State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Apple Rehab Mystic	
Address (No. & Street, City, State, Zip Code) 28 Broadway, Mystic CT 06355	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	1063-C			07-5337

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	10637		

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

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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 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 Mystic [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, 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)			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 Mystic	Period Covered:		From 10/1/2016	To 9/30/2017
Address of Facility 28 Broadway, Mystic CT 06355				
Report Prepared By Apple Health Care	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
860-678-9755	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Apple Rehab Mystic	28 Broadway, Mystic CT 06355

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	1063-C			07-5337

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.:	
Wesley Downing		2036

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
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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 Mystic	28 Broadway, Mystic CT 06355	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
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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 Road Avon, CT 06001	○	◉		Real Estate Rental	Pg. 22 Line 9	459,000	459,000
Apple Health Care	21 Waterville Road Avon, CT 06001	○	◉		Management & Accounting Services	Pg. 16 Line m12	218,694	218,694
Healthport Services	21 Waterville Road Avon, CT 06001	○	◉		Employee Staffing	Pg. 10 /16 m13	14,828	14,828
Corporate Employees	21 Waterville Road Avon, CT 06001	○	◉		Employee Staffing	Pg. 10 Schedule	6,043	6,043
Employees @ Various Apple Facilities		○	◉		Employee Staffing	Pg. 10 Schedule	112,472	112,472
Apple Health Care	21 Waterville Road Avon, CT 06001	○	◉		Pension Plan (401K)	Pg. 15 1a7	14,899	14,899
Aetna	PO Box 88860 Chicago, IL	◉	○		Group Medical	Pg. 15 1a5	312,554	
Delta Dental		◉	○		Group Dental	Pg. 15 1a5	18,953	
Aetna Ancillary		○	○		Group Life & Disability	Pg. 15 1a6	13,474	

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Mystic	1063-C	9/30/2017	4	37

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	%**				
Marsh	PO Box 19636 Newark, NJ	✠			Property,Liability & Umbrella Insurance	Pg. 27 14a	79,704	
AIG	PO Box 10472 Newark, NJ	✠			Worker's Compensation	Pg. 15 1a1	334,308	
Swallowing Diagnotics	21 Waterville Road Avon, CT	✠		83%	Diagnostic Services	Pg. 20 5f	0	
Ryan Vess	21 Waterville Road Avon, CT		✠			##		
Brendan Foley	21 Waterville Road Avon, CT		☒					
Wesley Downing	21 Waterville Road Avon, CT		☒		Administrator	Pg. 10a2	22,890	22,890

* 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

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General Information and Questionnaire
Basis for Allocation of Costs

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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 Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

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

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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	
4	

Services Provided by This Firm (*describe fully*)

1	Preparation of audited financials (disallow Pg. 28)	$ 3,768
2	Preparation of tax returns	$ 2,131
3		$
4		$
		Charge for Services Provided $ 5,899

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	60	60			60	60			60	60		
B. On last day of THIS report period	60	60			60	60			60	60		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	53	53			53	53			53	53		
B. As of midnight of THIS report period	51	51			51	51			51	51		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,678	2,678			1,971	1,971			707	707		
B. Medicaid (Conn.)	9,482	9,482			6,824	6,824			2,658	2,658		
C. Medicaid (other states)												
D. Private Pay	5,006	5,006			3,792	3,792			1,214	1,214		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	17,166	17,166			12,587	12,587			4,579	4,579		
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)**	17,166	17,166			12,587	12,587			4,579	4,579		

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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	7	31		13				
Per Diem Rate								
a. One bed rm.				424.00				
b. Two bed rms.	Various Rugs III	202.31		388.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	2,391	2,391		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	11,049	11,049		
D. ***Total Physical Therapy Treatments***	13,440	13,440		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	251	251		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	381	381		
D. ***Total Speech Therapy Treatments***	632	632		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,241	1,241		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	10,110	10,110		
D. ***Total Occupational Therapy Treatments***	11,351	11,351		

