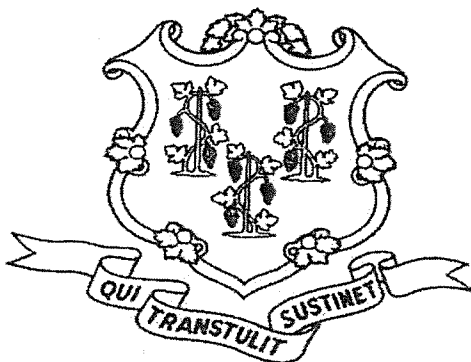


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as licensed) Northbridge Healthcare Center	
Address (No. & Street, City, State, Zip Code) 2875 Main Street Bridgeport, CT 06606	
Type of Facility Chronic and Convalescent                      Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH)    (RHNS)	
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

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 9/30/2019	Page 1	of 37
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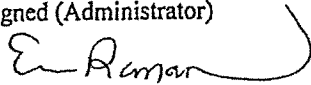


**Administrator's/Owner's Certification**

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, 2018 and ending September 30, 2019, 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 9/17/2020	Signed (Owner) 		Date 9/17/2020
Printed Name (Administrator) Erica Roman			Printed Name (Owner) Lawrence Santilli		
Subscribed and Sworn to before me:	State of CT	Date 9/17/2020	Signed (Notary Public) 	Comm. Expires 8.11.2022	
Address of Notary Public 38 Linda Dr. Plainville CT 06062					

(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 10/1/2018	To 9/30/2019	
Address of Facility 2875 Main Street Bridgeport, CT 06606				
Report Prepared By Athena Health Care Associates	Phone Number 860-751-3900	Date 2/3/2020		
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. <b>Total Wages Paid</b> \$				
7. Total salaries paid \$				
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report) \$				

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

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

Phone No. of Facility	Report for Year Ended	Page	of
203-336-0232	9/30/2019	2	37

Name of Facility (as shown on license)	Address (No. & Street, City, State, Zip)
Northbridge Healthcare Center	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 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	License No.:



**General Information and Questionnaire  
 Corporate Owners**

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2019	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address		State(s) in Which Incorporated	
Northbridge Health Care Center, Inc.	2875 Main Street Bridgeport, CT 06606		CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Lawrence G. Santilli	2875 Main Street Bridgeport, CT 06606	President	762.313	
Michael E. Mosier	2875 Main Street Bridgeport, CT 06606	Secretary/ Treasurer	40	
Names of Stockholders Owning at Least 10% of Shares				
Custodians fro Lawrence E. Santilli	2875 Main Street Bridgeport, CT 06606		132.687	





## General Information and Questionnaire Related Parties\*

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2019	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?  Yes  No

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No %**				
Laurel Ridge Health Care Center	642 Danbury Rd, Ridgfield, CT 06877	<input checked="" type="radio"/>	>98%	Bank charges	Pg 16, m13	5,188	5,188
Athena Captive LLC	135 South Rd, Farmington, CT 06032	<input type="radio"/>		Workers Comp Captive	Pg 15, line 1a	339,966	339,966
Northbridge Landlord LLC	135 South Rd, Farmington, CT 06032	<input type="radio"/>		Lease of facility/ Property taxes/ property ins	Pg22ln9&10b,Pg 27ln	1,070,629	1,070,629
Athena Health Care Services Inc. 401(k) Plan	135 South Rd, Farmington, CT 06032	<input type="radio"/>		Facility participates in a group 401 (k) plan			
Procure LTC	111 Executive Blvd, Farmingdale, NY 11735	<input checked="" type="radio"/>	>50%	Pharmacy	Pg 20, 5a2	232,540	232,540
Athena Health Care Insurance	135 South Rd, Farmington, CT 06032	<input type="radio"/>		Health Insurance	Pg 15, ln 1a5	1,282,692	1,282,692
Athena Health Care	135 South Rd, Farmington, CT 06032	<input type="radio"/>		see attached	see attached	see attached	see attached
		<input type="radio"/>					
		<input 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 9/30/2019	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	9/30/2019			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	966
Hewlett Packard Financial Services, PO Box 402582, Atlanta, GA	<input type="radio"/>	<input checked="" type="radio"/>	PCC Equipment	11/01/14	60 months	1,740	1,740
Leaf, 1720A Crete St., Moberly, MO 65270	<input type="radio"/>	<input checked="" type="radio"/>	Copier	03/04/17	60 months	18,999	18,918
	<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>						<b>21,624</b>	

\* 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.

0040223588

pitneybowes

Lease Agreement

--	--	--	--	--	--	--	--	--	--	--	--

Agreement Number

Your Business Information

Full Legal Name of Lessee / DBA Name of Lessee

NORTHBRIDGE HEALTH CENTER

Tax ID # (FED/TIN)

