State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2024

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 (CCNH) & RHNS Combined	☐ (Specify)	☐ (Specify)
Report for Year Beginning 10/1/2023	Report for Year Ending 9/30/2024	

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

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2024	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, 2023 and ending September 30, 2024, 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) Renea Watson			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 10/1/2023	To 9/30/2024
Address of Facility 2875 Main Street Bridgeport, CT 06606				
Report Prepared By Athena Health Care Associates, Inc	Phone Number (860) 751-3900		Date	

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
203-336-0232	9/30/2024	2	37

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

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

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2024	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	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

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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	%**				
		○	⊙					
Athena Captive LLC	135 South Road, Farmington, CT 06032	○	⊙		Workers Comp Captive	Pg 15, ln 1a	336,971	336,971
Northbridge Landord LLC	135 South Road, Farmington, CT 06062	○	⊙	>95%	Lease of facility/ Property Taxes/ Property In	Pg 22, ln 9 and 10b, Pg	821,923	821,923
Athena Health Care	135 South Road, Farmington, CT 06032	○	⊙	>50%	Health & General Insurance	Pg 15, ln 1a5	875,805	875,805
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	289,366	289,366
Athena Health Care		○	⊙	>50%	see attached			
Athnea Health Care		○	⊙		management fees			275,991
		○	⊙					

* 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.

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

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.

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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
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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 (Specify)	Total (Specify)	Period 10/1 Thru 6/30 Total	Period 10/1 Thru 6/30 CCNH / RHNS	Period 10/1 Thru 6/30 (Specify)	Period 10/1 Thru 6/30 (Specify)	Period 7/1 Thru 9/30 Total	Period 7/1 Thru 9/30 CCNH / RHNS	Period 7/1 Thru 9/30 (Specify)	Period 7/1 Thru 9/30 (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	117	117			117	117						
B. As of midnight of THIS report period	125	125							125	125		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,121	4,121			3,445	3,445			676	676		
B. Medicaid (Conn.)	41,275	41,275			30,716	30,716			10,559	10,559		
C. Medicaid (other states)												
D. Private Pay	450	450			335	335			115	115		
E. State SSI for RCH												
F. Other (Specify) Managed Care	105	105			105	105						
G. Total Care Days During Period (3A thru F)	45,951	45,951			34,601	34,601			11,350	11,350		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	45,951	45,951			34,601	34,601			11,350	11,350		

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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		120		2		3		
Per Diem Rate								
a. One bed rm.	622.63	######		672.00		571.71		
b. Two bed rms.	622.63	######		652.00		571.71		
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	3,852	3,852			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	4,753	4,753			
2. Restorative Treatments					
C. Other	5,690	5,690			
D. ***Total Physical Therapy Treatments***	14,295	14,295			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	414	414			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	798	798			
2. Restorative Treatments					
C. Other	541	541			
D. ***Total Speech Therapy Treatments***	1,753	1,753			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	3,243	3,243			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments	5,187	5,187			
2. Restorative Treatments					
C. Other	5,664	5,664			
D. ***Total Occupational Therapy Treatments***	14,094	14,094			

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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 / 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)	139,444		2,104						
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)									
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	380,646		12,680						
5. Dietary Service									
a. Head Dietitian									
b. Food Service Supervisor	73,333		2,066						
c. Dietary Workers	648,100		31,007						
6. Housekeeping Service									
a. Head Housekeeper	72,205		2,093						
b. Other Housekeeping Workers	367,079		20,111						
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	68,106		2,285						
b. Other Maintenance Workers	49,043		2,227						
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers	207,772		10,372						
9. Barber and Beautician Services									
10. Protective Services	15,263		859						
11. Accounting Services									
a. Head Accountant									
b. Other Accountants									
12. Professional Care of Residents									
a. Directors and Assistant Director of Nurses	138,524		2,046						
b. RN									
1. Direct Care	444,056		7,358						
2. Administrative**	576,970		16,369						
c. LPN									
1. Direct Care	2,100,068		52,081						
2. Administrative**									
d. Aides and Attendants	2,459,215		101,498						
e. Physical Therapists	394,080		9,991						
f. Speech Therapists	64,029		1,502						
g. Occupational Therapists	230,239	(230,239)	5,359						
h. Recreation Workers	344,973		13,444						
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	224,857		7,056						
n. Marketing									
o. Other (Specify) See Attached Schedule									
A-13. Total Salary Expenditures	8,998,002	(230,239)	302,508						

