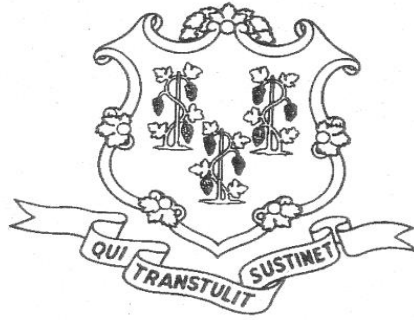


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2023

Name of Facility (as licensed) Apple Rehab Avon	
Address (No. & Street, City, State, Zip Code) 220 Scoville Rd. Avon, CT 06001	
Type of Facility Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 1035 -C	(Specify)	(Specify)	Medicare Provider 07 - 5388
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Medicaid Provider Numbers:	CCNH / RHNS 10356	(Specify)	(Specify)
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General Information

Name of Facility (as licensed) Apple Rehab Avon	License No. 1035 -C	Report for Year Ended 9/30/2023	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 Avon [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, 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) Samantha Perez			Printed Name (Owner) Brian 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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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 Avon	Period Covered:	From 10/1/2022	To 9/30/2023	
Address of Facility 220 Scoville Rd. Avon, CT 06001				
Report Prepared By Apple Health Care, Inc.	Phone Number (860) 678-9755	Date		
Item	Total	CCNH / RHNS	(Specify)	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-673-3265		Report for Year Ended 9/30/2023	Page 2	of 37
Name of Facility (as shown on license) Apple Rehab Avon		Address (No. & Street, City, State, Zip) 220 Scoville Rd. Avon, CT 06001		
License Numbers:	CCNH / RHNS 1035 -C	(Specify)	(Specify)	Medicare Provider No. 07 - 5388
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box) <input type="checkbox"/> Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> 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 Samantha Perez		Nursing Home Administrator's License No.:	2165	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

**General Information and Questionnaire
 Corporate Owners**

Name of Facility Apple Rehab Avon	License No. 1035 -C	Report for Year Ended 9/30/2023	Page 3A	of 37
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 Avon	220 Scoville Rd. Avon, CT 06001	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
 Related Parties***

Name of Facility Apple Rehab Avon	License No. 1035 -C	Report for Year Ended 9/30/2023	Page 4	of 37
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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	<input type="radio"/>	<input checked="" type="radio"/>		Real Estate Rental	Pg. 22 Line 9	432,000	432,000
Apple Health Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Management & Accounting Services	Pg. 16 Line m12	207,519	207,519
Corporate Employees	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	124,049	124,049
Healthport	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule		
Employees @ various Apple facilities		<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	36,284	36,284
Apple Health Care	21 Waterville Rd. Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Pension Plan (401K)	Pg. 15 Line 1a7	63,298	63,298
Lucent	424 Church St. Nashville, TN 37219	<input checked="" type="radio"/>	<input type="radio"/>		Group Medical	Pg. 15 Line 1a5	51,865	
Delta Dental	148 Eastern Blvd Glastonbury, CT 06033	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 Line 1a5	8,367	
USI	PO Box 62937 Virginia Beach, VA 23466	<input checked="" type="radio"/>	<input type="radio"/>		Property, Liability, & Umbrella Insurance	Pg. 27 Line 14a	104,005	

* Use additional sheets if necessary.