Sold-To: Address

2875 Main St, Bridgeport, CT, 06606-4204, US

Sold-To: Contact Name

Sharon Charest

Sold-To: Contact Phone #

(860) 751-3900

Sold-To: Account #

0010791395

Bill-To: Address

2875 Main St, Bridgeport, CT, 06606-4204, US

Bill-To: Contact Name

Sharon Charest

Bill-To: Contact Phone #

(860) 751-3900

Bill-To: Account #

0010791395

Bill-To: Email

scharesi@athenahealthcare.com

Ship-To: Address

2875 Main St, Bridgeport, CT, 06606-4204, US

Ship-To: Contact Name

Sharon Charest

Ship-To: Contact Phone #

(860) 751-3900

Ship-To: Account #

0010791395

PO #

Your Business Needs

Qty	Item	Business Solution Description
1	SENDPROC SERIES	SENDPRO C200, C300, C400
1	1FXA	1FXA DM Series INVIEW Dashboard
1	1H00	CSD Commercial PSD
1	2H00	C Series Base
1	APAC	Connect+ Accounting Weight Break Reports
1	APAV	Cost Acctg Accounts Level (25)
1	APB1	COST ACCOUNTING DEVICES (2)
1	APKN	ACCOUNT LIST IMPORT/EXPORT
1	C400	SendPro C400
1	CAAA	Cost Accounting Bronze plan
1	DM3RKL	RETURN KIT FOR DM300 - LARGE
1	FBS2	FBS2-SENDPRO C INSTALL TRNG W SHIPPING
1	HZ80001	SendPro C Series Drop Stacker
1	HZ80002	SCALE OPENING COVER

0040223588

1	MP00098	KIT-BACKLIT SCALE MOUNTED GRAPHICAL DISP
1	MP82	C Series Remota Display Scale
1	PTJ1	Postal Shipping
1	PTJA	SendPro Basic 1 User
1	PTJN	SINGLE USER ACCESS
1	PTK1	WEB BROWSER INTEGRATION
1	PTK2	CSD2 Integration
1	SJS4	C400 SOFTGUARD
1	STDSLA	Standard SLA-Equipment Service Agreement (for SENDPRO C200, C300, C400)
1	ZH01	5 LB WEIGHING OPTION FOR MP82 SCALE
1	ZH24	MANUAL WEIGHT ENTRY
1	ZH27	HZ02 65 LPM SPEED
1	ZHC4	SENDPRO C400 BASE SYSTEM IDENTIFIER
1	ZHD5	USPS RATES WITH METERED LETTER
1	ZHD7	E CONF SERVICES FOR METERED LTR. BDL

Your Payment Plan

Initial Term: 60 months	Initial Payment Amount:	
Number of Months:	Monthly Amount	Billed Quarterly at*
60	\$ 100.97	\$ 302.91

\*Does not include any applicable sales, use, or property taxes which will be billed separately.

- Tax Exempt Certificate Attached
- Tax Exempt Certificate Not Required
- Purchase Power<sup>®</sup> transaction fees included
- Purchase Power<sup>®</sup> transaction fees extra

0040223588

Your Signature Below

By signing below, you agree to be bound by all the terms of this Agreement including the Pitney Bowes Terms (Version 7/18), which are available at <http://www.pb.com/termsconditions> and are incorporated by reference. You acknowledge that you may not cancel the lease for any reason and that all payment obligations are unconditional. The lease will be binding on us after we have completed our credit and documentation approval process and have signed below. The lease requires you either to provide proof of insurance or participate in the ValueMAX® equipment protection program (see Section 15 of the Pitney Bowes Terms) for an additional fee. If software is included in the Order, additional terms apply which are available by clicking on the hyperlink for that software located at <http://www.pitneybowes.com/us/license-terms-of-use/software-and-subscription-terms-and-conditions.html>. Those additional terms are incorporated by reference.

Not Applicable

State/Entity's Contract#

*ER*

Lessee Signature

*TRICA ROMAN*

Print Name

*Administrator*

Title

*3/22/18*

Date

*Administrator @ nathanhodgehcc.com*

Email Address

*Salvatore Polletta*

*Salvatore Polletta*

*Director, Credit & New Business Operations*

Print Name

Title

Date

Monday, March 26, 2018

Sales Information

Jeffrey Mesite

*jeffrey.mesite@pb.com*

Account Rep Name

Email Address

**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2019	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Marcum LLP	555 Long Wharf Dr. Shelton, CT 06484
2 Dworkin, Hillman, Lamorte	Four Corporate Dr. Suite 488, Shelton, CT 06484
3 Midcap Financials	259 W 30th St Suite 301, New York, NY 10001
4	

Services Provided by This Firm (*describe fully*)

1 Medicare Cost Report Preparation	\$ 2,700
2 2017 Audit, Year End Financials	\$ 10,100
3 2019 audits: Disallow	\$ 3,253
4	\$
	Charge for Services Provided
	\$ 16,053

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 Murtha Cullina LLP	860-240-6000
2 Goldman, Gruder, & Woods LLC/ Littler Mendelson/ Senior Planning/ Pilicy & Ryan	203-899-8900/ 214-880-8100/860
3 Jackson Lewis/ Daly, Weihing, & Bochanis	914-872-8060
4 Midcap Financials	312-258-5500
5 Bridgeport Probate \$475/ Sheriff \$108	

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

- 1 185 Asylum St, Hartford, CT 06103
- 2 200 Connecticut Ave., Norwalk, CT 06854/ PO Box 207137 Dallas, TX 75320/ PO Box 760 365 Main St. Watertown, CT 06795
- 3 44 South Broadway, 14th Flr, White Plains, NY 10601/ 1776 North Ave. Bridgeport, CT 06604
- 4 259 W 30th St Suite 301, New York, NY 10001
- 5 Bridgeport CT

Services Provided by This Firm (*describe fully*)

