State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2022

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 10/1/2021	Report for Year Ending 9/30/2022	

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	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, 2021 and ending September 30, 2022, 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) Regina Butcher			Printed Name (Owner) Brian Foley	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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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 10/1/2021	To 9/30/2022
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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
(203) 924-4671	9/30/2022	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.:
Regina Butcher	2144

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	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 Foley	21 Waterville Rd. Avon, CT 06001	President	100
Ryan Vess	21 Waterville Rd. Avon, CT 06001	Secretary	
Names of Stockholders Owning at Least 10% of Shares			
Brian Foley	21 Waterville Rd. Avon, CT 06001	President	100

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? ⊙ Yes ○ No

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Brian J. Foley	21 Waterville Rd. Avon, CT 06001	○	⊙		Real Estate Rental	Pg. 22 Line 9	901,021	901,021
Apple Health Care	21 Waterville Rd. Avon, CT 06001	○	⊙		Management & Accounting Services	Pg. 16 Line m12	421,633	421,633
Corporate Employees	21 Waterville Rd. Avon, CT 06001	○	⊙		Employee Staffing	Pg. 10 Schedule	155,156	155,156
Healthport	21 Waterville Rd. Avon, CT 06001	○	⊙		Employee Staffing	Pg. 10 Schedule	1,530	1,530
Employees @ various Apple Facilities		○	⊙		Employee Staffing	Pg. 10 Schedule	(87,186)	(87,186)
Apple Health Care	21 Waterville Rd. Avon, CT 06001	○	⊙		Pension Plan (401K)	Pg. 15 Line 1a7	45,551	45,551
Lucent Health Solutions	424 Church St. Nashville, TN 37219	⊙	○		Group Medical	Pg. 15 Line 1a5	463,652	
MetLife	PO Box 360229 Pittsburgh, PA 15251	⊙	○		Group Dental	Pg. 15 Line 1a5	5,561	
Delta Dental of CT	148 Eastern Blvd Glastonbury, CT 06033	⊙	○		Group Dental	Pg. 15 Line 1a5	18,634	

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	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	%**				
USI	PO Box 62937 Virginia Beach, VA 23466	✠			Property, Liability, & Umbrella Insurance	Pg. 27 Line 14a	259,331	
Reliance Standard	2001 Market St. Philadelphia, PA	✠			Group Life & Disability	Pg. 15 1a6	24,192	
AIG	PO Box 10472 Newark, NJ	✠			Worker's Compensation	Pg. 15 1a1	204,880	
Swallowing Diagnotics	21 Waterville Road Avon, CT	✠		83%	Diagnostic Services	Pg 20 5f	1,800	1,697
Ryan Vess	21 Waterville Road Avon, CT		✠			##		
Tarah Foley	21 Waterville Road Avon, CT		✠			##		
Paula Meunier	21 Waterville Road Avon, CT		✠			##		
Kayla Foley	21 Waterville Road Avon, CT		✠			##		
Patricia Hyyppa	21 Waterville Road Avon, CT		✠			##		
Reino Hyyppa	21 Waterville Road Avon, CT		✠			##		
StaffonTap	76 Hartford rd Simsbury, CT		✠		Employee Staffing	Pg 13 11a1	15,964	15,964

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

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

N/A

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers 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.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1	Preparation of audited financials	$ 3,020
2	Preparation of Tax Returns	$ 2,863
3	Audit 401K	$ 802
4		$
		Charge for Services Provided $ 6,684

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

Legal Services Information

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

Address (*No. & Street, City, State, Zip Code*)
1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1		$
2		$
3		$
4		$
5		$
		Charge for Services Provided $