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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)	91,593	2,145				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	45,425	3,012				
5. Dietary Service						
a. Head Dietitian	73,041	2,180				
b. Food Service Supervisor	68,625	2,439				
c. Dietary Workers	153,034	11,168				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	89,064	6,325				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	50,461	2,393				
8. Laundry Service						
a. Supervisor	13,045	703				
b. Other Laundry Workers	29,774	2,353				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	85,297	3,364				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	109,109	2,209				
b. RN						
1. Direct Care	436,786	14,178				
2. Administrative**	109,062	3,703				
c. LPN						
1. Direct Care	209,523	8,418				
2. Administrative**						
d. Aides and Attendants	575,503	39,014				
e. Physical Therapists	221,475	5,393				
f. Speech Therapists	21,957	412				
g. Occupational Therapists	144,297	4,042				
h. Recreation Workers	48,941	2,639				
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	42,489	2,093				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	2,618,502	118,183				

* 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**
CT Purchasing Consultants	$ 2,053	21				
Patientping Inc	$ 1,837	18				
Pointright Inc	$ 3,300	33				
Total	$ 7,190	72	$ -	-	$ -	-

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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
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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 III - Administrators* **										
Lauren Dubuque	68,703				Administrator 10/1/16 - 6/17/17	1,585	A2			
					#REF!					
Wesley Downing	22,890				Administrator 6/18/17 - 9/30/17	560	A2	Waterbury	1,520	56,860
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 Mystic	1063-C	9/30/2017	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	7,476	78				
3. Pharmacist	9,189	247				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	39,650	161				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
Other Physician Fees	9,062	73				
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	7,190	72				
B-13 Total Fees Paid in Lieu of Salaries	72,566	631				

* 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	
Dr. Stephen Gross 81 Beach St., Westerly, RI 02891	Orthopedic	○	⊙	
Dr. David Burchenal 213 Elm Street, Stonington, CT 06378	Medical Director	○	⊙	
Dr. Michael Feltes 3 Heron Rd. Mystic, CT 06355	Medical Director	○	⊙	
Healthdrive Dental Group 85 Barnes Rd, Suite 207 Wallingford, CT 0006492	Dentist	○	⊙	
West River Pharmacy of Connecticut Plainville, CT	Pharmacist	○	⊙	
Pointright 150 Cambridge Park Drive, Suite 301,Cambridge, MA 02140	Data Integrity Auditor	○	⊙	
PatientPing 10 Post Office Square Boston, MA	Admissions/Discharge Consultant	○	⊙	
CT Purchasing Consultant 88 Ryders Lane Stratford, CT	Purchasing Consultant	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Mystic	1063-C	9/30/2017	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	334,308	334,308		
2. Disability Insurance	$				
3. Unemployment Insurance	$	32,186	32,186		
4. Social Security (F.I.C.A.)	$	176,454	176,454		
5. Health Insurance	$	254,493	254,493		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	13,474	13,474		
7. Pensions (Non-Discriminatory)	$	14,899	14,899		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	29,185	29,185		
d. Accounting and Auditing	$	5,899	5,899		
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	9,880	9,880		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	13,812	13,812		
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	250	250		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	272,924	272,924		
Subtotal	$	1,157,763	1,157,763		

* 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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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Mystic	1063-C	9/30/2017	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,157,763	1,157,763		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	1,198	1,198		
2. Holiday Parties for Staff	$	2,568	2,568		
3. Gifts to Staff and Residents	$	11,014	11,014		
4. Employee Travel	$	7,864	7,864		
5. Education Expenses Related to Seminars and Conventions	$	2,449	2,449		
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*)	$	308	308		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	16,192	16,192		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	361	361		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,373	2,373		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	4,734	4,734		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	340	340		
9. Subscriptions	$	3,774	3,774		
10. Contributions*** 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**	$	218,694	218,694		
13. Other (*Specify*) See Attached Schedule	$	68,672	68,672		
C-14 Total Administrative & General Expenditures	$	1,498,303	1,498,303		