1 Misc Matters \$51/ Sec of State Filing: Allow \$150	\$ 201
2 AR Collections : Disallowed	\$ 15,360
3 Misc Employee matters: Disallowed	\$ 49,577
4 Line of credit legal fees: Disallowed	\$ 219
5 Conservatorshit: Disallowed	\$ 583
	Charge for Services Provided
	\$ 65,940

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 9/30/2019				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Period 10/1 Thru 6/30		Period 7/1 Thru 9/30		
				Total	CCNH	RHNS	(Specify)	Total
1. Certified Bed Capacity								
A. On last day of PREVIOUS report period	145	145		145	145	145	145	
B. On last day of THIS report period	145	145		145	145	145	145	
2. Number of Residents								
A. As of midnight of PREVIOUS report period	144	144		144	144	140	140	
B. As of midnight of THIS report period	139	139		140	140	139	139	
3. Total Number of Days Care Provided During Period								
A. Medicare	3,995	3,995		2,817	2,817	1,178	1,178	
B. Medicaid (Conn.)	45,698	45,698		34,449	34,449	11,249	11,249	
C. Medicaid (other states)								
D. Private Pay	719	719		555	555	164	164	
E. State SSI for RCH								
F. Other (Specify) Managed Care	320	320		307	307	13	13	
G. Total Care Days During Period (3A thru F)	50,732	50,732		38,128	38,128	12,604	12,604	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds								
A. Medicaid Bed Reserve Days	243	243		172	172	71	71	
B. Other Bed Reserve Days	9	9		7	7	2	2	
5. <b>Total Resident Days (3G + 4A + 4B)</b>	50,984	50,984		38,307	38,307	12,677	12,677	

### Schedule of Resident Statistics (Cont'd)

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2019	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?  Yes  No

If "YES", provide the following information:

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

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

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

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

Item	Medicare		Medicaid		Self-Pay			Other State Assisted	
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	9		120		1		9		
Per Diem Rate									
a. One bed rm.	594.08		265.43		562.00		523.93		
b. Two bed rms.	594.08		265.43		542.00		523.93		
c. Three or more bed rms.									

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	3,147	3,147		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	3,222	3,222		
2. Restorative Treatments				
C. Other	8,289	8,289		
D. <b>Total Physical Therapy Treatments</b>	14,658	14,658		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	467	467		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	689	689		
2. Restorative Treatments				
C. Other	641	641		
D. <b>Total Speech Therapy Treatments</b>	1,797	1,797		

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	2,565	2,565		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	3,103	3,103		
2. Restorative Treatments				
C. Other	8,571	8,571		
D. <b>Total Occupational Therapy Treatments</b>	14,239	14,239		

### Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Northbridge Healthcare Center	2183C	9/30/2019	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	(Specify)	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	129,797	2,074				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	305,937	13,191				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	61,706	2,001				
c. Dietary Workers	631,662	33,805				
6. Housekeeping Service						
a. Head Housekeeper	58,390	2,142				
b. Other Housekeeping Workers	265,024	19,721				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	59,709	1,860				
b. Other Maintenance Workers	38,240	2,120				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	159,252	9,915				
9. Barber and Beautician Services						
10. Protective Services	12,258	1,012				
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	175,769	3,048				
b. RN						
1. Direct Care	935,621	24,312				
2. Administrative**	487,076	15,460				
c. LPN						
1. Direct Care	1,069,296	39,935				
2. Administrative**						
d. Aides and Attendants	2,146,040	133,905				
e. Physical Therapists	396,801	10,497				
f. Speech Therapists	53,597	1,354				
g. Occupational Therapists	192,228	4,817				
h. Recreation Workers	273,857	13,321				
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	231,826	7,642				
n. Marketing						
o. Other (Specify)						
See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	7,684,086	342,132				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

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

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

Name of Facility		License No.		Report for Year Ended		Page	of		
Northbridge Healthcare Center		2183C		9/30/2019		11	37		
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS (Specify)							
<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.

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

Name of Facility (as licensed) Northbridge Healthcare Center		License No. 2183C	Report for Year Ended 9/30/2019		Page 12	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 III - Administrators***</b>									
Erica Roman (10/1/18-9/30/19)	129,797		Health & Life insurances, payroll taxes	Day to day operations of the nursing home facility	2,074	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	License No.	Report for Year Ended	Page	of		
Northbridge Healthcare Center	2183C	9/30/2019	13	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 (For all such services complete Schedule B1)</b>						
1. Dietitian	29,310	539				
2. Dentist	8,850	42				
3. Pharmacist	15,279	212				
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	401				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	6,653					
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify) Medical Staff meetings	300					
9. Speech Therapist						
a. Resident Care	3,960	11				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	9,643	155				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>109,995</b>	<b>1,360</b>				

