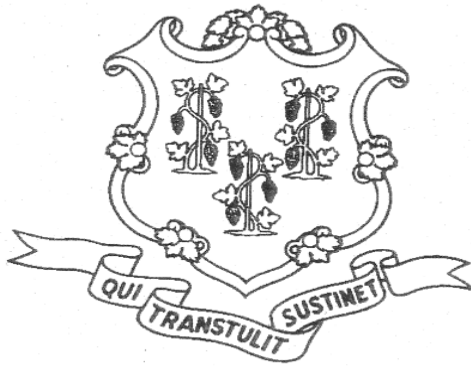


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Apple Rehab Cocomo	
Address (No. & Street, City, State, Zip Code) 33 Cone Ave Meriden, CT 06450	
Type of Facility Chronic and Convalescent Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH) (RHNS)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH 2074-C	RHNS	(Specify)	Medicare Provider 07-5345
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Medicaid Provider Numbers:	CCNH 20743	RHNS	ICF-IID
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For Department Use Only

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

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General Information

Name of Facility (as licensed) Apple Rehab Coccomo	License No. 2074-C	Report for Year Ended 9/30/2017	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 Coccomo [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) David Desell			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)

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 Cocomo	Period Covered:	From 10/1/2016	To 9/30/2017	
Address of Facility 33 Cone Ave Meriden, CT 06450				
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.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-238-1606		Report for Year Ended 9/30/2017		Page 2	of 37
Name of Facility (as shown on license) Apple Rehab Cocomo			Address (No. & Street, City, State, Zip) 33 Cone Ave Meriden, CT 06450		
License Numbers:	CCNH 2074-C	RHNS	(Specify)	Medicare Provider No. 07-5345	
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.					
Administrator					
Name of Administrator David Desell			Nursing Home Administrator's License No.:	1861	
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 Cocomo	License No. 2074-C	Report for Year Ended 9/30/2017	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 Cocomo	33 Cone Ave Meriden, CT 06450	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	

Annual Report of Long-Term Care Facility

**General Information and Questionnaire
Related Parties***

Name of Facility Apple Rehab Cocomo	License No. 2074-C	Report for Year Ended 9/30/2017	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 Road Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Real Estate Rental	Pg. 22 Line 9	685,249	685,249
Apple Health Care	21 Waterville Road Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Management & Accounting Services	Pg. 16 Line m12	372,623	372,623
Healthport Services	21 Waterville Road Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 /16 m13	28,795	28,795
Corporate Employees	21 Waterville Road Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	10,814	10,814
Employees @ Various Apple Facilities		<input type="radio"/>	<input checked="" type="radio"/>		Employee Staffing	Pg. 10 Schedule	(45,135)	(45,135)
Apple Health Care	21 Waterville Road Avon, CT 06001	<input type="radio"/>	<input checked="" type="radio"/>		Pension Plan (401K)	Pg. 15 1a7	18,292	18,292
Aetna	PO Box 88860 Chicago, IL	<input checked="" type="radio"/>	<input type="radio"/>		Group Medical	Pg. 15 1a5	512,690	
Delta Dental	PO Box 23700 Newark NJ	<input checked="" type="radio"/>	<input type="radio"/>		Group Dental	Pg. 15 1a5	31,698	
Aetna Ancillary	PO Box 88860 Chicago, IL	<input checked="" type="radio"/>	<input type="radio"/>		Group Life & Disability	Pg. 15 1a6	22,804	

* 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 Cocomo		License No. 2074-C		Report for Year Ended 9/30/2017		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	%**				
Marsh	PO Box 19636 Newark, NJ	✗			Property, Liability & Umbrella Insurance	Pg. 27 14a	25,275	
AIG	PO Box 10472 Newark, NJ	✗			Worker's Compensation	Pg. 15 1a1	290,790	
Swallowing Diagnostics	21 Waterville Road Avon, CT	✗		83%	Diagnostic Services	Pg 20 5 f	6,840	6,436
Ryan Vess	21 Waterville Road Avon, CT		✗			##		
Brendan Foley	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 (Brendan Foley through 3/9/17)

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Apple Rehab Cocomo	License No. 2074-C	Report for Year Ended 9/30/2017	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (<i>See listing page 13</i>)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required? Yes No If "No," explain fully why such allocation was not made.

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.

The costs incurred by Apple Health Care, inc. (a related party), to provide Accounting and Managerial services to each facility owned by Brian J. Foley, are allocated on a per bed basis.

