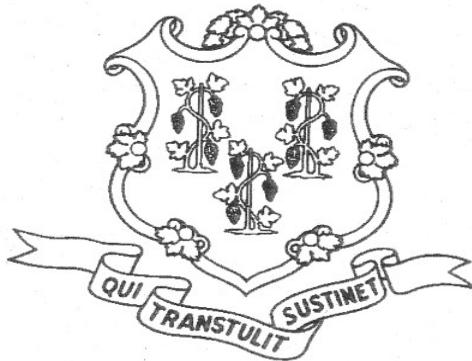


State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2022

Name of Facility (as licensed) Apple Rehab Farmington Valley		
Address (No. & Street, City, State, Zip Code) 269 Farmington Ave, Plainville, CT 06062		
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 10/1/2021	Report for Year Ending 9/30/2022	

License Numbers:	CCNH 2029-C	RHNS	(Specify)	Medicare Provider 07-5044
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Medicaid Provider Numbers:	CCNH 20298	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 Farmington Valley	License No. 2029-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 Apple Rehab Farmington Valley [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) Rob Fritz		Printed Name (Owner) Brian Foley		
Subscribed and Sworn to before me:	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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Apple Rehab Farmington Valley	Period Covered:		From 10/1/2021	To 9/30/2022
Address of Facility 269 Farmington Ave, Plainville, CT 06062				
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	\$			
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
860-747-1637	9/30/2022	2	37

Name of Facility (as shown on license)	Address (No. & Street, City, State, Zip)		
Apple Rehab Farmington Valley	269 Farmington Ave, Plainville, CT 06062		

License Numbers:	CCNH 2029-C	RHNS	(Specify)	Medicare Provider No. 07-5044
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Type of Facility (Check appropriate box(es))	<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)
--	--	---	------------------------------------

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 Robert Fritz	Nursing Home Administrator's License No.:	001250

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 Farmington Valley	License No. 2029-C	Report for Year Ended 9/30/2022	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 Farmington Valley	269 Farmington Ave, Plainville, CT 06062	Connecticut	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Brian Foley	21 Waterville Rd. Avon, CT 06001	President	100
Ryan Vess	21 Waterville Rd. Avon, CT 06001	Secretary	
Names of Stockholders Owning at Least 10% of Shares			
Brian Foley	21 Waterville Rd. Avon, CT 06001	President	100

General Information and Questionnaire

Individual Proprietorship

Name of Facility Apple Rehab Farmington Valley	License No. 2029-C	Report for Year Ended 9/30/2022	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 Farmington Valley	License No. 2029-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 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	858,820	858,820
Apple Health Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Management & Accounting Services	Pg. 16 Line m12	498,116	498,116
Corporate Employees	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	154,722	154,722
Healthport	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	68,631	68,631
Employees @ various Apple Facilities		<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	(37,966)	(37,966)
Apple Health Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Pension Plan (401K)	Pg. 15 Line 1a7	64,076	64,076
Lucent Health Solutions	424 Church St. Nashville, TN 37219	<input checked="" type="radio"/>	<input type="radio"/>		Group Medical	Pg. 15 Line 1a5	368,948	
MetLife	PO Box 360229 Pittsburgh, PA 15251	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 Line 1a5	7,982	
Delta Dental of CT	148 Eastern Blvd Glastonbury, CT 06033	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 Line 1a5	26,031	

* Use additional sheets if necessary.

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

General Information and Questionnaire

Related Parties*

Name of Facility Apple Rehab Farmington Valley	License No. 2029-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 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			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	%**				
USI	PO Box 62937 Virginia Beach, VA 23466	✗			Property, Liability, & Umbrella Insurance	Pg. 27 Line 14a	251,256	
Reliance Standard	2001 Market St. Philadelphia, PA	✗			Group Life & Disability	Pg. 15 1a6	32,220	
AIG	PO Box 10472 Newark, NJ	✗			Worker's Compensation	Pg. 15 1a1	220,303	
Swallowing Diagnostics	21 Waterville Road Avon, CT	✗		83%	Diagnostic Services	Pg 20 5f	2,160	2,037
CRS	P.O.Box 491 Simsbury, CT	✗			Landscaping/Snow Removal	Pg. 22 6a	14,357	14,357
Ryan Vess	21 Waterville Road Avon, CT		✗			##		
Tarah Foley	21 Waterville Road Avon, CT		✗			##		
Paula Meunier	21 Waterville Road Avon, CT		✗			##		
Kayla Foley	21 Waterville Road Avon, CT		✗			##		
Patricia Hyppa	21 Waterville Road Avon, CT		✗			##		
Reino Hyppa	21 Waterville Road Avon, CT		✗			##		

* Use additional sheets if necessary.