\* 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 Northbridge Healthcare Center		License No. 2183C	Report for Year Ended 9/30/2019	Page 14	of 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 Flr, 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"/>		
Athena Health Care Systems, 135 South Rd, Farmington, CT 06032	MDS fill-in	<input checked="" type="radio"/>	<input type="radio"/>	Common owners	
HD Audiology Group, 888 Worcester St., Wellesley, MA 02482	Speech	<input type="radio"/>	<input checked="" type="radio"/>		
CT Orthopaedic Specialists, 2408 Whitney Ave, Hamden, CT 06518	Orthopaedics	<input type="radio"/>	<input checked="" type="radio"/>		
Healthdrive Eye Care Group, 888 Worcester St., Wellesley, MA 02482	Eyecare	<input type="radio"/>	<input checked="" type="radio"/>		
Northeast Medical Group, PO Box 415126, Boston, MA 02241-5126	Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Adult & Pediatric Dermatology Specialists, 160 Hawley Lane Suite 104, Trumbull, CT 06611	Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Quest Diagnostic, 3 Sterling Dr., Wallingford, CT 06492	Physician	<input type="radio"/>	<input checked="" type="radio"/>		
St. Vincents Medical Center, 2800 Main St., Bridgeport, CT 06606	Physician	<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"/>		
		<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	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2019	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 339,966	339,966		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 133,843	133,843		
4. Social Security (F.I.C.A.)	\$ 526,883	526,883		
5. Health Insurance	\$ 1,111,522	1,111,522		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 35,271	35,271		
8. Uniform Allowance	\$			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 180,489	180,489		
d. Accounting and Auditing	\$ 16,053	16,053		
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 65,940	65,940		
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 71,395	71,395		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 76,324	76,324		
2. Cellular Phones	\$ 3,464	3,464		
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$			
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$			
k. Other Taxes ( <i>Not related to property - See Page 22</i> )				
1. Income*	\$ 2,340	2,340		
2. Other ( <i>Specify</i> ) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 987,709	987,709		
<b>Subtotal</b>	\$ 3,551,199	3,551,199		

\* 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**

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

-----  
**Schedule of Other Taxes**

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2019	16	37
Item	Total	CCNH	RHNS	(Specify)
<b>Subtotals Brought Forward:</b>	3,551,199	3,551,199		
<b>l. Travel and Entertainment</b>				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$ 7,225	7,225		
3. Gifts to Staff and Residents	\$ 25,385	25,385		
4. Employee Travel	\$ 2,189	2,189		
5. Education Expenses Related to Seminars and Conventions	\$ 7,988	7,988		
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$			
7. Other ( <i>Specify</i> ) See Attached Schedule	\$			
<b>m. Other Administrative and General Expenses</b>				
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 8,944	8,944		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$ 773	773		
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 8,993	8,993		
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	\$ 4,353	4,353		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 8,581	8,581		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 540	540		
9. Subscriptions	\$ 1,452	1,452		
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**	\$ 456,696	456,696		
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 99,006	99,006		
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 4,183,324	4,183,324		

\* 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>	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 8,993		
<b>Total Other Advertising</b>	\$ 8,993	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
ACHCA	\$ 1,034		
CAHCF	\$ 7,547		
<b>Total Dues</b>	\$ 8,581	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Employee physicals & background checks	\$ 17,634		
Bank fees	\$ 17,699		
Payroll processing fees	\$ 24,708		
Data processing fees	\$ 31,460		
Licenses	\$ 1,005		
CMS Penalty - 2019-01-LTC-047	\$ 6,500		
<b>Total Other Administrative and General</b>	\$ 99,006	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2019	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	635,236	Contract attached to a prior year	See Below
Allocation of Above	419,256	Admin/ Gen 66%	Pg 16, line 12
Allocation of Above	101,638	Indirect 16%	Pg 18, line 2c
Allocation of Above	114,342	Direct 18%	Pg 20, Line 5j
Athena Health Care Assoc, Inc 135 South Rd, Farmington, CT 06032	37,440	Admin/ Gen - Other Expenses	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
Northbridge Healthcare Center		2183C	9/30/2019		18	37
Item		Total	CCNH	RHNS	(Specify)	
<b>2. Dietary</b>						
<b>a. In-House Preparation &amp; Service</b>						
1.	Raw Food	\$ 372,872	372,872			
2.	Non-Food Supplies	\$ 48,243	48,243			
3.	Other (Specify) _____ Dishes	\$ 343	343			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$				
c. Other (Specify) _____ Management Services		\$ 101,638	101,638			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>		<b>\$ 523,096</b>	<b>523,096</b>			
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)	
F.	Resident Meals: Total no. of meals served per day:*	417	417			
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. \$3,027	
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 9/30/2019	Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$			
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. \$	21,866	21,866	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Other (Specify) Supplies		\$	7,120	7,120	
<b>3D. Total Laundry Expenditures (3a + b + c)</b>		\$	<b>28,986</b>	<b>28,986</b>	
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
Northbridge Healthcare Center		2183C	9/30/2019		20	37
Item		Total	CCNH	RHNS	(Specify)	
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	57,208	57,208		
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> )	\$				
4D.	<b>Total Housekeeping Expenditures</b> (4a + b + c)	\$	57,208	57,208		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from Procure LTC	\$	219,612	219,612		
b.	Medicine Cabinet Drugs	\$	4,758	4,758		
c.	Medical and Therapeutic Supplies	\$	368,408	368,408		
d.	Ambulance/Limousine***	\$	2,293	2,293		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	13,462	13,462		
f.	X-rays and Related Radiological Procedures***	\$	9,450	9,450		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h.	Laboratory***	\$	19,969	19,969		
i.	Recreation	\$	20,675	20,675		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	234,858	234,858		
5M.	<b>Total Resident Care Expenditures</b> (5a - 5j)	\$	893,485	893,485		

