

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) Apple Rehab Guilford	
Address (No. & Street, City, State, Zip Code) 10 Boston Post Rd. Guilford, CT 06437	
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 1068-C	RHNS	(Specify)	Medicare Provider 07-5144
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Medicaid Provider Numbers:	CCNH 210686	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 Guilford	License No. 1068-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 Guilford [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) David Bouchard		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 Guilford	Period Covered:		From 10/1/2021	To 9/30/2022
Address of Facility 10 Boston Post Rd. Guilford, CT 06437				
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 (203) 453-3725	Report for Year Ended 9/30/2022	Page 2	of 37
Name of Facility (as shown on license) Apple Rehab Guilford	Address (No. & Street, City, State, Zip) 10 Boston Post Rd. Guilford, CT 06437			
License Numbers: CCNH 1068-C	RHNS	(Specify)	Medicare Provider No. 07-5144	
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.				
Administrator				
Name of Administrator David Bouchard		Nursing Home Administrator's License No.:	2008	
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 Guilford	License No. 1068-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 Guilford	10 Boston Post Rd. Guilford, CT 06437	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 Guilford	License No. 1068-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 Guilford	License No. 1068-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	600,000	600,000
Apple Health Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Management & Accounting Services	Pg. 16 Line m12	426,544	426,544
Corporate Employees	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	137,445	137,445
Healthport	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule		
Employees @ various Apple Facilities		<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	1,720	1,720
Apple Health Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Pension Plan (401K)	Pg. 15 Line 1a7	43,983	43,983
Lucent Health Solutions	424 Church St. Nashville, TN 37219	<input checked="" type="radio"/>	<input type="radio"/>		Group Medical	Pg. 15 Line 1a5	114,873	
MetLife	PO Box 360229 Pittsburgh, PA 15251	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 Line 1a5	5,011	
Delta Dental of CT	148 Eastern Blvd Glastonbury, CT 06033	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 Line 1a5	14,051	

* 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 Guilford	License No. 1068-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.

Name of Facility Apple Rehab Guilford		License No. 1068-C		Report for Year Ended 9/30/2022			Page 6 of 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"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?		<input checked="" type="radio"/> Yes		<input type="radio"/> 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 Guilford	License No. 1068-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 Yes If "No," explain.
previous period? No

Independent Accounting Firm

Name of Accounting Firm 1 Clifton Larson Allen LLP (CLA) 2 Brazee & Huban 3 Clifton Larson Allen LLP (CLA) 4	Address (No. & Street, City, State, Zip Code) 29 South Main Street West Hartford, CT 06127 35 Wendell Ave. Pittsfield, MA 10202 29 South Main Street West Hartford, CT 06127
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Services Provided by This Firm (*describe fully*)

1 Preparation of audited financials	\$ 8,052
2 Preparation of Tax Returns	\$ 2,863
3 Audit 401K	\$ 802
4	\$
	Charge for Services Provided \$ 11,716

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
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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 Pg. 15 1e

Schedule of Resident Statistics

Name of Facility Apple Rehab Guilford			License No. 1068-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					90	90						
A. On last day of PREVIOUS report period	90	90										
B. On last day of THIS report period	90	90							90	90		
2. Number of Residents					65	65						
A. As of midnight of PREVIOUS report period	65	65										
B. As of midnight of THIS report period	78	78							78	78		
3. Total Number of Days Care Provided During Period					1,894	1,894			496	496		
A. Medicare	2,390	2,390										
B. Medicaid (Conn.)	21,187	21,187			15,577	15,577			5,610	5,610		
C. Medicaid (other states)												
D. Private Pay	4,967	4,967			3,691	3,691			1,276	1,276		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	28,544	28,544			21,162	21,162			7,382	7,382		
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)	28,544	28,544			21,162	21,162			7,382	7,382		

Schedule of Resident Statistics (Cont'd)

Name of Facility Apple Rehab Guilford	License No. 1068-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	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)
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	7	59		12				
Per Diem Rate								
a. One bed rm.				475.00				
b. Two bed rms.	RUGS	250.08		425.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	2,371	2,371	(Specify)
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	16,986	16,986	
D. Total Physical Therapy Treatments	19,357	19,357	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	425	425	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	1,548	1,548	
D. Total Speech Therapy Treatments	1,973	1,973	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	2,903	2,903	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	18,137	18,137	
D. Total Occupational Therapy Treatments	21,040	21,040	

