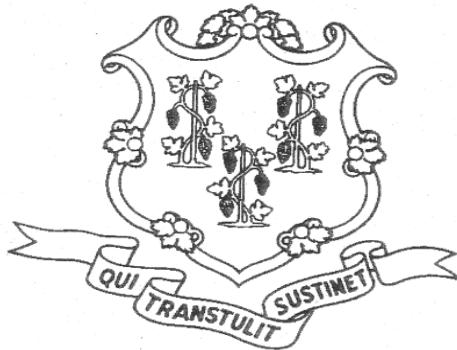


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) Apple Rehab West Haven	
Address (No. & Street, City, State, Zip Code) 308 Savin Ave. West Haven, CT 06516	
Type of Facility	
<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)
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022

License Numbers:	CCNH 2136-C	RHNS 151-RH	(Specify)	Medicare Provider 07-5403
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Medicaid Provider Numbers:	CCNH 92197	RHNS 21361	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 West Haven	License No. 2136-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 West Haven [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) Tanaya Wade		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 West Haven	Period Covered:		From 10/1/2021	To 9/30/2022
Address of Facility 308 Savin Ave. West Haven, CT 06516				
Report Prepared By Apple Health Care, Inc.	Phone Number (860) 678-9755	Date		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-932-6411	9/30/2022	2	37
Name of Facility (as shown on license) Apple Rehab West Haven		Address (No. & Street, City, State, Zip) 308 Savin Ave. West Haven, CT 06516	
License Numbers:	CCNH 2136-C	RHNS 151-RH	(Specify) Medicare Provider No. 07-5403
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 Tanaya Wade		Nursing Home Administrator's License No.:	2170
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 West Haven	License No. 2136-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 West Haven	308 Savin Ave. West Haven, CT 06516	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 West Haven	License No. 2136-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 West Haven	License No. 2136-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	480,000	480,000
Apple Health Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Management & Accounting Services	Pg. 16 Line m12	471,233	471,233
Corporate Employees	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	128,357	128,357
Healthport	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	64,223	64,223
Employees @ various Apple Facilities		<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	34,526	34,526
Apple Health Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Pension Plan (401K)	Pg. 15 Line 1a7	34,320	34,320
Lucent Health Solutions	424 Church St. Nashville, TN 37219	<input checked="" type="radio"/>	<input type="radio"/>		Group Medical	Pg. 15 Line 1a5	227,643	
MetLife	PO Box 360229 Pittsburgh, PA 15251	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 Line 1a5	3,209	
Delta Dental of CT	148 Eastern Blvd Glastonbury, CT 06033	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 Line 1a5	12,414	

* 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 West Haven	License No. 2136-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 West Haven	License No. 2136-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
--	---

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
---	------------------

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 West Haven			License No. 2136-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	89	1					
A. On last day of PREVIOUS report period	90	89	1									
B. On last day of THIS report period	90	89	1						90	89	1	
2. Number of Residents					64	63	1					
A. As of midnight of PREVIOUS report period	64	63	1									
B. As of midnight of THIS report period	71	70	1						71	70	1	
3. Total Number of Days Care Provided During Period					3,015	3,015						
A. Medicare	3,888	3,888							873	873		
B. Medicaid (Conn.)	19,583	19,218	365		14,547	14,274	273		5,036	4,944	92	
C. Medicaid (other states)												
D. Private Pay	3,105	3,105			2,330	2,330			775	775		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	26,576	26,211	365		19,892	19,619	273		6,684	6,592	92	
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)	26,576	26,211	365		19,892	19,619	273		6,684	6,592	92	

Schedule of Resident Statistics (Cont'd)

Name of Facility Apple Rehab West Haven	License No. 2136-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)
	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)
2nd change						
3rd change						
4th change						

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	8	53	1	9				
Per Diem Rate								
a. One bed rm.				475.00				
b. Two bed rms.		262.69	149.95	425.00				
c. Three or more bed rms.	RUGS							

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		2,750	2,750		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		15,837	15,837		
D. Total Physical Therapy Treatments		18,587	18,587		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		681	681		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		1,660	1,660		
D. Total Speech Therapy Treatments		2,341	2,341		

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		3,083	3,083		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other		11,440	11,440		
D. Total Occupational Therapy Treatments		14,523	14,523		