* 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	$ 16,192		
Total Other Advertising	$ 16,192	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM	$ 85		
CAHCF	$ 4,444		
ACADEMY OF NUTRITION & DIETETICS MEMBERSHIP	$ 205		
Total Dues	$ 4,734	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees Non Reimburable	$ 32,055		
Licenses & Fees	$ 1,971		
Pre Employment Screenings	$ 7,464		
Point Click Care Fees	$ 9,040		
Bank Charges, Penalties, Fees	$ 10,867		
Healthport Indirect	$ 4,213		
Legal Fees - Probate & Collection	$ 95		
Resident Expenses	$ -		
Account W/O & Prior Period Adjustments	$ 2,872		
Petty Cash	$ 95		
Total Other Administrative and General	$ 68,672	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Apple Rehab Mystic	1063-C	9/30/2017	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.	218,694	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 Mystic	1063-C	9/30/2017	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	110,624	110,624		
2. Non-Food Supplies	$	22,592	22,592		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	866	866		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	134,082	134,082		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	141	141		

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	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.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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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 Mystic	1063-C	9/30/2017	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. $	3,658	3,658		
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. $	4,577	4,577		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	8,235	8,235		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
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 laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	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 3E.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

*** 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 Mystic	1063-C	9/30/2017	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.	$	8,675	8,675		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	8,675	8,675		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from West River Pharmacy		$	207,033	207,033		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	110,192	110,192		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	19,168	19,168		
f. X-rays and Related Radiological Procedures***		$	6,084	6,084		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	20,353	20,353		
i. Recreation		$	30,554	30,554		
j. Other (Specify)**** See Attached Schedule		$	42,612	42,612		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	435,996	435,996		

* 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	$ 4,736		
Rehab Service Supplies	$ 9,430		
IV Therapy Supplies	$ 28,446		
Total Other Resident Care	$ 42,612	$ -	$ -

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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 Mystic	1063-C	9/30/2017	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
Jon's Quality Landscaping, LLC	150 Meridian St. Groton, CT 06340	○	⊙		Landscaping Services	14,071			22	6a
		○	⊙							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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 Mystic	1063-C	9/30/2017	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	111,658	111,658		
b. Heat	$	30,588	30,588		
c. Light & Power	$	44,465	44,465		
d. Water	$	17,415	17,415		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	6,988	6,988		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	211,115	211,115		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	240	240		
d. Movable Equipment	$	19,050	19,050		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	19,290	19,290		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	19,577	19,577		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	19,577	19,577		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	459,000	459,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	44,721	44,721		
c. Personal property taxes	$	3,707	3,707		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	546,294	546,294		

* 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	$ 6,988		
Total Other Repairs and Maintenance	$ 6,988	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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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	1,097,698		1,097,698	1,097,698				
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	13,056		13,056	11,211	S/L	Various	240	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								240

	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. Ford Van 1994	x		04	00	995		995	995	S/L	4 YRS		
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					496,579		496,579	429,006	S/L	Various	18,225	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					8,880		8,880		S/L	Various	825	
D-3. Subtotal												19,050
E. ***Total Depreciation***												19,290

Apple Rehab Mystic
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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	Cost	Useful Life	Depreciation	
Additions:					
4/27/2017	4 Cloud Wireless AP Units-KIT Assoc	$ 1,718	ME-5	$ 108	
12/31/2016	Patient Lifter (Transfer from Kent 11/18/10)	7162	ME-10	$ 716	
Total additions for Movable Equipment		$ 8,880		$ 825	*
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:					
9/12/2017	Asbestos Abatement-Hot Water Tank	$ 5,540	LHI-25	$ 19	
Total additions for Leasehold Improvement		$ 5,540		$ 19	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