Report of Expenditures - Salaries & Wages

Name of Facility Apple Rehab Guilford	License No. 1068-C	Report for Year Ended 9/30/2022		Page 10	of 37		
Are time records maintained by all individuals receiving compensation?	<input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours		
A. Salaries and Wages*							
1. Operators/Owners (Complete also Sec. I of Schedule A1)							
2. Administrator(s) (Complete also Sec. III of Schedule A1)	118,784	2,080					
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)							
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	90,826	4,300					
5. Dietary Service							
a. Head Dietitian	12,064	285					
b. Food Service Supervisor	64,025	2,036					
c. Dietary Workers	319,445	17,276					
6. Housekeeping Service							
a. Head Housekeeper	37,299	1,380					
b. Other Housekeeping Workers	108,314	6,234					
7. Repairs & Maintenance Services							
a. Engineer or Chief of Maintenance							
b. Other Maintenance Workers	78,747	3,513					
8. Laundry Service							
a. Supervisor							
b. Other Laundry Workers							
9. Barber and Beautician Services							
10. Protective Services							
11. Accounting Services							
a. Head Accountant							
b. Other Accountants	140,568	4,069					
12. Professional Care of Residents							
a. Directors and Assistant Director of Nurses	187,098	2,435					
b. RN							
1. Direct Care	529,593	10,837					
2. Administrative**	241,666	4,929					
c. LPN							
1. Direct Care	586,153	17,186					
2. Administrative**							
d. Aides and Attendants	1,222,289	59,963					
e. Physical Therapists	234,333	4,577					
f. Speech Therapists	24,472	449					
g. Occupational Therapists	214,961	6,002					
h. Recreation Workers	82,987	3,892					
i. Physicians							
1. Medical Director							
2. Utilization Review							
3. Resident Care***							
j. Dentists							
k. Pharmacists							
l. Podiatrists							
m. Social Workers/Case Management	105,175	3,384					
n. Marketing							
o. Other (Specify) See Attached Schedule							
<i>A-13. Total Salary Expenditures</i>	4,398,797	154,827					

* 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 Guilford			License No. 1068-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 Guilford				1068-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***										
David Bouchard	118,784				Administrator 10/1/21 - 9/30/22	2,080	A2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility Apple Rehab Guilford	License No. 1068-C	Report for Year Ended 9/30/2022		Page 13	of 37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist	9,612	107			
3. Pharmacist	11,468	154			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	18,000				
b. Utilization Review (Title 18 and 19 only) monthly meeting	319	3			
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)					
9. Speech Therapist					
a. Resident Care	6,840	95			
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	3,575	44			
B-13 Total Fees Paid in Lieu of Salaries	49,814	403			

* 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 Apple Rehab Guilford	License No. 1068-C	Report for Year Ended 9/30/2022	Page 15	of 37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 77,357	77,357		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 72,367	72,367		
4. Social Security (F.I.C.A.)	\$ 319,256	319,256		
5. Health Insurance	\$ 74,162	74,162		
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 22,375	22,375		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 43,983	43,983		
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*	\$ 806,946	806,946		
d. Accounting and Auditing	\$ 11,716	11,716		
e. Legal (Services should be fully described on Page 7)	\$			
f. Insurance on Lives of Owners and Operators (Specify)*	\$			
g. Office Supplies	\$ 12,404	12,404		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 5,420	5,420		
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*	\$ 39,510	39,510		
2. Other (Specify) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 529,281	529,281		
Subtotal	\$ 2,014,778	2,014,778		

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

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

Name of Facility Apple Rehab Guilford	License No. 1068-C	Report for Year Ended 9/30/2022		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		2,014,778	2,014,778		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 144	144			
2. Holiday Parties for Staff	\$ 4,586	4,586			
3. Gifts to Staff and Residents	\$ 7,364	7,364			
4. Employee Travel	\$ 7,687	7,687			
5. Education Expenses Related to Seminars and Conventions	\$ 1,172	1,172			
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	\$ 9,107	9,107			
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	\$ 2,590	2,590			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 9,374	9,374			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
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**	\$ 426,544	426,544			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 185,365	185,365			
<i>C-14 Total Administrative & General Expenditures</i>	\$ 2,669,142	2,669,142			

