			
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$	244,560	244,560			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$	18,407	18,407			
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$	18,407	18,407			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	33,266	33,266			
d. Other <i>(Specify)</i>	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$	33,266	33,266			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	341,949	341,949			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	29,033	29,033			
c. Personal property taxes	\$	7,168	7,168			
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$	429,823	429,823			

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

## **Schedule of Other Repairs and Maintenance**

## Depreciation Schedule

**Schedule of Land Improvements Acquired during this report period**

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

**Schedule of Building Improvements Acquired during this report period**

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

**Schedule of Non-Movable Equipment Acquired during this report period**

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
3/4/2019	Temporary Generator Capitalized 2020 CY.	\$ 4,602	ME-5	\$ 830
11/15/2019	Backflow Repair 1st Installment	\$ 720	ME-5	\$ 180
11/15/2019	Backflow Booster Balance	\$ 880	ME-5	\$ 220
6/3/2020	Firewall	\$ 990	ME-3	\$ 94
7/17/2020	Replace Dryer	\$ 6,390	ME-10	\$ 145
<b>Total additions for Movable Equipment</b>		\$ 13,582		\$ 1,468 *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
10/8/2019	Replace Pipe Section	\$ 2,499	LHI-10	\$ 312
11/8/2019	Replace Drain Piping	\$ 2,074	LHI-10	\$ 259
7/29/2020	Water Heater Replacement	\$ 8,740	LHI-10	\$ 180
05/1/2019	Installment of Rooftop AC 7.5 Ton Unit First Installment (Saucier)	\$ 5,332	10.00	\$ 755
05/1/2019	Installment of Rooftop AC 2 Ton Unit First Installment (Saucier)	\$ 3,127	5.00	\$ 886
<b>Total additions for Leasehold Improvements</b>		\$ 21,772		\$ 2,393 *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvements</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

## Amortization Schedule\*

Name of Facility Apple Rehab Colchester			License No. 1090 -C		Report for Year Ended 9/30/2020			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				1,154,933	879,738	A		30,873	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				21,772		A		2,393	
C-4. Subtotal									33,266
D. Total Amortization									33,266

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

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

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

Name of Facility Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020	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				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	60			
6. Square Footage	25,115			
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	12/27/16			
c. Interest Rate for the Cost Year	351.00%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	2,885,500			
f. Principal balance outstanding as of _____	2,718,688			

##### 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 9/30/2020			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. <b>Total Building Interest Expense</b> (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
		9/30/2020			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)			\$	11,620	11,620	
Gemino Loan Interest						
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)			\$	11,620	11,620	
14. Insurance						
a. Insurance on Property (buildings only)			\$	82,558	82,558	
b. Insurance on Automobiles			\$			
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)			\$			
2. Fire and Extended Coverage			\$			
3. Other (Specify)			\$			
14d. <b>Total Insurance Expenditures</b> (14a + b + c)			\$	82,558	82,558	
15. <b>Total All Expenditures</b> (A-13 thru C-14)			\$	5,678,247	5,678,247	

## **D. Adjustments to Statement of Expenditures**

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		1090 -C	9/30/2020	28   37	
			Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 131,832	131,832		
4.			Other - See attached Schedule	\$ 7,499	7,499		
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 16,083	16,083		
10.	15	1d	Accounting	\$ 1,961	1,961		
10a.			Legal	\$ 321	321		
11.			Telephone	\$			
12.			Cellular Telephone	\$			
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.			Automobile Expense (e.g. personal use)	\$			
18.	16	m2/3	Unallowable Advertising *	\$ 2,322	2,322		
19.	15	k1	Income Tax / Corporate Business Tax	\$ (318)	(318)		
20.	16	m10	Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 70,356	70,356		
<b>Page 18 - Dietary Expenditures</b>							
24.	30	IV1	Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 230,055	\$ 230,055			

\* 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)
10	A12m	Social Service - Marketing	\$ 7,499		
<b>Total Other Salaries Adjustment</b>			\$ 7,499	\$ -	\$ -

**Schedule of Fees Adjustments**

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

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fees Non Reimbursable	\$ 41,387		
16	1.3	Employee Recognition/Gifts/Parties	\$ 815		
16	8a	Chamber of Commerce	\$ 90		
16	m13	Bank Charges	\$ 11,367		
16	m13	Survey Fines & Citations	\$ -		
16	m13	Resident Expenses	\$ -		
16	m13	Prior Period Expense/Account W/O	\$ 2,718		
16	m13	Gemino Finance Expense	\$ 5,153		
30	IV 8	Acct W/O	\$ 7,073		
30	IV 8	Prior Period Adj	\$ 1,153		
30	IV 8	Rehab Settlement	\$ 600		
<b>Total Other A&amp;G Adjustments</b>			\$ 70,356	\$ -	\$ -

