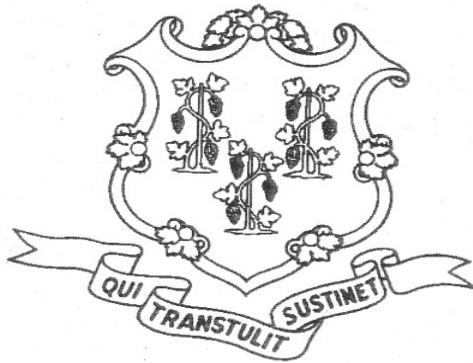


State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2022

Name of Facility (as licensed) Apple Rehab Mystic	
Address (No. & Street, City, State, Zip Code) 28 Broadway, Mystic CT 06355	
Type of Facility	
Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	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 1063-C	RHNS	(Specify)	Medicare Provider 07-5337
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Medicaid Provider Numbers:	CCNH 10637	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 Mystic	License No. 1063-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 Mystic [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) Sarah Krebs		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 Mystic	Period Covered:		From 10/1/2021	To 9/30/2022
Address of Facility 28 Broadway, Mystic CT 06355				
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 860-536-9655	Report for Year Ended 9/30/2022	Page 2	of 37
Name of Facility (as shown on license) Apple Rehab Mystic		Address (No. & Street, City, State, Zip) 28 Broadway, Mystic CT 06355	
License Numbers: 1063-C	CCNH 1063-C	RHNS	(Specify)
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <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 Sarah Krebs		Nursing Home Administrator's License No.: 2180	
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 Mystic	License No. 1063-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 Mystic	28 Broadway, Mystic CT 06355	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 Mystic	License No. 1063-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 Mystic	License No. 1063-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	432,000	432,000
Apple Health Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Management & Accounting Services	Pg. 16 Line m12	237,288	237,288
Corporate Employees	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	137,113	137,113
Healthport	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	5,564	5,564
Employees @ various Apple Facilities		<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	(19,067)	(19,067)
Apple Health Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Pension Plan (401K)	Pg. 15 Line 1a7	27,706	27,706
Lucent Health Solutions	424 Church St. Nashville, TN 37219	<input checked="" type="radio"/>	<input type="radio"/>		Group Medical	Pg. 15 Line 1a5	118,384	
MetLife	PO Box 360229 Pittsburgh, PA 15251	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 Line 1a5	2,387	
Delta Dental of CT	148 Eastern Blvd Glastonbury, CT 06033	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 Line 1a5	7,236	

* 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 Mystic	License No. 1063-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	101,569	
Reliance Standard	2001 Market St. Philadelphia, PA	☒			Group Life & Disability	Pg. 15 1a6	11,651	
AIG	PO Box 10472 Newark, NJ	☒			Worker's Compensation	Pg. 15 1a1	150,892	
Swallowing Diagnostics	21 Waterville Road Avon, CT	☒		83%	Diagnostic Services	Pg 20 5f	1,080	1,018
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 Hyypa	21 Waterville Road Avon, CT	☒				##		
Reino Hyypa	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 Mystic	License No. 1063-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 Mystic	License No. 1063-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	\$	5,400
2	Preparation of Tax Returns	\$	2,863
3	Audit 401K	\$	802
4		\$	
		Charge for Services Provided	
		\$	9,064

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.

© V © N Pg. 15 1e

Schedule of Resident Statistics

Name of Facility Apple Rehab Mystic			License No. 1063-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					60	60						
A. On last day of PREVIOUS report period	60	60										
B. On last day of THIS report period	60	60							60	60		
2. Number of Residents					45	45						
A. As of midnight of PREVIOUS report period	45	45										
B. As of midnight of THIS report period	45	45							45	45		
3. Total Number of Days Care Provided During Period					2,396	2,396						
A. Medicare	3,133	3,133							737	737		
B. Medicaid (Conn.)	7,180	7,180			6,424	6,424			756	756		
C. Medicaid (other states)												
D. Private Pay	4,800	4,800			2,591	2,591			2,209	2,209		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	15,113	15,113			11,411	11,411			3,702	3,702		
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)	15,113	15,113			11,411	11,411			3,702	3,702		