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

General Information and Questionnaire
Related Parties*

Name of Facility Apple Rehab Avon		License No. 0	Report for Year Ended 9/30/2023		Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.								
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? <input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the following information:								
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Metlife	PO Box 360229 Pittsburgh, PA 15251	✗			Group Life & Disability	Pg. 15 1a6	1,691	
AIG	PO Box 10472 Newark, NJ	✗			Worker's Compensation	Pg. 15 1a1	134,162	
Swallowing Diagnostics	21 Waterville Road Avon, CT	✗		83%	Diagnostic Services	Pg 20 5f	720	679
Staffon Tap	76 Hartford Rd. Simsbury, CT		✗		Employee Staffing	Pg. 13 Line 11a1	4,925	4,925
CRS Landscaping	68 HARTFORD RD. SIMSBURY, CT	✗			Landscaping/Snow removal	Pg. 22 6a	44,265	44,265
Ryan Vess	21 Waterville Road Avon, CT		✗			##		
Tarah Foley	21 Waterville Road Avon, CT		✗			##		
Paula Meunier	21 Waterville Road Avon, CT		✗			##		
Kayla Foley	21 Waterville Road Avon, CT		✗			##		
Patricia Hyyppa	21 Waterville Road Avon, CT		✗			##		
Reino Hyyppa	21 Waterville Road Avon, CT		✗			##		
Robert Wooley	21 Waterville Road Avon, CT		✗			##		
						##		

* Use additional sheets if necessary.
 ** Provide the percentage amount of revenue received from non-related parties.
 ## Related expense has been disallowed on Pg. 28 Line 23

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Apple Rehab Avon	License No. 1035 -C	Report for Year Ended 9/30/2023	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
Other Lines of Business

Name of Facility Apple Rehab Avon	License No. 1035 -C	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility.		10,136		
Outpatient Therapy				
Does the Facility provide outpatient therapy services?		Yes		
<i>If yes, please complete the following:</i>				
880	Square footage of therapy space.			
Meals on Wheels				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
	Square footage of kitchen			
	Number of meals served per week			
No	Are meals included in meals served on page 18 of the Annual Report?			
No	Are direct costs included in the Annual Report?			
	<i>If yes, please state where costs are reported.</i>			
No	Are drivers for the program included in the facility's payroll?			
	<i>If yes, please complete the following:</i>			
	Amount Reported			
	Annual Report page and line			
	Please state the salary amounts of specific cooks and/or dietary aides			
	Please state where the cooks and/or dietary aides are reported in the Annual Report			
Apartments, Independent Living, Assisted Living				
Does the facility have apartments, independent living, and/or assisted living?		No		
<i>If yes, please complete the following:</i>				
	Square footage of apartments			
	Square footage of independent living			
	Square footage of assisted living			
	Please identify the services provided:			

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility Apple Rehab Avon	License No. 1035 -C	Report for Year Ended 9/30/2023	Page 7	of 37
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Child Day Care

Does the Facility provide Child Day Care? No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care? No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

Schedule of Resident Statistics

Name of Facility Apple Rehab Avon			License No. 1035 -C		Report for Year Ended 9/30/2023				Page 8	of 37		
	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	60	60			60	60						
B. On last day of THIS report period	60	60							60	60		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	32	32			32	32						
B. As of midnight of THIS report period	50	50							50	50		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,460	2,460			1,996	1,996			464	464		
B. Medicaid (Conn.)	10,645	10,645			8,090	8,090			2,555	2,555		
C. Medicaid (other states)												
D. Private Pay	2,581	2,581			1,445	1,445			1,136	1,136		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	15,686	15,686			11,531	11,531			4,155	4,155		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	15,686	15,686			11,531	11,531			4,155	4,155		

Schedule of Resident Statistics (Cont'd)