\* 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)
Management Fee Direct	\$ 114,342		
Medical Equip Rentals- Medicaid	\$ 51,635		
Physical Therpay Supplies	\$ 34,447		
Speech Therapy Supplies	\$ 474		
Oxygen Concentrator Rentals	\$ 16,902		
Cable TV fees	\$ 15,468		
Medical Equip Rentals- Other	\$ 1,590		
<b>Total Other Resident Care</b>	<b>\$ 234,858</b>	<b>\$ -</b>	<b>\$ -</b>

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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					
Northbridge Healthcare Center		2183C	9/30/2019	21	37				
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS (Specify)	Pg	Line
		Yes	No						
ADP	Hartford Region, Richmond, VA 414, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Payroll Services	20,923		16	13
CWPM	111 Executive Blvd, Farmingdale, NY 11735	<input type="radio"/>	<input checked="" type="radio"/>	Common Owners: Minority Interest	Rubbish Removal Pharmacy	36,623 232,540		22	6f 5
Procare LTC	229 Alberta St, Fairfield, CT 06825	<input type="radio"/>	<input checked="" type="radio"/>		Snow Removal	14,450		22	6f
JDS Construction Services LLC		<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"/>						
		<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"/>						

\* List all contracted services over \$10,000. Use additional sheets if necessary.  
 \*\* Refer to Page 4 for definition of related.  
 \*\*\* Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended			Page	of
Northbridge Healthcare Center	2183C	9/30/2019			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 115,140	115,140				
b. Heat	\$ 57,872	57,872				
c. Light & Power	\$ 161,204	161,204				
d. Water	\$ 90,370	90,370				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 21,624	21,624				
f. Other ( <i>itemize</i> )	\$ 72,633	72,633				
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 518,843</b>	<b>518,843</b>				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 1,425	1,425				
b. Building & Building Improvements	\$ 75,131	75,131				
c. Non-Movable Equipment	\$ 11,174	11,174				
d. Movable Equipment	\$ 78,786	78,786				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 166,516</b>	<b>166,516</b>				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 10,717	10,717				
c. Leasehold Improvements	\$ 22,740	22,740				
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 33,457</b>	<b>33,457</b>				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 721,124	721,124				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 273,351	273,351				
c. Personal property taxes	\$ 37,587	37,587				
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 1,232,035</b>	<b>1,232,035</b>				

\* 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)
Rubbish Removal	\$ 36,623		
Snow Removal	\$ 14,450		
Supplies	\$ 21,560		
<b>Total Other Repairs and Maintenance</b>	\$ 72,633	\$ -	\$ -

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### Depreciation Schedule

Name of Facility Northbridge Healthcare Center		License No. 2183C		Report for Year Ended 9/30/2019				Page 23	of 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
<b>A. Land Improvements</b>									
1. Acquired prior to this report period		99,523		99,523	83,281	S/L	Various	1,425	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
<b>A-4. Subtotal</b>									1,425
<b>B. Building and Building Improvements</b>									
1. Acquired prior to this report period		2,141,554		2,141,554	1,749,581	S/L	Various	75,131	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
<b>B-4. Subtotal</b>									75,131
<b>C. Non-Movable Equipment</b>									
1. Acquired prior to this report period		896,157		896,157	820,251	S/L	Various	11,174	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
<b>C-4. Subtotal</b>									11,174
<b>D. Movable Equipment</b>									
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									
b. Disposals (attach schedule)									
c. Acquired during this report period (attach schedule)									
Date of Acquisition		9	2018	1,530,787	1,235,052	S/L	Various	76,952	
Var			Var	33,970		S/L	Various	1,834	
<b>D-3. Subtotal</b>									78,786
<b>E. Total Depreciation</b>									166,516

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Land Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Land Improvements</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
<b>Total additions for Building Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

## Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
See Attached	See Attached	\$ 33,970	See attached	\$ 1,834
<b>Total additions for Movable Equipment</b>		\$ 33,970		\$ 1,834 *
<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>				
6/30/2019	2 new AC compressors	\$ 20,775	15	\$ 692
6/30/2019	6 new bollards	\$ 2,800	5	\$ 279
9/30/2019	new elevator power unit	34420	10	1720
9/30/2019	replace RTU compressor	4900	10	244
9/30/2019	water pump repairs	4158	5	415
<b>Total additions for Leasehold Improvement</b>		\$ 67,053		\$ 3,350 *
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
Oct-18	door entry system	\$ 1,893	10	\$ 94
Oct-18	sofa & chair	\$ 8,604	15	\$ 287
Oct-18	bed control boxes	\$ 626	5	\$ 63
Nov-18	washer	\$ 11,327	10	\$ 566
Nov-18	bed control boxes	\$ 626	5	\$ 63
Jan-19	door renovations	\$ 2,771	10	\$ 139
Feb-19	computer	\$ 615	5	\$ 62
May-19	computer	\$ 521	5	\$ 52
Jun-19	65" tv	\$ 1,495	5	\$ 150
Jun-19	metal door	\$ 3,530	20	\$ 88
Jun-19	3 mattresses	\$ 826	5	\$ 83
Aug-19	laptop	\$ 556	3	\$ 93
Sep-19	fortinet	\$ 580	3	\$ 97
<b>Total additions for Movable Equipment</b>		<b>\$ 33,970</b>		<b>\$ 1,834 *</b>
<b>Deletions:</b>				
				\$ -
<b>Total deletions for Movable Equipment</b>		<b>\$ -</b>		<b>\$ - **</b>

