State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2022

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 Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	2183C		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2022	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Northbridge Healthcare Center [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Lavonn Davis			Printed Name (Owner) Lawrence Santilli	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Northbridge Healthcare Center	Period Covered:		From 10/1/2021	To 9/30/2022
Address of Facility 2875 Main Street Bridgeport, CT 06606				
Report Prepared By Athena Health Care Associates, Inc.	Phone Number 860-751-3900		Date 2/8/2023	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
	9/30/2022	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Northbridge Healthcare Center	2875 Main Street Bridgeport, CT 06606

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	2183C			07-5413

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ◉ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Lavonn Davis		002156

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

Name	License No.:
Not Applicable	

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General Information and Questionnaire
Partners/Members

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

Name of Partners/Members	Business Address	Title	% Owned
Not Applicable			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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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 St., Bridgeport, CT 06606	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	ecretary/ Treasur	40
Names of Stockholders Owning at Least 10% of Shares			
Custodians for Lawrence E Santilli	2875 Main St., Bridgeport, CT 06606		132.687

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General Information and Questionnaire
Individual Proprietorship

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

Owner(s) of Facility
Not Applicable

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Laurel Ridge Health Care Center	642 Danbury Road, Ridgefield, CT 06877	⊙	○	>98%	Bank charges	Pg 16, m13	4,217	4,217
Athena Captive LLC	135 South Road, Farmington, CT 06032	○	⊙		Workers Comp Captive	Pg 15, ln 1a	173,597	173,597
Northbridge Landlord LLC	135 South Road, Farmington, CT 06032	○	⊙		Lease of facility/ Property Taxes/ Property In	Pg 22, ln 9 & 10b, Pg 2	740,237	740,237
Athena Health Care	135 South Road, Farmington, CT 06032	○	⊙		Health & General Insurance	Pg 15, ln 1a5	1,279,446	1,279,446
Athena Health Care Services Inc. 401(K) plan	135 South Road, Farmington, CT 06032	○	⊙		Facility participates in a group 401(K) plan			
Procare LTC	110 Bi-County Blvd. Suite 121, Farmingdale, NY 11735	⊙	○	>50%	Pharmacy	Pg 20 5a2	398,026	398,026
Athena Health Care	135 South Road, Farmington, CT 06032	⊙	○		see attached			
Procare LTC	110 Bi-County Blvd. Suite 121, Farmingdale, NY 11735	⊙	○	>50%	Notes payable	Pg 34 B3, Pg 27 12d	73,707	73,707
		○	⊙					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Pitney Bowes, 60 Wellington Rd., Milford, CT 06484	○	⊙	Postal Equipment	03/26/18	60 months	1,289	1,289
De Lage Landen Financial Services	○	⊙	Copiers	09/25/20	48 months	21,326	21,326
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 22,615

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

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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	If "No," explain.
	○ No	

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Marcum LLP	555 Long Wharf Drive, Shelton, CT
2 Midcap Financial Services	259 W 30th St., Suite 301, New York, NY 10001
3 PKF O'Connor Davies LLP	Four Corporate Drive, Suite 488, Shelton, CT 06484
4	

Services Provided by This Firm (*describe fully*)

1	Medicare Cost Report Preparation: Allow	$ 2,750
2	Line of credit audits: Disallow	$ 4,865
3	Tax Returns: Allow	$ 6,800
4		$
		Charge for Services Provided $ 14,415

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 Jackson Lewis	914-872-6767
2 Goldman, Gruder, & Woods LLC/ Pilicy & Ryan	203-899-8900/ 860-274-0018
3 Midcap Financial Services	312-258-5500
4 Bridgeport Probate $471, Sheriff $324	860-274-0018
5 Brenner, Saltzman & Wallman LLP	203-772-2600

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

1 1133 Westchester Avenue, Suite S125, West Harrison, NY 10604
2 200 Connecticut Ave., Norwalk, CT 06854/ PO Box 760 365 Main St., Watertown, CT 06795
3 259 W 30th St., Suite 301, New York, NY 10001
4 Bridgeport, CT
5 271 Whitney Ave., New Haven, CT 06511

