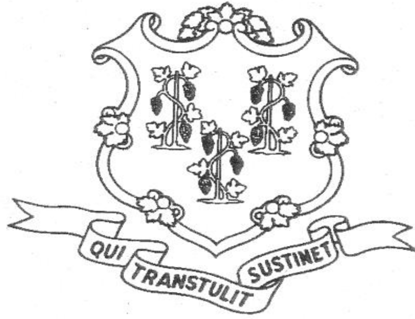
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2023

Name of Facility (as licensed)	
Northbridge Healthcare Center	
Address (No. & Street, City, State, Zip Code) 2875 Main Street	
Type of Facility ☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined ☐ (Specify) ☐ (Specify)	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

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

Medicaid Provider Numbers:	CCNH / RHNS	(Specify)	(Specify)
	2183C		

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CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2023	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, 2022 and ending September 30, 2023, 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 10/1/2022	To 9/30/2023
Address of Facility 2875 Main Street				
Report Prepared By Athena Health Care Associates, Inc.	Phone Number 860-751-3900		Date 2/28/2024	

Item	Total	CCNH / RHNS	(Specify)	(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
	9/30/2023	2	37

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

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

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined ☐ (Specify) ☐ (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
Northbridge Healthcare Center	2183C	9/30/2023	3	37

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

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

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CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2023	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
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	:cretary/ Treasur	40
Names of Stockholders Owning at Least 10% of Shares			
Custodians for Lawrence E Santilli	2875 Main St., Bridgeport, CT 06606		132.687

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2023	3B	37

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	4,719	4,719
Athena Captive LLC	135 South Road, Farmington, CT 06032	◉	○		Workers Comp Captive	Pg 15, ln 1a	327,438	327,438
Northbridge Landlord LLC	135 South Road, Farmington, CT 06032	◉	○	>95%	Lease of facility/ Property Taxes/ Property Ir	Pg 22, ln 9 & 10b, Pg 2	830,898	830,898
Athena Health Care	135 South Road, Farmington, CT 06032	◉	○	>50%	Health & General Insurance	Pg 15, ln 1a5	1,304,204	1,304,204
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	◉	○	<5%	Pharmacy	Pg 20 5a2	381,869	381,869
Athena Health Care	135 South Road, Farmington, CT 06032	◉	○	>50%	see attached			
Procare LTC	110 Bi-County Blvd. Suite 121, Farmingdale, NY 11735	◉	○	<5%	Notes payable	Pg 34 B3, Pg 27 12d	55,280	55,280
		○	◉					

* 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	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2023	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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
Other Lines of Business

Name of Facility	License No.	Report for Year Ended	Page	of
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Square footage of entire facility.	0

Outpatient Therapy

Does the Facility provide outpatient therapy services?	No

If yes, please complete the following:

	Square footage of therapy space.

Meals on Wheels

Does the facility provide Meals on Wheels?	No

If yes, please complete the following:

	Square footage of kitchen	
	Number of meals served per week	
No	Are meals included in meals served on page 18 of the Annual Report?	
No	Are direct costs included in the Annual Report?	
	If yes, please state where costs are reported.	
No	Are drivers for the program included in the facility's payroll?	
	If yes, please complete the following:	
		Amount Reported
		Annual Report page and line
	Please state the salary amounts of specific cooks and/or dietary aides	
	Please state where the cooks and/or dietary aides are reported in the Annual Report	

Apartments, Independent Living, Assisted Living

Does the facility have apartments, independent living, and/or assisted living?	No

If yes, please complete the following:

	Square footage of apartments
	Square footage of independent living
	Square footage of assisted living
	Please identify the services provided:

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General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthca	2183C	9/30/2023	7	37