Schedule of Resident Statistics (Cont'd)

Name of Facility Apple Rehab Mystic	License No. 1063-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	8	27		10				
Per Diem Rate								
a. One bed rm.				424.00				
b. Two bed rms.	various rugs	246.00		388.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	TOTAL	CCNH	RHNS	(Specify)
	2,860	2,860		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	12,428	12,428		
D. Total Physical Therapy Treatments	15,288	15,288		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	290	290	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	2,001	2,001	
D. Total Speech Therapy Treatments	2,291	2,291	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	1,685	1,685	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	8,771	8,771	
C. Other			
D. Total Occupational Therapy Treatments	10,456	10,456	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of		
		1063-C	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	(Specify)		
A. Salaries and Wages*					Hours		
1. Operators/Owners (Complete also Sec. I of Schedule A1)							
2. Administrator(s) (Complete also Sec. III of Schedule A1)	126,381	2,080					
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)							
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	83,942	4,207					
5. Dietary Service							
a. Head Dietitian	57,612	1,554					
b. Food Service Supervisor	65,488	2,187					
c. Dietary Workers	179,516	9,320					
6. Housekeeping Service							
a. Head Housekeeper	19,830	790					
b. Other Housekeeping Workers	99,964	5,401					
7. Repairs & Maintenance Services							
a. Engineer or Chief of Maintenance							
b. Other Maintenance Workers	56,996	2,351					
8. Laundry Service							
a. Supervisor	1,698	81					
b. Other Laundry Workers	20,857	1,312					
9. Barber and Beautician Services							
10. Protective Services							
11. Accounting Services							
a. Head Accountant							
b. Other Accountants	41,215	1,424					
12. Professional Care of Residents							
a. Directors and Assistant Director of Nurses	117,872	1,886					
b. RN							
1. Direct Care	518,073	9,294					
2. Administrative**	163,617	3,462					
c. LPN							
1. Direct Care	228,303	6,286					
2. Administrative**							
d. Aides and Attendants	692,781	31,160					
e. Physical Therapists	190,948	4,170					
f. Speech Therapists	34,520	606					
g. Occupational Therapists	76,655	1,579					
h. Recreation Workers	54,028	2,595					
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	62,514	1,822					
n. Marketing							
o. Other (Specify) See Attached Schedule							
<i>A-13. Total Salary Expenditures</i>	2,892,809	93,567					

* 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 Mystic			License No. 1063-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 Mystic				1063-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***										
Peter Allen	25,843			Administrator 06/21/22-09/21/2022		350	A2			
Sarah Krebs	4,639			Administrator 09/22/2022- 09/30/2022		74	A2			
Tina White	95,899			Administrator 10/01/2021- 06/20/2022		1,656	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 Mystic	License No. 1063-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	6,942	73			
3. Pharmacist	7,339	92			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	39,000	208			
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	1,080	11			
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	2,105	22			
B-13 Total Fees Paid in Lieu of Salaries	56,467	406			

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

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

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

Report of Expenditures

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

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2022		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	150,892	150,892		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	26,505	26,505		
4. Social Security (F.I.C.A.)	\$	208,285	208,285		
5. Health Insurance	\$	97,229	97,229		
6. Life Insurance (employees only) (not-owners and not-operators)	\$	11,651	11,651		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$	27,706	27,706		
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*	\$	883	883		
d. Accounting and Auditing	\$	9,064	9,064		
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	\$	10,565	10,565		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	18,124	18,124		
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*	\$	5,935	5,935		
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$	251,904	251,904		
<i>Subtotal</i>	\$	818,743	818,743		

* 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 Mystic	License No. 1063-C	Report for Year Ended 9/30/2022		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		818,743	818,743		
I. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 3,865	3,865			
2. Holiday Parties for Staff	\$ 1,749	1,749			
3. Gifts to Staff and Residents	\$ 11,002	11,002			
4. Employee Travel	\$ 6,796	6,796			
5. Education Expenses Related to Seminars and Conventions	\$ 3,684	3,684			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$				
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 2	2			
4. Fund-Raising***	\$				
5. Medical Records	\$ 39	39			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 2,555	2,555			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 5,129	5,129			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 340	340			
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**	\$ 237,288	237,288			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 175,253	175,253			
C-14 Total Administrative & General Expenditures	\$ 1,266,878	1,266,878			