Services Provided by This Firm (*describe fully*)

1	AR Collections: Disallowed	$ 249
2	AR Collections: Disallowed	$ 14,996
3	Line of credit legal fees: Disallowed	$ 1,272
4	Conservatorship: Disallowed	$ 795
5	Legal Matter: Disallowed	$ 2,552
		Charge for Services Provided $ 19,864

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

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	145	145			145	145						
B. On last day of THIS report period	145	145							145	145		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	135	135			135	135						
B. As of midnight of THIS report period	134	134							134	134		
3. Total Number of Days Care Provided During Period												
A. Medicare	6,060	6,060			3,083	3,083			2,977	2,977		
B. Medicaid (Conn.)	39,427	39,427			29,706	29,706			9,721	9,721		
C. Medicaid (other states)												
D. Private Pay	1,217	1,217			844	844			373	373		
E. State SSI for RCH												
F. Other (Specify) Managed Care	431	431			211	211			220	220		
G. Total Care Days During Period (3A thru F)	47,135	47,135			33,844	33,844			13,291	13,291		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	38	38			38	38						
B. Other Bed Reserve Days	29	29			8	8			21	21		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	47,202	47,202			33,890	33,890			13,312	13,312		

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Schedule of Resident Statistics (Cont'd)

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	6	116		4		8		
Per Diem Rate								
a. One bed rm.	601.58	307.35		622.00		402.12		
b. Two bed rms.	601.58	307.35		602.00		402.12		
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	5,468	5,468		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	6,022	6,022		
2. Restorative Treatments				
C. Other	11,735	11,735		
D. ***Total Physical Therapy Treatments***	23,225	23,225		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	421	421		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	604	604		
2. Restorative Treatments				
C. Other	908	908		
D. ***Total Speech Therapy Treatments***	1,933	1,933		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,838	2,838		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	4,711	4,711		
2. Restorative Treatments				
C. Other	10,275	10,275		
D. ***Total Occupational Therapy Treatments***	17,824	17,824		

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Report of Expenditures - Salaries & Wages

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	144,047	2,037				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	388,033	14,051				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	73,168	2,113				
c. Dietary Workers	628,176	30,775				
6. Housekeeping Service						
a. Head Housekeeper	64,069	2,112				
b. Other Housekeeping Workers	331,052	20,028				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	64,701	2,123				
b. Other Maintenance Workers	43,864	2,238				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	190,037	10,037				
9. Barber and Beautician Services						
10. Protective Services	15,034	930				
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	220,543	3,491				
b. RN						
1. Direct Care	318,337	5,445				
2. Administrative**	596,838	17,696				
c. LPN						
1. Direct Care	1,619,241	41,081				
2. Administrative**						
d. Aides and Attendants	2,615,513	109,578				
e. Physical Therapists	511,522	12,188				
f. Speech Therapists	65,125	1,596				
g. Occupational Therapists	257,743	6,119				
h. Recreation Workers	295,025	12,026				
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	197,724	6,607				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	8,639,792	302,271				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Other Fees (Page 13)

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

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Not Applicable										
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).										
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.