Name of Facility Apple Rehab Avon			License No. 1035 -C			Report for Year Ended 9/30/2023			Page of 9 37					
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> 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)	(Specify)	Lost			Gained			CCNH / RHNS	(Specify)	(Specify)		
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)					
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.														
Change in Resident Days										CCNH / RHNS	(Specify)	(Specify)		
1st change														
2nd change														
3rd change														
4th change														
6. Number of Residents and Rates on September 30 of Cost Year														
		Medicare	Medicaid			Self-Pay			Other State Assisted					
Item	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR						
No. of Residents	3	31		16										
Per Diem Rate														
a. One bed rm.				400.00										
b. Two bed rms.	Rugs III	247.99		350.00										
c. Three or more bed rms.														
7. Total Number of Physical Therapy Treatments				TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)						
A. Medicare - Part B				5,464	5,464									
B. Medicaid (Exclusive of Part B)														
1. Maintenance Treatments														
2. Restorative Treatments														
C. Other				10,936	10,936									
D. Total Physical Therapy Treatments				16,400	16,400									
8. Total Number of Speech Therapy Treatments														
A. Medicare - Part B				516	516									
B. Medicaid (Exclusive of Part B)														
1. Maintenance Treatments														
2. Restorative Treatments														
C. Other				1,618	1,618									
D. Total Speech Therapy Treatments				2,134	2,134									
9. Total Number of Occupational Therapy Treatments														
A. Medicare - Part B				2,922	2,922									
B. Medicaid (Exclusive of Part B)														
1. Maintenance Treatments														
2. Restorative Treatments														
C. Other				7,518	7,518									
D. Total Occupational Therapy Treatments				10,440	10,440									

Annual Report of Long-Term Care Facility

CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility Apple Rehab Avon	License No. 1035 -C	Report for Year Ended 9/30/2023	Page 10	of 37
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Are time records maintained by all individuals receiving compensation? Yes No

Item	Total Cost and Hours								
	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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)	110,041		2,086						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	55,508		2,485						
5. Dietary Service									
a. Head Dietitian	16,194		446						
b. Food Service Supervisor	48,918		1,748						
c. Dietary Workers	196,264		9,392						
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers	61,266	(36)	3,084						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance									
b. Other Maintenance Workers	58,667		2,126						
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers									
9. Barber and Beautician Services									
10. Protective Services									
11. Accounting Services									
a. Head Accountant									
b. Other Accountants	93,187		3,012						
12. Professional Care of Residents									
a. Directors and Assistant Director of Nurses	162,136		2,199						
b. RN									
1. Direct Care	742,625		12,701						
2. Administrative**	105,494		2,273						
c. LPN									
1. Direct Care	324,052		8,316						
2. Administrative**									
d. Aides and Attendants	756,458		28,939						
e. Physical Therapists	181,242		3,827						
f. Speech Therapists	24,871		547						
g. Occupational Therapists	97,621	(97,621)	2,731						
h. Recreation Workers	54,345		2,186						
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	77,552	(6,261)	2,350						
n. Marketing									
o. Other (Specify) See Attached Schedule									
<i>A-13. Total Salary Expenditures</i>	<i>3,166,442</i>	<i>(103,917)</i>	<i>90,447</i>						

* 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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
Total	\$ -	\$ -	-	\$ -	\$ -	-	\$ -	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
Long Term Care Specialist	\$ 4,500		100						
Admissions & Discharge Consultant Fee	\$ 2,036		17						
Total	\$ 6,536	\$ -	117	\$ -	\$ -	-	\$ -	\$ -	-

**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	
Apple Rehab Avon				1035 -C	9/30/2023			11	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)	(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.

**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 Avon				1035 -C	9/30/2023			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)	(Specify)							
Section III - Administrators***										
Samantha Perez	110,041				Administrator 10/01/22-9/30/23	2,086	A.2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended						Page	of
Apple Rehab Avon	1035 -C	9/30/2023						13	37
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)									
1. Dietitian									
2. Dentist	6,408		160						
3. Pharmacist	7,878		71						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	685								
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	30,000		5						
b. Utilization Review (Title 18 and 19 only) monthly meeting	45		2						
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)									
Internal Medicine Specialist	500		4						
9. Speech Therapist									
a. Resident Care	1,080		15						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	4,925		171						
2. Administrative***									
b. LPN									
1. Direct Care									
2. Administrative***									
c. Aides									
d. Other									
12. Other (Specify)									
See Attached Schedule	6,536		117						
B-13 Total Fees Paid in Lieu of Salaries	58,057		545						

* 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 in the Adjustment column.

