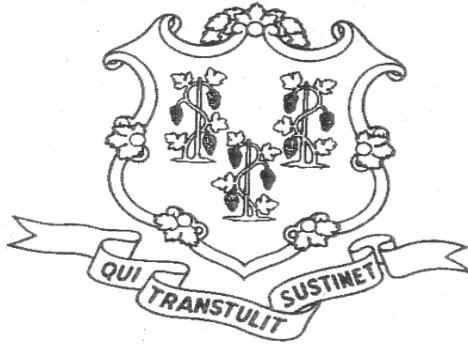


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Northbridge Healthcare Center	
Address (No. & Street, City, State, Zip Code) 2875 Main Street Bridgeport, CT 06606	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 2183C	RHNS	(Specify)	Medicare Provider 07-5413
------------------	---------------	------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 2183C	RHNS	ICF-IID
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### For Department Use Only

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

## General Information

Name of Facility (as licensed) Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021	Page 1	of 37
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### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Northbridge Healthcare Center [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, 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) Lavonn Davis		Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

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State of Connecticut  
**Department of Social Services**  
55 Farmington Avenue, Hartford, Connecticut 06105

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Northbridge Healthcare Center	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 2875 Main Street Bridgeport, CT 06606				
Report Prepared By Athena Health Care Associates, Inc.	Phone Number 860-751-3900	Date 2/1/2022		
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	\$			
<b>6. Total Wages Paid</b>	<b>\$</b>			
7. Total salaries paid	\$			
<b>8. Total Wages and Salaries Paid (As per page 10 of Report)</b>	<b>\$</b>			

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

	Phone No. of Facility 203-336-0232	Report for Year Ended 9/30/2021	Page 2
Name of Facility (as shown on license) Northbridge Healthcare Center		Address (No. & Street, City, State, Zip ) 2875 Main Street Bridgeport, CT 06606	
License Numbers:	CCNH 2183C	RHNS	(Specify)
Medicare Provider No. 07-5413			
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes <input checked="" type="radio"/> No	If "Yes," explain fully.
<b>Administrator</b>			
Name of Administrator Erica Roman		Nursing Home Administrator's License No.:	001948
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name Not Applicable		License No.:	

## **General Information and Questionnaire Partners/Members**

**General Information and Questionnaire**  
**Corporate Owners**

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021	Page of 3A   37
If this facility is owned or operated as a corporation, provide the following information:			
Legal Name of Corporation Northbridge Health Care Center, Inc.	Business Address 2875 Main St., Bridgeport, CT 06606	State(s) in Which Incorporated CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G. Santilli	2875 Main St., Bridgeport, CT 06606	President	762.313
Michael E. Mosier	2875 Main St., Bridgeport, CT 06606	Secretary/ Treasurer	40
Names of Stockholders Owning at Least 10% of Shares			
Custodians for Lawrence G. Santilli	2875 Main St., Bridgeport, CT 06606		132.687

# **General Information and Questionnaire**

## **Individual Proprietorship**

## General Information and Questionnaire

### Related Parties\*

Name of Facility Northbridge Healthcare Center		License No. 2183C			Report for Year Ended 9/30/2021			Page 4	of 37
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> No								If "Yes," provide the Name/Address and complete the information on Page 11 of the report.	
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? <input checked="" type="radio"/> Yes <input type="radio"/> No								If "Yes," provide the following information:	
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party	
		Yes	No	%**					
Laurel Ridge Health Care Center	642 Danbury Road, Ridgefield, CT 06877	<input checked="" type="radio"/>	<input type="radio"/>	>98%	Bank Charges	Pg 16, m13	4,480	4,480	
Athena Captive LLC	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Workers Comp Captive	Pg 15, ln 1a	173,597	173,597	
Northbridge Landlord LLC	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Lease of facility/ Property Taxes/ Property I	Pg 22, ln 9 and 10b, Pg	1,014,434	1,014,434	
Athena Health Care	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Health Insurance	Pg 15, ln 1a5	977,698	977,698	
Athena Health Care Services Inc., 401(k) Plan	135 South Road, Farmington, CT 06032	<input type="radio"/>	<input checked="" type="radio"/>		Facility participates in a group 401(k) plan				
Procare LTC	111 Executive Blvd., Farmingdale, NY 11735	<input checked="" type="radio"/>	<input type="radio"/>	>50%	Pharmacy	Pg 20, 5a2	391,515	391,515	
Athena Health Care	135 South Road, Farmington, CT 06032	<input checked="" type="radio"/>	<input type="radio"/>		See Attached				
		<input type="radio"/>	<input checked="" type="radio"/>						
		<input type="radio"/>	<input checked="" type="radio"/>						

\* Use additional sheets if necessary.