State of Connecticut

**Annual Report of Long-Term Care Facility**

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

Name of Facility			License No.	Report for Year Ended		Page of	
Apple Rehab Colchester			1090 -C	9/30/2020		29   37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 230,055	230,055		
			<b>Page 20 - Resident Care Supplies***</b>				
27.	20	5a2	Prescription Drugs	\$ 100,337	100,337		
28.	16	L1	Ambulance/Limousine	\$ 3,875	3,875		
29.	20	h	X-rays, etc	\$ 6,822	6,822		
30.	20	f	Laboratory	\$ 17,180	17,180		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 4,025	4,025		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 17,037	17,037		
			<b>Page 22 - Maintenance and Property</b>				
35.			Excess Movable Equipment Depreciation				
			See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
			<b>Page 27 - Insurance</b>				
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
			<b>Other - Miscellaneous</b>				
42.			Other - Indirect	\$ 11,620	11,620		
43.	30	IV5	Interest Income on Account Rec.	\$ 159	159		
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
			<b>Not For Profit Providers Only</b>				
48.			Building/Non Movable Eq. Depreciation				
			Unallowable Building Interest -				
			See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 391,109	391,109		

\*\*\* 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 Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020			Page 30   37
Item		Total	CCNH	RHNS	(Specify)
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 3,368,806	3,368,806			
b. Medicaid Room and Board Contractual Allowance **	\$				
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,017,724	1,017,724			
b. Medicare Room and Board Contractual Allowance **	\$ 343,733	343,733			
4. a. Private-Pay Residents and Other	\$ 797,034	797,034			
b. Private-Pay Room and Board Contractual Allowance **	\$				
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 92,877	92,877			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (92,728)	(92,728)			
c. Prescription Drugs - Non-Medicare	\$ 2,982	2,982			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (2,982)	(2,982)			
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	\$ 270,200	270,200			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (215,706)	(215,706)			
c. Physical Therapy - Non-Medicare	\$ 27,332	27,332			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (10,850)	(10,850)			
4. a. Speech Therapy - Medicare	\$ 23,940	23,940			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (18,462)	(18,462)			
c. Speech Therapy - Non-Medicare	\$ 3,330	3,330			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (1,125)	(1,125)			
5. a. Occupational Therapy - Medicare	\$ 321,975	321,975			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (268,850)	(268,850)			
c. Occupational Therapy - Non-Medicare	\$ 79,450	79,450			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (12,195)	(12,195)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 5,726,486	5,726,486			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$ 159	159			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 566,047	566,047			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 566,206	566,206			
<b>VI. Total All Revenue</b> (III +V)	\$ 6,292,692	6,292,692			

\* 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)
	<b>Total Other Resident Revenue - Medicare</b>	\$ -	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
	<b>Total Other Resident Revenue</b>	\$ -	\$ -	\$ -

**Interest Income****Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30 IV5	Interest income	1,017,724	\$ 159		
	<b>Total Interest Income</b>		\$ 159	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV8	Account W/O	\$ 7,073		
30 IV8	Prior oer Adj	\$ 1,153		
30 IV8	Rehabcare settlement	\$ 600		
30 IV8	Rebates	\$ 995		
30 IV8	Cares Act Relief	\$ 556,226		
	<b>Total Other Revenue</b>	\$ 566,047	\$ -	\$ -

**G. Balance Sheet**

Name of Facility Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	254
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	18,812
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	17,983
5. Prepaid Expenses			\$	
a. _____				
b. _____				
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	303,670
See Schedule		303,670		
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	340,720
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	1,176,705	\$	263,701
	Accum. Depreciation	913,004	Net	
5. Non-Movable Equipment	*Historical Cost	49,727	\$	
	Accum. Depreciation	49,727	Net	
6. Movable Equipment	*Historical Cost	490,340	\$	32,978
	Accum. Depreciation	457,361	Net	
7. Motor Vehicles	*Historical Cost	1,045	\$	
	Accum. Depreciation	1,045	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	14,584
See Schedule		14,584		
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	311,263

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

(Carry Total forward to next page)

**Schedule of Prepaid Expenses Page 31 Line A5**

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

Page Ref	Line Ref	Description	
		Due Affiliate (Debit Balance)	
31	A8	A/P Other (Intercompany)	\$ 14,384
31	A8	Payroll W/H	\$ 18,849
31	A8	Gemino Revolving A/R Loan	\$ 202,894
31	A8	A/P Other (Intercompany)	\$ 67,544
<b>Total Other Current Assets (Itemize)</b>			\$ 303,670