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

Yes No If "No," explain fully why such allocation was not made.

N/A

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility Apple Rehab Cocomo			License No. 2074-C			Report for Year Ended 9/30/2017		Page of 6 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 type="radio"/>								
	<input type="radio"/>	<input type="radio"/>								
	<input type="radio"/>	<input type="radio"/>								
	<input type="radio"/>	<input type="radio"/>								
	<input type="radio"/>	<input type="radio"/>								
	<input type="radio"/>	<input type="radio"/>								
	<input type="radio"/>	<input type="radio"/>								
	<input type="radio"/>	<input type="radio"/>								
	<input type="radio"/>	<input type="radio"/>								
	<input type="radio"/>	<input type="radio"/>								
Is a Mileage Log Book Maintained for All Leased Vehicles ?								<input checked="" 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.

General Information and Questionnaire Accounting Basis

Name of Facility Apple Rehab Cocomo	License No. 2074-C	Report for Year Ended 9/30/2017	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual Cash Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 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)	\$	1,466
2 Preparation of tax returns	\$	2,132
3	\$	
4	\$	
Charge for Services Provided		
\$		3,598

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 Wallingford Town Clerk	
2 J. Marinan	
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1 Probate fees	\$	63
2 State marshal - filing fees	\$	62
3	\$	
4	\$	
5	\$	
Charge for Services Provided		
\$		125

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Pg. 15 1e

Schedule of Resident Statistics

Name of Facility Apple Rehab Cocomo			License No. 2074-C			Report for Year Ended 9/30/2017				Page 8		of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	100	100			100	100			100	100			
B. On last day of THIS report period	100	100			100	100			100	100			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	88	88			88	88			88	88			
B. As of midnight of THIS report period	82	82			82	82			82	82			
3. Total Number of Days Care Provided During Period													
A. Medicare	4,548	4,548			3,431	3,431			1,117	1,117			
B. Medicaid (Conn.)	22,850	22,850			17,142	17,142			5,708	5,708			
C. Medicaid (other states)													
D. Private Pay	3,055	3,055			2,427	2,427			628	628			
E. State SSI for RCH													
F. Other (Specify)													
G. Total Care Days During Period (3A thru F)	30,453	30,453			23,000	23,000			7,453	7,453			
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)	30,453	30,453			23,000	23,000			7,453	7,453			

Schedule of Resident Statistics (Cont'd)

Name of Facility Apple Rehab Cocomo	License No. 2074-C	Report for Year Ended 9/30/2017	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No

If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(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)
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	6	60		16				
Per Diem Rate								
a. One bed rm.				447.00				
b. Two bed rms.	RUGS III	196.16		398.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	4,569	4,569		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	10,418	10,418		
D. Total Physical Therapy Treatments	14,987	14,987		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	856	856		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,134	1,134		
D. Total Speech Therapy Treatments	1,990	1,990		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	3,635	3,635		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	9,776	9,776		
D. Total Occupational Therapy Treatments	13,411	13,411		

Report of Expenditures - Salaries & Wages

Name of Facility Apple Rehab Cocomo	License No. 2074-C	Report for Year Ended 9/30/2017	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	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)	105,857	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	41,720	2,423				
5. Dietary Service						
a. Head Dietitian	67,038	2,134				
b. Food Service Supervisor	58,292	2,064				
c. Dietary Workers	307,375	21,382				
6. Housekeeping Service						
a. Head Housekeeper	41,768	2,024				
b. Other Housekeeping Workers	106,484	7,644				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	78,422	4,056				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	87,240	7,577				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	115,890	4,321				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	156,934	3,433				
b. RN						
1. Direct Care	574,532	14,193				
2. Administrative**	162,287	5,034				
c. LPN						
1. Direct Care	725,835	25,736				
2. Administrative**						
d. Aides and Attendants	1,087,581	70,245				
e. Physical Therapists	356,511	8,785				
f. Speech Therapists	69,761	1,764				
g. Occupational Therapists	142,472	4,289				
h. Recreation Workers	75,268	4,924				
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	95,630	3,849				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	4,456,900	197,957				

* 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)

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

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Purchase consult	\$ 2,053	27				
Deaf Interpreter	\$ 2,209	29				
MDS Consult	\$ 1,837	24				
Data Integrity Auditor	\$ 3,300	44				
Total	\$ 9,399	125	\$ -	-	\$ -	-

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

Name of Facility Apple Rehab Coccoma				License No. 2074-C	Report for Year Ended 9/30/2017			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

**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 Cocco				2074-C	9/30/2017			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Amy Pellerin	82,401				Admin 10/1/16 - 6/17/17	1,520	A 2	Harbor View	560	33,179
David Desell	23,456				Admin 6/18/17 - 9/30/17	560	A 2	Ledgecrest	1,520	56,549
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.