Child Day Care

Does the Facility provide Child Day Care?	No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care?	No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH / RHNS Level	Total	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(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	129	129			129	129						
B. As of midnight of THIS report period	117	117							117	117		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,632	4,632			3,566	3,566			1,066	1,066		
B. Medicaid (Conn.)	40,221	40,221			30,459	30,459			9,762	9,762		
C. Medicaid (other states)												
D. Private Pay	799	799			704	704			95	95		
E. State SSI for RCH												
F. Other (Specify) Managed Care	873	873			699	699			174	174		
G. Total Care Days During Period (3A thru F)	46,525	46,525			35,428	35,428			11,097	11,097		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	50	50			45	45			5	5		
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	46,575	46,575			35,473	35,473			11,102	11,102		

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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)	(Specify)	Lost			Gained			CCNH / RHNS	(Specify)	(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)	(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	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	6	106		1		4		
Per Diem Rate								
a. One bed rm.	607.23	######		652.00		499.91		
b. Two bed rms.	607.23	######		632.00		499.91		
c. Three or more bed rms.								

Item	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
7. Total Number of Physical Therapy Treatments					
A. Medicare - Part B	5,686	5,686			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	5,801	5,801			
2. Restorative Treatments					
C. Other	8,455	8,455			
D. ***Total Physical Therapy Treatments***	19,942	19,942			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	348	348			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	474	474			
2. Restorative Treatments					
C. Other	1,064	1,064			
D. ***Total Speech Therapy Treatments***	1,886	1,886			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	3,776	3,776			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	4,575	4,575			
2. Restorative Treatments					
C. Other	6,964	6,964			
D. ***Total Occupational Therapy Treatments***	15,315	15,315			

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2023	10	37

Are time records maintained by all individuals receiving compensation? ⦿ Yes ○ No

Item	Total Cost and Hours								
	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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)	126,634		2,107						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	377,508	(3,281)	13,181						
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor	79,024		2,254						
c. Dietary Workers	655,452		31,222						
6. Housekeeping Service									
a. Head Housekeeper	69,392		2,100						
b. Other Housekeeping Workers	360,707		20,182						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	59,166		1,932						
b. Other Maintenance Workers	45,994		2,265						
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers	207,645		10,056						
9. Barber and Beautician Services									
10. Protective Services	15,546		870						
11. Accounting Services									
a. Head Accountant									
b. Other Accountants									
12. Professional Care of Residents									
a. Directors and Assistant Director of Nurses	157,259		2,406						
b. RN									
1. Direct Care	373,300		6,304						
2. Administrative**	609,281		16,729						
c. LPN									
1. Direct Care	2,026,249		49,208						
2. Administrative**									
d. Aides and Attendants	2,822,181		116,433						
e. Physical Therapists	485,091		12,514						
f. Speech Therapists	62,427		1,511						
g. Occupational Therapists	240,539	(240,539)	5,695						
h. Recreation Workers	297,635		11,691						
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	196,633		6,660						
n. Marketing									
o. Other (Specify) See Attached Schedule									
A-13. Total Salary Expenditures	9,267,663	(243,820)	315,320						

* 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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

	CCNH / RHNS			(Specify)			(Specify)		
Position	$	Adjustment	Hours	$	Adjustment	Hours	$	Adjustment	Hours
Total	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-

Schedule of Other Fees (Page 13)

	CCNH / RHNS			(Specify)			(Specify)		
Service	$	Adjustment	Hours	$	Adjustment	Hours	$	Adjustment	Hours
Total	$ -	$ -	-	$ -	$ -	-	$ -	$ -	-

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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
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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)	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2023	12	37

Name	Salary Paid: CCNH / RHNS	Salary Paid: (Specify)	Salary Paid: (Specify)	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
Section III - Administrators* **										
Lavon Davis (10/1/22-9/30/23)	126,634			Health & life insurances, Payroll taxes	Day to day operations of the nursing home facility	2,107	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
Northbridge Healthcare Center	2183C	9/30/2023	13	37