*** 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 Apple Rehab Avon		License No. 1035 -C		Report for Year Ended 9/30/2023		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship			
		Yes	No				
Swallowing Diagnostics 21 Waterville Rd. Avon, CT	Speech Consultant	<input checked="" type="radio"/>	<input type="radio"/>	See Disclosure Pg. 4			
Rosella Crowley 265 Brown Street, West Haven, CT 06516	Long Term Care Specialist	<input type="radio"/>	<input checked="" type="radio"/>				
Healthdrive Dental 1 Prestige Dr. Meriden, CT	Dentist	<input type="radio"/>	<input checked="" type="radio"/>				
Gary Miller, MD LLC 22 Pine St, Bristol, CT 06010	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>				
Bamboo Health, Inc. (Patientping, Inc.), 10 Post Office Square, Boston, MA 02109	Adm & Discharge Fee	<input type="radio"/>	<input checked="" type="radio"/>				
Neighborcare PO Box 78000 Detroit, MI	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>				
Amor C Lomibao, 6 Frey Drive, Caton, CT 06019	Internal Medicine Specialist	<input type="radio"/>	<input checked="" type="radio"/>				
Staffon Tap 76 Hartford Rd. Simsbury, CT	Employee Staffing	<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"/>				

* 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
Apple Rehab Avon	1035 -C	9/30/2023					15	37
Item	Total Including Adjustment	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
I. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 134,162	134,162						
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 25,627	25,627						
4. Social Security (F.I.C.A.)	\$ 222,483	222,488	(5)					
5. Health Insurance	\$ 33,183	33,183						
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 1,691	1,691						
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 63,298	63,298						
8. Uniform Allowance	\$							
9. Other (<i>Specify</i>) See Attached Schedule	\$							
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$							
c. Bad Debts*	\$	99,222	(99,222)					
d. Accounting and Auditing	\$ 4,156	10,039	(5,883)					
e. Legal (<i>Services should be fully described on Page 15b</i>)	\$							
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$							
g. Office Supplies	\$ 6,685	6,799	(114)					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$ 27,515	27,515						
2. Cellular Phones	\$							
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$							
j. Corporation Business Taxes (<i>franchise tax</i>)	\$							
k. Other Taxes (<i>Not related to property - See Page 22</i>)								
1. Income*	\$							
2. Other (<i>Specify</i>) See Attached Schedule	\$							
3. Resident Day User Fee	\$ 275,887	275,887						
Subtotal	\$ 794,688	899,912	(105,224)					

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

***** DO NOT Include Holiday Parties / Awards / Gifts to Staff**

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

General Information and Questionnaire Accounting Basis

Name of Facility Apple Rehab Avon	License No. 1035 -C	Report for Year Ended 9/30/2023	Page 15b	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

Is the accounting basis for this period the same as for the previous period? Yes No If "No," explain.

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1 Preparation of audited financials	\$ 5,883
2 Preparation of Tax Returns	\$ 3,181
3 Audit 401K	\$ 975
4	\$
Charge for Services Provided	
\$ 10,039	

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	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

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

Name of Facility	License No.	Report for Year Ended					Page	of
Apple Rehab Avon	1035 -C	9/30/2023					16	37
Item	Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
Subtotals Brought Forward:	794,688	899,912	(105,224)					
l. Travel and Entertainment								
1. Resident Travel and Entertainment	\$	9,954	(9,954)					
2. Holiday Parties for Staff	\$ 2,400	2,400						
3. Gifts to Staff and Residents	\$	5,040	(5,040)					
4. Employee Travel	\$ 2,287	2,287						
5. Education Expenses Related to Seminars and Conventions	\$ 592	592						
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>)	\$ 366	366						
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$							
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	5,702	(5,702)					
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	\$ 1,301	1,301						
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 4,636	4,636						
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$							
9. Subscriptions	\$ 462	462						
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**	\$ 207,519	207,519						
13. Other (<i>Specify</i>) See Attached Schedule	\$ 44,054	98,299	(54,245)					
C-14 Total Administrative & General Expenditures	\$ 1,058,305	1,238,469	(180,164)					

* 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 in the Adjustment column.

Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Total Other Travel and Entertainment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Advertising - Public Relations	\$ 5,702	\$ (5,702)				
Total Other Advertising	\$ 5,702	\$ (5,702)	\$ -	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF	\$ 4,636					
Total Dues	\$ 4,636	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Corporate Fees - Non Reimbursable	\$ 49,988	\$ (49,988)				
Licenses & Fees	\$ 1,861					
Pre Employment Screenings	\$ 5,378					
System License & Subscription Fees	\$ 35,793					
Bank Service Charges	\$ 1,792	\$ (1,792)				
Legal Fees - Collection/Probate	\$ 465	\$ (465)				
IT Service Fees	\$ -					
Resident Expenses	\$ -					
Survey Fines & Citations	\$ -					
Healthport Indirect	\$ -					
User Audit Expense	\$ 1,023					
Settlement	\$ 2,000	\$ (2,000)				
Total Other Administrative and General	\$ 98,299	\$ (54,245)	\$ -	\$ -	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Apple Rehab Avon	License No. 1035 -C	Report for Year Ended 9/30/2023	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Apple Health Care, Inc.	207,519	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
Apple Rehab Avon		1035 -C	9/30/2023				18	37
Item	Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 111,600	111,605	(5)					
2. Non-Food Supplies	\$ 13,288	13,288						
3. Other (Specify) _____	\$							
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 3,792	3,792						
c. Other (Specify) _____	\$							
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 128,681	128,686	(5)					
2E. Dietary Questionnaire		Total	CCNH / RHNS		(Specify)	(Specify)		
F. Resident Meals:	Total no. of meals served per day:*	129	129					
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 Avon		License No. 1035 -C	Report for Year Ended 9/30/2023				Page 19	of 37
Item		Including Adjustment s	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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. \$	3,975	3,975				
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. \$	224	224				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	55,150	55,150				
c. Other (Specify)		\$						
3D. Total Laundry Expenditures (3a + b + c)		\$	59,349	59,349				
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	
Apple Rehab Avon		1035 -C	9/30/2023				20	37	
Item			Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4.	Housekeeping	Sq. Ft. Serviced by Personnel	10,136	10,136					
a.	In-House Care								
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	15,760	15,769	(9)				
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel							
		Amt. \$							
C.	Other (<i>Specify</i>)	\$							
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	15,760	15,769	(9)				
5.	Resident Care (Supplies)**								
a.	Prescription Drugs***								
	1. Own Pharmacy	\$							
	2. Purchased from Neighborcare	\$	3,270	144,647	(141,376)				
b.	Medicine Cabinet Drugs	\$							
c.	Medical and Therapeutic Supplies	\$	122,616	122,616					
d.	Ambulance/Limousine***	\$							
e.	Oxygen								
	1. For Emergency Use	\$							
	2. Other***	\$	8,681	11,887	(3,206)				
f.	X-rays and Related Radiological Procedures***	\$		7,788	(7,788)				
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$							
h.	Laboratory***	\$		19,105	(19,105)				
i.	Recreation	\$	8,209	8,209					
j.	Direct Management Services*	\$							
k.	Indirect Management Services*	\$							
l.	Cable TV	\$	19,715	19,715					
m.	Other (Specify)**** See Attached Schedule	\$		21,649	(21,649)				
n.	Physical Therapy Expense	\$							
o.	Speech Therapy Expense	\$							
5P.	Total Resident Care Expenditures (5a - 5o)	\$	162,492	355,615	(193,124)				

* 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 in the Adjustment column.
 **** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Nursing Station Supplies	\$ -					
IV Therapy	\$ 12,377	\$ (12,377)				
Rehab Service & Supplies	\$ 9,272	\$ (9,272)				
Total Other Resident Care	\$ 21,649	\$ (21,649)	\$ -	\$ -	\$ -	\$ -