Annual Report of Long-Term Care Facility

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Apple Rehab Cocomo	2074-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	11,570	340				
3. Pharmacist	15,238	448				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	2,699	36				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	30,000					
b. Utilization Review (Title 18 and 19 only) monthly meeting	600	4				
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	186	2				
b. Other						
10. Occupational Therapist						
a. Resident Care	17,674	236				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	1,783	32				
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	9,399	125				
B-13 Total Fees Paid in Lieu of Salaries	89,149	1,224				

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

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

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

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

Name of Facility Apple Rehab Cocomo		License No. 2074-C	Report for Year Ended 9/30/2017	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Jay Kaplan 816 Broad St Meriden CT	Medical Director - Utilization review	<input type="radio"/>	<input checked="" type="radio"/>		
West River 41 Northwest Dr. Plainville, CT	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>		
Healthdrive One Prestige Dr Meriden CT	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
State of CT Dept of Rehab Hartford CT	Deaf Interpretor	<input type="radio"/>	<input checked="" type="radio"/>		
Tatiana Feld 816 Broad St Meriden CT	Medical Director - Utilization review	<input type="radio"/>	<input checked="" type="radio"/>		
CONNECTICUT PURCHASING CONSULTANTS, LLC	Purchase Consult	<input type="radio"/>	<input checked="" type="radio"/>		
PATIENTPING INC	MDS Consult	<input type="radio"/>	<input checked="" type="radio"/>		
Pointright	Data Integrity Auditor	<input type="radio"/>	<input checked="" type="radio"/>		
RN STAFF INC DBA REHABILITY CARE	PT - OT	<input type="radio"/>	<input checked="" type="radio"/>		
Accelerated Care Plus Chicago Il	PT - OT	<input type="radio"/>	<input checked="" type="radio"/>		
Core Medical Group 3000 Goffs Falls Manchester NH	PT - OT - ST	<input type="radio"/>	<input checked="" type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input 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 Cocomo	2074-C	9/30/2017		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 290,790	290,790			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 66,674	66,674			
4. Social Security (F.I.C.A.)	\$ 325,236	325,236			
5. Health Insurance	\$ 395,502	395,502			
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 22,804	22,804			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 18,292	18,292			
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*	\$ 204,384	204,384			
d. Accounting and Auditing	\$ 3,598	3,598			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 125	125			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 13,783	13,783			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 15,217	15,217			
2. Cellular Phones	\$				
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 250	250			
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	\$ 540,425	540,425			
Subtotal	\$ 1,897,080	1,897,080			

* 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**

Apple Rehab Cocomo
9/30/2017

Attachment Page 15

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Cocomo	2074-C	9/30/2017	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	1,897,080	1,897,080		
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$ 2,997	2,997		
2. Holiday Parties for Staff	\$ 2,203	2,203		
3. Gifts to Staff and Residents	\$ 16,775	16,775		
4. Employee Travel	\$ 6,504	6,504		
5. Education Expenses Related to Seminars and Conventions	\$ 2,832	2,832		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 3,363	3,363		
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 9,846	9,846		
4. Fund-Raising***	\$			
5. Medical Records	\$ 3,350	3,350		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 4,150	4,150		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 8,022	8,022		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 662	662		
9. Subscriptions	\$			
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**	\$ 372,623	372,623		
13. Other (<i>Specify</i>) See Attached Schedule	\$ 110,927	110,927		
C-14 Total Administrative & General Expenditures	\$ 2,441,335	2,441,335		

* 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	\$ 9,846		
Total Other Advertising	\$ 9,846	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	\$ 7,174		
Rightcare - PCC	\$ 808		
Infection Control Membership - Kaplan	\$ 40		
Total Dues	\$ 8,022	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees Non Reimburable	\$ 63,339		
Licenses & Fees	\$ 8,607		
Pre Employment Screenings	\$ 17,762		
Point Click Care Fees	\$ 15,328		
Bank Charges, Penalties, Fees	\$ 82		
Healthport Indirect	\$ 5,342		
Legal Fees - Probate & Collection	\$ 445		
Resident Expenses	\$ 8		
Account W/O & Prior Period Adjustments	\$ 16		
Total Other Administrative and General	\$ 110,927	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Apple Rehab Cocomo	License No. 2074-C	Report for Year Ended 9/30/2017	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.	372,623	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.**