* 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										
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)	(Specify)							
Section III - Administrators* **										
Lavonn Davis	139,444			Health & life insurances, Payroll taxes	Day to day operations of the nursing home facility.	2,104	A2			
(10/1/23-9/30/2024)										
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 / 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	40,281		1,007						
2. Dentist									
3. Pharmacist	14,278		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		195						
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	390		1						
b. Other									
10. Occupational Therapist									
a. Resident Care									
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care			2,962						
2. Administrative***	295,999								
b. LPN									
1. Direct Care	41,535		419						
2. Administrative***									
c. Aides									
d. Other									
12. Other (Specify) See Attached Schedule									
B-13 Total Fees Paid in Lieu of Salaries	464,483		4,663						

* 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	9/30/2024	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
		○	⊙	
Procare LTC, 110 Bo-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	○	⊙	
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	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
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		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* 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
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Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	$	336,971	336,971					
2. Disability Insurance	$							
3. Unemployment Insurance	$	75,786	75,786					
4. Social Security (F.I.C.A.)	$	645,494	645,494					
5. Health Insurance	$	927,681	927,681					
6. Life Insurance (employees only)								
(not-owners and not-operators)	$							
7. Pensions (Non-Discriminatory)	$	229,215	229,215					
(not-owners and not-operators)								
8. Uniform Allowance	$	400	400					
9. Other (*Specify*)	$							
See Attached Schedule								
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$							
c. Bad Debts*	$		207,726	(207,726)				
d. Accounting and Auditing	$	13,185	20,792	(7,607)				
e. Legal (*Services should be fully described on Page 15b)*	$		36,728	(36,728)				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$							
g. Office Supplies	$	48,710	48,710					
h. Telephone and Cellular Phones								
1. Telephone & Pagers	$	65,478	65,478					
2. Cellular Phones	$	1,260	4,050	(2,790)				
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	$	880,675	880,675					
Subtotal	$	3,224,855	3,479,706	(254,851)				

* 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	9/30/2024	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	3001 Summer St., 5th Floor Stamford, CT
4		

Services Provided by This Firm (*describe fully*)

1	Medicare Cost Report Preparation:	$ 2,885
2	line of credit audits: disallow	$ 7,607
3	Audit	$ 10,300
4		$
		Charge for Services Provided $ 20,792

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

⊙ Yes ○ No — Pg 15, Line1d

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	Sheriff-Bridgeport	860-274-0018
5	Treasurer State of CT	

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*)

1	AR Collections : Disallowed	$ 232
2	AR Collections : Disallowed	$ 878
3	Line of credit legal fees : Disallowed	$ 32,228
4	Conservatorship: Disallowed	$ 640
5	Conservatorship: Disallowed	$ 2,750
		Charge for Services Provided $ 36,728

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

⊙ Yes ○ No — Pg 15, Line1e

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

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2024	16	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:		3,224,855	3,479,706	(254,851)				
l. Travel and Entertainment								
1. Resident Travel and Entertainment	$							
2. Holiday Parties for Staff	$	3,220	3,220					
3. Gifts to Staff and Residents	$		28,166	(28,166)				
4. Employee Travel	$	600	600					
5. Education Expenses Related to Seminars and Conventions	$	8,160	8,160					
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*)	$	773	773					
2. Advertising Telephone Directory (*all such expenses*)***	$							
3. Advertising Other (*Specify*)***	$		2,082	(2,082)				
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	$	2,944	2,944					
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	1,050	1,050					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$							
9. Subscriptions	$	291	291					
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**	$	182,154		182,154				
13. Other (*Specify*) See Attached Schedule	$	257,731	283,911	(26,180)				
C-14 Total Administrative & General Expenditures	$	3,681,778	3,810,903	(129,125)				

