State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2019

Name of Facility (as licensed) Apple Rehab Farmington Valley	
Address (No. & Street, City, State, Zip Code) 269 Farmington Ave, Plainville, CT 06062	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2029-C			07-5044

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	20298		

For Department Use Only

Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Number Assigned	Signed and Notarized	Date Received

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	1	37

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISIONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Apple Rehab Farmington Valley [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Rob Fritz			Printed Name (Owner) Brian J. Foley	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Apple Rehab Farmington Valley	Period Covered:		From 10/1/2018	To 9/30/2019
Address of Facility 269 Farmington Ave, Plainville, CT 06062				
Report Prepared By Apple Health Care, Inc.	Phone Number (860) 678-9755		Date	

Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid $				
2. Laundry wages paid $				
3. Housekeeping wages paid $				
4. Nursing wages paid $				
5. All other wages paid $				
6. ***Total Wages Paid*** $				
7. Total salaries paid $				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report) $				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-747-1637	9/30/2019	2	37

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

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2029-C			07-5044

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ◉ Profit Corp. ○ Non-Profit Corp. ○ Government ○ 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? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Rob Fritz	001250

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Apple Rehab Farmington Valley	269 Farmington Ave, Plainville, CT 06062	Connecticut

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Brian J. Foley	21 Waterville Road Avon, CT 06001	President	100
Ryan Vess	21 Waterville Road Avon, CT 06001	Secretary	
Names of Stockholders Owning at Least 10% of Shares			
Brian J. Foley	21 Waterville Road Avon, CT 06001	President	100

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ 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? ⊙ Yes ○ 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	%**				
Brian J. Foley	21 Waterville Rd. Avon, CT 06001	○	⊙		Real Estate Rental	Pg. 22 Line 9	825,095	825,095
Apple Heath Care	21 Waterville Rd. Avon, CT 06001	○	⊙		Management & Accounting Services	Pg. 16 Line m12	497,220	497,220
Corporate Employees	21 Waterville Rd. Avon, CT 06001	○	⊙		Employee Staffing	Pg. 10 Schedule	142,469	142,469
Employees @ various Apple Facilities		○	⊙		Employee Staffing	Pg. 10 Schedule	(61,913)	(61,913)
Apple Heath Care	21 Waterville Rd. Avon, CT 06001	○	⊙		Pension Plan (401K)	Pg. 15 Line 1a7	54,952	54,952
Aetna	PO Box 88860 Chicago, IL 60695	⊙	○		Group Medical	Pg. 15 Line 1a5	451,076	
Delta Dental	PO Box 222 Parsippany, NJ 07054	⊙	○		Group Dental	Pg. 15 1a5	12,406	
Metlife	PO Box 360229 Pitssburgh, PA 15251	⊙	○		Group Dental	Pg. 15 1a5	29,887	
USI	PO Box 62937 Virginia Beach, VA 23466	⊙	○		Property, Liability, & Umbrella Insurance	Pg. 27 Line 14a	150,965	

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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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 (*See listing page 13*)
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

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General Information and Questionnaire
Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

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.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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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 Blum Shapiro & Co. PC	29 South Main St. West Hartford, CT 06127
2 Brazee & Huban	35 Wendell Ave. Pittsfield, MA 10202
3 Blum Shapiro & Co. PC	29 South Main St. West Hartford, CT 06127
4	

Services Provided by This Firm (*describe fully*)

1	Preparation of audited financials (disallow Pg. 28)	$ 5,747
2	Preparation of tax returns	$ 2,394
3	Audit - 401K	$ 636
4		$

Charge for Services Provided $ 8,777

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

⊙ Yes ○ No Pg. 15 1d

Legal Services Information

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

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

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	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												
A. On last day of PREVIOUS report period	160	160			160	160			160	160		
B. On last day of THIS report period	160	160			160	160			160	160		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	105	105			105	105			121	121		
B. As of midnight of THIS report period	121	121			121	121			121	121		
3. Total Number of Days Care Provided During Period												
A. Medicare	7,321	7,321			5,628	5,628			1,693	1,693		
B. Medicaid (Conn.)	29,729	29,729			22,036	22,036			7,693	7,693		
C. Medicaid (other states)												
D. Private Pay	5,136	5,136			3,863	3,863			1,273	1,273		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	42,186	42,186			31,527	31,527			10,659	10,659		
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)**	42,186	42,186			31,527	31,527			10,659	10,659		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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.

