State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2018

Name of Facility (as licensed) Hewitt Health & Rehabilitation Center		
Address (No. & Street, City, State, Zip Code) 45 Maltby St. Shelton, CT 06484		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2297-C			07-5047

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	5876		

For Department Use Only

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Hewitt Health & Rehabilitation Center [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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) Marjorie Simpson			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)

Table of Contents

	General Information - Administrator's/Owner's Certification	1
	General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
	General Information and Questionnaire - Type of Facility - Organization Structure	2
	General Information and Questionnaire - Partners/Members	3
	General Information and Questionnaire - Corporate Owners	3A
	General Information and Questionnaire - Individual Proprietorship	3B
	General Information and Questionnaire - Related Parties	4
	General Information and Questionnaire - Basis for Allocation of Costs	5
	General Information and Questionnaire - Leases	6
	General Information and Questionnaire - Accounting Basis	7
	Schedule of Resident Statistics	8
	Schedule of Resident Statistics (Cont'd)	9
A.	Report of Expenditures - Salaries & Wages	10
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
	Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B.	Report of Expenditures - Professional Fees	13
	Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C.	Expenditures Other than Salaries - Administrative and General	15
C.	Expenditures Other than Salaries (Cont'd) - Administrative and General	16
	Schedule C-1 - Management Services	17
C.	Expenditures Other than Salaries (Cont'd) - Dietary	18
C.	Expenditures Other than Salaries (Cont'd) - Laundry	19
C.	Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
	Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C.	Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
	Depreciation Schedule	23
	Amortization Schedule	24
C.	Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C.	Expenditures Other than Salaries (Cont'd) - Interest	26
C.	Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D.	Adjustments to Statement of Expenditures	28
D.	Adjustments to Statement of Expenditures (Cont'd)	29
F.	Statement of Revenue	30
G.	Balance Sheet	31
G.	Balance Sheet (Cont'd)	32
G.	Balance Sheet (Cont'd)	33
G.	Balance Sheet (Cont'd)	34
G.	Balance Sheet (Cont'd) - Reserves and Net Worth	35
H.	Changes in Total Net Worth	36
I.	Preparer's/Reviewer's Certification	37

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1A Rev. 6/95

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 Hewitt Health & Rehabilitation Center	Period Covered:		From 10/1/2017	To 9/30/2018
Address of Facility 45 Maltby St. Shelton, CT 06484				
Report Prepared By Apple Health Care. Inc.	Phone Number (860) 678-9755		Date	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-2 Rev. 10/2005

General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
(203) 924-4671	9/30/2018	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Hewitt Health & Rehabilitation Center	45 Maltby St. Shelton, CT 06484

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	2297-C			07-5047

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.:	
Marjorie Simpson		001458

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

Name	License No.:

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3 Rev. 10/2005

General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	3	37

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

Name of Partners/Members	Business Address	Title	% Owned

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	3A	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
Hewitt Health & Rehabilitation Center	45 Maltby St. Shelton, CT 06484	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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	3B	37

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

Owner(s) of Facility

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	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	%**				
Brian J. Foley	21 Waterville Road Avon, CT 06001	○	⊙		Real Estate Rental	Pg. 22 Line 9	1,103,946	1,103,946
Apple Health Care	21 Waterville Road Avon, CT 06001	○	⊙		Management & Accounting Services	Pg. 16 Line m12	456,660	456,660
Corporate Employees	21 Waterville Road Avon, CT 06001	○	⊙		Employee Staffing	Pg. 10 Schedule	121,704	121,704
Employees @ Various Apple Facilities		○	⊙		Employee Staffing	Pg. 10 Schedule	64,419	64,419
Apple Health Care	21 Waterville Road Avon, CT 06001	○	⊙		Pension Plan (401K)	Pg. 15 Line 1a7	27,251	27,251
Aetna	PO Box 88860 Chicago, IL 60695	⊙	○		Group Medical	Pg. 15 Line 1a5	404,510	
Delta Dental	PO Box 222 Parsippany, NJ 07054	⊙	○		Group Dental	Pg. 15 Line 1a5	44,319	
Aetna Ancillary	PO Box 88860 Chicago, IL 60695	⊙	○		Group Life & Disability	Pg. 15 Line 1a6	36,268	
Marsh	PO Box 846015 Dallas, TX 75284	⊙	○		Property, Liability, & Umbrella Insurance	Pg. 27 Line 14a	102,289	

* Use additional sheets if necessary.