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of		
		9/30/2022		10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No							
Total Cost and Hours							
Item	CCNH	Hours	RHNS	Hours	(Specify)		
A. Salaries and Wages*							
1. Operators/Owners (Complete also Sec. I of Schedule A1)							
2. Administrator(s) (Complete also Sec. III of Schedule A1)	108,441	2,088					
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)							
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	110,323	4,603					
5. Dietary Service							
a. Head Dietitian	61,679	1,618					
b. Food Service Supervisor	56,110	2,103					
c. Dietary Workers	286,017	15,875					
6. Housekeeping Service							
a. Head Housekeeper	42,919	1,795					
b. Other Housekeeping Workers	146,090	8,754					
7. Repairs & Maintenance Services							
a. Engineer or Chief of Maintenance							
b. Other Maintenance Workers	95,060	4,183					
8. Laundry Service							
a. Supervisor	1,172	50					
b. Other Laundry Workers	72,760	4,230					
9. Barber and Beautician Services							
10. Protective Services							
11. Accounting Services							
a. Head Accountant							
b. Other Accountants	78,275	2,215					
12. Professional Care of Residents							
a. Directors and Assistant Director of Nurses	239,602	4,012					
b. RN							
1. Direct Care	407,857	7,405					
2. Administrative**	204,032	4,046					
c. LPN							
1. Direct Care	822,450	24,635					
2. Administrative**							
d. Aides and Attendants	1,069,499	52,835					
e. Physical Therapists	225,341	5,417					
f. Speech Therapists	34,892	737					
g. Occupational Therapists	88,448	2,131					
h. Recreation Workers	85,437	4,119					
i. Physicians							
1. Medical Director							
2. Utilization Review							
3. Resident Care***							
j. Dentists							
k. Pharmacists							
l. Podiatrists							
m. Social Workers/Case Management	107,104	3,330					
n. Marketing							
o. Other (Specify)							
See Attached Schedule							
<i>A-13. Total Salary Expenditures</i>	4,343,507	156,180					

* 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 West Haven			License No. 2136-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 West Haven				2136-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***										
Tanaya Wade	26,979				Administrator 6/23/2022 - 9/30/2022	536	A2			
Katerina Zhao	81,462				Administrator 10/01/2021-6/22/22	1,552	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 West Haven	License No. 2136-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	10,413	139			
3. Pharmacist	9,146	122			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	26,600	152			
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	4,320	43			
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	12,525	224			
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify) See Attached Schedule	2,355	17			
B-13 Total Fees Paid in Lieu of Salaries	65,359	696			

* 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*

Name of Facility	License No.	Report for Year Ended		Page	of
	2136-C	9/30/2022		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Bamboo Health, Inc (PatientPing Inc) 9901 Linn Station, Ste 500 Louisville, KY 40223	A&D Fees	<input type="radio"/>	<input checked="" type="radio"/>		
Mary B Jordan 75 High Farms Rd West Hartford, CT 06107	Employee relations specialist	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Horatiu Balas 609 Coleman Rd Cheshire, CT 06410	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Anthony Scialla 219 Hume Dr. Hamden, CT 06514	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Dr. Asefekh Heiat-Azodi P.O. Box 1086 Brandford, CT 06405	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Alec H. Jaret, DMD, PC Healthdrive Dental Group, 101 Centerpoint Dr Ste 215, Middletown,	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
Neighborcare Pharmacy Dept 781668 PO Box 78000 Detroit, MI 48278	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>		
Swallowing Diagnostics 21 Waterville Rd Avon, CT 06001	Speech Consultant	<input checked="" type="radio"/>	<input type="radio"/>	See Disclosure pg 4	
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input checked="" type="radio"/>		

* Use additional sheets if necessary.

** 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	\$ 156,933	156,933			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 67,366	67,366			
4. Social Security (F.I.C.A.)	\$ 310,748	310,748			
5. Health Insurance	\$ 188,230	188,230			
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 19,001	19,001			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 34,320	34,320			
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*	\$ 684,054	684,054			
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	\$ 14,010	14,010			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 5,007	5,007			
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*	\$ 1,310	1,310			
2. Other (Specify) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 476,963	476,963			
Subtotal	\$ 1,969,657	1,969,657			

* 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 West Haven	License No. 2136-C	Report for Year Ended 9/30/2022		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		1,969,657	1,969,657		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 9,985	9,985			
2. Holiday Parties for Staff	\$ 3,700	3,700			
3. Gifts to Staff and Residents	\$ 10,104	10,104			
4. Employee Travel	\$ 2,761	2,761			
5. Education Expenses Related to Seminars and Conventions	\$ 4,934	4,934			
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	\$ 275	275			
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	\$ 2,956	2,956			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 6,492	6,492			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 412	412			
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**	\$ 471,233	471,233			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 217,732	217,732			
<i>C-14 Total Administrative & General Expenditures</i>	\$ 2,700,242	2,700,242			