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

Related expense has been disallowed on Pg. 28 Line 23

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Apple Rehab Farmington Valley	License No. 2029-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.

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.

Is a Mileage Log Book Maintained for All Leased Vehicles?

○ Yes

○ No

Total ***

* 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 Farmington Valley	License No. 2029-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 Clifton Larson Allen LLP (CLA)	29 South Main Street West Hartford, CT 06127
2 Brazee & Huban	35 Wendell Ave. Pittsfield, MA 10202
3 Clifton Larson Allen LLP (CLA)	29 South Main Street West Hartford, CT 06127
4	

Services Provided by This Firm (*describe fully*)

1	Preparation of audited financials	\$	3,020
2	Preparation of Tax Returns	\$	2,863
3	Audit 401K	\$	802
4		\$	
		Charge for Services Provided	
		\$	6,684

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

Yes No Pg. 15 Line 1d

Legal Services Information

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

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

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$

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 Farmington Valley			License No. 2029-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					160	160						
A. On last day of PREVIOUS report period	160	160										
B. On last day of THIS report period	160	160							160	160		
2. Number of Residents					98	98						
A. As of midnight of PREVIOUS report period	98	98										
B. As of midnight of THIS report period	99	99							99	99		
3. Total Number of Days Care Provided During Period					6,316	6,316						
A. Medicare	8,220	8,220							1,904	1,904		
B. Medicaid (Conn.)	24,039	24,039			17,876	17,876			6,163	6,163		
C. Medicaid (other states)												
D. Private Pay	4,056	4,056			2,980	2,980			1,076	1,076		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	36,315	36,315			27,172	27,172			9,143	9,143		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	36,315	36,315			27,172	27,172			9,143	9,143		

Schedule of Resident Statistics (Cont'd)

Name of Facility Apple Rehab Farmington Valley	License No. 2029-C	Report for Year Ended 9/30/2022	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 (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH (1)	RHNS (2)	(Specify) (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.

1st change	Change in Resident Days			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	21	66		12				
Per Diem Rate								
a. One bed rm.				460.00				
b. Two bed rms.	Various rugs	253.40		440.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	TOTAL	CCNH	RHNS	(Specify)
	1,317	1,317		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	32,825	32,825		
D. Total Physical Therapy Treatments	34,142	34,142		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	182	182	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	2,781	2,781	
D. Total Speech Therapy Treatments	2,963	2,963	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	1,279	1,279	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	25,434	25,434	
D. Total Occupational Therapy Treatments	26,713	26,713	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes		<input type="radio"/> No	
		Total Cost and Hours			
Item		CCNH	Hours	RHNS	Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	125,972	2,080			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	119,929	5,508			
5. Dietary Service					
a. Head Dietitian	83,568	2,054			
b. Food Service Supervisor	65,417	1,962			
c. Dietary Workers	410,300	20,732			
6. Housekeeping Service					
a. Head Housekeeper	58,942	2,242			
b. Other Housekeeping Workers	210,042	12,186			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance					
b. Other Maintenance Workers	116,352	4,454			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	112,819	6,096			
9. Barber and Beautician Services					
10. Protective Services					
11. Accounting Services					
a. Head Accountant					
b. Other Accountants	165,428	4,821			
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	154,518	2,377			
b. RN					
1. Direct Care	672,030	12,386			
2. Administrative**	382,377	7,429			
c. LPN					
1. Direct Care	1,219,029	34,184			
2. Administrative**					
d. Aides and Attendants	2,014,160	94,083			
e. Physical Therapists	368,910	8,475			
f. Speech Therapists	66,476	1,418			
g. Occupational Therapists	288,352	7,492			
h. Recreation Workers	121,618	5,085			
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	178,639	5,836			
n. Marketing					
o. Other (Specify) See Attached Schedule					
<i>A-13. Total Salary Expenditures</i>	6,934,876	240,900			

* 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 Farmington Valley			License No. 2029-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).										