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

Name of Facility Apple Rehab Cocomo	License No. 2074-C	Report for Year Ended 9/30/2017	Page 18	of 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 219,729	219,729		
2. Non-Food Supplies	\$ 28,466	28,466		
3. Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 1,281	1,281		
c. Management Services**	\$			
d. Other (Specify) _____	\$			
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 249,476	249,476		
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*	250	250		
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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.

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

Name of Facility Apple Rehab Cocomo		License No. 2074-C	Report for Year Ended 9/30/2017	Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	10,545	10,545		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$	12,729	12,729		
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)		\$	23,274	23,274	
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
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 laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K. Did you receive revenue 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)			

* 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.

**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 Cocomo		2074-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 (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	26,558	26,558		
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.	Management Services*	\$				
d.	Other (<i>Specify</i>)	\$				
4E.	Total Housekeeping Expenditures (4a + b + c + d)	\$	26,558	26,558		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from West River Pharmacy	\$	294,741	294,741		
b.	Medicine Cabinet Drugs	\$				
c.	Medical and Therapeutic Supplies	\$	249,477	249,477		
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	38,900	38,900		
f.	X-rays and Related Radiological Procedures***	\$	20,772	20,772		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	20,521	20,521		
i.	Recreation	\$	26,195	26,195		
j.	Other (Specify)**** See Attached Schedule	\$	44,987	44,987		
5K.	Total Resident Care Expenditures (5a - 5j)	\$	695,594	695,594		

* 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.

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

Name of Facility Apple Rehab Cocomo			License No. 2074-C		Report for Year Ended 9/30/2017				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)	Pg	Line
CWPM	25 Norton Pl Plainville CT	<input type="radio"/>	<input checked="" type="radio"/>		Refuse removal	21,569			22	6 f
Roy's Landscaping	P.O. Box 224 Portland CT	<input type="radio"/>	<input checked="" type="radio"/>		Snow removal - Landscaping	41,315			22	6 a
Saucier Mechanical	148 Norton St Plantsville CT	<input type="radio"/>	<input checked="" type="radio"/>		Heating \ AC	28,351			22	6 a
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input 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 Cocomo	2074-C	9/30/2017			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 169,861	169,861				
b. Heat	\$ 10,890	10,890				
c. Light & Power	\$ 121,361	121,361				
d. Water	\$ 34,100	34,100				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$ 23,710	23,710				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 359,922	359,922				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$ 1,223	1,223				
d. Movable Equipment	\$ 31,624	31,624				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 32,847	32,847				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 55,199	55,199				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 55,199	55,199				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 685,249	685,249				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 27,746	27,746				
c. Personal property taxes	\$ 5,451	5,451				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 806,491	806,491				

* 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	\$ 23,710		
Total Other Repairs and Maintenance	\$ 23,710	\$ -	\$ -

Apple Rehab Coccoma
9/30/2017

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:				
6/16/2017	Kitchen Hood Exhaust Fan Repair-Motor	\$ 698	NME-10	\$ 19
6/16/2017	Kitchen Hood Exhaust Fan Repair-Motor	\$ 698	NME-10	\$ 19
Total additions for Non-Movable Equipment		\$ 1,395		\$ 38 *
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:				
11/28/2016	1 UniMac Washing Machine	\$ 13,403	ME-10	\$ 1,675
3/30/2017	Patient Lift Machine(Arjohuntleigh)	\$ 6,789	ME-10	\$ 227
8/30/2017	Food Processor-Blixer 3-1/2 Quart 1.5HP	\$ 1,671	ME-10	\$ 22
8/30/2017	Ice Machine and Ice Bin(Direct Supply)	\$ 3,529	ME-10	\$ 46
Total additions for Movable Equipment		\$ 25,392		\$ 1,971 *
Deletions:				
4/1/2005	Milnor washer	\$ (13,778)	ME - 10	
Total deletions for Movable Equipment		\$ (13,778)		\$ - **