* 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	\$ 2		
Total Other Advertising	\$ 2	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM	\$ 85		
CAHCF	\$ 4,794		
VFW	\$ 250		
Total Dues	\$ 5,129	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees - Non Reimbursable	\$ 52,311		
Licenses & Fees	\$ 495		
Pre Employment Screenings	\$ 14,745		
System License & Subscription Fees	\$ 31,413		
Bank Service Charges	\$ 2,236		
Legal Fees - Collection/Probate	\$ 1,197		
IT Service Fees	\$ 222		
Internet & Cable/Satellite TV	\$ 19,424		
Survey Fines & Citations	\$ 15,000		
Healthport Indirect	\$ 941		
Prior Period Adjustments	\$ 32,481		
Monthly Exp- Administrator	\$ 4,787		
	\$ 175,253	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Apple Rehab Mystic	1063-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.	237,288	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
	1063-C	9/30/2022		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 106,892	106,892		
2. Non-Food Supplies	\$ 15,348	15,348		
3. Other (Specify) _____	\$			
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 1,058	1,058		
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 123,298	123,298		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	124	124		
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 Mystic	License No. 1063-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. \$	6,348	6,348		
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. \$	7,519	7,519		
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	2,471	2,471		
c. Other (Specify)	\$				
3D. Total Laundry Expenditures (3a + b + c)	\$	16,337	16,337		
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 by Personnel	27,203	27,203		
a. In-House Care	Amt. \$	24,697	24,697		
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)	\$	24,697	24,697		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Neighborcare	\$	199,839	199,839		
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	136,798	136,798		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	4,209	4,209		
f. X-rays and Related Radiological Procedures***	\$	8,048	8,048		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	42,565	42,565		
i. Recreation	\$	8,814	8,814		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$	21,751	21,751		
5M. Total Resident Care Expenditures (5a - 5j)	\$	422,023	422,023		

* 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 Mystic	License No. 1063-C	Report for Year Ended 9/30/2022			Page 22 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 83,471	83,471			
b. Heat	\$ 63,250	63,250			
c. Light & Power	\$ 44,196	44,196			
d. Water	\$ 21,610	21,610			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$				
f. Other (<i>itemize</i>)	\$ 14,471	14,471			
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 226,998	226,998			
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$				
b. Building & Building Improvements	\$				
c. Non-Movable Equipment	\$ 105	105			
d. Movable Equipment	\$ 13,104	13,104			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 13,209	13,209			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$ 26,696	26,696			
d. Other (<i>Specify</i>)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$ 26,696	26,696			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 432,000	432,000			
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 48,803	48,803			
c. Personal property taxes	\$ 3,240	3,240			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 523,947	523,947			

* 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			
Additions:		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipment			\$ -	\$ -	*
Deletions:					
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:					
12/16/2021	Kitchen Roof Repairs	\$ 1,765	5	\$ 265	
1/24/2022	Watts Backflow Preventer Rebuilt Kit	\$ 1,053	10	\$ 39	
9/6/2022	Remove Maple Tree	\$7,923.08	20	43.06	
9/6/2022	Remove Maple Tree	\$7,923.07	20	43.06	
Total additions for Leasehold Improvement		\$ 18,664		\$ 390	*
Deletions:					
Total deletions for Leasehold Improvement		\$ -		\$ -	**