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
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	19	83		19				
Per Diem Rate								
a. One bed rm.				443.00				
b. Two bed rms.	RUGS III	266.00		417.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	3,519	3,519		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	19,230	19,230		
D. ***Total Physical Therapy Treatments***	22,749	22,749		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	235	235		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,978	1,978		
D. ***Total Speech Therapy Treatments***	2,213	2,213		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,605	2,605		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	18,344	18,344		
D. ***Total Occupational Therapy Treatments***	20,949	20,949		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	123,338	2,110				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	120,892	6,302				
5. Dietary Service						
a. Head Dietitian	80,412	2,132				
b. Food Service Supervisor	91,265	3,393				
c. Dietary Workers	410,129	27,956				
6. Housekeeping Service						
a. Head Housekeeper	22,555	1,160				
b. Other Housekeeping Workers	198,902	14,629				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	104,400	4,749				
8. Laundry Service						
a. Supervisor	22,187	953				
b. Other Laundry Workers	77,827	5,194				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	163,740	6,690				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	199,574	3,871				
b. RN						
1. Direct Care	832,133	19,770				
2. Administrative**	285,042	7,229				
c. LPN						
1. Direct Care	1,015,653	34,291				
2. Administrative**						
d. Aides and Attendants	1,825,205	106,618				
e. Physical Therapists	426,044	11,198				
f. Speech Therapists	92,806	2,210				
g. Occupational Therapists	294,681	8,224				
h. Recreation Workers	101,138	5,353				
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	181,226	7,335				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	6,669,148	281,367				

* 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)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Purchasing Consultant	$ 2,000	25				
Data Integrity Auditor	$ 1,650	22				
INTERPRETERS AND TRANSLATORS, INC	$ 393	4				
A&D Fees	$ 2,193	28				
Total	$ 6,235	79	$ -	-	$ -	-

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Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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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.

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Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Related Parties*

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	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* **										
Rob Fritz	122,530				Administrator 10/1/18-9/30/19	2,086				
Courtney Peterson	808				AIT 8/12/19-8/14/19	24		Var	176	5,923
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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	13,884	185				
3. Pharmacist	12,477	113				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	48,050	154				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting	394	4				
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)						
Detail needed						
9. Speech Therapist						
a. Resident Care						
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	6,235	79				
B-13 Total Fees Paid in Lieu of Salaries	81,040	535				

* 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.

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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
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Health Drive Dental 85 Barns Rd. Wallingford, Ct 06492	Dentist	○	⊙	
West River Pharmacy 41 Northwest Dr. Plainville, CT 06062	Pharmacist	○	⊙	
Craig Bogdanski 55 Meriden Ave., Southington, CT 06489	Medical Director	○	⊙	
Leonard Glazer 360-3 North Main St. Southington CT, 06032	Medical Director & untilization review	○	⊙	
Pointright	Data Integrity Auditor	○	⊙	
CT Purchasing Consultant 88 Ryders Lane Stratford, CT 06607	Purchasing Consultant	○	⊙	
Interpretrs and Translators, Inc. 232 Williams St. E. Glastonbury, CT 06033	Interpretor	○	⊙	
Patientping	A & D Fees	○	⊙	
		○	⊙	
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		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

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CSP-15 Rev. 9/2018

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	77,047	77,047		
2. Disability Insurance	$				
3. Unemployment Insurance	$	84,267	84,267		
4. Social Security (F.I.C.A.)	$	491,852	491,852		
5. Health Insurance	$	414,351	414,351		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	46,049	46,049		
7. Pensions (Non-Discriminatory)	$	54,952	54,952		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	247,496	247,496		
d. Accounting and Auditing	$	8,777	8,777		
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	12,484	12,484		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	21,139	21,139		
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*	$	250	250		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	719,788	719,788		
Subtotal	$	2,178,451	2,178,451		

* 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**

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,178,451	2,178,451		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	35,503	35,503		
2. Holiday Parties for Staff	$	5,176	5,176		
3. Gifts to Staff and Residents	$	9,973	9,973		
4. Employee Travel	$	998	998		
5. Education Expenses Related to Seminars and Conventions	$	3,249	3,249		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	17,304	17,304		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	55	55		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	3,393	3,393		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	10,524	10,524		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	185	185		
9. Subscriptions	$	4,617	4,617		
10. Contributions***	$	200	200		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	497,220	497,220		
13. Other (*Specify*)	$	210,585	210,585		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,977,434	2,977,434		