	Total Cost and Hours								
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	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	43,800		1,095						
2. Dentist									
3. Pharmacist	12,900		79						
4. Podiatrist									
5. Physical Therapy									
a. Resident Care									
b. Other									
6. Social Worker									
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	72,000		214						
b. Utilization Review									
(Title 18 and 19 only) monthly meeting									
c. Resident Care**									
d. Administrative Services facility									
1. Infection Control Committee (Quarterly meetings)									
2. Pharmaceutical Committee (Quarterly meetings)									
3. Staff Development Committee (Once annually)									
e. Other (Specify)									
9. Speech Therapist									
a. Resident Care	720		2						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	346,921		3,043						
2. Administrative***									
b. LPN									
1. Direct Care	235,788		2,626						
2. Administrative***									
c. Aides	(7,293)								
d. Other									
12. Other (Specify)									
See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	704,836		7,059						

* 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 in the Adjustment column.

*** 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
Northbridge Healthcare Center	2183C	9/30/2023	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Procare LTC, 110 Bi-County Blvd, Suite 121, Farmingdale, NY 11735	Pharmacy Services	⦿	○	Common Owners: Minority Interest
Quotidian Health LLC, 33 Dixwell Ave #312, New Haven, CT 06511	Medical Director	○	⦿	
Margaret Rose, 217 Hickory St., Bridgeport, CT 06610	Dietician	○	⦿	
SDX Dysphagia Experts, 21 Waterville Rd., Avon, CT 06001	Speech Therapy	○	⦿	
Heritage Private Nursing Inc., 174 South Rd., Suite 108, Enfield, CT 06082	RN, LPN Pool	○	⦿	
The Nurse Network, C/O Access Capital, 400 Park Ave., New York, NY 10022	RN, LPN Pool	○	⦿	
Norton & Associates, 97 Elm St., Cohasset, MA 02025	RN, LPN Pool	○	⦿	
Headcount Management, Inc., PO Box 742890, Atlanta, GA 30374-2890	RN, LPN Pool	○	⦿	
Heritage 7 Inc., 265 Hazard Ave., Enfield, CT 06082	RN, LPN Pool	○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	
		○	⦿	

* 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	9/30/2023	15	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	327,438	327,438					
2. Disability Insurance	$							
3. Unemployment Insurance	$	77,063	77,063					
4. Social Security (F.I.C.A.)	$	657,049	657,049					
5. Health Insurance	$	1,158,350	1,158,350					
6. Life Insurance (employees only) (not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	222,638	222,638					
8. Uniform Allowance	$	3,929	3,929					
9. Other (*Specify*) See Attached Schedule	$							
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$		248,255	(248,255)				
d. Accounting and Auditing	$	10,235	17,731	(7,496)				
e. Legal (*Services should be fully described on Page 15b)*	$		20,936	(20,936)				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	51,016	51,016					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	78,252	78,252					
2. Cellular Phones	$	720	2,449	(1,729)				
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	$	881,642	881,642					
Subtotal	$	3,468,332	3,746,748	(278,416)				

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2023	15b	37

The records of this facility for the period covered by this report were maintained on the following basis:

◉ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

	Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1	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*)

	Service	Amount
1	Medicare Cost Report Preparation: Allow	$ 2,835
2	Line of credit audits: Disallow	$ 7,496
3	Tax Returns: Allow	$ 7,400
4		$
	Charge for Services Provided	$ 17,731

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	203-899-8900
3	Midcap Financial Services	312-258-5500
4	Bridgeport Probate $500, Sheriff $118	860-274-0018
5		

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

1 1133 Westchester Avenue, Suite S125, West Harrison, NY 10604
2 200 Connecticut Ave., Norwalk, CT 06854
3 259 W 30th St., Suite 301, New York, NY 10001
4 Bridgeport, CT
5

Services Provided by This Firm (*describe fully*)

	Service	Amount
1	AR Collections: Disallowed	$ 3,478
2	AR Collections: Disallowed	$ 4,015
3	Line of credit legal fees: Disallowed	$ 12,825
4	Conservatorship: Disallowed	$ 618
5		$
	Charge for Services Provided	$ 20,936