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

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	120	120			120	120						
B. On last day of THIS report period	120	120							120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	86	86			86	86						
B. As of midnight of THIS report period	93	93							93	93		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,815	2,815			2,216	2,216			599	599		
B. Medicaid (Conn.)	26,083	26,083			19,667	19,667			6,416	6,416		
C. Medicaid (other states)												
D. Private Pay	4,135	4,135			2,636	2,636			1,499	1,499		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	33,033	33,033			24,519	24,519			8,514	8,514		
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)**	33,033	33,033			24,519	24,519			8,514	8,514		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	11	66		16				
Per Diem Rate								
a. One bed rm.				470.00				
b. Two bed rms.	RUGS	269.64		425.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,973	3,973		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	13,031	13,031		
D. ***Total Physical Therapy Treatments***	17,004	17,004		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	549	549		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	3,398	3,398		
D. ***Total Speech Therapy Treatments***	3,947	3,947		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,559	2,559		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	10,879	10,879		
D. ***Total Occupational Therapy Treatments***	13,438	13,438		

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Report of Expenditures - Salaries & Wages

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	132,092	2,072				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	96,709	4,700				
5. Dietary Service						
a. Head Dietitian	4,562	122				
b. Food Service Supervisor	58,230	2,038				
c. Dietary Workers	360,571	19,161				
6. Housekeeping Service						
a. Head Housekeeper	77,519	2,861				
b. Other Housekeeping Workers	159,911	9,695				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	99,659	3,878				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	43,628	2,261				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants	181,405	5,179				
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	232,442	3,874				
b. RN						
1. Direct Care	664,711	12,948				
2. Administrative**	168,900	3,332				
c. LPN						
1. Direct Care	726,037	21,187				
2. Administrative**						
d. Aides and Attendants	1,369,787	61,517				
e. Physical Therapists	277,313	6,321				
f. Speech Therapists	67,323	1,478				
g. Occupational Therapists	129,656	3,064				
h. Recreation Workers	92,423	3,767				
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	122,577	4,012				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	5,065,457	173,465				

* 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**
Mary B. Jordan- Employee Relaltions Specialist	$ 2,500					
Patientping/Bamboo Health, INC- A & D Fee	$ 1,855					
Respiratory Therapist	$ 38,832					
Total	$ 43,187	-	$ -	-	$ -	-

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

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

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	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* **										
Shanique Mightly	94,543				Administrator 10/1/21 - 6/27/21	1,560	A2			
Don Davanzo	13,850				Administrator 6/28/22-7/28/22	152	A2			
Regina Butcher	23,699				Administrator 7/25/22 -9-30-22	360	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	118				
3. Pharmacist	17,017	227				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	41,500	87				
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)						
Need Description						
9. Speech Therapist						
a. Resident Care	1,800	18				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	17,905	320				
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides	53,584	1,111				
d. Other						
12. Other (Specify)						
See Attached Schedule	43,187					
B-13 Total Fees Paid in Lieu of Salaries	183,814	1,880				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
CT Dental Partners, LLC 300 Church St,. Suite 203 Wallingford, CT 06492	Dentist	○	⊙	
Hafsa Nawaz 2080 Whitney Ave, Suite 250 Hamden, CT 06518	Medical Director	○	⊙	
NeighborCare Pharmacy Services, Inc.	Pharmacist	○	⊙	
Swallowing Diagnostics 21 Waterville Rd Avon, CT	Speech Consultant	⊙	○	See Disclosure pg 4
PatientPing, Inc. 10 Post Office Square Boston, MA 02109	Admission & Discharge Fee	○	⊙	
Procaire 51 Triano Dr, Southington, CT 06489	Respiratory Therapist	○	⊙	
Mary B. Jordan 75 High Farms Road West Hartford, CT 06107	Employee Relaltions Specialist	○	⊙	
Staffon Tap 76 Hartford Rd Simsbury, CT 06070	Employee Staffing	⊙	○	See Disclosure pg 4
Norton & Assoc 34 Elm Street Cohasset, MA 02025	Employee Staffing	○	⊙	
Solomon Page Group 260 Madison Ave, 4th Floor New	Employee Staffing	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	204,880	204,880		
2. Disability Insurance	$				
3. Unemployment Insurance	$	63,972	63,972		
4. Social Security (F.I.C.A.)	$	375,323	375,323		
5. Health Insurance	$	377,342	377,342		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	24,192	24,192		
7. Pensions (Non-Discriminatory)	$	45,551	45,551		
(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*	$	143,645	143,645		
d. Accounting and Auditing	$	6,684	6,684		
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	12,175	12,175		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	101,168	101,168		
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*	$	(96,202)	(96,202)		
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	632,281	632,281		
Subtotal	$	1,891,011	1,891,011		

* Facility should self-disallow the expense on Page 28 of the Cost Report.