* 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	$ 17,304		
Total Other Advertising	$ 17,304	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 10,524		
Total Dues	$ 10,524	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
BRISTOL HOSPITAL DEVELOPMENT FOUNDATION	$ 200		
Total Contributions	$ 200	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees Non Reimburable	$ 72,453		
Licenses & Fees	$ 1,605		
Pre Employment Screenings	$ 11,397		
System License & Subscription Fee	$ 30,969		
Bank Service Charges	$ 38,593		
Legal Fees - Collections, Probate, Conservator	$ 1,139		
Account W/O	$ -		
Resident Expenses	$ 295		
Survey Fines & Citations	$ 10,368		
Internet & Cable/Satellite TV	$ 10,643		
IT Service Fee	$ 7,063		
Rec CT Provider Tax Payment	$ 148		
Unclaimed Property	$ 205		
Gemino Finance fees	$ 25,709		
Total Other Administrative and General	$ 210,585	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Apple Rehab Farmington Valley	2029-C	9/30/2019	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.	497,220	Accounting & Management Services	Pg. 16 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.**

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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
Apple Rehab Farmington Valley	2029-C	9/30/2019	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	288,052	288,052		
2. Non-Food Supplies	$	42,277	42,277		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	1,485	1,485		
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	331,814	331,814		
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*		347	347		

G.	Is cost of employee meals included in 2D?	○ Yes	⊙ No	
H.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⊙ 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.

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C. Expenditures Other Than Salaries (cont'd) - Laundry Basis for Allocation of Costs (See Note on Page 5)

Name of Facility	License No.	Report for Year Ended	Page of
Apple Rehab Farmington Valley	2029-C	9/30/2019	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. $	6,715	6,715		
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. $	19,443	19,443		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)	$				
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	26,158	26,158		

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ 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.

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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
Apple Rehab Farmington Valley	2029-C	9/30/2019	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	42,475	42,475		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	42,475	42,475		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Neighborcare		$	405,975	405,975		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	273,576	273,576		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	62,503	62,503		
f. X-rays and Related Radiological Procedures***		$	23,016	23,016		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	43,963	43,963		
i. Recreation		$	23,069	23,069		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	60,459	60,459		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	892,562	892,562		

* 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

Description	CCNH	RHNS	(Specify)
Nursing Station Supplies	$ 1,303		
Rehab Service Supplies	$ 35,778		
IV Therapy	$ 23,378		
Total Other Resident Care	$ 60,459	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
SAUCIER MECHANICAL SVCS	148 NORTON STREET, PLANTSVILLE, CT	○	⊙		HVAC	13,522			22	6a
BRIAN CAMERON DBA CAMERON LAWNCARE	115 TRUMBULL AVE, PLAINVILLE, CT	○	⊙		LANDSCAPE & SNOW REMOVAL	22,149			22	6a
SCHRED IT USA	28883 NETWORK PLACE, CHICAGO IL	○	⊙		OFFICE SCHREDING SERVICES	10,683			22	6f
CWPM, LLC	25 NORTON PL. PLAINVILLE, CT	○	⊙		REFUSE REMOVAL	22,764			22	6f
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

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

Name of Facility	License No.	Report for Year Ended	Page of
Apple Rehab Farmington Valley	2029-C	9/30/2019	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	136,647	136,647		
b. Heat	$	59,788	59,788		
c. Light & Power	$	109,479	109,479		
d. Water	$	88,150	88,150		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	34,124	34,124		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	428,187	428,187		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	234	234		
d. Movable Equipment	$	41,431	41,431		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	41,665	41,665		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	98,946	98,946		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	98,946	98,946		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	825,095	825,095		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	965,706	965,706		

* 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

Description	CCNH	RHNS	(Specify)
Refuse Removal	$ 34,124		
Total Other Repairs and Maintenance	$ 34,124	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	23	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	30,461		30,461	30,461	S/L	VAR		
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	5,105						234	
C-4. Subtotal								234

	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								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. Dodge Ram	X		11	2001	6,823		6,823	6,823	SL	4 Yrs		
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					364,048		364,048	200,316	S/L	VAR	40,851	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					5,712						580	
D-3. Subtotal												41,431
E. ***Total Depreciation***												41,665