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

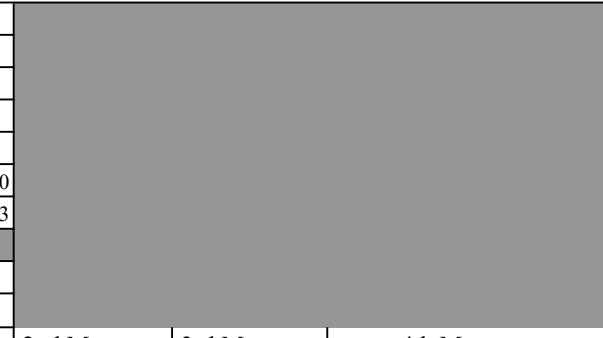
Name of Facility Apple Rehab Mystic			License No. 1063-C		Report for Year Ended 9/30/2022			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	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				889,787	706,976			26,306	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				18,664				390	
C-4. Subtotal									26,696
D. Total Amortization									26,696

* 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 Mystic	License No. 1063-C	Report for Year Ended 9/30/2022	Page 25	of 37																																
11. Property Questionnaire																																				
Part A Is the property either owned by the Facility <input checked="" type="radio"/> Yes <input type="radio"/> No or leased from a Related Party?* <small>*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.</small>																																				
<table border="1"> <tr> <th>Description</th> <th>Total</th> </tr> <tr> <td>1. Date Land Purchased</td> <td></td> </tr> <tr> <td>2. Date Structure Completed</td> <td></td> </tr> <tr> <td>3. If NOT Original Owner, Date of Purchase</td> <td></td> </tr> <tr> <td>4. Date of Initial Licensure</td> <td></td> </tr> <tr> <td>5. Total Licensed Bed Capacity</td> <td>60</td> </tr> <tr> <td>6. Square Footage</td> <td>27,203</td> </tr> <tr> <td>7. Acquisition Cost a. Land</td> <td></td> </tr> <tr> <td>b. Building</td> <td></td> </tr> </table>		Description	Total	1. Date Land Purchased		2. Date Structure Completed		3. If NOT Original Owner, Date of Purchase		4. Date of Initial Licensure		5. Total Licensed Bed Capacity	60	6. Square Footage	27,203	7. Acquisition Cost a. Land		b. Building																		
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6. Square Footage	27,203																																			
7. Acquisition Cost a. Land																																				
b. Building																																				
Part B - Owner and Related Parties <table border="1"> <tr> <th></th> <th>1st Mortgage</th> <th>2nd Mortgage</th> <th>3rd Mortgage</th> <th>4th Mortgage</th> </tr> <tr> <td>1. Financing a. Type of Financing (e.g., fixed, variable)</td> <td>Fixed</td> <td></td> <td></td> <td></td> </tr> <tr> <td>b. Date Mortgage Obtained</td> <td>04/21/22</td> <td></td> <td></td> <td></td> </tr> <tr> <td>c. Interest Rate for the Cost Year</td> <td>4.50%</td> <td></td> <td></td> <td></td> </tr> <tr> <td>d. Term of Mortgage (number of years)</td> <td>25</td> <td></td> <td></td> <td></td> </tr> <tr> <td>e. Amount of Principal Borrowed</td> <td>4,183,894</td> <td></td> <td></td> <td></td> </tr> <tr> <td>f. Principal balance outstanding as of</td> <td>4,148,405</td> <td></td> <td></td> <td></td> </tr> </table>			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	4,183,894				f. Principal balance outstanding as of	4,148,405			
	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage																																
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f. Principal balance outstanding as of	4,148,405																																			
Complete if Mortgage was Refinanced During Current Cost Year <table border="1"> <tr> <td>g. Type of Financing (e.g., fixed, variable)</td> <td></td> </tr> <tr> <td>h. Date of Refinancing</td> <td></td> </tr> <tr> <td>i. New Interest Rate</td> <td></td> </tr> <tr> <td>j. Term of Mortgage (number of years)</td> <td></td> </tr> <tr> <td>k. Amount of Principal Borrowed</td> <td></td> </tr> <tr> <td>l. Principal Outstanding on Note Paid-Off</td> <td></td> </tr> </table>		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																								
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k. Amount of Principal Borrowed																																				
l. Principal Outstanding on Note Paid-Off																																				
Part C - Arms-Length Leases for Real Property Improvements Only <table border="1"> <thead> <tr> <th>Name and Address of Lessor</th> <th>Property Leased</th> <th>Date of Lease</th> <th>Term of Lease</th> <th>Annual Amount of Lease</th> </tr> </thead> <tbody> <tr><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>					Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease																											
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)		\$	101,569	101,569		
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)		\$	101,569	101,569		
15. Total All Expenditures (A-13 thru C-14)		\$	5,655,022	5,655,022		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		1063-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	\$ 76,655	76,655		
4.			Other - See attached Schedule	\$ 7,408	7,408		
<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	\$ 883	883		
10.	15	1d	Accounting	\$ 5,400	5,400		
10a.			Legal	\$ 1,197	1,197		
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 *	\$ 2	2		
19.	15	k1	Income Tax / Corporate Business Tax	\$ 5,935	5,935		
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 122,445	122,445		
<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)			\$ 219,924	219,924			