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	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	%**				
AIG	PO Box 10472 Newark, NJ	✠			Worker's Compensation	Pg. 15 1a1	228,508	
Swallowing Diagnotics	21 Waterville Road Avon, CT	✠		83%	Diagnostic Services	Pg 20 5f	12,030	11,344
Ryan Vess	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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-5 Rev. 9/2002

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	5	37

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-6 Rev. 9/2002

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
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	6	37

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
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	

Is a Mileage Log Book Maintained for All Leased Vehicles ? ⊙ Yes ○ No

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-7 Rev. 6/95

General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Cer	2297-C	9/30/2018	7	37

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)	$	(6,356)
2 Preparation of tax returns	$	2,206
3	$	
4	$	
	Charge for Services Provided	
	$	(4,150)

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	8	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	160	160			160	160			160	160		
B. On last day of THIS report period	160	160			160	160			160	160		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	103	103			103	103			102	102		
B. As of midnight of THIS report period	102	102			102	102			102	102		
3. Total Number of Days Care Provided During Period												
A. Medicare	3,939	3,939			2,945	2,945			994	994		
B. Medicaid (Conn.)	30,401	30,401			22,458	22,458			7,943	7,943		
C. Medicaid (other states)												
D. Private Pay	3,664	3,664			2,617	2,617			1,047	1,047		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	38,004	38,004			28,020	28,020			9,984	9,984		
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)**	38,004	38,004			28,020	28,020			9,984	9,984		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	9	37

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	3	82		17				
Per Diem Rate								
a. One bed rm.				396.00				
b. Two bed rms.	various RUG	227.77		295.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	5,337	5,337		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	10,818	10,818		
D. ***Total Physical Therapy Treatments***	16,155	16,155		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	854	854		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,038	1,038		
D. ***Total Speech Therapy Treatments***	1,892	1,892		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	4,416	4,416		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	11,227	11,227		
D. ***Total Occupational Therapy Treatments***	15,643	15,643		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	10	37

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)	112,518	2,126				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	84,047	5,055				
5. Dietary Service						
a. Head Dietitian	45	2				
b. Food Service Supervisor	32,512	1,375				
c. Dietary Workers	391,775	24,926				
6. Housekeeping Service						
a. Head Housekeeper	53,558	2,388				
b. Other Housekeeping Workers	198,169	14,751				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	157,311	7,436				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	44,413	2,874				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	161,058	6,382				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	197,721	4,132				
b. RN						
1. Direct Care	567,173	15,616				
2. Administrative**	240,881	7,058				
c. LPN						
1. Direct Care	897,141	32,571				
2. Administrative**						
d. Aides and Attendants	1,612,568	93,792				
e. Physical Therapists	261,232	7,666				
f. Speech Therapists	71,635	1,691				
g. Occupational Therapists	237,819	6,236				
h. Recreation Workers	108,832	5,304				
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	150,523	5,749				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	5,580,932	247,128				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Purchasing Consultant	$ 4,762	95				
Data Integrity Auditor	$ 3,300	66				
A&D Consultant	$ 2,341	47				
Total	$ 10,404	208	$ -	-	$ -	-

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-11 Rev. 10/2005

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	11	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	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* **										
Marjorie Simpson	112,518				Administrator 10/1/17-9/30/18	2,126				
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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	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	8,820	119				
3. Pharmacist	3,573	42				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	33,403	52				
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)						
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	10,404	208				
B-13 Total Fees Paid in Lieu of Salaries	56,200	421				