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b



### Amortization Schedule\*

Name of Facility Northbridge Healthcare Center		Date of Acquisition		License No. 2183C	Report for Year Ended		Basis for Computing Amortization**	Rate %	Amortization for This Year	of
					9/30/2019	24				
Item		Month	Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations				Totals
<b>A. Organization Expense</b>										
1.	Bed License Purchase	9	1997	None	525,000	237,708	None			
2.										
3.										
A-4. Subtotal										
<b>B. Mortgage Expense</b>										
1.	Finance Fees	2	2018	3 yrs	32,151	7,145	S/L		10,717	
2.	Finance Fees -Greystone		2019		45,387		S/L			
3.										
B-4. Subtotal										10,717
<b>C. Leasehold Improvements and Other</b>										
1.	Acquired prior to this report period	9	2018	Various	181,960	48,805	S/L	Various	19,390	
2.	Disposals (attach schedule)									
3.	Acquired during this report period (attach schedule)									
		Var	Var	Various	67,053		S/L	Various	3,350	
C-4. Subtotal										22,740
<b>D. Total Amortization</b>										33,457

\* Straight-line method must be used.  
 \*\* Specify which of the following bases were used:  
 A. Minimum of 5 years or 60 months.  
 B. Life of mortgage; OR  
 C. Remaining Life of Lease; OR  
 D. Actual Life if owned by Related Party.

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

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2019	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 <b>NOT</b> 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			

<b>Part B - Owner and Related Parties</b>	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD			
b. Date Mortgage Obtained	03/29/12			
c. Interest Rate for the Cost Year	3.22%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	8,800,000			
f. Principal balance outstanding as of 9/30/19	7,340,539			
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
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		Page	of
Northbridge Healthcare Center		2183C	9/30/2019		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. <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		License No.		Report for Year Ended		Page	of
Northbridge Healthcare Center		2183C		9/30/2019		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)				\$	67,505	67,505	
Vendor Int \$14,348, Midcap LOC \$53,157							
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$	67,505	67,505	
14. Insurance							
a. Insurance on Property (buildings only)				\$	83,316	83,316	
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>				\$	83,316	83,316	
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$	15,381,879	15,381,879	

### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center				2183C	9/30/2019	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 192,228	192,228		
4.			Other - See attached Schedule	\$ 8,826	8,826		
<b>Page 13 - Professional Fees</b>							
5.	13	B8c	Resident Care Physicians **	\$ 6,653	6,653		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 180,489	180,489		
10.	15	1d	Accounting	\$ 3,253	3,253		
10a.			Legal	\$ 65,790	65,790		
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 2,984	2,984		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	13	Gifts, flowers and coffee shops	\$ 25,385	25,385		
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 *	\$ 9,766	9,766		
19.	15	k1	Income Tax / Corporate Business Tax	\$ 2,340	2,340		
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$ 252,349	252,349		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 24,739	24,739		
<b>Page 18 - Dietary Expenditures</b>							
24.	18	2a1	Meals to employees, guests and others who are not residents	\$ 3,027	3,027		
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 777,829	777,829		

\* 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	\$ 8,826		
<b>Total Other Salaries Adjustment</b>			<b>\$ 8,826</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	8a	Disallowed dues	\$ 540		
16	m13	Bank charges	\$ 17,699		
16	m13	CMS Penalty 2019-01-LTAC-047	\$ 6,500		
<b>Total Other A&amp;G Adjustments</b>			<b>\$ 24,739</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Northbridge Healthcare Center			2183C	9/30/2019	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 777,829	777,829		
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$ 219,612	219,612		
28.			Ambulance/Limousine	\$ 2,293	2,293		
29.			X-rays, etc	\$ 9,450	9,450		
30.			Laboratory	\$ 19,969	19,969		
31.			Medical Supplies	\$ 20,820	20,820		
32.			Oxygen (non emergency)	\$ 13,462	13,462		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 1,590	1,590		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ 12,482	12,482		
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>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$ 221	221		
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$ 68,823	68,823		
46.			Management Fees Indirect	\$ 61,176	61,176		
47.			Other - Direct	\$ 11,868	11,868		
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 1,219,595	1,219,595		

\*\*\* 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.





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

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Radio and television revenue	\$ 11,868		
<b>Total Other Adjustments</b>			\$ 11,868	\$ -	\$ -