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

## **General Information and Questionnaire**

### **Basis for Allocation of Costs**

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

Not Applicable

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

Not Applicable

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.

Not Applicable: No Non-Nursing Home Cost Centers

## **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
Northbridge Healthcare Center		2183C		9/30/2021			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Pitney Bowes, 60 Wellington Rd., Milford, CT 06484	<input type="radio"/>	<input checked="" type="radio"/>	Postal Equipment	03/26/18	60 months	1,289	1,289	
De Lage Landen Financial Services	<input type="radio"/>	<input checked="" type="radio"/>	Copiers	09/25/20	48 months	20,053	19,549	
Leaf, 1720A Crate St., Moberly, MO 65270	<input type="radio"/>	<input checked="" type="radio"/>	Copiers	03/04/17	48 months	18,999	3,254	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?				<input type="radio"/>	Yes	<input checked="" type="radio"/>	No	<b>Total ***</b> 24,092

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

\*\* Attach copies of newly acquired leases.

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

## General Information and Questionnaire

### Accounting Basis

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual     Cash     Modified Cash

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

#### Independent Accounting Firm

Name of Accounting Firm 1    Marcum LLP 2    Midcap Financial Services 3 4	Address (No. & Street, City, State, Zip Code) 555 Long Wharf Dr., Shelton, CT 259 W 30th St., Suite 301, New York, NY 10001
--	---

Services Provided by This Firm (*describe fully*)

1    Medicare Cost Report preparation	\$    2,700
2    line of credit audits - disallow	\$    3,418
3	\$
4	\$
	Charge for Services Provided \$    6,118

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 1    Murtha Cullina LLP 2    Goldman, Gruder, & Woods LLC 3    Midcap Financial Services 4    Bridgeport Probate/ Sheriff 5    Senior Planning/ Estate of Jean-Pierre Lanie	Telephone Number 860-240-6000 203-899-8900 312-258-5500 860-274-0018 855-775-2664
---	--

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

1    185 Asylum St., Hartford, CT 06103
2    200 Connecticut Ave., Norwalk, CT 06854
3    259 W 30th St., Suite 301, New York, NY 10001
4    Bridgeport, CT
5    100 Blvd of the Americas, Lakewood, NJ 08701/ 495 Orange St., New Haven, CT 06511-3809

Services Provided by This Firm (*describe fully*)

1    Misc Matters: Disallowed	\$    3,100
2    A/R collections: Disallowed	\$    2,656
3    Line of credit legal fees: Disallowed	\$    32
4    Conservatorship: Disallowed	\$    1,216
5    CT Medicaid App \$636: Disallowed/ Resident Settlement \$26,667: Disallowed	\$    27,303
	Charge for Services Provided \$    34,307

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

Yes     No    |Pg 15, line 1e

## Schedule of Resident Statistics

Name of Facility Northbridge Healthcare Center			License No. 2183C				Report for Year Ended 9/30/2021				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					145	145						
A. On last day of PREVIOUS report period	145	145										
B. On last day of THIS report period	145	145							145	145		
2. Number of Residents					77	77						
A. As of midnight of PREVIOUS report period	77	77										
B. As of midnight of THIS report period	135	135							135	135		
3. Total Number of Days Care Provided During Period					5,504	5,504						
A. Medicare	6,978	6,978							1,474	1,474		
B. Medicaid (Conn.)	31,248	31,248			21,752	21,752			9,496	9,496		
C. Medicaid (other states)												
D. Private Pay	743	743			559	559			184	184		
E. State SSI for RCH												
F. Other (Specify) Managed Care	180	180			100	100			80	80		
G. Total Care Days During Period (3A thru F)	39,149	39,149			27,915	27,915			11,234	11,234		
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. <b>Total Resident Days (3G + 4A + 4B)</b>	<b>39,149</b>	<b>39,149</b>			<b>27,915</b>	<b>27,915</b>			<b>11,234</b>	<b>11,234</b>		

## Schedule of Resident Statistics (Cont'd)

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?

 Yes No

If "YES", provide the following information:

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

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.