* 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	\$ 275		
Total Other Advertising	\$ 275	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 6,492		
Total Dues	\$ 6,492	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees - Non Reimbursable	\$ 92,583		
Licenses & Fees	\$ (1,202)		
Pre Employment Screenings	\$ 13,651		
System License & Subscription Fees	\$ 42,965		
Bank Service Charges	\$ 2,440		
Legal Fees - Collection/Probate	\$ 1,170		
IT Service Fees	\$ 2,185		
Internet & Cable/Satellite TV	\$ 22,695		
Survey Fines & Citations	\$ -		
Healthport Indirect	\$ 11,281		
Resident Expenses	\$ 136		
Prior Period/Account W/O	\$ 16,262		
Settlement	\$ 13,567		
	\$ 217,732	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Apple Rehab West Haven	2136-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.	471,233	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
	2136-C	9/30/2022		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 196,277	196,277		
2. Non-Food Supplies	\$ 26,666	26,666		
3. Other (Specify) _____	\$ _____			
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 1,948	1,948		
c. Other (Specify) _____	\$ _____			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 224,891	224,891		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	215	215		
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 West Haven	License No. 2136-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. \$	10,552	10,552	
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. \$	12,816	12,816	
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	445	445	
c. Other (Specify)	\$			
3D. Total Laundry Expenditures (3a + b + c)	\$	23,813	23,813	
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	25,480	25,480		
a. In-House Care	Amt. \$	36,700	36,700		
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt. \$				
C. Other (Specify)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	36,700	36,700		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Neighbors	\$	157,578	157,578		
b. Medicine Cabinet Drugs	\$				
c. Medical and Therapeutic Supplies	\$	267,061	267,061		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	13,509	13,509		
f. X-rays and Related Radiological Procedures***	\$	10,589	10,589		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	39,655	39,655		
i. Recreation	\$	12,545	12,545		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$	66,059	66,059		
5M. Total Resident Care Expenditures (5a - 5j)	\$	566,995	566,995		

* 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 West Haven	License No. 2136-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	\$	165,947	165,947			
b. Heat	\$	18,009	18,009			
c. Light & Power	\$	86,930	86,930			
d. Water	\$	65,617	65,617			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$					
f. Other <i>(itemize)</i>	\$	18,275	18,275			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	354,778	354,778			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$	2,580	2,580			
d. Movable Equipment	\$	2,261	2,261			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	4,841	4,841			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	60,319	60,319			
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$	60,319	60,319			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	480,000	480,000			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	76,917	76,917			
c. Personal property taxes	\$	6,296	6,296			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	628,372	628,372			

* 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

Name of Facility Apple Rehab West Haven				License No. 2136-C			Report for Year Ended 9/30/2022				Page 23	of 37	
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
A. Land Improvements													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
B. Building and Building Improvements													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal													
C. Non-Movable Equipment													
1. Acquired prior to this report period				57,540			57,540		42,281	SL	Various	2,580	
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal												2,580	
D. Movable Equipment	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
	Yes	No	Month	Year									
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period			Var	Var	486,150		486,150		483,889	SL	Various	2,261	
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative													
d. Standard Resident													
e. Specialized Resident													
Total Acquired during this report period													
D-3. Subtotal													
E. Total Depreciation													

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:		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	Depreciation
			Life	
Additions:				
10/22/2021	Remove and Replace Hot Water Pump	\$ 914	5	\$ 228
12/20/2021	Generator Controller Replacement	\$ 14,311	10	\$ 1,789
1/21/2022	Fire Alarm Panel	\$ 3,786	10	139
Total additions for Leasehold Improvements		\$ 19,011		\$ 2,157
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 West Haven			License No. 2136-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		2,065,890	1,788,946			58,162	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				19,011				2,157	
C-4. Subtotal									60,319
D. Total Amortization									60,319

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Apple Rehab West Haven	License No. 2136-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	25,480			
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 years			
e. Amount of Principal Borrowed	5,673,077			
f. Principal balance outstanding as of _____	5,624,956			