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

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	9/30/2023	16	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:		3,468,332	3,746,748	(278,416)				
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$	3,397	3,397					
3. Gifts to Staff and Residents	$		52,214	(52,214)				
4. Employee Travel	$	2,228	2,228					
5. Education Expenses Related to Seminars and Conventions	$	4,376	4,376					
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*)	$	9,120	9,120					
2. Advertising Telephone Directory (*all such expenses*)***	$							
3. Advertising Other (*Specify*)***	$		6,386	(6,386)				
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	$	3,188	3,188					
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	9,843	9,843					
See Attached Schedule								
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$	1,550	1,550					
10. Contributions***	$		200	(200)				
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**	$	262,811		262,811				
13. Other (*Specify*)	$	181,671	231,034	(49,363)				
See Attached Schedule								
C-14 Total Administrative & General Expenditures	$	3,946,516	4,070,284	(123,768)				

* 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 expensein the Adjustment column.

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Promotional	$ 6,386	$ (6,386)				
Total Other Advertising	$ 6,386	$ (6,386)	$ -	$ -	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF	$ 9,843					
Total Dues	$ 9,843	$ -	$ -	$ -	$ -	$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF - Inaugural Ball	$ 200	$ (200)				
Total Contributions	$ 200	$ (200)	$ -	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Employee Physicals	$ 10,117					
Bank Fees	$ 34,175	$ (34,175)				
Payroll Processing Fees	$ 25,198					
Other Processing Fees	$ 75,038					
Data Processing Fees	$ 70,153					
Licenses	$ 1,165					
State of CT Citation No. 2023-02	$ 6,540	$ (6,540)				
CMP Case No. 2023-01-LTC-361	$ 8,648	$ (8,648)				
Total Other Administrative and General	$ 231,034	$ (49,363)	$ -	$ -	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Northbridge Healthcare Center	License No. 2183C	Report for Year Ended 9/30/2023	Page of 17 | 37
Name & Address of Individual or Company Supplying Service	**Cost of Management Service**	**Full Description of Mgmt. Service Provided**	**Indicate Where Costs are Included in Annual Report Page #/Line #**
Athena Health Care Assoc, Inc 135 South Rd, Farmington, CT 06032		Contract attached to a prior year	See Below
Allocation of Above		Admin/ General 66%	Pg 16, line 12
Allocation of Above		Indirect 16%	Pg 20, line 5k
Allocation of Above		Direct 18%	Pg 20, Line 5j
Athena Health Care Assoc, Inc 135 South Rd, Farmington, CT 06032		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.**

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	9/30/2023	18	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	460,668	464,448	(3,780)				
2. Non-Food Supplies	$	51,101	51,101					
3. Other (*Specify*)_____________________ Dishes	$	3,431	3,431					
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)	$	515,200	518,980	(3,780)				

2E. Dietary Questionnaire	Total	CCNH / RHNS	(Specify)	(Specify)
F. Resident Meals: Total no. of meals served per day:*	382	382		

	Question	Yes	No	If yes	
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.	3780
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.

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	9/30/2023	19	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.							
	Amt. $							
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. $	19,392	19,392					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*) Supplies	$	11,258	11,258					
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	30,650	30,650					

3E. Laundry Questionnaire

	Question	Yes	No	
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	9/30/2023	20	37

Item	Basis		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel								
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	58,536	58,536					
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel								
(Complete Schedule C-2 att. Page 21)	Amt.	$							
C. Other (*Specify*)		$							
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	58,536	58,536					
5. Resident Care (Supplies)** a. Prescription Drugs***									
1. Own Pharmacy		$							
2. Purchased from Procare LTC		$		347,823	(347,823)				
b. Medicine Cabinet Drugs		$	329	329					
c. Medical and Therapeutic Supplies		$	315,226	330,446	(15,220)				
d. Ambulance/Limousine***		$		952	(952)				
e. Oxygen									
1. For Emergency Use		$							
2. Other***		$		9,254	(9,254)				
f. X-rays and Related Radiological Procedures***		$		22,245	(22,245)				
g. Dental (*Not dentists who should be included under salaries or fees)*		$							
h. Laboratory***		$		40,284	(40,284)				
i. Recreation		$	24,648	24,648					
j. Direct Management Services*		$	71,676		71,676				
k. Indirect Management Services*		$	63,712		63,712				
l. Cable TV		$	3,600	18,252	(14,652)				
m. Other (Specify)**** See Attached Schedule		$	78,773	83,794	(5,021)				
n. Physical Therapy Expense		$							
o. Speech Therapy Expense		$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)		$	557,964	878,027	(320,063)				