* 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 Farmington Valley			2029-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***										
R. Fritz	125,972			Administrator 10/01/2021- 09/30/2022		2,080				
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
	2029-C	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					
2. Dentist	13,884	146			
3. Pharmacist	17,113	214			
4. Podiatrist	120	1			
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	51,000	90			
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) Need Description					
9. Speech Therapist					
a. Resident Care	2,188	22			
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	5,880	60			
B-13 Total Fees Paid in Lieu of Salaries	90,185	532			

* 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
	2029-C	9/30/2022		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	220,303	220,303		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	55,846	55,846		
4. Social Security (F.I.C.A.)	\$	507,841	507,841		
5. Health Insurance	\$	300,206	300,206		
6. Life Insurance (employees only) (not-owners and not-operators)	\$	32,220	32,220		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	64,076	64,076		
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$	46,282	46,282		
d. Accounting and Auditing	\$	6,684	6,684		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$				
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$	19,793	19,793		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	78,273	78,273		
2. Cellular Phones	\$				
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$	(32,469)	(32,469)		
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$	589,505	589,505		
<i>Subtotal</i>	\$	1,888,561	1,888,561		

* 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)
Total	\$ -	\$ -	\$ -

Schedule of Other Taxes

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

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

Name of Facility Apple Rehab Farmington Valley	License No. 2029-C	Report for Year Ended 9/30/2022		Page 16	of 37
Item	Total	CCNH	RHNS	(Specify)	
<i>Subtotals Brought Forward:</i>	1,888,561	1,888,561			
I. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 28,116	28,116			
2. Holiday Parties for Staff	\$ 5,597	5,597			
3. Gifts to Staff and Residents	\$ 18,383	18,383			
4. Employee Travel	\$ 3,141	3,141			
5. Education Expenses Related to Seminars and Conventions	\$ 4,248	4,248			
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	\$ 763	763			
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 5,296	5,296			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 10,784	10,784			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 185	185			
9. Subscriptions	\$ 432	432			
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**	\$ 498,116	498,116			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 424,934	424,934			
<i>C-14 Total Administrative & General Expenditures</i>	\$ 2,888,557	2,888,557			

* 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 - Public Relations	\$ 763		
Total Other Advertising	\$ 763	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 10,524		
ALTCFM	\$ 85		
R. Fritz	\$ 175		
Total Dues	\$ 10,784	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Need Detail (delete in \$0)	\$ -		
Total Contributions	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees - Non Reimbursable	\$ 133,733		
Licenses & Fees	\$ 3,885		
Pre Employment Screenings	\$ 117,067		
System License & Subscription Fees	\$ 55,368		
Bank Service Charges	\$ 55,823		
Legal Fees - Collection/Probate	\$ 183		
IT Service Fees	\$ 1,204		
Internet & Cable/Satellite TV	\$ 21,525		
Prior Period Adj/Acct W/O	\$ 22,461		
Healthport Indirect	\$ 12,766		
Resident Expenses	\$ 920		
Total	\$ 424,934	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Apple Rehab Farmington Valley	2029-C	9/30/2022	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.	498,116	Accounting and Management Services	Pg. 16 Line m12

* 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
	2029-C	9/30/2022		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 286,067	286,067		
2. Non-Food Supplies	\$ 35,509	35,509		
3. Other (Specify) _____	\$			
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 3,345	3,345		
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 324,921	324,921		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	298	298		
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 Farmington Valley	License No. 2029-C	Report for Year Ended 9/30/2022	Page 19	of 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. \$	10,883	10,883	
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. \$	14,698	14,698	
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	171	171	
c. Other (Specify)	\$			
3D. Total Laundry Expenditures (3a + b + c)	\$	25,752	25,752	
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 Apple Rehab Farmington Valley	License No. 2029-C	Report for Year Ended 9/30/2022		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel	54,995	54,995		
a. In-House Care	Amt. \$	57,728	57,728		
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. \$				
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	57,728	57,728		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Neighborcare	\$	376,819	376,819		
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	269,014	269,014		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	36,975	36,975		
f. X-rays and Related Radiological Procedures***	\$	74,168	74,168		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	41,945	41,945		
i. Recreation	\$	10,791	10,791		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	26,067	26,067		
5M. Total Resident Care Expenditures (5a - 5j)	\$	835,778	835,778		