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,891,011	1,891,011		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	2,374	2,374		
2. Holiday Parties for Staff	$	4,170	4,170		
3. Gifts to Staff and Residents	$	9,512	9,512		
4. Employee Travel	$	4,836	4,836		
5. Education Expenses Related to Seminars and Conventions	$	320	320		
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*)	$	501	501		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	4,212	4,212		
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	$	4,318	4,318		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	11,760	11,760		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	600	600		
9. Subscriptions	$	2,377	2,377		
10. Contributions***	$	3,333	3,333		
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**	$	421,633	421,633		
13. Other (*Specify*)	$	324,189	324,189		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,685,147	2,685,147		

* 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	$ 4,212		
Total Other Advertising	$ 4,212	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 11,186		
ALTCFM	$ 205		
Academy of Nutrition and Dietetics	$ 369		
Total Dues	$ 11,760	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Griffin Hospital	$ 3,333		
Total Contributions	$ 3,333	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Corporate Fees - Non Reimbursable	$ 108,016		
Licenses & Fees	$ 2,623		
Pre Employment Screenings	$ 17,294		
System License & Subscription Fees	$ 61,251		
Bank Service Charges	$ 43,037		
Legal Fees - Collection/Probate	$ 503		
IT Service Fees	$ 222		
Internet & Cable/Satellite TV	$ 28,739		
Survey Fines & Citations	$ -		
Healthport Indirect	$ 547		
Resident Expenses	$ 652		
Prior Period Adj/Account W/O	$ 61,305		
	$ 324,189	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	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.	421,633	Accounting and Management Services	Pg. 16 Line m12

*** In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.**

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

Name of Facility	License No.	Report for Year Ended	Page of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	251,143	251,143		
2. Non-Food Supplies	$	23,774	23,774		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	7,793	7,793		
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	282,711	282,711		

2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F. Resident Meals:	Total no. of meals served per day:*	272	272		

G.	Is cost of employee meals included in 2D?	○ Yes	⊙ No	
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	○ Yes	⊙ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⊙ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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

Name of Facility Hewitt Health & Rehabilitation Center	License No. 2297-C	Report for Year Ended 9/30/2022		Page of 19 | 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. $ 1,614	1,614		
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. $ 1,817	1,817		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$ 125,125	125,125		
c. Other (*Specify*)	$			
3D. ***Total Laundry Expenditures*** (3a + b + c)	$ 128,555	128,555		

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
H.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
K.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel		57,879	57,879		
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	40,176	40,176		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	40,176	40,176		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Neighborcare		$	115,946	115,946		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	231,260	231,260		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	32,491	32,491		
f. X-rays and Related Radiological Procedures***		$	34,230	34,230		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	12,152	12,152		
i. Recreation		$	20,381	20,381		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	12,106	12,106		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	458,567	458,567		

* 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	$ 15		
IV Therapy	$ 2,131		
Rehab Service & Supplies	$ 9,960		
Total Other Resident Care	$ 12,106	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	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
Facilities Compliance Protection LLC	12 Curtis St. Suite#23 Meriden, CT 06450	○	⊙		Fire Protection Service	12,932			22	6a
Hartford Elevator LLC	1275 Cromwell Ave F5	○	⊙		Elevator Contract Service	15,651			22	6a
Susan Fernandes - Miguel	39 Knorr Rd, Monroe, CT	○	⊙		Landscaping / Snow Removal	24,062			22	6a
CWPM	25 Norton Place Plainville, CT 06062	○	⊙		Refuse Removal	26,983			22	6f
Unitex Textile	Mount Vernon, NY 10550	○	⊙		Resident Laundry Service	99,171			19	3b
Med Apparel	Mount Vernon, NY 10550	○	⊙		Facility Laundry Service	26,545			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).