* 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	$ 2,082	$ (2,082)				
Total Other Advertising	$ 2,082	$ (2,082)	$ -	$ -	$ -	$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
CAHCF	$ 1,050					
Total Dues	$ 1,050	$ -	$ -	$ -	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Employee Physicals & background checks	$ 11,893					
Bank fees	$ 26,180	$ (26,180)				
Payroll processing fees	$ 33,364					
Other Professional fees	$ 157,317					
Data processing fees	$ 53,142					
Licenses	$ 2,015					
Total Other Administrative and General	$ 283,911	$ (26,180)	$ -	$ -	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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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 #

*** 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	9/30/2024					18	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	$	520,866	524,555	(3,689)				
2. Non-Food Supplies	$	55,825	55,825					
3. Other (*Specify*)_____ Dishes	$	5,187	5,187					
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)	$	581,878	585,567	(3,689)				

2E. Dietary Questionnaire	Total	CCNH / RHNS	(Specify)	(Specify)
F. Resident Meals: Total no. of meals served per day:*	377	377		

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2024	19	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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. $	23,148	23,148					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$							
c. Other (*Specify*) Supplies	$	11,313	11,313					
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	34,461	34,461					

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	9/30/2024	20	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4. Housekeeping	Sq. Ft. Serviced by Personnel							
a. In-House Care								
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt. $	65,038	65,038					
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)	$	65,038	65,038					
5. Resident Care (Supplies)**								
a. Prescription Drugs***								
1. Own Pharmacy	$							
2. Purchased from Procare LTC	$		281,385	(281,385)				
b. Medicine Cabinet Drugs	$	9,281	9,281					
c. Medical and Therapeutic Supplies	$	366,847	384,707	(17,860)				
d. Ambulance/Limousine***	$							
e. Oxygen								
1. For Emergency Use	$							
2. Other***	$		11,264	(11,264)				
f. X-rays and Related Radiological Procedures***	$		20,138	(20,138)				
g. Dental (*Not dentists who should be included under salaries or fees)*	$							
h. Laboratory***	$		73,042	(73,042)				
i. Recreation	$	17,059	17,059					
j. Direct Management Services*	$	49,678		49,678				
k. Indirect Management Services*	$	44,159		44,159				
l. Cable TV	$	7,200	17,735	(10,535)				
m. Other (Specify)**** See Attached Schedule	$	83,237	98,138	(14,901)				
n. Physical Therapy Expense	$							
o. Speech Therapy Expense	$							
5P. ***Total Resident Care Expenditures*** (5a - 5o)	$	577,461	912,749	(335,288)				

* 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
0	0					
	0					
Medical Equip Rentals-Medicaid	44320					
Physical Therapy Supplies	19669					
	0					
	0					
Oxygen Concentrator Rentals	19248					
Medical Equip Rentals-Other	14901	$ (14,901)				
	0					
	0					
	0					
0	0					
0	0					
0	0					
0	0					
0	0					
0	0					
0	0					
0	0					
0	0					
0	0					
	0					
Total Other Resident Care	$ 98,138	$ (14,901)	$ -	$ -	$ -	$ -

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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	9/30/2024	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)	(Specify)	Pg	Line
ADP	Hartford Region, Richmond, VA	○	⊙		Payroll Services	25,198			16	m13
CWPM	415, Plainville, CT 06062	○	⊙		Rubbish Removal	33,364			22	6f
Procare LTC	Suite 121, Farmingdale, NY 11735	⊙	○	Common Owners: Minority Interest	Pharmacy	289,366			20	5
Outdoor Lawn Service LLC	PO Box 320144, Fairfield, CT 06825	○	⊙		Landscaping & Snow removal	22,010			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	9/30/2024	22	37

Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	$	206,574	206,574					
b. Heat	$	54,729	54,729					
c. Light & Power	$	140,777	140,777					
d. Water	$	63,281	63,281					
e. Equipment Lease (*Provide detail on page 22b*)	$	19,085	19,085					
f. Other (*itemize*)	$	101,873	101,873					
See Attached Schedule								
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	586,319	586,319					
7. Depreciation (*complete schedule page 23**)								
a. Land Improvements	$	1,425	1,425					
b. Building & Building Improvements	$	27,010	27,010					
c. Non-Movable Equipment	$	6,862	6,862					
d. Movable Equipment	$	33,737	36,893	(3,156)				
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	69,034	72,190	(3,156)				
8. Amortization (*Complete att. Schedule Page 24**)								
a. Organization Expense	$							
b. Mortgage Expense	$	1,620	1,620					
c. Leasehold Improvements	$	70,807	70,807					
d. Other (*Specify*)	$							
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	72,427	72,427					
9. Rental payments on leased real property less real estate taxes included in item 10b	$	585,421	585,421					
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	$	25,900	25,900					
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	835,776	838,932	(3,156)				

* 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	$ 7,657					
Rubbish Removal	$ 50,766					
Snow Removal	$ 14,353					
Supplies	$ 29,097					
0	$ -					
0	$ -					
0	$ -					
0	$ -					
0	$ -					
0	$ -					
0	$ -					
Total Other Repairs and Maintenance	$ 101,873	$ -	$ -	$ -	$ -	$ -

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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	1,313
De Lage Landen Financial Services	○	⊙	Copier s	09/25/20	48 months	21,326	17,772
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ⊙ Yes ○ No **Total ***** 19,085

* 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	9/30/2024	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	90,408	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	2,012,882	S/L	Various	27,010	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								27,010
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	896,157		896,157	860,116	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	2023	1,692,559		1,692,559	1,535,017	S/L	Various	35,530	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative			9	2024								
d. Standard Resident					21,645		21,645		S/L	Various	1,363	
e. Specialized Resident												
Total Acquired during this report period					21,645		21,645				1,363	
D-3. Subtotal												36,893
E. ***Total Depreciation***												72,190

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:						
11/30/2023		Standard Resident	$ 1,161	15	$ 39	
11/30/2023		Standard Resident	$ 3,800	10	$ 190	
11/30/2023		Standard Resident	$ 2,850	10	$ 143	
5/31/2024		Standard Resident	$ 4,268	5	$ 427	
5/31/2024		Standard Resident	$ 7,859	10	$ 393	
8/31/2024		Standard Resident	$ 1,707	5	$ 171	
		PICK A CATEGORY				
		PICK A CATEGORY				
		PICK A CATEGORY				
Total additions for Movable Equipment			$ 21,645		$ 1,363	*
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:					
11/30/2023		$ 10,285	10	$ 514	
11/30/2023		$ 2,800	10	$ 139	
8/31/2024		$ 12,800	10	$ 639	
8/31/2024		$ 5,105	5	$ 510	
9/30/2024		$ 7,016	5	$ 701	
Total additions for Leasehold Improvement		$ 38,006		$ 2,503	*
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	9/30/2024	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1. Finance Fees									
2. Finance Fees	2	2018	3 yrs	32,151	32,151	SL			
3. Finance Fees-Greystone				48,387	3,827	SL		1,620	
B-4. Subtotal									1,620
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2023	Various	643,076	248,278	SL	Variou	68,304	
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)	9	2024	Various	38,006		SL	Variou	2,503	
C-4. Subtotal									70,807
D. ***Total Amortization***									72,427

* 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	9/30/2024	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 _____	6,325,352			
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	9/30/2024	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			(52)				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $			(52)				