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-14 Rev. 6/95

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
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Brijesh Chandwani 3200 Park Ave. Unit 10D2 Bridgeport, CT 06604	Dentist	○	⊙	
West River Pharmacy of Connecticut 41 Northwes Dr. Plainville, CT	Pharmacist	○	⊙	
Pointright, Inc. 150 Cambridge Park Drive Cambridge, MA 02140	Data Integrity Audit	○	⊙	
Connecticut Purchasing Consultants, LLC 88 Ryders Lane Stratford, CT 06614-1397	Purchasing Consultant	○	⊙	
PatientPing, Inc. 10 Post Office Square Boston, MA 02109	Admission & Discharge Consultant	○	⊙	
Hafsa Nawaz 17 Carriage Hill Rd Woodbridge, CT 06525	Medical Director	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	228,508	228,508		
2. Disability Insurance	$				
3. Unemployment Insurance	$	70,327	70,327		
4. Social Security (F.I.C.A.)	$	395,074	395,074		
5. Health Insurance	$	257,621	257,621		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	36,268	36,268		
7. Pensions (Non-Discriminatory)	$	27,251	27,251		
(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*	$	458,935	458,935		
d. Accounting and Auditing	$	(4,150)	(4,150)		
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	17,141	17,141		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	70,588	70,588		
2. Cellular Phones	$				
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	703,645	703,645		
Subtotal	$	2,261,209	2,261,209		

* 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	$ -	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
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
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,261,209	2,261,209		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	8,964	8,964		
2. Holiday Parties for Staff	$	2,746	2,746		
3. Gifts to Staff and Residents	$	1,688	1,688		
4. Employee Travel	$	6,133	6,133		
5. Education Expenses Related to Seminars and Conventions	$	2,717	2,717		
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*)	$	68	68		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	14,366	14,366		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	5,331	5,331		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	11,536	11,536		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	545	545		
9. Subscriptions	$	360	360		
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**	$	456,660	456,660		
13. Other (*Specify*)	$	147,088	147,088		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,919,411	2,919,411		

* 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	$ 14,366		
Total Other Advertising	$ 14,366	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 11,336		
Music & Memory	$ 200		
Total Dues	$ 11,536	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees Non Reimbursable	$ 74,607		
Licenses & Fees	$ 17,845		
Pre Employment Screenings	$ 6,270		
Point Click Care Fees	$ 24,980		
Bank Charges, Penalties, Fees	$ 9,386		
Legal Fees - Collections, Probate, Conservator	$ 386		
Resident Expenses	$ 1,575		
Account W/O	$ 40		
Settlement	$ 12,000		
Total Other Administrative and General	$ 147,088	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	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.	456,660	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.**

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-18 Rev. 9/2002

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
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	261,568	261,568		
2. Non-Food Supplies	$	42,686	42,686		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	3,778	3,778		
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	308,031	308,031		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	312	312		

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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-19 Rev. 9/2002

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

Name of Facility Hewitt Health & Rehabilitation Center	License No. 2297-C	Report for Year Ended 9/30/2018		Page 19 | of 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.*** — Lbs.				
Amt. $	969	969		
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. $	12,652	12,652		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)* — $	132,526	132,526		
c. Other (*Specify*) — $				
3D. ***Total Laundry Expenditures*** (3a + b + c) — $	146,148	146,148		

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.

*** Pounds of Laundry only required for multi-level facilities.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-20 Rev. 9/2002

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
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	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.	$	55,212	55,212		
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	55,212	55,212		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from West River/Neighborcare		$	306,089	306,089		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	286,395	286,395		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	80,835	80,835		
f. X-rays and Related Radiological Procedures***		$	152,520	152,520		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	11,851	11,851		
i. Recreation		$	56,838	56,838		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	17,852	17,852		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	912,379	912,379		

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Nursing Station Supplies	$ 1,524		
Rehab Service Supplies	$ 7,143		
IV Therapy	$ 9,185		
Total Other Resident Care	$ 17,852	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	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
Kone Inc	16 Old Forge Rd, Ste B Rocky Hill, CT 06067	○	⊙		Elevator Repair	18,199			22	6a
Perfectemp Heating & Air Conditioning	635 Old Turnpike Rd. Plantsville, CT 06479	○	⊙		Heating and Air Conditioning	13,911			22	6a
Stephen Rodrigues	327 Pepper St, Monroe. CT 06468	○	⊙		Landscaping/Snow Plow	22,183			22	6a
Med Apparel	Mount Vernon, NY 10550	○	⊙		Laundry Service	34,771			19	3b
Unitex Textile Rental	Mount Vernon, NY 10550	○	⊙		Laundry Service	95,949			19	3b
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* 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).