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

Name of Facility	License No.	Report for Year Ended	Page of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	138,555	138,555		
b. Heat	$	66,923	66,923		
c. Light & Power	$	158,964	158,964		
d. Water	$	30,673	30,673		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$	30,538	30,538		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	425,654	425,654		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	2,340	2,340		
d. Movable Equipment	$	21,433	21,433		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	23,773	23,773		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	93,718	93,718		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	93,718	93,718		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	901,021	901,021		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	57,931	57,931		
c. Personal property taxes	$	8,792	8,792		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,085,236	1,085,236		

* 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	$ 30,538		
Total Other Repairs and Maintenance	$ 30,538	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	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	37,462		37,462	28,556	S\L	Var	2,340	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								2,340

	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					1,185,507		1,185,507	1,092,604	S\L	Var	21,290	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative					1,915						144	
d. Standard Resident												
e. Specialized Resident												
Total Acquired during this report period					1,915						144	
D-3. Subtotal												21,433
E. ***Total Depreciation***												23,773

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	Pick One Movable Category	Cost	Useful Life	Depreciation
Additions:					
7/21/2021	Ice Machine Replacement	Administrative	$ 1,915	ME-10	$ 144
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipmen			$ 1,915		$ 144
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:				
8/25/2022	Replace Symmon's 7-400 Mixing Valve	$ 3,566	LHI-8	$ 52
8/12/2022	Replace 2 Mixing Valves Boiler	$ 2,252	LHI-8	$ 40
8/12/2022	Replace 2 Mixing Valves Boiler	$ 2,508	LHI-8	$ 44
8/12/2022	Replace 2 Mixing Valves Boiler	$ 319	LHI-8	$ 6
8/12/2022	Replace 2 Mixing Valves Boiler	$ 447	LHI-5	$ 8
3/24/2022	Elevator Repairs	$ 9,742	LHI-5	$ 165
3/24/2022	Elevator Repairs	$ 8,582	LHI-5	$ 145
3/16/2022	Underground Tank Overfill Protection	$ 3,334	LHI-5	$ 114
2/4/2022	Circulator Pump for Small Boiler	$ 2,812	LHI-5	$ 204
10/12/2021	Asphalt Parking Lot	$ 25,349	LHI-5	$ 3,169
4/1/2020	Replace Boiler Room Gate Valves	$ 3,148	LHI-5	$ 315
3/1/2021	Hot Water Heater	$ 3,616	LHI-5	$ 362
3/22/2022	Replace Bearing Assembly on Circulator Pump	$ 4,224	LHI-5	$ 739
Total additions for Leasehold Improvemer		$ 69,899		$ 5,361
Deletions:				
Total deletions for Leasehold Improvemer		$ -		$ -

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	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				1,642,696	978,682	A		88,357	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				69,899		A		5,361	
C-4. Subtotal									93,718
D. ***Total Amortization***									93,718

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	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	120
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 _____	8,987,970			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Hewitt Health & Rehabilitation Cente	2297-C	9/30/2022	26 | 37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Hewitt Health & Rehabilitation Cen	2297-C	9/30/2022	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*) $	12,149	12,149		
Gemino Loan Advances				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	12,149	12,149		
14. Insurance				
a. Insurance on Property (buildings only) $	259,331	259,331		
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)*** $	259,331	259,331		
15. ***Total All Expenditures (A-13 thru C-14)*** $	10,626,797	10,626,797		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	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.			Occupational Therapy $	129,656	129,656		
4.			Other - See attached Schedule $	15,093	15,093		
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	143,645	143,645		
10.	15	1d	Accounting $	3,020	3,020		
10a.			Legal $	503	503		
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	m 2/3	Unallowable Advertising * $	4,212	4,212		
19.			Income Tax / Corporate Business Tax $				
20.	16	m10	Fund Raising / Contributions $	3,333	3,333		
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	225,953	225,953		
Page 18 - Dietary Expenditures							
24.			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) $	525,414	525,414		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A12m	Social Service - Marketing	$ 15,093		
Total Other Salaries Adjustment			$ 15,093	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B8a	Medical Director			
Total Other Fees Adjustments			$ -	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Corporate Fees Non Reimbursable	$ 108,016		
16	1.3	Employee Recognition/Gifts/Parties	$ 9,512		
16	m13	Bank Charges	$ 43,037		
16	8a	Chamber of Commerce	$ 600		
16	m13	Prior Period Adj/Account W/O	$ 61,305		
16	m13	Resident Expenses	$ 652		
30	IV8	Account W/O	$ 286		
30	IV8	Medical Supply refund	$ 2,544		
Total Other A&G Adjustments			$ 225,953	$ -	$ -