* 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 Farmington Valley	License No. 2029-C	Report for Year Ended 9/30/2022			Page 22 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 150,267	150,267			
b. Heat	\$ 68,056	68,056			
c. Light & Power	\$ 104,267	104,267			
d. Water	\$ 126,168	126,168			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 65,023	65,023			
f. Other (<i>itemize</i>)	\$ 34,284	34,284			
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 548,065	548,065			
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$				
b. Building & Building Improvements	\$				
c. Non-Movable Equipment	\$ 638	638			
d. Movable Equipment	\$ 30,259	30,259			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 30,897	30,897			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$ 97,206	97,206			
d. Other (<i>Specify</i>)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$ 97,206	97,206			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 858,820	858,820			
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 112,540	112,540			
c. Personal property taxes	\$ 6,488	6,488			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,105,950	1,105,950			

* 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	Pick One	Cost	Useful Life		Depreciation
		Movable Category		Cost	Useful Life	
Additions:						
9/9/2021	Smart-31S Simplex printer	Administrative	\$ 1,048	5	\$ 157	
9/23/2021	Syclone Dehumidifier	Administrative	\$ 5,162	8	\$ 807	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			\$ 6,210		\$ 964	*
Deletions:						
Total deletions for Movable Equipment			\$ -		\$ -	**

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life		Depreciation
			Cost	Useful Life	
Additions:					
4/27/2022	Replace Water Softener Control Head	\$ 3,802	10	\$ 120	
5/27/2022	Elevator Repairs	\$ 1,531	10	\$ 44	
5/27/2022	Elevator Repairs	\$ 3,137.33	10	\$ 91.13	
11/1/2021	New Roofing	\$ 26,100.00	10	\$ 2,392.50	
9/1/2021	Repair to Air Conditioning Unit	\$ 1,100.90	5	\$ 220.18	
9/1/2021	Steam Condensate Pump	\$ 2,365.86	15	\$ 157.72	
8/1/2021	Replace the Condensor	\$ 5,234.55	15	\$ 348.97	
8/1/2021	Generator Rebuild	\$ 13,293.75	5	\$ 2,658.75	
10/1/2021	Generator Rebuild	\$ 4,573.05	5	\$ 914.61	
10/1/2021	Generator Rebuild	\$ 8,188.95	5	\$ 1,637.79	
12/1/2021	New Roofing	\$ 46,643.40	10	\$ 3,886.95	
5/1/2022	Compressor and Filter Drier	\$ 4,370.00	10	\$ 136.56	
7/1/2022	Compressor and Filter Drier	\$ 4,370.00	10	\$ 131.10	
Total additions for Leasehold Improvement		\$ 124,711		\$ 12,741	*
Deletions:					
Total deletions for Leasehold Improvement		\$ -		\$ -	**

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Apple Rehab Farmington Valley			License No. 2029-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				3,014,758	2,396,512	A		84,465	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				124,711		A		12,741	
C-4. Subtotal									97,206
D. Total Amortization									97,206

* 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 Apple Rehab Farmington Valley	License No. 2029-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				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	160			
6. Square Footage	54,995			
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	12/17/16			
c. Interest Rate for the Cost Year	3.51%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	9,061,100			
f. Principal balance outstanding as of	7,991,845			

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 9/30/2022			Page 27	of 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						
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			\$			
12. D. Other Interest Expense (Specify) Record Gemino Loan Advances			\$	10,429	10,429	
13. Total All Interest Expense (12B7 + 12C3 + 12D)			\$	10,429	10,429	
14. Insurance						
a. Insurance on Property (buildings only)			\$	251,256	251,256	
b. Insurance on Automobiles			\$			
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)			\$	251,256	251,256	
15. Total All Expenditures (A-13 thru C-14)			\$	13,073,499	13,073,499	