1st change	Change in Resident Days			CCNH	RHNS	(Specify)
	CCNH	RHNS	(Specify)	CCNH	RHNS	(Specify)
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	10	108		2			15	
Per Diem Rate								
a. One bed rm.	620.00	310.35		622.00			524.83	
b. Two bed rms.	620.00	310.35		602.00			524.83	
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		3,105	3,105		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		6,443	6,443		
2. Restorative Treatments					
C. Other		11,814	11,814		
D. <b>Total Physical Therapy Treatments</b>		21,362	21,362		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		220	220	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments		1,530	1,530	
2. Restorative Treatments				
C. Other		1,477	1,477	
D. <b>Total Speech Therapy Treatments</b>		3,227	3,227	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		1,705	1,705	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments		6,409	6,409	
2. Restorative Treatments				
C. Other		10,793	10,793	
D. <b>Total Occupational Therapy Treatments</b>		18,907	18,907	

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		2183C	9/30/2021	10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes		<input type="radio"/> No	
		Total Cost and Hours			
Item		CCNH	Hours	RHNS	Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	143,618	2,122			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	354,553	14,011			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor	63,649	2,023			
c. Dietary Workers	615,380	31,690			
6. Housekeeping Service					
a. Head Housekeeper	60,231	2,113			
b. Other Housekeeping Workers	296,782	19,551			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	61,587	2,081			
b. Other Maintenance Workers	43,340	2,337			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	166,275	9,709			
9. Barber and Beautician Services					
10. Protective Services	11,052	822			
11. Accounting Services					
a. Head Accountant					
b. Other Accountants					
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	211,348	3,527			
b. RN					
1. Direct Care	569,845	11,680			
2. Administrative**	511,493	14,555			
c. LPN					
1. Direct Care	1,189,179	40,402			
2. Administrative**					
d. Aides and Attendants	1,901,245	101,480			
e. Physical Therapists	523,651	12,958			
f. Speech Therapists	70,388	1,634			
g. Occupational Therapists	309,663	7,061			
h. Recreation Workers	292,193	13,307			
i. Physicians					
1. Medical Director					
2. Utilization Review					
3. Resident Care***					
j. Dentists					
k. Pharmacists					
l. Podiatrists					
m. Social Workers/Case Management	202,124	7,063			
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
<i>A-13. Total Salary Expenditures</i>	7,597,596	300,126			

\* 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)**

**Schedule of Other Fees (Page 13)**

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 Northbridge Healthcare Center			License No. 2183C		Report for Year Ended 9/30/2021			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
Not Applicable										
<b>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).</b>										
Not Applicable										

\* 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
Northbridge Healthcare Center				2183C		9/30/2021			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)							
<b>Section III - Administrators***</b>										
Erica Roman (10/1/20-9/30/21)	143,618			Health & life insurances, payroll taxes	Day to day operations of the nursing home facility	2,122	A2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

**B. Report of Expenditures - Professional Fees**

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021		Page 13	of 37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)					
1. Dietitian	30,578	597			
2. Dentist	12,150	98			
3. Pharmacist	15,394	1,248			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	36,000	147			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**	4,300				
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	1,800	5			
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	192,822	1,732			
2. Administrative***					
b. LPN					
1. Direct Care	435,607	5,677			
2. Administrative***					
c. Aides	405,196	8,556			
d. Other					
12. Other (Specify)					
See Attached Schedule					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	1,133,847	18,060			

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

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

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

## Report of Expenditures

## Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis\*

Name of Facility	License No.	Report for Year Ended		Page	of
	2183C	9/30/2021		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
CT Dental, 300 Church St., Ste 203, Wallingford, CT 06492	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
Procare LTC, 110 Bi-County Blvd, Suite 121, Farmingdale, NY 11735	Pharmacy Services	<input checked="" type="radio"/>	<input type="radio"/>	Common Owners: Minority Interest	
Dr. Vasudha Vallabhneni, Northeast Medical Group, 99 Hawley Lane 3rd Floor, Stratford, CT	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Margaret Rose, 217 Hickory St., Bridgeport, CT 06610	Dietician	<input type="radio"/>	<input checked="" type="radio"/>		
SDX Dysphagia Experts, 21 Waterville Rd., Avon, CT 06001	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>		
Advanced Radiology, 2876 Main St., Stratford, CT 06614-4984	Radiology	<input type="radio"/>	<input checked="" type="radio"/>		
Connecticut Vascular & Thoracic, 501 Kings Hwy East, Suite 112, Fairfield, CT 06825	Physician	<input type="radio"/>	<input checked="" type="radio"/>		
The Nurse Network, C/O Access Capital, 400 Park Ave., New York, NY 10022	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Norton & Associates, 97 Elm St., Cohasset, MA 02025	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Solomon Page Staffing Solutions, 260 Madison Ave., 4th Floor, New York, NY 10016	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Heritage Private Nursing Inc., 174 South Rd., Suite 108, Enfield, CT 06082	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Genie Healthcare Inc., 104 Interchange Plaza, Suite 100, Monroe, NJ 08831	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Marvel Medical Staffing, C/O ANB PO Box 3544, Omaha, NE 68103-0544	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>		
Bridgeport Hospital, PO Box 780504, Philadelphia, PA 19178	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
CT Orthopaedic Specialists, 888 White Plains Rd., Trumbull, CT 06611-4552	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
DVA Laboratory Services, 3951 SW 30th Ave., Ft Lauderdale, FL 33126	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Healthdrive Audiology Group, PO Box 22010, New York, NY 10087-22010	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Healthdrive Eye-Care Group, PO Box 22010, New York, NY 10087-22010	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Orthopaedic Specialty Group, 321 Boston Post Rd., Milford, CT 06450-2574	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Preventice Services LLC, 400 Oyster Point Blvd 100, South San Francisco, CA 94080	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
Quest Diagnostics LLC, 3 Sterling Dr., Wallingford, CT 06492	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		
SCVC Stratford, 495 Hawley Lane Suite 2A, Strat	Physician services	<input type="radio"/>	<input checked="" type="radio"/>		

\* Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021	Page 15	of 37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 168,445	168,445		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 94,881	94,881		
4. Social Security (F.I.C.A.)	\$ 514,722	514,722		
5. Health Insurance	\$ 1,123,561	1,123,561		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 27,797	27,797		
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*	\$ 48,739	48,739		
d. Accounting and Auditing	\$ 6,118	6,118		
e. Legal (Services should be fully described on Page 7)	\$ 34,307	34,307		
f. Insurance on Lives of Owners and Operators (Specify)*	\$			
g. Office Supplies	\$ 71,477	71,477		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 131,663	131,663		
2. Cellular Phones	\$ 3,413	3,413		
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*	\$ (3,120)	(3,120)		
2. Other (Specify) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 676,234	676,234		
<b>Subtotal</b>	\$ 2,898,237	2,898,237		

\* 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**

Attachment Page 15

## **Schedule of Other Employee Benefits**

### Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
<b>Total</b>	\$ -	\$ -	\$ -

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

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<b><i>Subtotals Brought Forward:</i></b>		2,898,237	2,898,237		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	6,080	6,080		
3. Gifts to Staff and Residents	\$	34,749	34,749		
4. Employee Travel	\$	1,221	1,221		
5. Education Expenses Related to Seminars and Conventions	\$	11,312	11,312		
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$				
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$	18,060	18,060		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	13,134	13,134		
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	\$	7,233	7,233		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	18,356	18,356		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	329	329		
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract ( <i>Specify and Complete     Schedule C-2, Page 21 for each firm or individual</i> )	\$				
12. Administrative Management Services**	\$	441,061	441,061		
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	105,610	105,610		
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$	3,555,382	3,555,382		

\* 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)
<b>Total Other Travel and Entertainment</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Promotional	\$ 13,134		
<b>Total Other Advertising</b>	<b>\$ 13,134</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
ACHCA	\$ 310		
CAHCF	\$ 18,046		
<b>Total Dues</b>	<b>\$ 18,356</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
<b>Total Contributions</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Employee Physicals & background checks	\$ 6,274		
Bank Fees	\$ 19,549		
Payroll Processing Fees	\$ 21,025		
Data Processing Fees	\$ 56,769		
Licenses	\$ 1,993		
<b>Total Other Administrative and General</b>	<b>\$ 105,610</b>	<b>\$ -</b>	<b>\$ -</b>

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-17 Rev. 10/97

**Schedule C-1 - Management Services\***

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Athena Health Care Assoc, Inc 135 South Rd, Farmington, CT 06032	611,547	Contract attached to a prior year	See Below
Allocation of Above	403,621		Pg 16, line 12
Allocation of Above	97,848		Pg 18, line 2c
Allocation of Above	110,078		Pg 20, Line 5j
Athena Health Care Assoc, Inc 135 South Rd, Farmington, CT 06032	37,440		Pg 16, line 12

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

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

Name of Facility	License No.	Report for Year Ended		Page of
	2183C	9/30/2021		18   37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 335,474	335,474		
2. Non-Food Supplies	\$ 53,694	53,694		
3. Other (Specify) _____	\$ _____			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ _____			
c. Other (Specify) _____ Management services	\$ 97,848	97,848		
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 487,016</b>	<b>487,016</b>		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*	320	320		
G. Is cost of employee meals included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input checked="" type="radio"/> Yes <input type="radio"/> No			If yes, specify cost.	\$3,545
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.	
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021		Page of 19   37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
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. \$	22,575	22,575	
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$			
c. Other (Specify) Supplies	\$	10,351	10,351	
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	32,926	32,926	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

\* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2021		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced				
a. In-House Care	by Personnel				
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	52,357	52,357		
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel				
	Amt. \$				
C. Other ( <i>Specify</i> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>52,357</b>	<b>52,357</b>		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Procare LTC	\$	381,611	381,611		
b. Medicine Cabinet Drugs	\$	800	800		
c. Medical and Therapeutic Supplies	\$	508,141	508,141		
d. Ambulance/Limousine***	\$	32,664	32,664		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	14,595	14,595		
f. X-rays and Related Radiological Procedures***	\$	22,650	22,650		
g. Dental ( <i>Not dentists who should be included under             salaries or fees</i> )	\$				
h. Laboratory***	\$	21,717	21,717		
i. Recreation	\$	12,879	12,879		
j. Direct Management Services*	\$	110,078	110,078		
k. Indirect Management Services*	\$				
l. Other ( <i>Specify</i> )**** See Attached Schedule	\$	136,625	136,625		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>1,241,760</b>	<b>1,241,760</b>		

\* 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**

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

\* List all contracted services over \$10,000. Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

\*\*\* Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	122,197	122,197			
b. Heat	\$	53,799	53,799			
c. Light & Power	\$	158,659	158,659			
d. Water	\$	90,038	90,038			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	24,092	24,092			
f. Other <i>(itemize)</i>	\$	91,534	91,534			
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$	540,319	540,319			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$	1,425	1,425			
b. Building & Building Improvements	\$	52,734	52,734			
c. Non-Movable Equipment	\$	6,981	6,981			
d. Movable Equipment	\$	62,870	62,870			
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$	124,010	124,010			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$	5,085	5,085			
c. Leasehold Improvements	\$	37,709	37,709			
d. Other <i>(Specify)</i>	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$	42,794	42,794			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	779,758	779,758			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	91,007	91,007			
c. Personal property taxes	\$	27,720	27,720			
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$	1,065,289	1,065,289			

\* 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**

## Depreciation Schedule

**Schedule of Land Improvements Acquired during this report period**

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

**Schedule of Building Improvements Acquired during this report period**

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

\*\*Ties to Page 23, Line B2

**Schedule of Non-Movable Equipment Acquired during this report period**

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

\*\*Ties to Page 23, Line C3

**Schedule of Movable Equipment Acquired during this report period**

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
1/31/2021	steam table	\$ 4,646	10	\$ 232
1/31/2021	quick print thermal printer	\$ 1,057	10	\$ 53
5/31/2021	3 eye wash stations	1196	15	40
6/30/2021	projector	1064	5	106
<b>Total additions for Movable Equipment</b>		\$ 7,963		\$ 431 *
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		\$ -		\$ - **

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

\*\*Ties to Page 23, Line D2b

**Schedule of Leasehold Improvements Acquired during this report period**

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
6/30/2021	new condensor coil	\$ 7,354	5	\$ 735
7/31/2021	new phone system	\$ 73,452	10	\$ 3,672
<b>Total additions for Leasehold Improvemen</b>		\$ 80,806		\$ 4,407 *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvemen</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

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

**Annual Report of Long-Term Care Facility**

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**Amortization Schedule\***

Name of Facility Northbridge Healthcare Center			License No. 2183C		Report for Year Ended 9/30/2021			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1. Bed License Purchase	9	1997	None	525,000	342,708	None			
2.									
3.									
<b>A-4. Subtotal</b>									
<b>B. Mortgage Expense</b>									
1. Finance Fees	2	2018	3 years	32,151	29,335			3,572	
2. Finance Fees - Greystone		2019	30 years	45,387				1,513	
3.									
<b>B-4. Subtotal</b>									5,085
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period	9	2020	Various	327,071	100,001	S/L	Various	33,302	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)		9	2021	Various	80,806		S/L	Various	4,407
<b>C-4. Subtotal</b>									37,709
<b>D. Total Amortization</b>									42,794

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

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

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

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021	Page 25	of 37
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#### 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	11/13/96			
4. Date of Initial Licensure	11/13/96			
5. Total Licensed Bed Capacity	145			
6. Square Footage				
7. Acquisition Cost				
a. Land	393,226			
b. Building	7,959,774			

##### Part B - Owner and Related Parties

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	02/27/20			
c. Interest Rate for the Cost Year	3.45%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	7,696,000			
f. Principal balance outstanding as of _____	7,470,618			

##### 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.

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

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount		\$				
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$				

(Carry Subtotals forward to next page )