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	165,165	165,165		
b. Heat	$	75,711	75,711		
c. Light & Power	$	148,209	148,209		
d. Water	$	31,165	31,165		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	36,704	36,704		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	456,953	456,953		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	1,891	1,891		
d. Movable Equipment	$	44,774	44,774		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	46,665	46,665		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	100,568	100,568		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	100,568	100,568		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	1,103,946	1,103,946		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	90,707	90,707		
c. Personal property taxes	$	10,962	10,962		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,352,848	1,352,848		

* 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	$ 36,704		
Total Other Repairs and Maintenance	$ 36,704	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-23 Rev. 10/2006

Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	28,330		28,330	20,755	S/L	Var	1,891	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								1,891

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					1,137,342		1,137,342	945,560	S/L	Var	44,227	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					11,201		11,201		S/L	Var	547	
D-3. Subtotal												44,774
E. ***Total Depreciation***												46,665

Hewitt Health & Rehabilitation Center
9/30/2018

Schedule of Land Improvements Acquired during this report period

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

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

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

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report peri

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

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
1/8/2018	ice machine	$ 3,456	10	$ 129	
2/20/2018	battery	$ 1,243	10	$ 44	
4/10/2018	Wanderguard	$ 3,566	5	$ 234	
4/10/2018	Wanderguard	$ 1,533	5	$ 100	
8/1/2018	Wanderguard	$ 1,402	7	$ 40	
Total additions for Movable Equipmen		$ 11,201		$ 547	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/17/2017	Replacement mixing valve	$ 1,000	10	$ 125	
10/17/2017	balance - mixing valve	$ 300	10	$ 38	
11/15/2017	50% deposit - mixing valve	$ 635	10	$ 79	
11/15/2017	remaining balance - mixing valve	$ 635	10	$ 79	
12/22/2017	replacement bearing	$ 2,814	10	$ 352	
2/14/2018	generator repairs	$ 1,124	10	$ 40	
3/16/2018	non-contractural elevator service	$ 1,241	10	$ 42	
4/12/2018	additional elevator service	$ 1,044	10	$ 34	
9/11/2018	water heater tubing deposit	$ 10,000	10	$ 91	
9/11/2018	balance water heater tubing	$ 3,000	10	$ 27	
1/31/2016	PT room, lobby, shower room reno	$ 12,694	15	$ 1,904	
5/10/2018	Elevator	$ 85,771	20	$ 2,144	
11/30/2016	Asbestos Abatement	$ 15,208	25	$ 608	
9/30/2017	Elevator repair	$ 38,890	10	$ 3,403	
7/1/2018	Pavement repairs	$ 31,214	8	$ 1,463	
5/1/2018	Elevator installation	$ 10,579	20	$ 198	
Total additions for Leasehold Improvemer		$ 216,147		$ 10,629	*
Deletions:					
9/22/2017	Elevator Repair-Power Unit,Roller Guides	$ (38,890)	10	$ (456)	
11/28/2016	Asbestos Abatement-Lower Level Boiler Rm	$ (15,208)	25	$ (177)	
Total deletions for Leasehold Improvemer		$ (54,098)		$ (633)	**

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				1,477,194	593,541	A		90,572	
2. Disposals (attach schedule)				(54,098)				(633)	
3. Acquired during this report period (attach schedule)				216,147				10,629	
C-4. Subtotal									100,568
D. ***Total Amortization***									100,568

* 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.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-25 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	160
6. Square Footage	57,879
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	12/07/16			
c. Interest Rate for the Cost Year	3.52%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	10,190,500			
f. Principal balance outstanding as of 09/30/18	9,861,253			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-26 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Hewitt Health & Rehabilitation Cente	2297-C	9/30/2018	26 | 37

Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage $				
Name of Lender / Rate				
Address of Lender				
2. Second Mortgage $				
Name of Lender / Rate				
Address of Lender				
3. Third Mortgage $				
Name of Lender / Rate				
Address of Lender				
4. Fourth Mortgage $				
Name of Lender / Rate				
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount $				
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $				

(*Carry Subtotals forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-27 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Hewitt Health & Rehabilitation Cen	2297-C	9/30/2018	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*) $	22,719	22,719		
Shelton Tax Collector/Gemino				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	22,719	22,719		
14. Insurance				
a. Insurance on Property (buildings only) $	102,289	102,289		
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)*** $	102,289	102,289		
15. ***Total All Expenditures (A-13 thru C-14)*** $	11,913,124	11,913,124		