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

**Schedule of Other Assets Page 32 Line D7**

Page Ref	Line Ref	Description	
32	D7	Leasehold Deposits	\$ -
32	D7	Deferred Tax Asset	\$ 11,313
32	D7	Goodwill	\$ -
<b>Total Other Assets</b>			\$ 11,313

**Schedule of Notes Payable (Itemize) Page 33 Line A2**

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			\$ -

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

Page Ref	Line Ref	Description	
33	A12	A/P Patient Exchange	
33	A12	Due Affiliate (Credit Balance)	\$ 2,525,797
33	A12	Gemino Revolving AR Loan	
33	A12	Accrued PTO	\$ 125,057
33	A12	Payroll W/H	
33	A12	Accrued Professional Fees	\$ 7,042
33	A12	Accrued Pension	\$ -
33	A12	Accrued Worker Comp	\$ 25,180
33	A12	Accrued Group Insurance	\$ 13,158
33	A12	Accrued Other Expenses	\$ 313,656
33	A12	Medicare Accelerated Payment	\$ 232,618
<b>Total Other Current Liabilities (Itemize)</b>			\$ 3,242,508

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

Page Ref	Line Ref	Description	
		A/P Other (Intercompany)	
		Dostie Note	\$ -
		Marlin Capital Lease	\$ -
		Loan Payable Officer	\$ -
		Security Deposit/Deferred Revenue	\$ -
34	B4	State Income Tax Payable	\$ 8,606
<b>Total Other Current Liabilities (Itemize)</b>			\$ 8,606

## G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
		9/30/2020	32   37
Account		Amount	
		Total Brought Forward:	\$ 651,983
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 <b>Total Leasehold or Like Properties</b> (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> )			\$ 11,313
See Schedule	11,313		
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$ 11,313
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$ 663,296

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

## **G. Balance Sheet (cont'd)**

Name of Facility Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020	Page 33	of 37
Account				Amount
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 250,090
2. Notes Payable ( <i>itemize</i> )				\$
See Schedule				
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$
Name of Lender		Purpose	Amount	Date Due
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$ 83,991
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$
6. Accrued Payroll Taxes Payable				\$ 64,991
7. Medicare Final Settlement Payable				\$
8. Medicare Current Financing Payable				\$
9. Mortgage Payable ( <i>Current Portion</i> )				\$
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$
11. Accrued Income Taxes*				\$
12. Other Current Liabilities ( <i>itemize</i> )				\$ 3,242,508
See Schedule				3,242,508
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)				<b>\$ 3,641,580</b>

\* 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 Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020	Page 34	of 37
Account			Amount	
Total Brought Forward:			3,641,580	
<b>Liabilities (cont'd)</b>				
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> )			\$	
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )			\$	8,606
See Schedule		8,606		
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)			\$	8,606
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)			\$	3,650,186

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

Name of Facility	License No.	Report for Year Ended	Page of
		9/30/2020	35   37
Account			Amount
<b>A. Reserves</b>			
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>B. Net Worth</b>			
1. Owner's Capital			\$ 615,109
2. Capital Stock			\$
3. Paid-in Surplus			\$
4. Treasury Stock			\$
5. Cumulated Earnings			\$ (4,216,443)
6. Gain or Loss for Period	10/1/2019	thru	\$ 614,444
7. Total Net Worth			\$ (2,986,890)
<b>C. Total Reserves and Net Worth</b>			\$ (2,986,890)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$ 663,296

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Apple Rehab Colchester	1090 -C	9/30/2020	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2019				\$ (3,617,188)		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 6,292,692		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 5,678,247		
D. Net Income or Deficit				\$ 614,444		
E. Balance				\$ (3,002,744)		
F. Additions						
1. Additional Capital Contributed ( <i>itemize</i> )						
Brian Foley				19,717		
2. Other ( <i>itemize</i> )						
F-3. Total Additions				\$ 19,717		
G. Deductions						
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )				\$ 3,863		
Name and Address (No., City, State, Zip )		Title	Amount			
Brian J Foley		President	3,863			
2. Other Withdrawings ( <i>Specify</i> )				\$		
Purpose		Amount				
3. Total Deductions				\$ 3,863		
H. <b>Balance at End of Period</b>				\$ (2,986,890)		

## I. Preparer's/Reviewer's Certification

Name of Facility Apple Rehab Colchester	License No. 1090 -C	Report for Year Ended 9/30/2020	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input 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		
Robert Gwizdak		
Address		Phone Number
21 Waterville Rd Avon CT		860-678-9755
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Susan Southey		860-470-7542
Contact Email Address		
ssouthey@apple-rehab.com		