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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	9/30/2022	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	525,414	525,414		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $	109,913	109,913		
28.			Ambulance/Limousine $	2,374	2,374		
29.			X-rays, etc $	34,230	34,230		
30.			Laboratory $	12,152	12,152		
31.			Medical Supplies $				
32.			Oxygen (non emergency) $	22,958	22,958		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	12,091	12,091		
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 $	15,764	15,764		
43.	30	IV5	Interest Income on Account Rec. $	70	70		
44.			Other - Miscellaneous Administrative $				
45.			Management Fees Direct $				
46.			Management Fees Indirect $				
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49.			***Total Amount of Decrease (Items 1 - 48)*** $	734,967	734,967		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	IV Therapy	$ 2,131		
20	5j	Rehab Service Supplies	$ 9,960		
Total Other Ancillary Costs			$ 12,091	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	12D	Interest	$ 12,149		
var	var	Gift Shop - A&G	$ 1,357		
var	var	Gift Shop - Capital	$ 1,012		
var	var	Gift Shop - Fair Rent	$ 1,246		
Total Other Adjustments			$ 15,764	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	7,130,260	7,130,260		
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)*	$	1,100,339	1,100,339		
b. Medicare Room and Board Contractual Allowance **	$	481,451	481,451		
4. a. Private-Pay Residents and Other	$	1,843,090	1,843,090		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	74,742	74,742		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(71,384)	(71,384)		
c. Prescription Drugs - Non-Medicare	$	19,690	19,690		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(19,690)	(19,690)		
2. a. Medical Supplies - Medicare	$	894	894		
b. Medical Supplies - Medicare Contractual Allowance **	$	(894)	(894)		
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	476,480	476,480		
b. Physical Therapy - Medicare Contractual Allowance **	$	(443,819)	(443,819)		
c. Physical Therapy - Non-Medicare	$	118,658	118,658		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(73,230)	(73,230)		
4. a. Speech Therapy - Medicare	$	150,250	150,250		
b. Speech Therapy - Medicare Contractual Allowance **	$	(144,028)	(144,028)		
c. Speech Therapy - Non-Medicare	$	24,610	24,610		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(14,915)	(14,915)		
5. a. Occupational Therapy - Medicare	$	464,935	464,935		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(437,887)	(437,887)		
c. Occupational Therapy - Non-Medicare	$	139,760	139,760		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(60,715)	(60,715)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	10,758,599	10,758,599		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	70	70		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	801,815	801,815		
V. Total Other Revenue (1 thru 8)	$	801,885	801,885		
VI. Total All Revenue (III +V)	$	11,560,483	11,560,483		

* *Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.*

** *Facility should report all contractual allowances and/or payer discounts.*

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 30 IV5	Interest Income	808,837	$ 70		
Total Interest Income			$ 70	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV8	Covid Relief	$ 769,693		
30 IV8	Rebates	$ 18,496		
30 IV8	Account W/O	$ 286		
30 IV8	Medical Supply refund	$ 2,544		
30 IV8	Dividend	$ 10,690		
30 IV8	Medical Records	$ 105		
`				
Total Other Revenue		$ 801,815	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 13,675
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 808,837
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 1,755
4 Inventories				$ 29,239
5. Prepaid Expenses				$ 15,357
a.				
b.				
c.				
d. See Schedule		15,357		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ 1,828,651
See Schedule		1,828,651		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,697,513
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	1,712,595		$ 640,195
	Accum. Depreciation	1,072,400	Net	
5. Non-Movable Equipment	*Historical Cost	37,462		$ 6,567
	Accum. Depreciation	30,896	Net	
6. Movable Equipment	*Historical Cost	1,187,422		$ 73,385
	Accum. Depreciation	1,114,037	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 76,011
See Schedule		76,011		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 796,157