* 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	\$ 9,107		
Total Other Advertising	\$ 9,107	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 6,674		
ACHCA	\$ 2,700		
Total Dues	\$ 9,374	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees - Non Reimbursable	\$ 86,727		
Licenses & Fees	\$ 5,831		
Pre Employment Screenings	\$ 12,760		
System License & Subscription Fees	\$ 38,196		
Bank Service Charges	\$ 5,345		
Legal Fees - Collection/Probate	\$ 2,375		
IT Service Fees	\$ 222		
Internet & Cable/Satellite TV	\$ 21,308		
Survey Fines & Citations	\$ -		
Healthport Indirect	\$ 59		
Resident Expenses	\$ 1,344		
Prior Period Adj/Account W/O	\$ 11,197		
	\$ 185,365	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Apple Rehab Guilford	License No. 1068-C	Report for Year Ended 9/30/2022	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Apple Health Care, Inc.	426,544	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
	1068-C	9/30/2022		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 192,088	192,088		
2. Non-Food Supplies	\$ 18,963	18,963		
3. Other (Specify) _____	\$ _____			
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 2,908	2,908		
c. Other (Specify) _____	\$ _____			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 213,959	213,959		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	235	235		
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 Guilford	License No. 1068-C	Report for Year Ended 9/30/2022		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. \$			
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. \$	12,361	12,361	
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	137,232	137,232	
c. Other (Specify)	\$			
3D. Total Laundry Expenditures (3a + b + c)	\$	149,593	149,593	
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
		9/30/2022		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced	17,845	17,845		
a. In-House Care	by Personnel				
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	43,254	43,254		
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt. \$				
C. Other (Specify)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	43,254	43,254		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Neighborhood	\$	141,856	141,856		
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	280,147	280,147		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	15,514	15,514		
f. X-rays and Related Radiological Procedures***	\$	6,599	6,599		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	34,453	34,453		
i. Recreation	\$	17,817	17,817		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$	16,885	16,885		
5M. Total Resident Care Expenditures (5a - 5j)	\$	513,272	513,272		

* 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 *

Name of Facility Apple Rehab Guilford				License No. 1068-C	Report for Year Ended 9/30/2022				Page of 21 37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				Pg	Line
		Yes	No			CCNH	RHNS	(Specify)			
United Laundry	72 Cook Ave, Meriden, CT 06451	<input type="radio"/>	<input checked="" type="radio"/>		Laundry service	44,250				19	3b
Unitex Textile Rental	Mount Vernon, NY 10550	<input type="radio"/>	<input checked="" type="radio"/>		Laundry service	92,998				19	3b
Med Apparel	Mount Vernon, NY 10550	<input type="radio"/>	<input checked="" type="radio"/>		Laundry service	11,341				19	3b
CWPM, LLC	25 Norton Pl Plainville CT	<input type="radio"/>	<input checked="" type="radio"/>		Refuse removal	26,517				22	6f
Saucier Mechanical Services	148 Norton St Plantsville, CT 06479	<input type="radio"/>	<input checked="" type="radio"/>		HVAC	20,950				22	6a
Giuseppe R. Suppa	5 Chapel Drive, Brandford, CT 06405	<input type="radio"/>	<input checked="" type="radio"/>		Landscaping/Snow Removal	23,856				22	6a
		<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"/>								

* 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 Guilford	License No. 1068-C	Report for Year Ended 9/30/2022			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	99,202	99,202			
b. Heat	\$	24,040	24,040			
c. Light & Power	\$	50,038	50,038			
d. Water	\$	15,255	15,255			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$					
f. Other <i>(itemize)</i>	\$	27,292	27,292			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	215,827	215,827			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$	3,606	3,606			
d. Movable Equipment	\$	11,724	11,724			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	15,330	15,330			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	55,705	55,705			
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$	55,705	55,705			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	600,000	600,000			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	59,376	59,376			
c. Personal property taxes	\$	4,503	4,503			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	734,913	734,913			

* 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 C3

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
1/13/2022	SMART-31S Simplex Printer/USB	Administrative	\$ 1,073	ME-5	\$ 80
8/10/2022	Replace Fire Damper	Administrative	\$ 980	ME-5	\$ 36
		PICK A CATEGORY			\$ 641
		PICK A CATEGORY			\$ 112
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipment			\$ 2,053		\$ 868
Deletions:					
Total deletions for Movable Equipment			\$ -		\$ -

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
11/17/2021	Install Nurse Call System From Watrous	8,260.30	LHI-10	\$ 1,033
11/17/2021	Install Nurse Call System From Watrous	10,041.70	LHI-10	\$ 1,255
10/11/2021	Steelcraft Metal Doors	10,262.78	LHI-20	\$ 641
11/16/2021	Removal of tree in courtyard	2,977.80	LHI-20	\$ 112
Total additions for Leasehold Improvements		\$ 31,543		\$ 3,041
Deletions:				
Total deletions for Leasehold Improvements		\$ -		\$ -

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

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Amortization Schedule*

Name of Facility Apple Rehab Guilford			License No. 1068-C		Report for Year Ended 9/30/2022			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	Var	Var		1,446,218	1,012,230	A		52,664	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	Var	Var		31,543		A		3,041	
C-4. Subtotal									55,705
D. Total Amortization									55,705