*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:				
5/31/2017	Compressor Install-Lobby HVAC Unit	\$ 4,650	LHI-15	\$ 89
5/31/2017	Compressor Install-Lobby HVAC Unit	\$ 4,650	LHI-15	\$ 89
8/22/2017	A/C Repair in Wing 100 - Compressor	\$ 3,673	LHI-15	\$ 37
Total additions for Leasehold Improvement		\$ 12,973		\$ 215 *
Deletions:				
3/24/2016	Vinyl Flooring-Resident Room & Lounge	\$ (1,195)	LHI-10	
3/24/2016	Vinyl Flooring-Resident Room & Lounge	\$ (672)	LHI-10	
Total deletions for Leasehold Improvement		\$ (1,867)		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Apple Rehab Cocomo			License No. 2074-C		Report for Year Ended 9/30/2017			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				1,279,299	745,234	A		54,984	
2. Disposals (attach schedule)				(1,867)					
3. Acquired during this report period (attach schedule)				12,973				215	
C-4. Subtotal									55,199
D. Total Amortization									55,199

* 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 Cocomo	License No. 2074-C	Report for Year Ended 9/30/2017	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" 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	100			
6. Square Footage	33,656			
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)	Fixed			
h. Date of Refinancing	12/07/16			
i. New Interest Rate	3.51%			
j. Term of Mortgage (number of years)	30			
k. Amount of Principal Borrowed	4,221,600			
l. Principal Outstanding on Note Paid-Off	5,622,474			
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 Cocomo		License No. 2074-C	Report for Year Ended 9/30/2017			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
B. CHEFA Loan Information							
1. Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expense							
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$					

(Carry Subtotals forward to next page)

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

Name of Facility Apple Rehab Cocomo		License No. 2074-C		Report for Year Ended 9/30/2017		Page of 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)				\$			
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$			
14. Insurance							
a. Insurance on Property (buildings only)				\$ 25,275	25,275		
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)				\$ 25,275	25,275		
15. Total All Expenditures (A-13 thru C-14)				\$ 9,173,972	9,173,972		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Apple Rehab Cocomo				2074-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	\$ 142,472	142,472		
4.			Other - See attached Schedule	\$ 9,563	9,563		
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 17,674	17,674		
7.			Other - See attached Schedule	\$ 30,000	30,000		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 204,384	204,384		
10.	15/16	1d/m	Accounting & Legal	\$ 2,036	2,036		
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 *	\$ 9,846	9,846		
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	\$ 112,023	112,023		
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)				\$ 527,997	527,997		

* 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	A 12 m	Salaries - Social Services/Admissions	\$ 9,563		
Total Other Salaries Adjustment			\$ 9,563	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B 8 a	Medical Director	\$ 30,000		
Total Other Fees Adjustments			\$ 30,000	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fee - Non Reimbursable	\$ 63,339		
16	1.3	Employee Recognition/Gift/Parties	\$ 16,775		
16	8a	Chamber of Commerce	\$ 662		
16	m13	Bank Charges	\$ 82		
16	m13	Resident Expenses	\$ 8		
16	m13	Prior Period Adj/Account W/O	\$ 16		
16	m13	User Fee			
30	IV 8	Account W\O	\$ 567		
30	IV 8	Insurance claim gain	\$ 7,192		
30	IV 8	Rebates	\$ 21,285		
30	IV 8	Medical Records	\$ 167		
30	IV 8	State of CT Labor Refund	\$ 1,931		
Total Other A&G Adjustments			\$ 112,023	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Apple Rehab Cocomo				2074-C	9/30/2017	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 527,997	527,997		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 291,182	291,182		
28.	16	L1	Ambulance/Limousine	\$ 2,997	2,997		
29.	20	h	X-rays, etc	\$ 20,772	20,772		
30.	20	f	Laboratory	\$ 20,521	20,521		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 27,915	27,915		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 40,741	40,741		
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	\$ 30	30		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
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)			\$ 932,155	932,155		

*** 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.

Apple Rehab Cocomo
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy Supplies	\$ 32,900		
20	5j	Rehab Service Supplies	\$ 7,841		
Total Other Ancillary Costs			\$ 40,741	\$ -	\$ -