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

Name of Facility Apple Rehab Avon			License No. 1035 -C		Report for Year Ended 9/30/2023				Page of 21 37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	(Specify)	Pg	Line
UNITEX	MACQUESTIEN PKY. MT VERON, CT	<input type="radio"/>	<input checked="" type="radio"/>		Laundry Service	48,477			19	3B
CRS LANDSCAPING	68 HARTFORD RD. SIMSBURY, CT	<input checked="" type="radio"/>	<input type="radio"/>	See Page 4	Landscaping/snow Removal	44,265			22	6A
CWPM, LLC	25 Norton Place, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Refuse Removal	16,733			22	6f
ADVANCED POWER SERVICES	145 Whiting St, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Emergency Power Services	29,011			22	6A
FACILITIES COMPLIANCE FIRE PROTECTION	221 West Main St., Plantsville, CT 06479	<input type="radio"/>	<input checked="" type="radio"/>		Fire Protection Services	11,128			22	6A
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

* List all contracted services over \$10,000. Use additional sheets if necessary.
 ** Refer to Page 4 for definition of related.
 *** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended					Page	of
Apple Rehab Avon	1035 -C	9/30/2023					22	37
Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$	129,610	129,686	(75)				
b. Heat	\$	22,822	22,836	(13)				
c. Light & Power	\$	47,369	47,396	(28)				
d. Water	\$	9,597	9,603	(6)				
e. Equipment Lease (Provide detail on page 22b)	\$							
f. Other (itemize)	\$	19,342	19,354	(11)				
See Attached Schedule								
6g. Total Maint. & Operating Expense (6a - 6f)	\$	228,741	228,874	(133)				
7. Depreciation (complete schedule page 23*)								
a. Land Improvements	\$							
b. Building & Building Improvements	\$							
c. Non-Movable Equipment	\$							
d. Movable Equipment	\$	8,284	8,284					
*7e. Total Depreciation Costs (7a + b + c + d)	\$	8,284	8,284					
8. Amortization (Complete att. Schedule Page 24*)								
a. Organization Expense	\$							
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$	26,390	26,390					
d. Other (Specify)	\$							
*8e. Total Amortization Costs (8a + b + c + d)	\$	26,390	26,390					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	432,000	432,000					
10. Property Taxes								
a. Real estate taxes paid by owner	\$							
b. Real estate taxes paid by lessor	\$	56,724	56,724					
c. Personal property taxes	\$	3,571	3,571					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	526,969	526,969					

* 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	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Refuse Removal	\$ 19,354	\$ (11)				
Total Other Repairs and Maintenance	\$ 19,354	\$ (11)	\$ -	\$ -	\$ -	\$ -

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Apple Rehab Avon			License No. 1035 -C			Report for Year Ended 9/30/2023		Page 22b	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed		
	Yes	No							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input checked="" type="radio"/>	<input type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
	<input type="radio"/>	<input checked="" type="radio"/>							
Is a Mileage Log Book Maintained for All Leased Vehicles ?								<input type="radio"/> Yes	<input type="radio"/> No
Total ***									

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.

Depreciation Schedule

Name of Facility Apple Rehab Avon			License No. 1035 -C		Report for Year Ended 9/30/2023			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			9,247		9,247	9,247	SL	VAR					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal													
		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.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period					Var	Var	471,993		471,993	463,710	SL	VAR	8,284
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative					Var	Var				SL	VAR		
d. Standard Resident													
e. Specialized Resident													
Total Acquired during this report period													
D-3. Subtotal													8,284
E. Total Depreciation													8,284

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Non-Movable Equipment		\$ -		\$ - *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipment			\$ -		\$ - *
Deletions:					
Total deletions for Movable Equipment			\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
4/7/2023	Excavation Generator Engine Rebuild	\$ 8,680	LHI-10	\$ 286
7/19/2023	Replace Condensing unit #4	\$ 5,245	LHI-5	\$ 234
Total additions for Leasehold Improvement		\$ 13,925		\$ 520 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility Apple Rehab Avon			License No. 1035 -C		Report for Year Ended 9/30/2023			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	Var	Var		1,289,970	1,130,942	SL		25,869	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	Var	Var		13,925		SL		520	
C-4. Subtotal									26,390
D. Total Amortization									26,390