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Erica Roman (10/1/21 - 12/31/21)	40,909			Health & life insurances, payroll taxes	Day to day operations of the nursing home facility	321	A2			
Lavonn Davis (1/1/22 - 9/30/22)	103,138			Health & life insurances, payroll taxes	Day to day operations of the nursing home facility	1,716	A2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	43,606	584				
2. Dentist	545	11				
3. Pharmacist	14,554	1,265				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	45,000	202				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	14,392					
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	3,240	9				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	564,649	5,039				
2. Administrative***	27,500					
b. LPN						
1. Direct Care	1,113,486	14,569				
2. Administrative***						
c. Aides	1,193,334	25,926				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	3,020,306	47,605				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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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	○	⊙	
Procare LTC, 110 Bi-County Blvd, Suite 121, Farmingdale, NY 11735	Pharmacy Services	⊙	○	Common Owners: Minority Interest
Dr. Vasudha Vallabhneni, Northeast Medical Group, 99 Hawley Lane 3rd Floor, Stratford, CT	Medical Director	○	⊙	
Margaret Rose, 217 Hickory St., Bridgeport, CT 06610	Dietician	○	⊙	
SDX Dysphagia Experts, 21 Waterville Rd., Avon, CT 06001	Speech Therapy	○	⊙	
Connecticut Vascular & Thoracic, 501 Kings Hwy East, Suite 112, Fairfield, CT 06825	Physician	○	⊙	
Five Star Care, 410 Melville Ave., Lakewood, NJ 08701	Nursing Pool	○	⊙	
The Nurse Network, C/O Access Capital, 400 Park Ave., New York, NY 10022	Nursing Pool	○	⊙	
Norton & Associates, 97 Elm St., Cohasset, MA 02025	Nursing Pool	○	⊙	
Solomon Page Staffing Solutions, 260 Madison Ave., 4th Floor, New York, NY 10016	Nursing Pool	○	⊙	
Heritage Private Nursing Inc., 174 South Rd., Suite 108, Enfield, CT 06082	Nursing Pool	○	⊙	
Genie Healthcare Inc., 104 Interchange Plaza, Suite 100, Monroe, NJ 08831	Nursing Pool	○	⊙	
Marvel Medical Staffing, C/O ANB PO Box 3544, Omaha, NE 68103-0544	Nursing Pool	○	⊙	
Employer Solutions Staffing Group, PO Box 741383, Atlanta, GA 30374-1383	Nursing Pool	○	⊙	
Sambacare, 310 Melville Ave., Lakewood, NJ 08701	Nursing Pool	○	⊙	
Headcount Management, Inc., PO Box 742890, Atlanta, GA 30374-2890	Nursing Pool	○	⊙	
Dependable Nursing LLC, 1162 West Woods Rd., Hamden, CT 06518	Nursing Pool	○	⊙	
Professional Nursing Service LLC, 27 Siemon Company Dr., Ste 228W, Watertown, CT 06795	Nursing Pool	○	⊙	
Orthopaedic Specialty Group, 321 Boston Post Rd., Milford, CT 06450-2574	Physician services	○	⊙	
Bridgeport Hospital, PO Box 780504, Philadelphia, PA 19178	Physician services	○	⊙	
Quest Diagnostics LLC, 3 Sterling Dr., Wallingford, CT 06492	Physician services	○	⊙	
see attached for more physicians		○	⊙	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2022	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	330,184	330,184		
2. Disability Insurance	$				
3. Unemployment Insurance	$	100,965	100,965		
4. Social Security (F.I.C.A.)	$	603,137	603,137		
5. Health Insurance	$	1,140,719	1,140,719		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	83,905	83,905		
(not-owners and not-operators)					
8. Uniform Allowance	$	943	943		
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	267,294	267,294		
d. Accounting and Auditing	$	14,415	14,415		
e. Legal (*Services should be fully described on Page 7)*	$	19,864	19,864		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	72,970	72,970		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	93,282	93,282		
2. Cellular Phones	$	3,537	3,537		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$				
See Attached Schedule					
3. Resident Day User Fee	$	864,805	864,805		
Subtotal	$	3,596,020	3,596,020		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2022	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,596,020	3,596,020		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	3,220	3,220		
3. Gifts to Staff and Residents	$	56,940	56,940		
4. Employee Travel	$	6,308	6,308		
5. Education Expenses Related to Seminars and Conventions	$	6,500	6,500		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	6,074	6,074		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	8,659	8,659		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,336	2,336		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	7,732	7,732		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	1,172	1,172		
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$				
12. Administrative Management Services**	$	314,489	314,489		
13. Other (*Specify*) See Attached Schedule	$	153,728	153,728		
C-14 Total Administrative & General Expenditures	$	4,163,178	4,163,178		

* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	$ -	$ -	$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	$ 8,659		
Total Other Advertising	$ 8,659	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CAHCF	$ 7,732		
Total Dues	$ 7,732	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Employee Physicals & background checks	$ 20,009		
Bank Fees	$ 24,890		
Payroll Processing Fees	$ 21,598		
Medicare assessment	$ 6,250		
Date processing fees	$ 66,625		
Licenses	$ 1,313		
State of CT Citation No. 2022-02	$ 6,120		
CMP Case No. 2022-01-LTC210	$ 6,923		
Total Other Administrative and General	$ 153,728	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2022	Page 17 of 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	433,953	Contract attached to a prior year	See Below
Allocation of Above	286,409	Admin/ General 66%	Pg 16, line 12
Allocation of Above	69,432	Indirect 16%	Pg 20, line 5k
Allocation of Above	78,112	Direct 18%	Pg 20, Line 5j
Athena Health Care Assoc, Inc 135 South Rd, Farmington, CT 06032	28,080	Admin/ General-Other Expense	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.**

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

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2022	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	401,339	401,339		
2. Non-Food Supplies	$	57,250	57,250		
3. Other (*Specify*) Dishes	$	1,895	1,895		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	460,484	460,484		

		Total	CCNH	RHNS	(Specify)
2E.	Dietary Questionnaire				
F.	Resident Meals: Total no. of meals served per day:*	387	387		

G.	Is cost of employee meals included in 2D?	⊙ Yes	○ No		
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	⊙ Yes	○ No	If yes, specify cost.	$3,467
K.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⊙ No	If yes, specify cost.	
N.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.	
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2022	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. $	20,164	20,164		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Supplies	$	8,362	8,362		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	28,526	28,526		

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2022	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	53,937	53,937		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	53,937	53,937		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Procare LTC		$	393,760	393,760		
b. Medicine Cabinet Drugs		$	221	221		
c. Medical and Therapeutic Supplies		$	400,013	400,013		
d. Ambulance/Limousine***		$	2,735	2,735		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	11,884	11,884		
f. X-rays and Related Radiological Procedures***		$	23,262	23,262		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	26,368	26,368		
i. Recreation		$	21,616	21,616		
j. Direct Management Services*		$	78,112	78,112		
k. Indirect Management Services*		$	69,432	69,432		
l. Other (Specify)**** See Attached Schedule		$	126,738	126,738		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	1,154,141	1,154,141		

* 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)
Medical Equip Rentals-Medicaid	$ 47,370		
Physical Therapy Supplies	$ 26,447		
Oxygen Concentrator Rentals	$ 11,121		
Cable TV Fees	$ 17,839		
Medical Equip Rentals-Other	$ 23,961		
Total Other Resident Care	$ 126,738	$ -	$ -

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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	9/30/2022	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
ADP	Hartford Region, Richmond, VA	○	⊙		Payroll Services	21,598			16	m13
CWPM	415, Plainville, CT 06062	○	⊙		Rubbish Removal	40,389			22	6f
Procare LTC	Suite 121, Farmingdale, NY 11735	⊙	○	Common Owners: Minority Interest	Pharmacy	398,026			20	5
Outdoor Lawn Service LLC	PO Box 320144, Fairfield, CT 06825	○	⊙		Landscaping & Snow Removal	27,252			22	6f
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

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

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CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2022	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	144,671	144,671		
b. Heat	$	64,004	64,004		
c. Light & Power	$	160,089	160,089		
d. Water	$	99,872	99,872		
e. Equipment Lease (*Provide detail on page 6*)	$	22,615	22,615		
f. Other (*itemize*)	$	92,147	92,147		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	583,398	583,398		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	1,425	1,425		
b. Building & Building Improvements	$	38,313	38,313		
c. Non-Movable Equipment	$	6,910	6,910		
d. Movable Equipment	$	49,912	49,912		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	96,560	96,560		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	1,558	1,558		
c. Leasehold Improvements	$	48,283	48,283		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	49,841	49,841		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	498,571	498,571		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	82,994	82,994		
c. Personal property taxes	$	34,752	34,752		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	762,718	762,718		

* 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)
Groundskeeping	$ 12,899		
Rubbish Removal	$ 40,870		
Snow Removal	$ 14,353		
Supplies	$ 24,025		
Total Other Repairs and Maintenance	$ 92,147	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2022	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	99,523		99,523	87,557	S/L	Various	1,425	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								1,425
B. **Building and Building Improvements**								
1. Acquired prior to this report period	2,141,554		2,141,554	1,944,657	S/L	Various	38,313	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								38,313
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	896,157		896,157	846,344	S/L	Various	6,910	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								6,910