Schedule of Land Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Land Improvement		$ -		$ -	*
Deletions:					
Total deletions for Land Improvement		$ -		$ -	**

***Ties to Page 23, Line A3**

****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Building Improvemen		$ -		$ -	*
Deletions:					
Total deletions for Building Improvement		$ -		$ -	**

***Ties to Page 23, Line B3**

****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
1/25/2019	Walk in Cooler Repairs	$ 5,105	NME-8	$ 234	
Total additions for Non-Movable Equipmen		$ 5,105		$ 234	*
Deletions:					
Total deletions for Non-Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line C3**

****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report peri

Acquisition Dat	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
9/13/2018	Washing Machine	$ 1,652	ME-5	$ 413	
1/21/2019	Additional Patient Sling	$ 321	ME-10	$ 12	
1/21/2019	Patient Slings	$ 962	ME-10	$ 35	
3/4/2019	Phone System Repairs	$ 1,469	ME-5	$ 102	
8/30/2019	Food Processor	$ 1,309	ME-10	$ 17	
Total additions for Movable Equipmen		$ 5,712		$ 580	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report peri

Acquisition Dat	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/2/2017	Window Repairs	$ 928	LHI-5	$ 417	
12/31/2018	Install Water Cutoff	$ 1,423	LHI-10	$ 178	
12/31/2018	Replace Circular Pump	$ 3,654	LHI-10	$ 457	
1/3/2019	Replace Pipe	$ 857	LHI-10	$ 32	
2/13/2019	Sensor & High Limit Switch	$ 873	LHI-10	$ 31	
2/14/2019	Actuator Replacement	$ 1,276	LHI-10	$ 46	
3/11/2019	Heat Pump	$ 864	LHI-10	$ 30	
6/4/2019	Boiler Relief Valves	$ 1,442	LHI-10	$ 41	
7/15/2019	Replace FDC connections	$ 2,591	LHI-10	$ 60	
8/13/2019	Additional Compressor Work	$ 1,589	LHI-10	$ 28	
8/13/2019	1st Installment Replace Compressor	$ 3,403	LHI-10	$ 59	
8/13/2019	2nd Installment replace compressor	$ 3,403	LHI-10	$ 59	
1/10/2018	Deposit Steam Condensation	$ 1,525	LHI-10	$ 305	
1/10/2018	Balance Steam Condensation	$ 1,525	LHI-10	$ 305	
1/10/2018	Side Drywall Sprinkles	$ 1,505	LHI-10	$ 60	
1/1/2019	Hot Water Boiler (Saucier)	$ 1,886	LHI-10	$ 141	
1/4/2019	Sidewalk Paving (CrossroadsPaving)	$ 6,000	LHI-10	$ 200	
1/8/2019	Replacement of Boiler Sections	$ 7,816	LHI-10	$ 195	
1/8/2019	Second Phase of Roofing	$ 9,967	LHI-10	$ 249	
1/9/2019	Second Phase of Roofing	$ 36,270	LHI-10	$ 453	
Total additions for Leasehold Improvemen		$ 88,796		$ 3,347	*
Deletions:					
9/16/2018	Fire Doors	$ (9,476)	LHI-20	$ (52)	
Total deletions for Leasehold Improvemen		$ (9,476)		$ (52)	**

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	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
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				2,816,776	2,125,868	A		95,650	
2. Disposals (attach schedule)				(9,476)				(52)	
3. Acquired during this report period (attach schedule)				88,796				3,347	
C-4. Subtotal									98,946
D. ***Total Amortization***									98,946

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ⊙ Yes ○ No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	160
6. Square Footage	54,995
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	12/07/16			
c. Interest Rate for the Cost Year	3.51%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	9,061,100			
f. Principal balance outstanding as of _____	8,584,302			
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.

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

Name of Facility	License No.	Report for Year Ended	Page of
Apple Rehab Farmington Valley	2029-C	9/30/2019	26 | 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*)

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C. Expenditures Other Than Salaries (cont'd) - Interest and Insurance

Name of Facility	License No.	Report for Year Ended	Page of
Apple Rehab Farmington Valley	2029-C	9/30/2019	27 | 37

Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment			$				
A. Item	Rate	Amount					
Lender							
Address of Lender							
2. Other (*Specify*)			$				
A. Item	Rate	Amount					
Lender							
Address of Lender							
B. Item	Rate	Amount					
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			$				
12. D. Other Interest Expense (*Specify*) Gemino Loan Interest			$	56,557	56,557		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	56,557	56,557		
14. Insurance							
a. Insurance on Property (buildings only)			$	150,965	150,965		
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)***			$	150,965	150,965		
15. ***Total All Expenditures (A-13 thru C-14)***			$	12,622,045	12,622,045		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Apple Rehab Farmington Valley	2029-C	9/30/2019	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.	10	A12g	Occupational Therapy $	294,681	294,681		
4.			Other - See attached Schedule $	18,123	18,123		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.	13	B10a	Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	247,496	247,496		
10.	15	1d	Accounting $	5,747	5,747		
10a.			Legal $	1,139	1,139		
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	m2/3	Unallowable Advertising * $	17,304	17,304		
19.	15	1k1	Income Tax / Corporate Business Tax $	250	250		
20.	16	m10	Fund Raising / Contributions $	200	200		
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	157,993	157,993		
Page 18 - Dietary Expenditures							
24.	30	IV1	Meals to employees, guests and others who are not residents $	15	15		
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	742,949	742,949		

* 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 Services - Marketing	$ 18,123		
Total Other Salaries Adjustment			$ 18,123	$ -	$ -

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	Corp Fees Non reimbursable	$ 72,453		
16	1.3	Employee Recognition/Gifts/Parties	$ 9,973		
16	8a	Chamber of Commerce	$ 185		
16	m13	Bank Charges	$ 38,593		
16	m13	Rec CT Provider Tax Payment	$ 148		
16	m13	Unclaimed Property	$ 205		
16	m13	Gemino Finance Fees	$ 25,709		
16	m13	Resident Expense	$ 295		
16	m13	Survey Fine & Citations	$ 10,368		
30	IV8	Account W/O	$ 65		
Total Other A&G Adjustments			$ 157,993	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Apple Rehab Farmington Valley	2029-C	9/30/2019	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	742,949	742,949		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	183,606	183,606		
28.	16	L1	Ambulance/Limousine $	35,503	35,503		
29.	20	h	X-rays, etc $	23,016	23,016		
30.	20	f	Laboratory $	43,963	43,963		
31.			Medical Supplies $				
32.	20	5e2	Oxygen (non emergency) $	38,167	38,167		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	59,342	59,342		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $	56,557	56,557		
43.	30	IV5	Interest Income on Account Rec. $	159	159		
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49.			***Total Amount of Decrease (Items 1 - 48)*** $	1,183,263	1,183,263		

*** 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.

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy Supplies	$ 23,378		
20	5j	Rehab Sevice Supplies	$ 35,778		
Var	Var	Outpatient	$ 186		
Total Other Ancillary Costs			$ 59,342	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12D	Interest	$ 56,557		

Total Other Adjustments			$ 56,557	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Apple Rehab Farmington Valley	2029-C	9/30/2019	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,431,340	6,431,340		
b. Medicaid Room and Board Contractual Allowance **	$				
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	3,003,460	3,003,460		
b. Medicare Room and Board Contractual Allowance **	$	649,073	649,073		
4. a. Private-Pay Residents and Other	$	1,963,874	1,963,874		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	484,200	484,200		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(470,697)	(470,697)		
c. Prescription Drugs - Non-Medicare	$	(116,010)	(116,010)		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	116,010	116,010		
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	928,152	928,152		
b. Physical Therapy - Medicare Contractual Allowance **	$	(825,522)	(825,522)		
c. Physical Therapy - Non-Medicare	$	(130,725)	(130,725)		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	137,165	137,165		
4. a. Speech Therapy - Medicare	$	113,670	113,670		
b. Speech Therapy - Medicare Contractual Allowance **	$	(104,857)	(104,857)		
c. Speech Therapy - Non-Medicare	$	(11,115)	(11,115)		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	14,085	14,085		
5. a. Occupational Therapy - Medicare	$	1,104,436	1,104,436		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(1,006,744)	(1,006,744)		
c. Occupational Therapy - Non-Medicare	$	(145,420)	(145,420)		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	161,730	161,730		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	12,296,105	12,296,105		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	15	15		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	159	159		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	50,171	50,171		
V. Total Other Revenue (1 thru 8)	$	50,345	50,345		
VI. Total All Revenue (III +V)	$	12,346,450	12,346,450		