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Apple Rehab Avon	License No. 1035 -C	Report for Year Ended 9/30/2023	Page 25	of 37																																																																											
11. Property Questionnaire																																																																															
Part A																																																																															
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> 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	60																																																																														
6. Square Footage	10,136																																																																														
7. Acquisition Cost																																																																															
a. Land		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Part B - Owner and Related Parties</td> <td style="text-align: center;">1st Mortgage</td> <td style="text-align: center;">2nd Mortgage</td> <td style="text-align: center;">3rd Mortgage</td> <td style="text-align: center;">4th Mortgage</td> </tr> <tr> <td>1. Financing</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> a. Type of Financing (e.g., fixed, variable)</td> <td style="text-align: center;">Variable</td> <td></td> <td></td> <td></td> </tr> <tr> <td> b. Date Mortgage Obtained</td> <td style="text-align: center;">04/21/22</td> <td></td> <td></td> <td></td> </tr> <tr> <td> c. Interest Rate for the Cost Year</td> <td style="text-align: center;">5.00%</td> <td></td> <td></td> <td></td> </tr> <tr> <td> d. Term of Mortgage (number of years)</td> <td style="text-align: center;">25</td> <td></td> <td></td> <td></td> </tr> <tr> <td> e. Amount of Principal Borrowed</td> <td style="text-align: center;">2,518,487</td> <td></td> <td></td> <td></td> </tr> <tr> <td> f. Principal balance outstanding as of _____</td> <td style="text-align: center;">2,427,077</td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="5">Complete if Mortgage was Refinanced During Current Cost Year</td> </tr> <tr> <td> g. Type of Financing (e.g., fixed, variable)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> h. Date of Refinancing</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> i. New Interest Rate</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> j. Term of Mortgage (number of years)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> k. Amount of Principal Borrowed</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> l. Principal Outstanding on Note Paid-Off</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>			Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage	1. Financing					a. Type of Financing (e.g., fixed, variable)	Variable				b. Date Mortgage Obtained	04/21/22				c. Interest Rate for the Cost Year	5.00%				d. Term of Mortgage (number of years)	25				e. Amount of Principal Borrowed	2,518,487				f. Principal balance outstanding as of _____	2,427,077				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 B - Owner and Related Parties	1st Mortgage				2nd Mortgage	3rd Mortgage	4th Mortgage																																																																								
1. Financing																																																																															
a. Type of Financing (e.g., fixed, variable)	Variable																																																																														
b. Date Mortgage Obtained	04/21/22																																																																														
c. Interest Rate for the Cost Year	5.00%																																																																														
d. Term of Mortgage (number of years)	25																																																																														
e. Amount of Principal Borrowed	2,518,487																																																																														
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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 Apple Rehab Avon		License No. 1035 -C	Report for Year Ended 9/30/2023				Page 26	of 37
Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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				Page	of
Apple Rehab Avon		1035 -C		9/30/2023				27	37
Item				Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(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)				\$ 103,945	104,005	(60)			
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)				\$ 103,945	104,005	(60)			
15. Total All Expenditures (A-13 thru C-14)				\$ 5,404,822	5,882,234	(477,413)			