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	2021	1,597,598		1,597,598	1,444,901	S/L	Various	49,507	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative			9	2022	8,100		8,100		S/L	Various	405	
d. Standard Resident												
e. Specialized Resident												
Total Acquired during this report period					8,100		8,100				405	
D-3. Subtotal												49,912
E. ***Total Depreciation***												96,560

Schedule of Land Improvements Acquired during this report period

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

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

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

Schedule of Building Improvements Acquired during this report period

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

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

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

Schedule of Non-Movable Equipment Acquired during this report period

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

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One Movable Category	Cost	Useful Life	Depreciation	
Additions:						
3/31/2022	refrigerator	Administrative	$ 8,100	10	$ 405	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			$ 8,100		$ 405	*
Deletions:						
Total deletions for Movable Equipment			$ -		$ -	**

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

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
3/31/2022	new flooring	$ 10,103	10	$ 505	
3/31/2022	replace compressor	$ 24,248	12	$ 1,009	
3/31/2022	replace controller	$ 3,055	5	$ 305	
3/31/2022	transfer switch	$ 2,144	5	$ 213	
3/31/2022	mixing valve	$ 3,124	5	$ 311	
5/31/2022	replace backflow preventer	$ 6,298	5	$ 629	
5/31/2022	replace controller	$ 4,506	5	$ 450	
7/31/2022	new condensor fan motors	$ 2,488	5	$ 248	
7/31/2022	new blower assembly	$ 2,756	5	$ 275	
7/31/2022	new blower motor	$ 3,943	5	$ 393	
7/31/2022	caulking all windows & doors	$ 30,300	5	$ 3,027	
8/31/2022	glass screen	$ 9,466	5	$ 946	
8/31/2022	new mixing valve	2469	5	246	
8/31/2022	replace baseboard heat coverings	8297	5	829	
Total additions for Leasehold Improvement		$ 113,197		$ 9,386	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2022	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1. Bed License Purchase	9	1997	None	525,000	342,708	None			
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1. Finance Fees	2	2018	3 years	32,151	32,151				
2. Finance Fees - Greystone		2019	30 years	45,387	2,269			1,558	
3.									
B-4. Subtotal									1,558
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2021	Various	407,877	137,711	SL	Var	38,897	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2022	Various	113,197		SL	Var	9,386	
C-4. Subtotal									48,283
D. ***Total Amortization***									49,841

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2022	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	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 _____	7,313,761			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2022	26 | 37

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

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2022	27 | 37

Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment 1. Automotive Equipment $						
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (*Specify*) $						
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $						
12. D. Other Interest Expense (*Specify*) $ Vendor Int=$4,539; Midcap LOC=$9,951			14,490	14,490		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $			14,490	14,490		
14. Insurance						
a. Insurance on Property (buildings only) $			163,412	163,412		
b. Insurance on Automobiles $						
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*) $						
2. Fire and Extended Coverage $						
3. Other (*Specify*) $						
14d. ***Total Insurance Expenditures (14a + b + c)*** $			163,412	163,412		
15. ***Total All Expenditures (A-13 thru C-14)*** $			19,044,382	19,044,382		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2022	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.	10	A12g	Occupational Therapy $	257,743	257,743		
4.			Other - See attached Schedule $	8,239	8,239		
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians ** $	14,392	14,392		
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	267,294	267,294		
10.	15	1d	Accounting $	4,865	4,865		
10a.			Legal $	19,864	19,864		
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	2,817	2,817		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.	16	l3	Gifts, flowers and coffee shops $	56,940	56,940		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	m2&3	Unallowable Advertising * $	8,659	8,659		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.	16	m12	Unallowable Management Fees $	78,589	78,589		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	37,933	37,933		
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents $	3,467	3,467		
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	760,802	760,802		