* 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 in the Adjustment column.
**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Medical Equip Rentals-Medicaid	$ 47,841					
Physical Therapy Supplies	$ 20,246					
Oxygen Concentrator Rentals	$ 10,686					
Medical Equip Rentals-Other	$ 5,021	$ (5,021)				
Total Other Resident Care	$ 83,794	$ (5,021)	$ -	$ -	$ -	$ -

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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
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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)	(Specify)	Pg	Line
ADP	Hart	○	⊙	Payroll Services		25,198			16	m13
CWPM		○	⊙	Rubbish Removal		46,924			22	6f
Procare LTC		○	⊙	Pharmacy		381,869			20	5
Outdoor Lawn Service LLC		○	⊙	Landscaping & Snow removal		25,679			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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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	9/30/2023	22	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	90,420	90,420					
b. Heat	$	54,289	54,289					
c. Light & Power	$	134,123	134,123					
d. Water	$	96,016	96,016					
e. Equipment Lease (*Provide detail on page 22b*)	$	23,131	23,131					
f. Other (*itemize*)	$	98,205	98,205					
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	496,184	496,184					
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$	1,425	1,425					
b. Building & Building Improvements	$	29,912	29,912					
c. Non-Movable Equipment	$	6,862	6,862					
d. Movable Equipment	$	34,975	40,204	(5,229)				
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	73,174	78,403	(5,229)				
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$	1,620	1,620					
c. Leasehold Improvements	$	62,285	62,285					
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	63,905	63,905					
9. Rental payments on leased real property less real estate taxes included in item 10b	$	579,766	579,766					
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	$	74,758	74,758					
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	874,597	879,826	(5,229)				

* 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	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Groundskeeping	$ 11,326					
Rubbish Removal	$ 47,927					
Snow Removal	$ 14,353					
Supplies	$ 24,599					
Total Other Repairs and Maintenance	$ 98,205	$ -	$ -	$ -	$ -	$ -

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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
Northbridge Healthcare Center	2183C	9/30/2023	22b of 37

Name and Address of Lessor	Related * to Owners, Operators, Officers: Yes	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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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2023	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	88,982	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	1,982,970	S/L	Various	29,912	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								29,912
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	896,157		896,157	853,254	S/L	Various	6,862	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								6,862

	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	2022	1,605,698		1,605,698	1,494,813	S/L	Various	32,792	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative			9	2023	71,568		71,568		S/L	Various	6,647	
d. Standard Resident			9	2023	15,293		15,273		S/L	Various	765	
e. Specialized Resident												
Total Acquired during this report period					86,861		86,841				7,412	
D-3. Subtotal												40,204
E. ***Total Depreciation***												78,403