Schedule of Unallowable Building Interest

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

Cost Year

Northbridge Moveable Equipment Carryforward Schedule

Totals

Cost Year	2008 Cost Report-Heritage Furn	2008 Cost Report-Heritage Furn	2009 Cost Report-Heritage Furn	2009 Cost Report-Heritage Furn	2014 cost report - tv's	2015 cost report - tv's	2016 cost report - tv's	2017 cost report - tv's	2018 cost report-TV's	Totals
1997										\$ 1,431
1997	Def: Book Value									\$ 22,257
1998	Dep: Book Value									\$ 2,957
1998	Dep: Book Value									\$ 22,114
1999	Dep: Book Value									\$ 3,282
1999	Dep: Book Value									\$ 21,210
2000	Dep: Book Value									\$ 3,339
2001	Dep: Book Value									\$ 17,940
2001	Dep: Book Value									\$ 3,670
2002	Dep: Book Value									\$ 14,911
2002	Dep: Book Value									\$ 3,292
2003	Dep: Book Value									\$ 12,556
2003	Dep: Book Value									\$ 2,888
2004	Dep: Book Value									\$ 9,837
2004	Dep: Book Value									\$ 2,681
2005	Dep: Book Value									\$ 7,158
2005	Dep: Book Value									\$ 2,458
2006	Dep: Book Value									\$ 5,076
2006	Dep: Book Value									\$ 2,395
2007	Dep: Book Value									\$ 3,059
2007	Dep: Book Value									\$ 2,988
2008	Dep: Book Value									\$ 36,081
2008	Dep: Book Value									\$ 3,839
2009	Dep: Book Value									\$ 39,056
2009	Dep: Book Value									\$ 4,091
2010	Dep: Book Value									\$ 35,001
2010	Dep: Book Value									\$ 4,104
2011	Dep: Book Value									\$ 30,897
2011	Dep: Book Value									\$ 4,062
2012	Dep: Book Value									\$ 26,836
2012	Dep: Book Value									\$ 3,775
2013	Dep: Book Value									\$ 23,062
2013	Dep: Book Value									\$ 3,394
2014	Dep: Book Value									\$ 19,668
2014	Dep: Book Value									\$ 3,541
2015	Dep: Book Value									\$ 18,929
2015	Dep: Book Value									\$ 4,409
2016	Dep: Book Value									\$ 21,136
2016	Dep: Book Value									\$ 6,243
2017	Dep: Book Value									\$ 26,747
2017	Dep: Book Value									\$ 7,542
2018	Dep: Book Value									\$ 27,371
2018	Dep: Book Value									\$ 10,210
2019	Dep: Book Value									\$ 43,542
2019	Dep: Book Value									\$ 12,482
2020	Dep: Book Value									\$ 31,060
2020	Dep: Book Value									\$ 11,540
2021	Dep: Book Value									\$ 19,520
2021	Dep: Book Value									\$ 9,691
2022	Dep: Book Value									\$ 9,829
2022	Dep: Book Value									\$ 7,048
2023	Dep: Book Value									\$ 2,781
2023	Dep: Book Value									\$ 2,786
2024	Dep: Book Value									\$ (5)
2024	Dep: Book Value									\$ (5)
										\$ 0
										\$ 130,320

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended		Page	of
Northbridge Healthcare Center	2183C	9/30/2019		30	37
Item	Total	CCNH	RHNS	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 24,638,604	24,638,604			
b. Medicaid Room and Board Contractual Allowance **	\$ (12,596,732)	(12,596,732)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,109,304	1,109,304			
b. Medicare Room and Board Contractual Allowance **	\$ 251,293	251,293			
4. a. Private-Pay Residents and Other	\$ 1,934,533	1,934,533			
b. Private-Pay Room and Board Contractual Allowance **	\$ (356,740)	(356,740)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 114,847	114,847			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (114,847)	(114,847)			
c. Prescription Drugs - Non-Medicare	\$ 176,266	176,266			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (176,266)	(176,266)			
2. a. Medical Supplies - Medicare	\$ 6,320	6,320			
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$ 15,255	15,255			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (15,255)	(15,255)			
3. a. Physical Therapy - Medicare	\$ 409,121	409,121			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (363,892)	(363,892)			
c. Physical Therapy - Non-Medicare	\$ 349,145	349,145			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (349,145)	(349,145)			
4. a. Speech Therapy - Medicare	\$ 91,185	91,185			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (79,378)	(79,378)			
c. Speech Therapy - Non-Medicare	\$ 183,785	183,785			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (183,785)	(183,785)			
5. a. Occupational Therapy - Medicare	\$ 379,542	379,542			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (339,384)	(339,384)			
c. Occupational Therapy - Non-Medicare	\$ 338,190	338,190			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (338,190)	(338,190)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (96,385)	(96,385)			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 14,987,391	14,987,391			
<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> )	\$ 221	221			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 168,582	168,582			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 168,803	168,803			
<b>VI. Total All Revenue</b> (III +V)	\$ 15,156,194	15,156,194			

\* 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	Retroactives	\$ (96,385)		
<b>Total Other Resident Revenue</b>		\$ (96,385)	\$ -	\$ -

**Interest Income**

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 31, line	Interest on Accts Rec	N/A	\$ 221		
<b>Total Interest Income</b>			\$ 221	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Bad debt recoveries	\$ 168,582		
<b>Total Other Revenue</b>		\$ 168,582	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2019	31	37
Account			Amount	
<b>Assets</b>				
<b>A. Current Assets</b>				
1. Cash ( <i>on hand and in banks</i> )			\$	74,425
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,585,063
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	27,289
5. Prepaid Expenses			\$	351,882
a. Prepaid Insurance	337,812			
b. Prepaid Expense other	3,214			
c. Prepaid Health Insurance	10,856			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	268,314
A/R Related Party Facilities	268,314			
_____ _____ See Schedule				
<b>A-9. Total Current Assets (Lines A1 thru 8)</b>			<b>\$</b>	<b>2,306,973</b>
<b>B. Fixed Assets</b>				
1. Land			\$	
2. Land Improvements	*Historical Cost	99,523	\$	14,817
	Accum. Depreciation	84,706		Net
3. Buildings	*Historical Cost	2,141,550	\$	316,842
	Accum. Depreciation	1,824,708		Net
4. Leasehold Improvements	*Historical Cost	249,013	\$	177,468
	Accum. Depreciation	71,545		Net
5. Non-Movable Equipment	*Historical Cost	896,157	\$	64,732
	Accum. Depreciation	831,425		Net
6. Movable Equipment	*Historical Cost	1,533,698	\$	219,860
	Accum. Depreciation	1,313,838		Net
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation			Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	31,060
Equipment Carry forward adjustment	31,060			
See Schedule				
<b>B-10. Total Fixed Assets (Lines B1 thru 9)</b>			<b>\$</b>	<b>824,779</b>