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		2029-C	9/30/2022	28 37	
Item Description				Total Amount of Decrease	CCNH	RHNS	(Specify)
<i>Page 10 - Salaries and Wages</i>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$ 288,352	288,352		
4.			Other - See attached Schedule	\$ 20,966	20,966		
<i>Page 13 - Professional Fees</i>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 46,282	46,282		
10.	15	1d	Accounting	\$ 3,020	3,020		
10a.			Legal	\$ 183	183		
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	m 2/3	Unallowable Advertising *	\$ 763	763		
19.	15	1k1	Income Tax / Corporate Business Tax	\$ (32,469)	(32,469)		
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 261,240	261,240		
<i>Page 18 - Dietary Expenditures</i>							
24.			Meals to employees, guests and others who are not residents	\$			
<i>Page 19 - Laundry Expenditures</i>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<i>Page 20 - Housekeeping Expenditures</i>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 588,337	588,337			

* 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	\$ 20,966		
Total Other Salaries Adjustment			\$ 20,966	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B8a	Medical Director			
Total Other Fees Adjustments			\$ -	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fees Non Reimbursable	\$ 133,733		
16	1.3	Employee Recognition/Gifts/Parties	\$ 18,383		
16	m13	Bank Charges	\$ 55,823		
16	8a	Chamber of Commerce	\$ 185		
16	m13	Prior Period adj/Acct w/o	\$ 22,461		
16	m13	Resident Expenses	\$ 920		
30	IV8	Settlement	\$ 685		
30	IV8	Prior Period adj/Acct w/o	\$ 29,050		
Total Other A&G Adjustments			\$ 261,240	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-29 Rev. 9/2018

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.		2029-C	9/30/2022	29	37
Item Description				Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward			\$	588,337	588,337		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$ 370,331	370,331		
28.			Ambulance/Limousine	\$ 28,116	28,116		
29.			X-rays, etc	\$ 74,168	74,168		
30.			Laboratory	\$ 41,945	41,945		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$ 16,375	16,375		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 26,067	26,067		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$ 10,429	10,429		
43.	30 IV		Interest Income on Account Rec.	\$ 1,360	1,360		
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49.	Total Amount of Decrease (Items 1 - 48)		\$	1,157,127	1,157,127		

*** 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>)	\$	6,123,795	6,123,795			
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>)	\$	3,682,524	3,682,524			
b. Medicare Room and Board Contractual Allowance **	\$	931,791	931,791			
4. a. Private-Pay Residents and Other	\$	1,767,193	1,767,193			
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$	307,394	307,394			
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(301,427)	(301,427)			
c. Prescription Drugs - Non-Medicare	\$	35,939	35,939			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(35,939)	(35,939)			
2. a. Medical Supplies - Medicare	\$	1,754	1,754			
b. Medical Supplies - Medicare Contractual Allowance **	\$	(1,754)	(1,754)			
c. Medical Supplies - Non-Medicare	\$	120	120			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$	(120)	(120)			
3. a. Physical Therapy - Medicare	\$	1,019,622	1,019,622			
b. Physical Therapy - Medicare Contractual Allowance **	\$	(955,052)	(955,052)			
c. Physical Therapy - Non-Medicare	\$	175,348	175,348			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$	(121,110)	(121,110)			
4. a. Speech Therapy - Medicare	\$	118,255	118,255			
b. Speech Therapy - Medicare Contractual Allowance **	\$	(106,765)	(106,765)			
c. Speech Therapy - Non-Medicare	\$	12,945	12,945			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	(5,445)	(5,445)			
5. a. Occupational Therapy - Medicare	\$	1,012,905	1,012,905			
b. Occupational Therapy - Medicare Contractual Allowance **	\$	(932,252)	(932,252)			
c. Occupational Therapy - Non-Medicare	\$	189,165	189,165			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(112,095)	(112,095)			
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$	12,806,791	12,806,791			
IV. Other Revenue*						
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>)	\$	1,360	1,360			
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$	752,699	752,699			
V. Total Other Revenue (1 thru 8)	\$	754,058	754,058			
VI. Total All Revenue (III +V)	\$	13,560,850	13,560,850			

* 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)
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue		\$ -	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 30 IV5	Interest Income	1,173,121	\$ 1,360		
Total Interest Income			\$ 1,360	\$ -	\$ -