***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
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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				738,443	591,147	A		19,557	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)				5,540				19	
C-4. Subtotal									19,577
D. ***Total Amortization***									19,577

* 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 Mystic	1063-C	9/30/2017	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	60
6. Square Footage	27,203
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)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)	Variable			
h. Date of Refinancing	12/07/16			
i. New Interest Rate	4.48%			
j. Term of Mortgage (number of years)	5 Years			
k. Amount of Principal Borrowed	4,452,250			
l. Principal Outstanding on Note Paid-Off	4,366,385			

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
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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 Mystic	1063-C	9/30/2017	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*) Value/Property Tax Interest			$	1,026	1,026		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)			$	1,026	1,026		
14. Insurance							
a. Insurance on Property (buildings only)			$	79,704	79,704		
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)***			$	79,704	79,704		
15. ***Total All Expenditures (A-13 thru C-14)***			$	5,614,499	5,614,499		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Apple Rehab Mystic	1063-C	9/30/2017	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 $	144,297	144,297		
4.			Other - See attached Schedule $	4,249	4,249		
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 $	29,185	29,185		
10.	15/16	1d/m1	Accounting & Legal $	3,863	3,863		
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 * $	16,192	16,192		
19.			Income Tax / Corporate Business Tax $				
20.	16	m10	Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	57,365	57,365		
Page 18 - Dietary Expenditures							
24.	30	IV1	Meals to employees, guests and others who are not residents $				
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) $	255,151	255,151		

* 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	12m	Social Service - Marketing	$ 4,249		
Total Other Salaries Adjustment			$ 4,249	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fees Non Reimburable	$ 32,055		
16	1.3	Employee Recognition/Gift/Parties	$ 11,014		
16	8a	Chamber of Commerce	$ 340		
16	m13	Bank Charges, Penalties, Fees	$ 10,867		
16	m13	Account W/O & Prior Period Adjustments	$ 2,872		
16	m13	Petty Cash	95		
30	IV8	Misc Income	123		
Total Other A&G Adjustments			$ 57,365	$ -	$ -

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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 Mystic	1063-C	9/30/2017	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	255,151	255,151		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	204,887	204,887		
28.	16	L1	Ambulance/Limousine $	1,198	1,198		
29.	20	h	X-rays, etc $	6,084	6,084		
30.	20	f	Laboratory $	20,353	20,353		
31.			Medical Supplies $				
32.	20	5e2	Oxygen (non emergency) $	15,317	15,317		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	37,877	37,877		
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.			Research or Experimental Activities $				
43.	30	IV4	Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.	30	IV5	Interest Income on Accounts Rec $	12	12		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $	983	983		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			***Total Amount of Decrease (Items 1 - 50)*** $	541,862	541,862		

*** 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

Apple Rehab Mystic
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy Supplies	$ 28,446		
20	5j	Rehab Service Supplies	$ 9,430		
Total Other Ancillary Costs			$ 37,877	$ -	$ -

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 Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12D	Tax Collector Town of Stonington	$ 983		
Total Other Adjustments			$ 983	$ -	$ -

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 Mystic	1063-C	9/30/2017	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	1,898,161	1,898,161		
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)*	$	1,590,966	1,590,966		
b. Medicare Room and Board Contractual Allowance **	$	497,326	497,326		
4. a. Private-Pay Residents and Other	$	1,421,411	1,421,411		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	93,157	93,157		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(93,157)	(93,157)		
c. Prescription Drugs - Non-Medicare	$	82,324	82,324		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(82,324)	(82,324)		
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	$	350,948	350,948		
b. Physical Therapy - Medicare Contractual Allowance **	$	(278,718)	(278,718)		
c. Physical Therapy - Non-Medicare	$	119,455	119,455		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(119,455)	(119,455)		
4. a. Speech Therapy - Medicare	$	26,011	26,011		
b. Speech Therapy - Medicare Contractual Allowance **	$	(16,262)	(16,262)		
c. Speech Therapy - Non-Medicare	$	2,430	2,430		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(2,430)	(2,430)		
5. a. Occupational Therapy - Medicare	$	383,132	383,132		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(334,931)	(334,931)		
c. Occupational Therapy - Non-Medicare	$	127,665	127,665		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(127,665)	(127,665)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	5,538,043	5,538,043		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	12	12		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	3,346	3,346		
V. Total Other Revenue (1 thru 8)	$	3,358	3,358		
VI. Total All Revenue (III +V)	$	5,541,401	5,541,401		