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-28 Rev. 9/2002

D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	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 $	237,819	237,819		
4.			Other - See attached Schedule $	17,803	17,803		
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 $	458,935	458,935		
10.	15/16	1d/m	Accounting $	(5,970)	(5,970)		
10a.			Legal $				
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 * $	14,366	14,366		
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 $	102,310	102,310		
Page 18 - Dietary Expenditures							
24.	30	Iv1	Meals to employees, guests and others who are not residents $	73	73		
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) $	825,336	825,336		

* 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)
Var	Var	Social Service - Marketing	$ 17,803		
Total Other Salaries Adjustment			$ 17,803	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corp Fee- Non-reimbursable	$ 74,607		
16	1.3	Employee Recognition/Gifts/Parties	$ 1,688		
16	8a	Chamber of Commerce	$ 545		
16	m13	Bank Charges, penalties, fines	$ 9,386		
16	m13	Resident Expenses	$ 1,575		
16	m13	Account W/O	$ 40		
16	m13	Settlement	$ 12,000		
30	Iv8	Account W/O	$ 1,178		
30	Iv8	Refund	$ 1,291		
Total Other A&G Adjustments			$ 102,310	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-29 Rev. 10/2006

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

Name of Facility	License No.	Report for Year Ended	Page of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	825,336	825,336		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	296,479	296,479		
28.	16	L1	Ambulance/Limousine $	8,964	8,964		
29.	20	h	X-rays, etc $	152,520	152,520		
30.	20	f	Laboratory $	11,851	11,851		
31.			Medical Supplies $				
32.	20	5e2	Oxygen (non emergency) $	49,390	49,390		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	18,921	18,921		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $				
43.	30	Iv5	Interest Income on Account Rec. $	84	84		
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $	25,499	25,499		
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49. ***Total Amount of Decrease (Items 1 - 48)*** $				1,389,044	1,389,044		

*** 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

Hewitt Health & Rehabilitation Center
9/30/2018

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy Supplies	$ 9,185		
20	5j	Rehab Service Supplies	$ 7,143		
29	49	Outpatient Services	$ 1,494		
30	Iv8	Medical Supply refund	$ 1,100		
Total Other Ancillary Costs			$ 18,921	$ -	$ -

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	Interest-Shelton Tax Collector/Gemino	$ 22,719		
VAR	VAR	Gift shop - A&G	$ 1,487		
VAR	VAR	Gift shop - capital	$ 68		
VAR	VAR	Gift shop - fair rent	$ 1,225		
Total Other Adjustments			$ 25,499	$ -	$ -

Schedule of Unallowable Building Interest

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-30 Rev.10/2005

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,704,784	6,704,784		
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)*	$	1,522,012	1,522,012		
b. Medicare Room and Board Contractual Allowance **	$	752,176	752,176		
4. a. Private-Pay Residents and Other	$	1,542,281	1,542,281		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	140,760	140,760		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(140,760)	(140,760)		
c. Prescription Drugs - Non-Medicare	$	94,123	94,123		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(94,420)	(94,420)		
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	$	246,470	246,470		
b. Physical Therapy - Medicare Contractual Allowance **	$	(247,326)	(247,326)		
c. Physical Therapy - Non-Medicare	$	318,961	318,961		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(131,040)	(131,040)		
4. a. Speech Therapy - Medicare	$	33,165	33,165		
b. Speech Therapy - Medicare Contractual Allowance **	$	(33,027)	(33,027)		
c. Speech Therapy - Non-Medicare	$	51,980	51,980		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(13,725)	(13,725)		
5. a. Occupational Therapy - Medicare	$	528,485	528,485		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(376,652)	(376,652)		
c. Occupational Therapy - Non-Medicare	$	175,455	175,455		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(175,455)	(175,455)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	10,898,246	10,898,246		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	73	73		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	84	84		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	4,648	4,648		
V. Total Other Revenue (1 thru 8)	$	4,805	4,805		
VI. Total All Revenue (III +V)	$	10,903,051	10,903,051		

* *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	Optum Capitation	$ -		
Total Other Resident Revenue		$ -	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30	Interest on Accounts Receivable	1,640,992	$ 84		
Total Interest Income			$ 84	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV 8	Medical Supply refund	$ 1,100		
30 IV 8	Health Drive Dental Refund	$ 1,291		
30 IV 8	Medical Records	$ 1,078		
30 IV 8	Account W/O	$ 1,178		
Total Other Revenue		$ 4,648	$ -	$ -