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
31	A5	Prepaid Insurance	$ -
31	A5	Prepaid Propert Tax	$ 15,357
31	A5	Other Prepaid Expenses	$ -
31	A5	Prepaid Income Tax	$ -
Total Prepaid Expenses			$ 15,357

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

Page Ref	Line Ref	Description	
31	A8	Exchange Accounts (10401 - 10403) (Debit Balance)	
31	A8	Due Affiliate (Debit Balance)	$ 1,809,383
31	A8	A/P Patient Exchange	$ 19,268
Total Other Current Assets (Itemize)			$ 1,828,651

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

Page Ref	Line Ref	Description	
31	B9	Fixed Asset Clearing Account	$ 76,012
31	B9	Capitalized Refinance Expense	$ 45,749
31	B9	Construction in Progress	$ -
31	B9	Accumulated Amort Refin Exp	$ (45,750)
Total Other Other Fixed Assets (Itemize)			$ 76,011

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	Leasehold Deposits	$ -
32	D7	Deferred Tax Asset	$ (119,272)
32	D7	Goodwill	$ -
32	D7	Loans Rec. - Officers/Owner	$ 1,000
Total Other Assets			$ (118,272)

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	Due Affiliate (Credit Balance	
33	A12	Exchange Accounts (10401-10403) (Credit Balance)	
33	A12	Accrued PTO	$ 193,069
33	A12	Payroll W/H	$ 6,148
33	A12	Accrued Professional Fees	$ 8,739
33	A12	Accrued Worker's Comp	$ 245,317
33	A12	Accrued Group Insurance	$ 160,291
33	A12	Accrued Other Expense	$ 525,986
33	A12	Gemino Revolving A/R Loan	$ 2,095,565
Total Other Current Liabilities (Itemize)			$ 3,235,115

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

Page Ref	Line Ref	Description	
34	B4	A/P Other (Intercompany)	$ 1,230,744
34	B4	Marlin Capital Lease	$ -
34	B4	Loan Payable Officer	$ -
34	B4	Security Deposit/Deferred Revenue	$ 0
34	B4	Deferred Income Tax Payable	$ (252,582)
34	B4	State Income Tax Payable	$ 58,101
34	B4	L/T Accrued Other Expenses	$ -
Total Other Current Liabilities (Itemize)			$ 1,036,264

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	32	37

Account				Amount
			Total Brought Forward:	$ 3,493,671
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*)				$ (118,272)
See Schedule		(118,272)		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (118,272)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 3,375,399

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 436,191
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*)	$ 90,299
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$ 15,574
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*)	$ 3,235,115
See Schedule 3,235,115	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 3,777,179

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	34	37

Account	Amount
Total Brought Forward:	3,777,179
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*)	$	1,036,264
See Schedule 1,036,264		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$	1,036,264
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$	4,813,443

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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	9/30/2022	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	$ 3,263,000
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (5,635,731)
	6. Gain or Loss for Period 10/1/2021 thru 9/30/2022	$ 933,687
	7. Total Net Worth	$ (1,438,044)
C.	***Total Reserves and Net Worth***	$ (1,438,044)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 3,375,399

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Hewitt Health & Rehabilitation Center	2297-C	9/30/2022	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2021			$ (2,213,438)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 11,560,483
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 10,626,797
D.	Net Income or Deficit			$ 933,687
E.	Balance			$ (1,279,751)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$ 158,293
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	Brian Foley	President	8,293	
	Brian Foley	President	150,000	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$ 158,293
H.	***Balance at End of Period*** 09/30/22			$ (1,438,044)

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	9/30/2022	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

Addres Address	Phone Number
21 Waterville Road Avon, CT 06001	(860) 678-9755

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Susan Southey	(860) 470-7542

Contact Email Address
ssouthey@apple-rehab.com