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

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021			Page 27	of 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) Vendor Int \$5,261; Midcap LOC \$35,461		\$	40,722	40,722		
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>		\$	40,722	40,722		
14. Insurance						
a. Insurance on Property (buildings only)		\$	150,213	150,213		
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. <b>Total Insurance Expenditures (14a + b + c)</b>		\$	150,213	150,213		
15. <b>Total All Expenditures (A-13 thru C-14)</b>		\$	15,897,427	15,897,427		

## **D. Adjustments to Statement of Expenditures**

Name of Facility Northbridge Healthcare Center			License No. 2183C	Report for Year Ended 9/30/2021		Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b><i>Page 10 - Salaries and Wages</i></b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 309,663	309,663		
4.			Other - See attached Schedule	\$ 7,783	7,783		
<b><i>Page 13 - Professional Fees</i></b>							
5.	13	B8c	Resident Care Physicians **	\$ 4,300	4,300		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b><i>Pages 15 &amp; 16 - Administrative and General</i></b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 48,739	48,739		
10.	15	1d	Accounting	\$ 3,418	3,418		
10a.			Legal	\$ 34,307	34,307		
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 2,693	2,693		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	I3	Gifts, flowers and coffee shops	\$ 34,749	34,749		
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&	Unallowable Advertising *	\$ 13,134	13,134		
19.	15	1k1	Income Tax / Corporate Business Tax	\$ (3,120)	(3,120)		
20.			Fund Raising / Contributions	\$			
21.	16	m12	Unallowable Management Fees	\$ 263,000	263,000		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 19,549	19,549		
<b><i>Page 18 - Dietary Expenditures</i></b>							
24.	18	2a1	Meals to employees, guests and others who are not residents	\$ 3,545	3,545		
<b><i>Page 19 - Laundry Expenditures</i></b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b><i>Page 20 - Housekeeping Expenditures</i></b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 741,760	741,760			

\* 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	A4	Marketing Salaries & Benefits	\$ 7,783		
<b>Total Other Salaries Adjustment</b>			\$ 7,783	\$ -	\$ -

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**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Fees Adjustments</b>			\$ -	\$ -	\$ -

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**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Bank charges	\$ 19,549		
<b>Total Other A&amp;G Adjustments</b>			\$ 19,549	\$ -	\$ -

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State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-29 Rev. 9/2018

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

Name of Facility			License No.	Report for Year Ended		Page of
Item No.	Page No.	Line No.	2183C	9/30/2021		29   37
				Total Amount of Decrease	CCNH	RHNS
			Subtotals Brought Forward	\$ 741,760	741,760	
<b><i>Page 20 - Resident Care Supplies***</i></b>						
27.	20	5a1&	Prescription Drugs	\$ 381,611	381,611	
28.	20	5d	Ambulance/Limousine	\$ 32,664	32,664	
29.	20	5f	X-rays, etc	\$ 22,650	22,650	
30.	20	5h	Laboratory	\$ 21,717	21,717	
31.	20	5c	Medical Supplies	\$ 17,540	17,540	
32.	20	500	Oxygen (non emergency)	\$ 14,595	14,595	
33.			Occupational Therapy	\$		
34.			Other - See Attached Schedule	\$ 57,519	57,519	
<b><i>Page 22 - Maintenance and Property</i></b>						
35.			Excess Movable Equipment Depreciation			
			See Attached Schedule	\$ 11,043	11,043	
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	\$		
<b><i>Page 27 - Insurance</i></b>						
40.			Mortgage Insurance	\$		
41.			Property Insurance	\$		
<b><i>Other - Miscellaneous</i></b>						
42.			Other - Indirect	\$		
43.	30	IV5	Interest Income on Account Rec.	\$ 11	11	
44.			Other - Miscellaneous Administrative	\$		
45.	18	2c	Management Fees Direct	\$ 71,727	71,727	
46.	20	5j	Management Fees Indirect	\$ 63,758	63,758	
47.			Other - Direct	\$		
<b><i>Not For Profit Providers Only</i></b>						
48.			Building/Non Movable Eq. Depreciation			
			Unallowable Building Interest - See Attached Schedule	\$		
49.	<b><i>Total Amount of Decrease (Items 1 - 48)</i></b>			\$ 1,436,595	1,436,595	

\*\*\* 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.