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-31 Rev. 6/95

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,640,992
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 27,934
5. Prepaid Expenses				$
a.				
b.				
c.				
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 53,745
See Schedule		53,745		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,722,672
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	1,639,244		$ 945,135
	Accum. Depreciation	694,109	Net	
5. Non-Movable Equipment	*Historical Cost	28,330		$ 5,684
	Accum. Depreciation	22,646	Net	
6. Movable Equipment	*Historical Cost	1,148,543		$ 158,209
	Accum. Depreciation	990,334	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 102,105
See Schedule		102,105		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 1,211,132

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

(*Carry Total forward to next page*)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	32	37

Account				Amount
			Total Brought Forward:	$ 2,933,803
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*)				$ 32,832
See Schedule		32,832		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 32,832
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 2,966,635

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

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-33 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 767,356
2. Notes Payable (*itemize*)	$
See Schedule	
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)	$ 112,365
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$ 16,112
7. Medicare Final Settlement Payable	$
8. Medicare Current Financing Payable	$
9. Mortgage Payable (*Current Portion*)	$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)	$
11. Accrued Income Taxes*	$
12. Other Current Liabilities (*itemize*)	$ 2,348,422
See Schedule 2,348,422	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 3,244,255

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

(Carry Total forward to next page)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	34	37

Account	Amount
Total Brought Forward:	3,244,255
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 1,584,983
See Schedule	1,584,983	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 1,584,983
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 4,829,238

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Prepaid Other	$ -
Total Prepaid Expenses			$ -

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

Page Ref	Line Ref	Description	
31	A 8	Payroll Deducted Life Insurance	$ 40,514
31	A 8	A/P Patient Exchange	$ 13,231
Total Other Current Assets (Itemize)			$ 53,745

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

Page Ref	Line Ref	Description	
31	B9	Fixed Asset Clearing Account	$ 102,105
31	B9	Construction in Progress	$ -
Total Other Other Fixed Assets (Itemize)			$ 102,105

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Loans Rec. - Officers/Owners	$ 1,000
		Capitalized Refinance	$ 31,832
		Leasehold Deposits	$ -
Total Other Assets			$ 32,832

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description	
33	A12	Accrued PTO	$ 215,794
33	A12	Accrued Pension	$ 1,257
33	A12	Accrued Worker's Comp	$ 196,789
33	A12	Accrued Expense Other	$ 409,088
33	A12	Accrued Professional Fees	$ 3,819
33	A12	Payroll W/H	$ 2,268
33	A12	Due Affiliate (Credit Balance)	$ 808,182
33	A12	Gemino Revolving Loan	$ 600,807
33	A12	Exchange	$ 104,056
33	A12	Prepaid Property Tax	$ 6,362
Total Other Current Liabilities (Itemize)			$ 2,348,422

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

Page Ref	Line Ref	Description	
34	B4	A/P Other	$ 1,584,983
Total Other Current Liabilities (Itemize)			$ 1,584,983

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-35 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	35	37

Account		Amount
A.	**Reserves**	
1.	Reserve for value of leased land	$
2.	Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
3.	Reserve for depreciation value of leased personal property (*Equity)*	$
4.	Reserve for leasehold real properties on which fair rental value is based	$
5.	Reserve for funds set aside as donor restricted	$
6.	Total Reserves	$
B.	**Net Worth**	
1.	Owner's Capital	$ 2,420,000
2.	Capital Stock	$ 1,000
3.	Paid-in Surplus	$
4.	Treasury Stock	$
5.	Cumulated Earnings	$ (3,273,530)
6.	Gain or Loss for Period 10/1/2017 thru 9/30/2018	$ (1,010,073)
7.	Total Net Worth	$ (1,862,603)
C.	***Total Reserves and Net Worth***	$ (1,862,603)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 2,966,635

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2017			$ (194,971)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 10,903,051
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 11,913,124
D.	Net Income or Deficit			$ (1,010,073)
E.	Balance			$ (1,205,044)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 657,559
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	Brian J Foley	President	7,559	
	Brian J Foley	President	650,000	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$ 657,559
H.	***Balance at End of Period*** 09/30/18			$ (1,862,603)

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2018	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

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