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A12m	Social Service - Marketing	\$ 7,408		
Total Other Salaries Adjustment			\$ 7,408	\$ -	\$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fees Non Reimbursable	\$ 52,311		
16	1.3	Employee Recognition/Gifts/Parties	\$ 11,002		
16	m13	Bank Charges	\$ 2,236		
16	8a	Chamber of Commerce	\$ 340		
16	m13	Survey Fines & Citations	\$ 15,000		
16	m13	Prior Period Adj	\$ 32,481		
16	m13	Misc Exp-Administrator	\$ 4,787		
30	IV8	Account W/O	\$ 4,287		
Total Other A&G Adjustments			\$ 122,445	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

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

Name of Facility			License No.	Report for Year Ended		Page	of
Item No.	Page No.	Line No.		1063-C	9/30/2022	29	37
Item Description				Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward			\$	219,924	219,924		
			<i>Page 20 - Resident Care Supplies***</i>				
27.			Prescription Drugs	\$ 194,233	194,233		
28.			Ambulance/Limousine	\$ 3,865	3,865		
29.			X-rays, etc	\$ 8,048	8,048		
30.			Laboratory	\$ 42,565	42,565		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$ 2,526	2,526		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 21,263	21,263		
			<i>Page 22 - Maintenance and Property</i>				
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	\$			
			<i>Page 27 - Insurance</i>				
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
			<i>Other - Miscellaneous</i>				
42.			Other - Indirect	\$			
43.	30	IV5	Interest Income on Account Rec.	\$ 575	575		
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
			<i>Not For Profit Providers Only</i>				
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49.	<i>Total Amount of Decrease (Items 1 - 48)</i>		\$	492,998	492,998		

*** 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 37	
		Item	Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$	2,059,680	2,059,680			
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>)	\$	1,273,689	1,273,689			
b. Medicare Room and Board Contractual Allowance **	\$	497,115	497,115			
4. a. Private-Pay Residents and Other	\$	1,372,021	1,372,021			
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$	147,366	147,366			
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(142,369)	(142,369)			
c. Prescription Drugs - Non-Medicare	\$	17,945	17,945			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(17,945)	(17,945)			
2. a. Medical Supplies - Medicare	\$	1,790	1,790			
b. Medical Supplies - Medicare Contractual Allowance **	\$	(1,790)	(1,790)			
c. Medical Supplies - Non-Medicare	\$	128	128			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$	(128)	(128)			
3. a. Physical Therapy - Medicare	\$	442,590	442,590			
b. Physical Therapy - Medicare Contractual Allowance **	\$	(414,302)	(414,302)			
c. Physical Therapy - Non-Medicare	\$	92,471	92,471			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$	(65,800)	(65,800)			
4. a. Speech Therapy - Medicare	\$	82,715	82,715			
b. Speech Therapy - Medicare Contractual Allowance **	\$	(79,032)	(79,032)			
c. Speech Therapy - Non-Medicare	\$	17,290	17,290			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	(6,545)	(6,545)			
5. a. Occupational Therapy - Medicare	\$	390,300	390,300			
b. Occupational Therapy - Medicare Contractual Allowance **	\$	(368,869)	(368,869)			
c. Occupational Therapy - Non-Medicare	\$	80,265	80,265			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(52,345)	(52,345)			
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)		\$ 5,326,240	5,326,240			
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>)	\$	575	575			
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$	48,046	48,046			
V. Total Other Revenue (1 thru 8)		\$ 48,621	48,621			
VI. Total All Revenue (III +V)		\$ 5,374,861	5,374,861			