Schedule of Other Revenue

G. Balance Sheet

Name of Facility Apple Rehab Farmington Valley	License No. 2029-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>)			\$ 5,299	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,173,121	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$ 25,039	
4. Inventories			\$ 45,196	
5. Prepaid Expenses			\$ 7,857	
a. _____				
b. _____				
c. _____				
d. See Schedule		7,857		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$ 945,072	
See Schedule		945,072		
A-9. Total Current Assets (Lines A1 thru 8)			\$ 2,201,584	
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	3,139,469	\$	645,752
	Accum. Depreciation	2,493,718 Net		
5. Non-Movable Equipment	*Historical Cost	35,566	\$	1,688
	Accum. Depreciation	33,878 Net		
6. Movable Equipment	*Historical Cost	398,434	\$	61,950
	Accum. Depreciation	336,484 Net		
7. Motor Vehicles	*Historical Cost	6,823	\$	0
	Accum. Depreciation	6,823 Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	0
See Schedule		0		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	709,390

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Prepaid Insurance	\$ -
31	A5	Prepaid Property Tax	\$ -
31	A5	Other Prepaid Expenses	\$ 7,857
31	A5	Prepaid Income Tax	\$ -
Total Prepaid Expenses			\$ 7,857

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

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	\$ 163,542
32	D7	Goodwill	\$ -
32	D7	Valuation Allowance (on Deffered Tax Asset)	\$ (80,856)
Total Other Assets			\$ 82,686

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	Due Affiliate (Credit Balance)	
33	A12	Exchange Accounts (10401-10403) (Credit Balance)	
33	A12	Accrued PTO	\$ 234,858
33	A12	Payroll W/H	\$ 21,977
33	A12	Accrued Professional Fees	\$ 8,739
33	A12	Accrued Worker's Comp	\$ 73,679
33	A12	Accrued Group Insurance	\$ (13,911)
33	A12	Accrued Other Expense	\$ 518,080
Total Other Current Liabilities (Itemize)			\$ 843,421

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
		9/30/2022	32 37
Account		Amount	
		Total Brought Forward:	\$ 2,910,974
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>)			\$ 82,686
See Schedule	82,686		
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 82,686
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 2,993,660

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2022	33	37
		Account	Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 468,631
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>)				\$ 117,099
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$
6. Accrued Payroll Taxes Payable				\$ 15,905
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>)				\$ 843,421
See Schedule				843,421
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 1,445,056

* 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 Farmington Valley	License No. 2029-C	Report for Year Ended 9/30/2022	Page 34	of 37
Account				Amount
Total Brought Forward:				1,445,056
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>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 1,540,213
See Schedule				1,540,213
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 1,540,213
C. Total All Liabilities (Lines A-13 + B-5)				\$ 2,985,269

G. Balance Sheet (cont'd)

Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2022	35	37
Account				Amount
A. Reserves				
1. Reserve for value of leased land				\$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				\$
3. Reserve for depreciation value of leased personal property (<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				\$ 2,827,933
2. Capital Stock				\$ 1,000
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ (3,307,893)
6. Gain or Loss for Period 10/1/2021 thru 9/30/2022				\$ 487,351
7. Total Net Worth				\$ 8,391
C. Total Reserves and Net Worth				\$ 8,391
D. Total Liabilities, Reserves, and Net Worth				\$ 2,993,660

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Apple Rehab Farmington Valley	2029-C	9/30/2022	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ (468,692)		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 13,560,850		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 13,073,499		
D. Net Income or Deficit				\$ 487,351		
E. Balance				\$ 18,659		
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>)				\$ 10,268		
Name and Address (No., City, State, Zip)		Title	Amount			
Brian Foley		President	10,268			
2. Other Withdrawings (<i>Specify</i>)				\$		
Purpose		Amount				
3. Total Deductions				\$ 10,268		
H. Balance at End of Period				\$ 8,391		

I. Preparer's/Reviewer's Certification

Name of Facility Apple Rehab Farmington Valley	License No. 2029-C	Report for Year Ended 9/30/2022	Page 37	of 37
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Check appropriate category

<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)
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Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
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Printed Name of Preparer

Robert Gwizdak

Address Address 21 Waterville Road Avon, CT 06001	Phone Number (860) 678-9755
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Contacted Person Regarding Additional Information Needed Regarding This Report Susan Southey	Phone Number (860) 470-7542
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Contact Email Address ssouthey@apple-rehab.com	
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