Attachment Pages 23 24

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:						
1/31/2023	3 bay kitchen sink	Administrative	$ 5,113	10	$ 256	
2/28/2023	food blender	Administrative	$ 1,707	10	$ 85	
5/31/2023	3 bay dishwashing table	Administrative	$ 3,393	10	$ 170	
5/31/2023	6 phones	Administrative	$ 3,220	5	$ 322	
7/31/2023	ice & water dispenser	Standard Resident	$ 7,859	10	$ 393	
7/31/2023	ice & water dispenser	Standard Resident	$ 7,434	10	$ 372	
9/30/2023	computers	Administrative	$ 58,135	5	$ 5,814	
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			$ 86,861		$ 7,412	*
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:					
11/30/2022	new circulating pump	$ 10,927	5	$ 1,093	
11/30/2022	new mixing valve	$ 6,035	5	$ 603	
11/30/2022	packing & vic fittings on elevator	$ 5,915	5	$ 591	
11/30/2022	closed loop door on elevator	$ 37,681	5	$ 3,767	
11/30/2022	optiguard on elevator	$ 9,785	5	$ 978	
11/30/2022	packing & vic fittings on elevator	$ 5,915	5	$ 591	
11/30/2022	new motor for mixer	$ 1,795	5	$ 179	
1/31/2023	PTAC replacement	$ 5,291	5	$ 528	
1/31/2023	dish room exhaust fan	$ 4,626	5	$ 462	
1/31/2023	ice machine door	$ 1,292	5	$ 128	
4/30/2023	laundry backflow preventer	$ 1,835	5	$ 183	
8/31/2023	control board	$ 13,570	10	$ 678	
8/31/2023	compressor	$ 10,369	10	$ 517	
8/31/2023	condensor fan motor	$ 6,966	10	$ 347	
Total additions for Leasehold Improvement		$ 122,002		$ 10,645	*
Deletions:					
Total deletions for Leasehold Improvement		$ -		$ -	**

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

Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2023	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	3,827			1,620	
3.									
B-4. Subtotal									1,620
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2022	Various	521,074	185,993	S/L	Variou	51,640	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2023	Various	122,002		S/L	Variou	10,645	
C-4. Subtotal									62,285
D. ***Total Amortization***									63,905

* 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	9/30/2023	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	9/30/2023	26	37

Item			Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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*)

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	9/30/2023	27	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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*) $	105,568	105,568					
Vendor Int $41,233; Midcap LOC $64,335							
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	105,568	105,568					
14. Insurance a. Insurance on Property (buildings only) $	175,928	175,928					
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)*** $	175,928	175,928					
15. ***Total All Expenditures (A-13 thru C-14)*** $	16,489,822	17,186,482	(696,660)				

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2023	30 | 37

Item		Total	CCNH / RHNS	(Specify)	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	25,337,580	25,337,580		
b. Medicaid Room and Board Contractual Allowance **	$	(12,842,095)	(12,842,095)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,196,090	1,196,090		
b. Medicare Room and Board Contractual Allowance **	$	269,591	269,591		
4. a. Private-Pay Residents and Other	$	3,016,161	3,016,161		
b. Private-Pay Room and Board Contractual Allowance **	$	(830,760)	(830,760)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	103,394	103,394		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(103,394)	(103,394)		
c. Prescription Drugs - Non-Medicare	$	247,235	247,235		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(247,235)	(247,235)		
2. a. Medical Supplies - Medicare	$	720	720		
b. Medical Supplies - Medicare Contractual Allowance **	$	(720)	(720)		
c. Medical Supplies - Non-Medicare	$	36,606	36,606		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(36,606)	(36,606)		
3. a. Physical Therapy - Medicare	$	509,308	509,308		
b. Physical Therapy - Medicare Contractual Allowance **	$	(404,776)	(404,776)		
c. Physical Therapy - Non-Medicare	$	606,380	606,380		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(606,380)	(606,380)		
4. a. Speech Therapy - Medicare	$	78,345	78,345		
b. Speech Therapy - Medicare Contractual Allowance **	$	(63,701)	(63,701)		
c. Speech Therapy - Non-Medicare	$	144,525	144,525		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(144,525)	(144,525)		
5. a. Occupational Therapy - Medicare	$	401,850	401,850		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(323,297)	(323,297)		
c. Occupational Therapy - Non-Medicare	$	515,940	515,940		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(515,940)	(515,940)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	177,157	177,157		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	16,521,453	16,521,453		
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)*	$	53,063	54,855	(1,792)	
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	97,693	97,693		
V. Total Other Revenue (1 thru 8)	$	150,756	152,548	(1,792)	
VI. Total All Revenue (III +V)	$	16,672,209	16,674,001	(1,792)	