* 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	502,834	\$ 575		
Total Interest Income			\$ 575	\$ -	\$ -

Schedule of Other Revenue

G. Balance Sheet

Name of Facility Apple Rehab Mystic	License No. 1063-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>)			\$ 1,700	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 502,834	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$ 1,804	
4. Inventories			\$ 27,855	
5. Prepaid Expenses			\$ 14,724	
a. _____				
b. _____				
c. _____				
d. See Schedule		14,724		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$ 1,517,463	
See Schedule		1,517,463		
A-9. Total Current Assets (Lines A1 thru 8)			\$ 2,066,380	
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
3. Buildings	*Historical Cost	1,097,698	\$	
	Accum. Depreciation	1,097,698	Net	
4. Leasehold Improvements	*Historical Cost	908,451	\$	174,779
	Accum. Depreciation	733,672	Net	
5. Non-Movable Equipment	*Historical Cost	13,056	\$	1,012
	Accum. Depreciation	12,044	Net	
6. Movable Equipment	*Historical Cost	535,110	\$	12,772
	Accum. Depreciation	522,337	Net	
7. Motor Vehicles	*Historical Cost	_____	\$	
	Accum. Depreciation	_____	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	188,564

* 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	\$ 14,724
31	A5	Other Prepaid Expenses	\$ 0
31	A5	Prepaid Income Tax	\$ -
Total Prepaid Expenses			\$ 14,724

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	\$ 254
32	D7	Deferred Tax Asset	\$ -
32	D7	Goodwill	\$ -
Total Other Assets			\$ 254

Schedule of Notes Payable (Itemize) Page 33 Line A2

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

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
Apple Rehab Mystic	1063-C	9/30/2022	32 37
Account			Amount
Total Brought Forward:			\$ 2,254,943
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>)			\$ 254
See Schedule		254	
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 254
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 2,255,197

* 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
	1063-C	9/30/2022	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	195,179
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>)			\$	45,870
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	7,165
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>)			\$	406,363
See Schedule			406,363	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	654,577

* 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 Mystic	License No. 1063-C	Report for Year Ended 9/30/2022	Page 34	of 37
Account				Amount
Total Brought Forward:				654,577
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>)				\$ 274,214
See Schedule				274,214
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 274,214
C. Total All Liabilities (Lines A-13 + B-5)				\$ 928,791

G. Balance Sheet (cont'd)

Reserves and Net Worth

Name of Facility Apple Rehab Mystic	License No. 1063-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				\$ 297,221
2. Capital Stock				\$ 1,000
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ 1,308,348
6. Gain or Loss for Period	10/1/2021	thru	9/30/2022	\$ (280,162)
7. Total Net Worth				\$ 1,326,407
C. Total Reserves and Net Worth				\$ 1,326,407
D. Total Liabilities, Reserves, and Net Worth				\$ 2,255,197

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Apple Rehab Mystic	1063-C	9/30/2022	36	37		
Account			Amount			
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ 1,610,123		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 5,374,861		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 5,655,022		
D. Net Income or Deficit				\$ (280,162)		
E. Balance				\$ 1,329,961		
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>)				\$ 3,554		
Name and Address (No., City, State, Zip)		Title	Amount			
Brian Foley		President	3,554			
2. Other Withdrawings (<i>Specify</i>)				\$		
Purpose		Amount				
3. Total Deductions				\$ 3,554		
H. Balance at End of Period				\$ 1,326,407		

I. Preparer's/Reviewer's Certification

Name of Facility Apple Rehab Mystic	License No. 1063-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 Address 21 Waterville Road Avon, CT 06001		Phone Number (860) 678-9755
Contacted Person Regarding Additional Information Needed Regarding This Report Susan Southey		Phone Number (860) 470-7542
Contact Email Address ssouthey@apple-rehab.com		