### **Schedule of Other Ancillary Costs**

### **Schedule of Excess Movable Equipment Depreciation**

### **Schedule of Other Property Adjustments**

### **Schedule of Other - Indirect Adjustments**

Attachment Page 29

### **Schedule of Other - Miscellaneous Administrative Adjustments**

### **Schedule of Other - Direct Adjustments**

## Schedule of Unallowable Building Interest

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 30	of 37
		Item	Total	CCNH	RHNS	(Specify)
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )		\$ 17,950,766	17,950,766			
b. Medicaid Room and Board Contractual Allowance **		\$ (8,891,568)	(8,891,568)			
2. a. Medicaid ( <i>All other states</i> )		\$				
b. Other States Room and Board Contractual Allowance **		\$				
3. a. Medicare Residents ( <i>all inclusive</i> )		\$ 2,266,532	2,266,532			
b. Medicare Room and Board Contractual Allowance **		\$ 750,598	750,598			
4. a. Private-Pay Residents and Other		\$ 2,283,726	2,283,726			
b. Private-Pay Room and Board Contractual Allowance **		\$ (522,434)	(522,434)			
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare		\$ 166,204	166,204			
b. Prescription Drugs - Medicare Contractual Allowance **		\$ (166,204)	(166,204)			
c. Prescription Drugs - Non-Medicare		\$ 195,866	195,866			
d. Prescription Drugs - Non-Medicare Contractual Allowance **		\$ (195,866)	(195,866)			
2. a. Medical Supplies - Medicare		\$ 6,700	6,700			
b. Medical Supplies - Medicare Contractual Allowance **		\$ (6,700)	(6,700)			
c. Medical Supplies - Non-Medicare		\$ 36,504	36,504			
d. Medical Supplies - Non-Medicare Contractual Allowance **		\$ (36,504)	(36,504)			
3. a. Physical Therapy - Medicare		\$ 531,709	531,709			
b. Physical Therapy - Medicare Contractual Allowance **		\$ (452,254)	(452,254)			
c. Physical Therapy - Non-Medicare		\$ 611,415	611,415			
d. Physical Therapy - Non-Medicare Contractual Allowance **		\$ (611,415)	(611,415)			
4. a. Speech Therapy - Medicare		\$ 116,765	116,765			
b. Speech Therapy - Medicare Contractual Allowance **		\$ (105,571)	(105,571)			
c. Speech Therapy - Non-Medicare		\$ 250,162	250,162			
d. Speech Therapy - Non-Medicare Contractual Allowance **		\$ (250,162)	(250,162)			
5. a. Occupational Therapy - Medicare		\$ 430,024	430,024			
b. Occupational Therapy - Medicare Contractual Allowance **		\$ (386,783)	(386,783)			
c. Occupational Therapy - Non-Medicare		\$ 592,320	592,320			
d. Occupational Therapy - Non-Medicare Contractual Allowance **		\$ (592,320)	(592,320)			
6. a. Other ( <i>Specify</i> ) - Medicare		\$				
b. Other ( <i>Specify</i> ) - Non-Medicare		\$ 1,341,232	1,341,232			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)		\$ 15,312,742	15,312,742			
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others		\$				
2. Rental of rooms to non-residents		\$				
3. Telephone		\$				
4. Rental of Television and Cable Services		\$				
5. Interest Income ( <i>Specify</i> )		\$ 11	11			
6. Private Duty Nurses' Fees		\$				
7. Barber, Coffee, Beauty and Gift shops		\$				
8. Other ( <i>Specify</i> )		\$ 650	650			
<b>V. Total Other Revenue</b> (1 thru 8)		\$ 661	661			
<b>VI. Total All Revenue</b> (III +V)		\$ 15,313,403	15,313,403			

\* 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)
	<b>Total Other Resident Revenue - Medicare</b>	\$ -	\$ -	\$ -

**Schedule of Other Non-Medicare Resident Revenue****Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Misc Revenue from 2021 CRF funding	\$ 409,826		
	Misc Revenue from 2020 CRF funding	\$ 931,406		
	<b>Total Other Resident Revenue</b>	\$ 1,341,232	\$ -	\$ -

**Interest Income****Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 31, Ln A	Interest on Accts Rec	N/A	\$ 11		
	<b>Total Interest Income</b>		\$ 11	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
n/a	bad debt recoveries	\$ 650		
	<b>Total Other Revenue</b>	\$ 650	\$ -	\$ -

**G. Balance Sheet**

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$ 33,693	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,685,637	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$ 9,939	
4. Inventories			\$ 24,354	
5. Prepaid Expenses			\$ 164,604	
a. Prepaid Insurance		138,832		
b. Prepaid Expense Other		5,492		
c. Prepaid Health Insurance		20,280		
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$ 112,985	
A/R Related Party Facilities		268,314		
Medicare Covid Grant		(155,329)		
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 2,031,212	
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	99,523	\$	11,966
	Accum. Depreciation	87,557	Net	
3. Buildings	*Historical Cost	2,141,550	\$	196,897
	Accum. Depreciation	1,944,653	Net	
4. Leasehold Improvements	*Historical Cost	407,877	\$	270,167
	Accum. Depreciation	137,710	Net	
5. Non-Movable Equipment	*Historical Cost	896,157	\$	49,813
	Accum. Depreciation	846,344	Net	
6. Movable Equipment	*Historical Cost	1,576,965	\$	132,064
	Accum. Depreciation	1,444,901	Net	
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	20,635
Equipment Carry Forward Adjustment		20,635		
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	681,542