* 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	$ 8,239		
Total Other Salaries Adjustment			$ 8,239	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Bank charges	$ 24,890		
16	m13	State of CT Citation No. 2022-02	$ 6,120		
16	m13	CMP Case No. 2022-01-LTC210	$ 6,923		
Total Other A&G Adjustments			$ 37,933	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2022	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	760,802	760,802		
Page 20 - Resident Care Supplies***							
27.	20	5a1&	Prescription Drugs $	393,760	393,760		
28.	20	5d	Ambulance/Limousine $	2,735	2,735		
29.	20	5f	X-rays, etc $	23,262	23,262		
30.	20	5h	Laboratory $	26,368	26,368		
31.	20	5c	Medical Supplies $	16,020	16,020		
32.	20	500	Oxygen (non emergency) $	11,884	11,884		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	38,200	38,200		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $	9,492	9,492		
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Other - Indirect $				
43.	30	IV5	Interest Income on Account Rec. $	325	325		
44.			Other - Miscellaneous Administrative $				
45.	18	2c	Management Fees Direct $	21,433	21,433		
46.	20	5j	Management Fees Indirect $	19,052	19,052		
47.			Other - Direct $				
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
49.	***Total Amount of Decrease (Items 1 - 48)***		$	1,323,333	1,323,333		

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

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equip Rental	$ 23,961		
20	5j	Cable & TV	$ 14,239		
Total Other Ancillary Costs			$ 38,200	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Move Equipment Depreciation Carryforward AJE	$ 9,492		
Total Excess Movable Equipment Depreciation			$ 9,492	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2022	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	23,705,966	23,705,966		
b. Medicaid Room and Board Contractual Allowance **	$	(11,576,647)	(11,576,647)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,835,862	1,835,862		
b. Medicare Room and Board Contractual Allowance **	$	373,784	373,784		
4. a. Private-Pay Residents and Other	$	3,032,658	3,032,658		
b. Private-Pay Room and Board Contractual Allowance **	$	(685,990)	(685,990)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	125,532	125,532		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(125,532)	(125,532)		
c. Prescription Drugs - Non-Medicare	$	232,219	232,219		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(232,219)	(232,219)		
2. a. Medical Supplies - Medicare	$	3,505	3,505		
b. Medical Supplies - Medicare Contractual Allowance **	$	(3,505)	(3,505)		
c. Medical Supplies - Non-Medicare	$	50,099	50,099		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(50,099)	(50,099)		
3. a. Physical Therapy - Medicare	$	636,083	636,083		
b. Physical Therapy - Medicare Contractual Allowance **	$	(514,191)	(514,191)		
c. Physical Therapy - Non-Medicare	$	617,880	617,880		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(617,880)	(617,880)		
4. a. Speech Therapy - Medicare	$	111,375	111,375		
b. Speech Therapy - Medicare Contractual Allowance **	$	(86,095)	(86,095)		
c. Speech Therapy - Non-Medicare	$	175,055	175,055		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(175,055)	(175,055)		
5. a. Occupational Therapy - Medicare	$	444,416	444,416		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(384,127)	(384,127)		
c. Occupational Therapy - Non-Medicare	$	497,835	497,835		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(497,835)	(497,835)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	1,278,078	1,278,078		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	18,171,172	18,171,172		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	325	325		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	44,948	44,948		
V. Total Other Revenue (1 thru 8)	$	45,273	45,273		
VI. Total All Revenue (III +V)	$	18,216,445	18,216,445		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Medicaid recoupment	$ (18,800)		
	CRF funding	$ 1,296,990		
	Medicare rate adj	$ (112)		
Total Other Resident Revenue		$ 1,278,078	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 31, ln A	Interest on Accts Rec	N/A	$ 325		
Total Interest Income			$ 325	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Bad debt recoveries	$ 44,948		
Total Other Revenue		$ 44,948	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2022	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 58,676
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,241,316
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 27,504
5. Prepaid Expenses				$ 114,502
a. Prepaid Insurance		101,882		
b. Prepaid expense Other		12,620		
c.				
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (177,145)
Medicaid advance		(350,000)		
Medicare Covid Grant		172,855		
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,264,853
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	99,523		$ 10,541
	Accum. Depreciation	88,982	Net	
3. Buildings	*Historical Cost	2,141,550		$ 158,584
	Accum. Depreciation	1,982,966	Net	
4. Leasehold Improvements	*Historical Cost	521,074		$ 335,080
	Accum. Depreciation	185,994	Net	
5. Non-Movable Equipment	*Historical Cost	896,157		$ 42,903
	Accum. Depreciation	853,254	Net	
6. Movable Equipment	*Historical Cost	1,594,557		$ 99,744
	Accum. Depreciation	1,494,813	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 11,143
Equipment Carry Forward Adjustment		11,143		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 657,995