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)	\$ 147,384			147,384		
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)	\$ 147,384			147,384		
15. Total All Expenditures (A-13 thru C-14)	\$ 9,092,041			9,092,041		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of
Item No.	Page No.	Line No.		CCNH	RHNS	28 37
			Item Description	Total Amount of Decrease		
<i>Page 10 - Salaries and Wages</i>						
1.			Outpatient Service Costs	\$		
2.			Salaries not related to Resident Care	\$		
3.			Occupational Therapy	\$ 88,448	88,448	
4.			Other - See attached Schedule	\$ 13,393	13,393	
<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	\$ 684,054	684,054	
10.	15	1d	Accounting	\$ 8,052	8,052	
10a.			Legal	\$ 1,170	1,170	
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 *	\$ 275	275	
19.			Income Tax / Corporate Business Tax	\$		
20.			Fund Raising / Contributions	\$		
21.			Unallowable Management Fees	\$		
22.			Barber and Beauty	\$		
23.			Other - See attached Schedule	\$ 137,455	137,455	
<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)			\$ 932,847	932,847		

* 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	\$ 13,393		
Total Other Salaries Adjustment			\$ 13,393	\$ -	\$ -

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	\$ 92,583		
16	1.3	Employee Recognition/Gifts/Parties	\$ 10,104		
16	m13	Bank Charges	\$ 2,440		
16	8a	Chamber of Commerce	\$ -		
16	m13	Survey Fines & Citations	\$ -		
16	m13	Resident Expenses	\$ 136		
16	m13	Prior Period Adj/Account W/O	\$ 16,262		
16	m13	Settlement	\$ 13,567		
30	IV8	Account W/O	\$ 1,950		
30	IV8	Medical Supply Refund	\$ 412		
Total Other A&G Adjustments			\$ 137,455	\$ -	\$ -

State of Connecticut

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

Name of Facility Apple Rehab West Haven			License No. 2136-C	Report for Year Ended 9/30/2022		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 932,847	932,847		
			<i>Page 20 - Resident Care Supplies***</i>				
27.			Prescription Drugs	\$ 151,016	151,016		
28.			Ambulance/Limousine	\$ 9,985	9,985		
29.			X-rays, etc	\$ 10,589	10,589		
30.			Laboratory	\$ 39,655	39,655		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$ 4,959	4,959		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 65,786	65,786		
			<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.	\$ 572	572		
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>		\$ 1,215,408	1,215,408			

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Schedule of Other Ancillary Costs

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page 30	of 37
Item		Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 4,866,491	4,866,491				
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>)	\$ 1,658,675	1,658,675				
b. Medicare Room and Board Contractual Allowance **	\$ 573,929	573,929				
4. a. Private-Pay Residents and Other	\$ 1,572,164	1,572,164				
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 115,378	115,378				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (111,150)	(111,150)				
c. Prescription Drugs - Non-Medicare	\$ 27,858	27,858				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (27,858)	(27,858)				
2. a. Medical Supplies - Medicare	\$ 1,720	1,720				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (1,720)	(1,720)				
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 436,925	436,925				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (420,382)	(420,382)				
c. Physical Therapy - Non-Medicare	\$ 213,602	213,602				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (123,070)	(123,070)				
4. a. Speech Therapy - Medicare	\$ 67,515	67,515				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (62,245)	(62,245)				
c. Speech Therapy - Non-Medicare	\$ 34,370	34,370				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (22,070)	(22,070)				
5. a. Occupational Therapy - Medicare	\$ 441,455	441,455				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (417,610)	(417,610)				
c. Occupational Therapy - Non-Medicare	\$ 207,310	207,310				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (101,720)	(101,720)				
6. a. Other (<i>Specify</i>) - Medicare	\$ 155	155				
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 8,929,723	8,929,723				
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>)	\$ 572	572				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 165,686	165,686				
V. Total Other Revenue (1 thru 8)	\$ 166,258	166,258				
VI. Total All Revenue (III +V)	\$ 9,095,981	9,095,981				

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

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

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

Page Ref	Description	CCNH	RHNS	(Specify)
30 II 1b7	Oxygen - Private	\$ 180		
	X-Ray	\$ (25)		
Total Other Resident Revenue - Medicare		\$ 155	\$ -	\$ -