\* 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>			<b>\$ -</b>

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

Page Ref	Line Ref	Description	
<b>Total Other Current Assets (Itemize)</b>			<b>\$ -</b>

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

Page Ref	Line Ref	Description	
<b>Total Other Fixed Assets (Itemize)</b>			<b>\$ -</b>

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		LOC Finance Fees	\$ 39,676
<b>Total Other Assets</b>			<b>\$ 39,676</b>

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			<b>\$ -</b>

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ -</b>

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ -</b>

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

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2019	32	37
Account			Amount	
Total Brought Forward:			\$	3,131,752
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
1. Land			\$	393,226
2. Land Improvements			*Historical Cost _____	
Accum. Depreciation _____			Net \$ _____	
3. Buildings			*Historical Cost <u>6,999,069</u>	
Accum. Depreciation <u>5,336,791</u>			Net \$ 1,662,278	
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			\$ _____	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$ 2,055,504	
<b>D. Investment and Other Assets</b>				
1. Deferred Deposits			\$ _____	
2. Escrow Deposits			\$ _____	
3. Organization Expense			*Historical Cost <u>525,000</u>	
Accum. Depreciation <u>342,708</u>			Net \$ 182,292	
4. Goodwill (Recorded Only)			\$ 625,498	
5. Investments Related to Resident Care (itemize)			\$ _____	
6. Loans to Owners or Related Parties (itemize)			\$ (4,301,880)	
Name and Address		Amount	Loan Date	
		(4,301,880)		
7. Other Assets (itemize)			\$ 186,246	
Project Development			89,559	
Deposits IRS			37,011	
See Schedule			59,676	
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$ (3,307,844)	
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$ 1,879,412	

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



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

Name of Facility		License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center		2183C	9/30/2019	33	37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	1,768,995
2. Notes Payable ( <i>itemize</i> )				\$	1,009,679
Due to related parties			341,000		
Midcap Line of credit			668,679		
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> )				\$	220,756
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	11,205
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> )				\$	338,847
Accrued Operating expenses			85,019		
Accrued expense-sales tax			703		
Provider tax due			241,709		
Accrued Health Insurance			11,416 See Schedule		
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				<b>\$</b>	<b>3,349,482</b>

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

(Carry Total forward to next page)

NORTHBRIDGE HEALTHCARE  
ACCRUED EXPENSES OPERATING  
ACCOUNT 2170  
9/30/2019

9/30/2018	\$	43,835.33	health insurance
9/30/2019	\$	10,100.00	audit fee
9/30/2019	\$	7,782.00	workers comp
9/30/2019	\$	23,301.36	management fee

Balance	<u>\$</u>	<u>85,018.69</u>
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**G. Balance Sheet (cont'd)**

Name of Facility Northbridge Healthcare Center		License No. 2183C	Report for Year Ended 9/30/2019	Page 34	of 37
Account				Amount	
Total Brought Forward:				3,349,482	
<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> )				\$ 111,715	
Name and Address of Lender	Amount	Loan Date			
Related Party	63,926	3/29/12			
McKesson	47,789				
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 102,809	
Related Party Notes		102,809			
See Schedule					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 214,524	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 3,564,006	

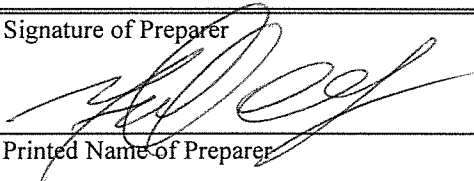
**G. Balance Sheet (cont'd)**  
**Reserves and Net Worth**

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2019	35	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			\$	1,662,278
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			\$	2,055,504
<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			\$	(3,765,868)
6. Gain or Loss for Period	10/1/2018	thru 9/30/2019	\$	(225,685)
7. Total Net Worth			\$	(3,740,098)
<b>C. Total Reserves and Net Worth</b>			\$	(1,684,594)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	1,879,412

### H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2019	36	37
<b>Account</b>			<b>Amount</b>	
A. Balance at End of Prior Period as shown on Report of 09/30/2018			\$	(3,568,167)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	15,156,194
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	15,381,879
D. Net Income or Deficit			\$	(225,685)
E. Balance			\$	(3,793,852)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
Health Insurance	53,754			
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	53,754
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>	Title	Amount		
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose	Amount			
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	(3,740,098)
	09/30/19			

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

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2019	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)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer 	Title CFO	Date Signed 2/17/2020		
Printed Name of Preparer				
Athena Health Care Associates, Inc.				
Address Address		Phone Number		
135 South Rd, Farmington, CT 06032		860-751-3900		
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number		
Neil Kluczwski		860-751-3986		
Contact Email Address				
nkluczwski@athenahealthcare.com				