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			\$ -	\$ -	\$ -

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Apple Rehab Cocomo	2074-C	9/30/2017			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 4,391,393	4,391,393				
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>)	\$ 1,595,056	1,595,056				
b. Medicare Room and Board Contractual Allowance **	\$ 427,569	427,569				
4. a. Private-Pay Residents and Other	\$ 1,440,740	1,440,740				
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 130,474	130,474				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (130,496)	(130,496)				
c. Prescription Drugs - Non-Medicare	\$ 115,756	115,756				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (115,756)	(115,756)				
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	\$ 357,035	357,035				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (216,361)	(216,361)				
c. Physical Therapy - Non-Medicare	\$ 167,515	167,515				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (161,210)	(161,210)				
4. a. Speech Therapy - Medicare	\$ 67,186	67,186				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (33,300)	(33,300)				
c. Speech Therapy - Non-Medicare	\$ 22,365	22,365				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (21,780)	(21,780)				
5. a. Occupational Therapy - Medicare	\$ 409,593	409,593				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (265,697)	(265,697)				
c. Occupational Therapy - Non-Medicare	\$ 193,905	193,905				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (193,905)	(193,905)				
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$ 2,616	2,616				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 8,182,698	8,182,698				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 30	30				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 31,141	31,141				
V. Total Other Revenue (1 thru 8)	\$ 31,171	31,171				
VI. Total All Revenue (III +V)	\$ 8,213,869	8,213,869				

* 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)
30 II 6 b	Private Lab	\$ 2,616		
Total Other Resident Revenue		\$ 2,616	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30 IV 5	Interest income	1,595,056	\$ 30		
Total Interest Income			\$ 30	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV 8	Account W/O	\$ 567		
30 IV 8	Insurance claim gain	\$ 7,192		
30 IV 8	Rebates	\$ 21,285		
30 IV 8	Medical Records	\$ 167		
30 IV 8	State of CT Labor Refund	\$ 1,931		
Total Other Revenue		\$ 31,141	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Cocomo	2074-C	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	400
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,788,170
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	16,035
5. Prepaid Expenses			\$	
a. Prepaid Property Tax				
b. Prepaid Insurance				
c. Prepaid Other				
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	76,303
Due Affiliate (Debit Balance)				
Payroll W/H	14,367			
AP Other	61,936			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,880,908
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>1,290,406</u>		\$	489,972
	Accum. Depreciation <u>800,433</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>61,675</u>		\$	185
	Accum. Depreciation <u>61,489</u>	Net		
6. Movable Equipment	*Historical Cost <u>580,366</u>		\$	149,565
	Accum. Depreciation <u>430,801</u>	Net		
7. Motor Vehicles	*Historical Cost <u>3,658</u>		\$	
	Accum. Depreciation <u>3,658</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
Fixed Asset Clearing Account				
Construction in Progress				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	639,723

* 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 Apple Rehab Cocomo	License No. 2074-C	Report for Year Ended 9/30/2017	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 2,520,631	
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>)			\$	
Loans Rec. - Officers/Owner				
Capitalized Refinance				
Leasehold Deposits				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 2,520,631	

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Cocomo	2074-C	9/30/2017	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	457,471
2. Notes Payable (<i>itemize</i>)			\$	

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>)			\$	47,859
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	13,594
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable (<i>Current Portion</i>)			\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$	
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities (<i>itemize</i>)			\$	2,616,057
Accrued PTO	151,444	Accrued Prof Fees	7,605	
Accrued Pension	708	Payroll W/H	3,723	
Accrued Worker's Comp	291,113	Due Affiliate (Credit Bal	1,936,635	
Accrued Expense Other	219,696	Exchange 1,846 Prepaid	5,133	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	3,134,981

* 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 Cocomo		License No. 2074-C	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount	
Total Brought Forward:				3,134,981	
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			
Brian J. Foley		Demand			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$	
Security Deposits					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 3,134,981	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Cocomo	2074-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 (<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			\$	64,742
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	280,011
6. Gain or Loss for Period			\$	(960,103)
	10/1/2016	thru	9/30/2017	
7. Total Net Worth			\$	(614,350)
C. Total Reserves and Net Worth			\$	(614,350)
D. Total Liabilities, Reserves, and Net Worth			\$	2,520,631

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Apple Rehab Cocomo	2074-C	9/30/2017	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	351,435
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	8,213,869
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	9,173,972
D. Net Income or Deficit			\$	(960,103)
E. Balance			\$	(608,668)
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	5,682
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
Brian Foley		President	5,682	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	5,682
H. Balance at End of Period			\$	(614,350)
				09/30/17

I. Preparer's/Reviewer's Certification

Name of Facility Apple Rehab Cocomo	License No. 2074-C	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<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			Phone Number	
21 Waterville Road Avon, CT 06001			(860) 678-9755	