* 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 Guilford	License No. 1068-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	90			
6. Square Footage	17,845			
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	04/21/22			
c. Interest Rate for the Cost Year	4.50%			
d. Term of Mortgage (number of years)	25			
e. Amount of Principal Borrowed	6,736,779			
f. Principal balance outstanding as of _____	6,679,636			

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	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)	\$					
12. D. Other Interest Expense (Specify)	\$					
13. Total All Interest Expense (12B7 + 12C3 + 12D)	\$					
14. Insurance						
a. Insurance on Property (buildings only)	\$ 151,143			151,143		
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. Total Insurance Expenditures (14a + b + c)	\$ 151,143			151,143		
15. Total All Expenditures (A-13 thru C-14)	\$ 9,139,715			9,139,715		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		1068-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	\$ 214,961	214,961		
4.			Other - See attached Schedule	\$ 6,191	6,191		
<i>Page 13 - Professional Fees</i>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 18,000	18,000		
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 806,946	806,946		
10.	15	1d	Accounting	\$ 8,052	8,052		
10a.			Legal	\$ 2,375	2,375		
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 *	\$ 9,107	9,107		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 116,620	116,620		
<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)			\$ 1,182,251	1,182,251			

* 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

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B8a	Medical Director	\$ 18,000		
Total Other Fees Adjustments			\$ 18,000	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fees Non Reimbursable	\$ 86,727		
16	1.3	Employee Recognition/Gifts/Parties	\$ 7,364		
16	m13	Bank Charges	\$ 5,345		
16	8a	Chamber of Commerce	\$ -		
16	m13	Survey Fines & Citations	\$ -		
16	m13	Resident Expenses	\$ 1,344		
16	m13	Prior Period Expenses/Account W/O	\$ 11,197		
30	IV 8	Refunds	\$ 274		
30	IV 8	Account W/O	\$ 1,933		
30	IV 8	Prior Period /Account W/O	\$ 2,126		
30	IV 8	Settlement	\$ 310		
Total Other A&G Adjustments			\$ 116,620	\$ -	\$ -

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	
Apple Rehab Guilford			1068-C	9/30/2022		29 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 1,182,251	1,182,251		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$ 137,807	137,807		
28.			Ambulance/Limousine	\$ 144	144		
29.			X-rays, etc	\$ 6,599	6,599		
30.			Laboratory	\$ 34,453	34,453		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$ 7,310	7,310		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 15,146	15,146		
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	\$			
43.	30	IV5	Interest Income on Account Rec.	\$ 844	844		
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)				\$ 1,384,554	1,384,554		

*** 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 Guilford	License No. 1068-C	Report for Year Ended 9/30/2022			Page 30 37
Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 5,325,170	5,325,170			
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>)	\$ 1,513,761	1,513,761			
b. Medicare Room and Board Contractual Allowance **	\$ 350,075	350,075			
4. a. Private-Pay Residents and Other	\$ 1,919,614	1,919,614			
b. Private-Pay Room and Board Contractual Allowance **	\$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 73,143	73,143			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (69,709)	(69,709)			
c. Prescription Drugs - Non-Medicare	\$ 12,820	12,820			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (12,820)	(12,820)			
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	\$ 520,680	520,680			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (569,966)	(569,966)			
c. Physical Therapy - Non-Medicare	\$ 156,813	156,813			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (54,040)	(54,040)			
4. a. Speech Therapy - Medicare	\$ 62,530	62,530			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (73,881)	(73,881)			
c. Speech Therapy - Non-Medicare	\$ 21,660	21,660			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (5,645)	(5,645)			
5. a. Occupational Therapy - Medicare	\$ 334,185	334,185			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (411,770)	(411,770)			
c. Occupational Therapy - Non-Medicare	\$ 612,600	612,600			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (299,460)	(299,460)			
6. a. Other (<i>Specify</i>) - Medicare	\$				
b. Other (<i>Specify</i>) - Non-Medicare	\$				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 9,405,760	9,405,760			
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>)	\$ 844	844			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 120,814	120,814			
V. Total Other Revenue (1 thru 8)	\$ 121,657	121,657			
VI. Total All Revenue (III +V)	\$ 9,527,417	9,527,417			

* 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

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	2,065,941	\$ 844		
Total Interest Income			\$ 844	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV8	Covid Relief	\$ 100,225		
30 IV8	Rebates	\$ 8,235		
30 IV 4	Account W/O	\$ 1,933		
30 IV 8	Dividend	\$ 7,671		
30 IV 8	Medical Records	\$ 40		
30 IV 8	Refunds	\$ 274		
30 IV 8	Settlement	\$ 310		
	Prior Period /Account W/O	\$ 2,126		
Total Other Revenue		\$ 120,814	\$ -	\$ -