* 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	
Total Prepaid Expenses			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			$ -

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

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ -

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2022	32	37

Account				Amount
		Total Brought Forward:	$	2,922,848
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	6,999,069		
	Accum. Depreciation	6,036,698 Net	$	962,371
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation	Net	$	
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation	Net	$	
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation	Net	$	
7. Minor Equipment-Not Depreciable			$	
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)			$	1,355,597
D. Investment and Other Assets				
1. Deferred Deposits			$	
2. Escrow Deposits			$	
3. Organization Expense	*Historical Cost	525,000		
	Accum. Depreciation	342,708 Net	$	182,292
4. Goodwill (Purchased Only)			$	625,498
5. Investments Related to Resident Care (*itemize*)			$	
6. Loans to Owners or Related Parties (*itemize*)			$	(4,469,880)
Name and Address	Amount	Loan Date		
	(4,469,880)			
7. Other Assets (*itemize*)			$	187,025
Project Development		142,465		
LOC Finance Fees		44,560		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$	(3,475,065)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	803,380

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2022	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 3,233,886
	2. Notes Payable (*itemize*)				$ 423,240
	Midcap Line of Credit	423,240			
	See Schedule				
	3. Loans Payable for Equipment (*Current portion*) (*itemize*)				$
	Name of Lender	Purpose	Amount	Date Due	
	4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)				$ 382,902
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 484,471
	7. Medicare Final Settlement Payable				$
	8. Medicare Current Financing Payable				$
	9. Mortgage Payable (*Current Portion*)				$
	10. Interest Payable (*Exclusive of Owner and/or Related Parties*)				$
	11. Accrued Income Taxes*				$
	12. Other Current Liabilities (*itemize*)				$ 2,158,660
	Acc'd State Income Tax	(3,120)	Provider Tax Due	1,963,394	
	Deferred Rent	32,768			
	Acc'd Operating Expenses	164,836			
	Acc'd Expense - Sales Tax	782	See Schedule		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 6,683,159

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2022	34	37

Account				Amount
			Total Brought Forward:	6,683,159
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (*itemize*)				$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				$
3. Loans from Owners or Related Parties (*itemize*)				$ 243,232
Name and Address of Lender	Amount	Loan Date		
Related Party	63,926	3/29/12		
Procare	179,306			
4. Other Long-Term Liabilities (*itemize*)				$ 580,344
Notes Payable Procare CT		141,826		
Related Party Notes		438,518		
See Schedule				
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ 823,576
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 7,506,735

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

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2022	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$ 393,226
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$ 962,371
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	4. Reserve for leasehold real properties on which fair rental value is based	$
	5. Reserve for funds set aside as donor restricted	$
	6. Total Reserves	$ 1,355,597
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$ 250,455
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (7,482,470)
	6. Gain or Loss for Period 10/1/2021 thru 9/30/2022	$ (827,937)
	7. Total Net Worth	$ (8,058,952)
C.	***Total Reserves and Net Worth***	$ (6,703,355)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 803,380

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2022	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2021			$ (7,231,017)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 18,216,445
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 19,044,382
D.	Net Income or Deficit			$ (827,937)
E.	Balance			$ (8,058,954)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Rounding			2
	2. Other (*itemize*)			
F-3.	Total Additions			$ 2
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/22		$ (8,058,952)

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

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2022	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Athena Health Care Associates, Inc.

Addres Address	Phone Number
135 South Road Farmington, CT 06032	860-751-3900

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number

Contact Email Address