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Apple Rehab Avon	1035 -C	9/30/2023		30	37
Item	Total	CCNH / RHNS	(Specify)	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 2,847,891	2,847,891			
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>)	\$ 1,000,843	1,000,843			
b. Medicare Room and Board Contractual Allowance **	\$ 476,045	476,045			
4. a. Private-Pay Residents and Other	\$ 645,069	645,069			
b. Private-Pay Room and Board Contractual Allowance **	\$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 81,206	81,206			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (80,178)	(80,178)			
c. Prescription Drugs - Non-Medicare	\$ 37,397	37,397			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (37,397)	(37,397)			
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	\$ 367,587	367,587			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (326,636)	(326,636)			
c. Physical Therapy - Non-Medicare	\$ 206,397	206,397			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (125,825)	(125,825)			
4. a. Speech Therapy - Medicare	\$ 72,210	72,210			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (67,241)	(67,241)			
c. Speech Therapy - Non-Medicare	\$ 19,915	19,915			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (6,195)	(6,195)			
5. a. Occupational Therapy - Medicare	\$ 371,315	371,315			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (343,159)	(343,159)			
c. Occupational Therapy - Non-Medicare	\$ 98,480	98,480			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (41,915)	(41,915)			
6. a. Other (<i>Specify</i>) - Medicare	\$				
b. Other (<i>Specify</i>) - Non-Medicare	\$				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 5,195,808	5,195,808			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$ 5	5			
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 110	110			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 55,584	55,584			
V. Total Other Revenue (1 thru 8)	\$ 55,700	55,700			
VI. Total All Revenue (III +V)	\$ 5,251,507	5,251,507			

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
Pg 30 IV5	Interest on AR	667,155	\$ 110		
Total Interest Income			\$ 110	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30 IV8	Covid Relief	\$ 34,266		
30 IV8	Maxor/Empirian Pharmacy Rebates	\$ 21,204		
30 IV8	Refunds	\$ -		
30 IV8	Medical Records	\$ 114		
Total Other Revenue		\$ 55,584	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Avon	1035 -C	9/30/2023	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	300
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	667,155
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	9,218
5. Prepaid Expenses			\$	16,964
a. _____				
b. _____				
c. _____				
d. See Schedule		16,964		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	384

See Schedule		384		
A-9. Total Current Assets (Lines A1 thru 8)			\$	694,021
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 <u>1,303,895</u>		\$	146,563
	Accum. Depreciation <u>1,157,332</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>9,247</u>		\$	
	Accum. Depreciation <u>9,247</u>	Net		
6. Movable Equipment	*Historical Cost <u>471,993</u>		\$	
	Accum. Depreciation <u>471,993</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	146,563

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Avon	1035 -C	9/30/2023	32	37
Account			Amount	
Total Brought Forward:			\$	840,585
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)			\$	840,585

* 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 Apple Rehab Avon		License No. 1035 -C	Report for Year Ended 9/30/2023	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	313,743
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>)				\$	55,637
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	7,334
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>)				\$	1,137,405

See Schedule					1,137,405
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,514,119

* 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 Avon	License No. 1035 -C	Report for Year Ended 9/30/2023		Page 34	of 37
Account				Amount	
Total Brought Forward:				1,514,119	
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>)				\$ 997,544	
See Schedule				997,544	
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 997,544	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 2,511,663	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Avon	1035 -C	9/30/2023	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	4,239,192
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(5,911,270)
6. Gain or Loss for Period			\$	
	10/1/2022	thru	9/30/2023	
7. Total Net Worth			\$	(1,671,078)
C. Total Reserves and Net Worth			\$	(1,671,078)
D. Total Liabilities, Reserves, and Net Worth			\$	840,585

H. Changes in Total Net Worth

Name of Facility Apple Rehab Avon	License No. 1035 -C	Report for Year Ended 9/30/2023	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	(2,202,642)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	5,251,507
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	5,404,822
D. Net Income or Deficit			\$	(153,315)
E. Balance			\$	(2,355,957)
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
Brian Foley	690,000			
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	690,000
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	4,878
Name and Address (<i>No., City, State, Zip</i>)	Title	Amount		
Brian Foley	President	4,878		
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose	Amount			
3. Total Deductions			\$	4,878
H. Balance at End of Period			\$	(1,670,835)
				09/30/23

I. Preparer's/Reviewer's Certification

Name of Facility Apple Rehab Avon	License No. 1035 -C	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> Home (CCNH) & RHNS Combined	<input type="checkbox"/> (Specify)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>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.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
Robert Gwizdak				
Address 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				