Prior Period /Acc 2,126.32

G. Balance Sheet

Name of Facility Apple Rehab Guilford	License No. 1068-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>)			\$ 410	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 2,065,941	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$ 8,575	
4. Inventories			\$ 17,396	
5. Prepaid Expenses			\$ 14,487	
a. _____				
b. _____				
c. _____				
d. See Schedule		14,487		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$ 1,000,321	
See Schedule		1,000,321		
A-9. Total Current Assets (Lines A1 thru 8)			\$ 3,107,130	
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	1,477,760	\$	409,825
	Accum. Depreciation	1,067,935	Net	
5. Non-Movable Equipment	*Historical Cost	88,443	\$	9,038
	Accum. Depreciation	79,405	Net	
6. Movable Equipment	*Historical Cost	442,634	\$	33,099
	Accum. Depreciation	409,535	Net	
7. Motor Vehicles	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	6,655
See Schedule		6,655		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	458,617

* 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 Propert Tax	\$ 14,487
31	A5	Other Prepaid Expenses	\$ -
31	A5	Prepaid Income Tax	\$ -
Total Prepaid Expenses			\$ 14,487

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

		Exchange Accounts (10401 - 10403) (Debit Balance)	
		Due Affiliate (Debit Balance)	\$ 990,295
		AP Patient Exchange (Debit Balance)	\$ 10,026
Total Other Current Assets (Itemize)			\$ 1,000,321

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

31	B9	Fixed Asset Clearing Account	\$ 6,655
31	B9	Capitalized Refinance Expense	\$ -
31	B9	Construction in Progress	\$ -
Total Other Other Fixed Assets (Itemize)			\$ 6,655

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

32	D7	Leasehold Deposits	\$ -
32	D7	Deferred Tax Asset	\$ -
32	D7	Goodwill	\$ -
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

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

Page Ref	Line Ref	Description	
		Due Affiliate (Credit Balance)	
		Exchange Accounts (10401-10403) (Credit Balance)	
		Accrued PTO	\$ 159,707
		Payroll W/H	\$ 11,412
		Accrued Professional Fees	\$ 13,473
		AP Patient Exchange (Credit Balance)	
		Accrued Worker's Comp	\$ 103,747
		Accrued Group Insurance	\$ 9,043
		Accrued Other Expense	\$ 424,218
Total Other Current Liabilities (Itemize)			\$ 721,600

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:	\$ 3,565,747
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>)			\$
See Schedule			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 3,565,747

* 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				\$ 283,472
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>)				\$ 73,327
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$
6. Accrued Payroll Taxes Payable				\$ 11,582
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>)				\$ 721,600
See Schedule				721,600
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 1,089,981

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

(Carry Total forward to next page)

State of Connecticut

Annual Report of Long-Term Care Facility

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G. Balance Sheet (cont'd)

Name of Facility Apple Rehab Guilford	License No. 1068-C	Report for Year Ended 9/30/2022	Page 34	of 37
Account			Amount	
Total Brought Forward:			\$ 1,089,981	
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>)			\$	1,580,428
See Schedule			\$ 1,580,428	
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	1,580,428
C. Total All Liabilities (Lines A-13 + B-5)			\$	2,670,409

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

Name of Facility Apple Rehab Guilford	License No. 1068-C	Report for Year Ended 9/30/2022	Page 35	of 37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	3,316,730
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(2,810,094)
6. Gain or Loss for Period	10/1/2021	thru	9/30/2022	\$ 387,702
7. Total Net Worth			\$	895,338
C. Total Reserves and Net Worth			\$	895,338
D. Total Liabilities, Reserves, and Net Worth			\$	3,565,747

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Guilford	1068-C	9/30/2022	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ 513,560
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 9,527,417
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 9,139,715
D. Net Income or Deficit				\$ 387,702
E. Balance				\$ 901,262
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>)				\$ 5,924
Name and Address (No., City, State, Zip)		Title	Amount	
Brian Foley		President	5,924	
2. Other Withdrawings (<i>Specify</i>)				\$
Purpose		Amount		
3. Total Deductions				\$ 5,924
H. Balance at End of Period			\$ 09/30/22	\$ 895,338

I. Preparer's/Reviewer's Certification

Name of Facility Apple Rehab Guilford	License No. 1068-C	Report for Year Ended 9/30/2022	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input 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 Road Avon, CT 06001		(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		