* *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)
30	Interest Income	1,546,129	$ 159		
Total Interest Income			$ 159	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30	Account W/O	$ 65		
30	Recl Bad Debt 2018 Variance	$ 28,618		
30	Medical Records	$ 423		
30	Optum Divident	$ 21,065		
Total Other Revenue		$ 50,171	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 1,221,613
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,546,129
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 34,498
5. Prepaid Expenses				$ 4,501
a.				
b.				
c.				
d. See Schedule		4,501		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 10,293
See Schedule		10,293		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,817,033
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	2,896,096		$ 671,281
	Accum. Depreciation	2,224,814	Net	
5. Non-Movable Equipment	*Historical Cost	35,566		$ 4,871
	Accum. Depreciation	30,695	Net	
6. Movable Equipment	*Historical Cost	369,760		$ 128,014
	Accum. Depreciation	241,747	Net	
7. Motor Vehicles	*Historical Cost	6,823		$
	Accum. Depreciation	6,823	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 1,583
See Schedule		1,583		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 805,749

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Prepaid Insurance	$ -
31	A5	Prepaid Property Tax	$ -
31	A5	Prepaid Other	$ 4,501
Total Prepaid Expenses			$ 4,501

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

Page Ref	Line Ref	Description	
31	A8	Due Affiliate (Debit Balance)	
31	A8	Payroll W/H	$ 7,934
31	A8	A/P Patient Exchange	$ 2,359
Total Other Current Assets (Itemize)			$ 10,293

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

Page Ref	Line Ref	Description	
31	B9	Fixed Asset Clearing Account	$ 1,583
31	B9	Construction in Progess	$ -
Total Other Other Fixed Assets (Itemize)			$ 1,583

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	Leasehold Deposits	$ -
31	B9	Capitalized Refinance Expenses	$ 65,503
Total Other Assets			$ 65,503

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	Accrued PTO	$ 211,047
33	A12	Accrued Pension	$ 510
33	A12	Accrued Worker's Comp	$ 58,840
33	A12	Accrued Professional Fees	$ 7,225
33	A12	Accrued Expense Other	$ 397,915
33	A12	Accrued Group Insurance	$ 6,458
33	A12	Payroll W/H	
33	A12	A/P Patient Exchange	
33	A12	Due Affiliate (Credit Balance)	$ 803,371
33	A12	Gemino Revolving Loan	$ 780,154
33	A12	Marlin Capital Lease S/T	$ -
33	A12	State Income Tax	$ -
33	A12	Dostie Note S/T	$ -
Total Other Current Liabilities (Itemize)			$ 2,265,521

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

Page Ref	Line Ref	Description	
34	B4	Dostie Note L/T	$ -
34	B4	AP Other (Intercompany)	$ 1,406,073
Total Other Current Liabilities (Itemize)			$ 1,406,073

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	32	37

	Account			Amount
			Total Brought Forward:	$ 3,622,782
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 (*itemize*)			$
	6. Loans to Owners or Related Parties (*itemize*)			$
	Name and Address	Amount	Loan Date	
	7. Other Assets (*itemize*)			$ 65,503
	See Schedule		65,503	
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)			$ 65,503
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ 3,688,286

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 788,114
2. Notes Payable (*itemize*)				$
See Schedule				
3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 161,321
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 21,290
7. Medicare Final Settlement Payable				$
8. Medicare Current Financing Payable				$
9. Mortgage Payable (*Current Portion*)				$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 2,265,521
See Schedule		2,265,521		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 3,236,245

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	34	37

Account	Amount
Total Brought Forward:	3,236,245
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 1,406,073
See Schedule	1,406,073	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 1,406,073
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 4,642,318

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

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$
B.	**Net Worth**	
	1. Owner's Capital	$ 2,197,050
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (2,876,487)
	6. Gain or Loss for Period 10/1/2018 thru 9/30/2019	$ (275,596)
	7. Total Net Worth	$ (954,032)
C.	***Total Reserves and Net Worth***	$ (954,032)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 3,688,286

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2018			$ (624,349)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 12,346,450
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 12,622,045
D.	Net Income or Deficit			$ (275,596)
E.	Balance			$ (899,945)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 54,088
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	Brian Foley	President	8,205	
	Brian Foley	President	45,883	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$ 54,088
H.	***Balance at End of Period*** 09/30/19			$ (954,032)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Farmington Valley	2029-C	9/30/2019	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. 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

Addres Address	Phone Number
21 Waterville Rd. 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