* *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)	(Specify)
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
N/A	Medicaid Recoupments	$ 350,000		
	Medicare Recoupments	$ (172,843)		
Total Other Resident Revenue		$ 177,157	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH / RHNS	(Specify)	(Specify)
Pg 31, Ln A	Interest on Accts Rec	N/A	$ 1,792	$ (1,792)	
	Interest on ERC		$ 53,063		
Total Interest Income			$ 54,855	$ (1,792)	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
n/a	Bad Debts Recoveries	$ 97,693		
Total Other Revenue		$ 97,693	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2023	31 | 37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 52,226
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,547,513
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 27,357
5. Prepaid Expenses				$ 103,212
a. Prepaid Insurance		99,709		
b. Prepaid expense other		3,503		
c.				
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,730,308
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	99,523		$ 9,116
	Accum. Depreciation	90,407	Net	
3. Buildings	*Historical Cost	2,141,550		$ 128,672
	Accum. Depreciation	2,012,878	Net	
4. Leasehold Improvements	*Historical Cost	643,076		$ 394,798
	Accum. Depreciation	248,278	Net	
5. Non-Movable Equipment	*Historical Cost	896,157		$ 36,041
	Accum. Depreciation	860,116	Net	
6. Movable Equipment	*Historical Cost	1,686,648		$ 151,631
	Accum. Depreciation	1,535,017	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 5,914
Equipment Carry Forward Adjustment		5,914		
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 726,172

* 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)			$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2023	32 | 37

Account				Amount
		Total Brought Forward:		$ 3,456,480
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	6,270,000	Net	$ 729,069
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)				$ 1,122,295
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		
Investments-Related Party	(4,469,880)			
7. Other Assets (*itemize*)				$ 138,623
Project Development		95,683		
LOC Finance Fees		42,940		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ (3,523,467)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 1,055,308

* 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	9/30/2023	33 | 37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 2,319,009
2. Notes Payable (*itemize*)				$ 1,160,587
Midcap Line of credit		1,160,587		
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*)				$ 375,820
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 308,044
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*)				$ 2,948,884
Accrued State Income tax	(3,120)	Provider Tax Due	2,845,036	
Deferred Rent	36,068			
Accrued Operating Expenses	70,477			
Accrued Expense - Sales Tax	423	See Schedule		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 7,112,344

* 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	9/30/2023	34	37

Account	Amount
Total Brought Forward:	7,112,344
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
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 Note Payable	179,306	

Account		Amount
4. Other Long-Term Liabilities (*itemize*)		$ (1,638,109)
Notes Payable - Procare CT	89,853	
Related Party Notes	(1,727,962)	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ (1,394,877)
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 5,717,467

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

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2023	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	$	729,069
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	$	1,122,295
B. **Net Worth**		
1. Owner's Capital	$	
2. Capital Stock	$	1,000
3. Paid-in Surplus	$	250,455
4. Treasury Stock	$	
5. Cumulated Earnings	$	(5,523,428)
6. Gain or Loss for Period 10/1/2022 thru 9/30/2023	$	(512,481)
7. Total Net Worth	$	(5,784,454)
C. ***Total Reserves and Net Worth***	$	(4,662,159)
D. ***Total Liabilities, Reserves, and Net Worth***	$	1,055,308

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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	9/30/2023	36 | 37

	Account			Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2022			$ (8,058,952)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 16,674,001
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 17,186,482
D.	Net Income or Deficit			$ (512,481)
E.	Balance			$ (8,571,433)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Rounding		1	
	ERC JE		2,786,978	
	2. Other (*itemize*)			
F-3.	Total Additions			$ 2,786,979
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*** 09/30/23			$ (5,784,454)

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2023	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home (CCNH) & RHNS Combined	☐ (Specify)	☐ (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	
Addres Address	**Phone Number**
135 South Road Farmington, CT 06032	(860) 751-3900
Contacted Person Regarding Additional Information Needed Regarding This Report	**Phone Number**
Amanda Doncet	(860) 751-3900
Contact Email Address	
adoncet@athenahealthcare.com	