* *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)
30IV5	Interest Income	657,291	$ 12		
Total Interest Income			$ 12	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30IV 8	Sale of Assets (Transfer asset from Kent 11/18/10)	$ 3,223		
	Account W/O	$ 1		
	Small Claims Court fee	$ 101		
	State of CT Dept of Rev Svcs	$ 19		
	Interest	$ 2		
Total Other Revenue		$ 3,346	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Mystic	1063-C	9/30/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 1,445
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 657,291
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 21,250
5. Prepaid Expenses				$ 29,084
a. Prepaid Property Tax		15,012		
b. Prepaid Insurance				
c. Prepaid Other		14,071		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 1,975,268
Due Affiliate (Debit Balance)		1,975,268		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,684,337
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	1,097,698		$
	Accum. Depreciation	1,097,698	Net	
4. Leasehold Improvements	*Historical Cost	743,983		$ 133,259
	Accum. Depreciation	610,724	Net	
5. Non-Movable Equipment	*Historical Cost	13,056		$ 1,605
	Accum. Depreciation	11,451	Net	
6. Movable Equipment	*Historical Cost	496,579		$ 48,524
	Accum. Depreciation	448,056	Net	
7. Motor Vehicles	*Historical Cost	995		$
	Accum. Depreciation	995	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 11,550
Fixed Asset Clearing Account		11,550		
Construction in Progress				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 194,937

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

(*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 Mystic	1063-C	9/30/2017	32	37

Account				Amount
			Total Brought Forward:	$ 2,879,275
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*)				$ 254
Loans Rec. - Officers/Owner				
Capitalized Refinance				
Leasehold Deposits		254		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 254
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 2,879,529

* 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 Mystic	1063-C	9/30/2017	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 304,454
2. Notes Payable (*itemize*)					$
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*)					$ 28,897
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 7,134
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*)					$ 532,245
Accrued PTO	98,499	Accrued Prof Fees	4,999		
Accrued Pension	640	Payroll W/H	4,396		
Accrued Worker's Comp	337,736	Due Affiliate (Credit Bal			
Accrued Expense Other	85,975				
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 872,730

* 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 Mystic	1063-C	9/30/2017	34 | 37

Account	Amount
Total Brought Forward:	872,730
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*)	$ 782,973

Name and Address of Lender	Amount	Loan Date
Brian J. Foley	782,973	Demand

4. Other Long-Term Liabilities (*itemize*)	$
Security Deposits	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 782,973
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 1,655,703

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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 Mystic	1063-C	9/30/2017	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	$ 97,221
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 1,198,703
	6. Gain or Loss for Period 10/1/2016 thru 9/30/2017	$ (73,098)
	7. Total Net Worth	$ 1,223,826
C.	***Total Reserves and Net Worth***	$ 1,223,826
D.	***Total Liabilities, Reserves, and Net Worth***	$ 2,879,529

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Mystic	1063-C	9/30/2017	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016			$ 1,296,924
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 5,541,401
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 5,614,499
D.	Net Income or Deficit			$ (73,098)
E.	Balance			$ 1,223,826
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 3,409
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	Brian Foley		3,409	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/17			$ 1,223,826

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Mystic	1063-C	9/30/2017	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. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer	
Robert Gwizdak	
Address	**Phone Number**
21 Waterville Road Avon, CT 06001	(860) 678-9755