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	2,069,115	\$ 572		
Total Interest Income			\$ 572	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV8	Covid Relief	\$ 111,022		
30 IV8	Rebates	\$ 51,508		
30 IV 4	Account W/O	\$ 1,950		
30 IV 8	Medical Supply refund	\$ 412		
30 IV 8	Medical Records	\$ 794		
Total Other Revenue		\$ 165,686	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page of
			31 37
Account			Amount
Assets			
A. Current Assets			
1. Cash (<i>on hand and in banks</i>)		\$ 536	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)		\$ 2,069,115	
3. Other Accounts Receivable (Excluding Owners or Related Parties)		\$ (62,203)	
4. Inventories		\$ 28,550	
5. Prepaid Expenses		\$ 29,987	
a. _____			
b. _____			
c. _____			
d. See Schedule		29,987	
6. Interest Receivable		\$	
7. Medicare Final Settlement Receivable		\$	
8. Other Current Assets (<i>itemize</i>)		\$	

See Schedule			
A-9. Total Current Assets (Lines A1 thru 8)		\$ 2,065,986	
B. Fixed Assets			
1. Land		\$	
2. Land Improvements	*Historical Cost _____	\$	
	Accum. Depreciation _____ Net		
3. Buildings	*Historical Cost _____	\$	
	Accum. Depreciation _____ Net		
4. Leasehold Improvements	*Historical Cost 2,084,900	\$ 235,635	
	Accum. Depreciation 1,849,265 Net		
5. Non-Movable Equipment	*Historical Cost 57,540	\$ 12,680	
	Accum. Depreciation 44,861 Net		
6. Movable Equipment	*Historical Cost 486,150	\$ 0	
	Accum. Depreciation 486,150 Net		
7. Motor Vehicles	*Historical Cost _____	\$	
	Accum. Depreciation _____ Net		
8. Minor Equipment-Not Depreciable		\$	
9. Other Fixed Assets (<i>itemize</i>)		\$ 36,926	
See Schedule	36,926		
B-10. Total Fixed Assets (Lines B1 thru 9)		\$ 285,241	

* 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	\$ 29,987
31	A5	Other Prepaid Expenses	\$ -
31	A5	Prepaid Income Tax	\$ -
Total Prepaid Expenses			\$ 29,987

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	Leasehold Deposits	\$ -
32	D7	Deferred Tax Asset	\$ -
32	D7	Goodwill	\$ -
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description		
Total Notes Payable			\$	-

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

Page Ref	Line Ref	Description	
	33 A12	Due Affiliate (Credit Balance)	\$ 1,573,966
	33 A12	Exchange Accounts (10401-10403) (Credit Balance)	
	33 A12	Accrued PTO	\$ 148,491
	33 A12	Payroll W/H	\$ 14,816
	33 A12	Accrued Professional Fees	\$ 13,473
	33 A12	Accrued Worker's Comp	\$ 13,202
	33 A12	Accrued Group Insurance	\$ 2,805
	33 A12	Accrued Other Expense	\$ 393,376
Total Other Current Liabilities (Itemize)			\$ 2,160,129

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
		9/30/2022	32 37
Account		Amount	
		Total Brought Forward:	\$ 2,351,227
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)			\$ 2,351,227

* 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				\$ 292,659
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>)				\$ 78,490
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$
6. Accrued Payroll Taxes Payable				\$ 14,576
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>)				\$ 2,160,129
See Schedule				2,160,129
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 2,545,852

* 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 West Haven	License No. 2136-C	Report for Year Ended 9/30/2022	Page 34	of 37
Account			Amount	
Total Brought Forward:			2,545,852	
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>)				\$ 200,319
See Schedule	200,319			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 200,319
C. Total All Liabilities (Lines A-13 + B-5)				\$ 2,746,171

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

Name of Facility Apple Rehab West Haven	License No. 2136-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			\$	4,887,308
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(5,287,193)
6. Gain or Loss for Period	10/1/2021	thru	9/30/2022	\$ 3,941
7. Total Net Worth			\$	(394,944)
C. Total Reserves and Net Worth				
D. Total Liabilities, Reserves, and Net Worth			\$ 2,351,227	

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Apple Rehab West Haven	2136-C	9/30/2022	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ (391,777)		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 9,095,981		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 9,092,041		
D. Net Income or Deficit				\$ 3,941		
E. Balance				\$ (387,836)		
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>)				\$ 7,108		
Name and Address (No., City, State, Zip)		Title	Amount			
Brian Foley		President	7,108			
2. Other Withdrawings (<i>Specify</i>)				\$		
Purpose		Amount				
3. Total Deductions				\$ 7,108		
H. Balance at End of Period				\$ (394,944)		

I. Preparer's/Reviewer's Certification

Name of Facility Apple Rehab West Haven	License No. 2136-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		