\* 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

<b>Total Prepaid Expenses</b>		\$ -

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

Page Ref Line Ref Description

<b>Total Other Current Assets (Itemize)</b>		\$ -

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

Page Ref Line Ref Description

<b>Total Other Other Fixed Assets (Itemize)</b>		\$ -

## Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

<b>Total Other Assets</b>		\$ -

## Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref Line Ref Description

<b>Total Notes Payable</b>		\$ -

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

Page Ref Line Ref Description

<b>Total Other Current Liabilities (Itemize)</b>		\$ -

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

Page Ref Line Ref Description

<b>Total Other Current Liabilities (Itemize)</b>		\$ -

## G. Balance Sheet (cont'd)

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021	Page 32	of 37
Account		Amount		
		Total Brought Forward:		\$ 2,712,754
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	393,226
2. Land Improvements	*Historical Cost Accum. Depreciation	Net	\$	
3. Buildings	*Historical Cost Accum. Depreciation	6,999,069 5,803,396 Net	\$	1,195,673
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 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	1,588,899
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense	*Historical Cost Accum. Depreciation	525,000 342,708 Net	\$	182,292
4. Goodwill (Purchased Only)			\$	625,498
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	(4,301,880)
Name and Address	Amount	Loan Date		
	(4,301,880)			
7. Other Assets ( <i>itemize</i> )			\$	209,351
Project Development	166,233			
LOC Finance Fees	43,118			
See Schedule				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	(3,284,739)
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	1,016,914

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

## **G. Balance Sheet (cont'd)**

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021	Page 33	of 37
Account				Amount
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 2,454,000
2. Notes Payable ( <i>itemize</i> )				\$ 1,741,826
Due to Related Parties				622,848
Midcap Line of Credit				1,118,978
See Schedule				
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$
Name of Lender		Purpose	Amount	Date Due
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$ 330,569
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$
6. Accrued Payroll Taxes Payable				\$ 432,326
7. Medicare Final Settlement Payable				\$
8. Medicare Current Financing Payable				\$
9. Mortgage Payable ( <i>Current Portion</i> )				\$
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$
11. Accrued Income Taxes*				\$
12. Other Current Liabilities ( <i>itemize</i> )				\$ 1,330,562
Acc'd State Income Tax				(3,120) Provider Tax Due 1,098,589
Deferred Rent				32,768 Acc'd Health Insurance 9,255
Acc'd Operating Expenses				191,784
Acc'd Expense - Sales Tax				1,286 See Schedule
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)				<b>\$ 6,289,283</b>

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

**G. Balance Sheet (cont'd)**

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			\$ 6,289,283	
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$ 63,926
Name and Address of Lender	Amount	Loan Date		
Related Party	63,926	3/29/12		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 305,822
Related Party Notes	305,822			
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 369,748
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 6,659,031

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

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021	Page 35	of 37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	393,226
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	1,195,674
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	1,588,900
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	250,455
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(6,898,448)
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ (584,024)
7. Total Net Worth			\$	(7,231,017)
<b>C. Total Reserves and Net Worth</b>				\$ (5,642,117)
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 1,016,914

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Northbridge Healthcare Center	2183C	9/30/2021	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ (6,456,151)		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 15,313,403		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 15,897,427		
D. Net Income or Deficit				\$ (584,024)		
E. Balance				\$ (7,040,175)		
F. Additions						
1. Additional Capital Contributed ( <i>itemize</i> )						
Rounding				2		
Health Insurance 2020				(163,989)		
Rent Expense 2020				(27,635)		
State Income Tax 2020				780		
2. Other ( <i>itemize</i> )						
F-3. Total Additions				\$ (190,842)		
G. Deductions						
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )				\$		
Name and Address (No., City, State, Zip )		Title	Amount			
2. Other Withdrawings ( <i>Specify</i> )				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. <b>Balance at End of Period</b>				\$ (7,231,017)		
09/30/21						

## I. Preparer's/Reviewer's Certification

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2021	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

### Preparer/Reviewer Certification

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		
Athena Health Care Associates, Inc.		
Address 135 South Road Farmington, CT 06032		Phone Number 860-751-3900
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Contact Email Address		