(*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	9/30/2024	27	37

Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:			(52)				
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*) $	101,357	101,357					
Vendor Int=89,068; Midcap LOC= 12,289							
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	101,305	101,357	(52)				
14. Insurance							
a. Insurance on Property (buildings only) $	158,582	158,582					
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)*** $	158,582	158,582					
15. ***Total All Expenditures (A-13 thru C-14)*** $	15,854,844	16,556,393	(701,549)				

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2024	30 | 37

Item		Total	CCNH / RHNS	(Specify)	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	27,005,243	27,005,243		
b. Medicaid Room and Board Contractual Allowance **	$	(13,669,623)	(13,669,623)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	915,060	915,060		
b. Medicare Room and Board Contractual Allowance **	$	192,110	192,110		
4. a. Private-Pay Residents and Other	$	2,212,784	2,212,784		
b. Private-Pay Room and Board Contractual Allowance **	$	(515,469)	(515,469)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	63,398	63,398		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(63,398)	(63,398)		
c. Prescription Drugs - Non-Medicare	$	168,526	168,526		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(168,526)	(168,526)		
2. a. Medical Supplies - Medicare	$	4,602	4,602		
b. Medical Supplies - Medicare Contractual Allowance **	$	(4,602)	(4,602)		
c. Medical Supplies - Non-Medicare	$	15,944	15,944		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(15,944)	(15,944)		
3. a. Physical Therapy - Medicare	$	340,867	340,867		
b. Physical Therapy - Medicare Contractual Allowance **	$	(259,565)	(259,565)		
c. Physical Therapy - Non-Medicare	$	455,350	455,350		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(455,350)	(455,350)		
4. a. Speech Therapy - Medicare	$	75,980	75,980		
b. Speech Therapy - Medicare Contractual Allowance **	$	(58,253)	(58,253)		
c. Speech Therapy - Non-Medicare	$	154,625	154,625		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(154,625)	(154,625)		
5. a. Occupational Therapy - Medicare	$	309,630	309,630		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(241,997)	(241,997)		
c. Occupational Therapy - Non-Medicare	$	495,090	495,090		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(495,090)	(495,090)		
6. a. Other *(Specify)* - Medicare	$	9	9		
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	16,306,776	16,306,776		
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)*	$	52	52		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	43,340	43,340		
V. Total Other Revenue (1 thru 8)	$	43,392	43,392		
VI. Total All Revenue (III +V)	$	16,350,168	16,350,168		

* *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)
	Medicare recoupments	$ 9		
Total Other Resident Revenue - Medicare		$ 9	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	(Specify)
	Interest on Accts Rec		$ 52		
	0		$ -		
	0		$ -		
	0				
Total Interest Income			$ 52	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
	0	$ -		
	0	$ -		
	Bad Debt Recoveries	$ 43,340		
	0	$ -		
	0	$ -		
	0	$ -		
	0	$ -		
Total Other Revenue		$ 43,340	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2024	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 1,386
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 3,579,440
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 31,340
5. Prepaid Expenses				$ 112,092
a.				
b.				
c.				
d. See Schedule		112,092		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 3,724,258
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	99,523		$ 7,690
	Accum. Depreciation	91,833	Net	
3. Buildings	*Historical Cost	2,141,550		$ 101,662
	Accum. Depreciation	2,039,888	Net	
4. Leasehold Improvements	*Historical Cost	681,082		$ 361,997
	Accum. Depreciation	319,085	Net	
5. Non-Movable Equipment	*Historical Cost	896,157		$ 29,179
	Accum. Depreciation	866,978	Net	
6. Movable Equipment	*Historical Cost	1,696,172		$ 124,262
	Accum. Depreciation	1,571,910	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 18,035
See Schedule		18,035		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 642,825

* 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	
		Prepaid Insurance	$ 102,734
		Prepaid expense Other	$ 9,358
			$ -
		0	$ -
Total Prepaid Expenses			$ 112,092

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)			$ 18,035

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
		Project Development	$ 73,867
		Bed License Intangible	$ 182,292
		LOC Finance Fees	$ 41,319
Total Other Assets			$ 297,478

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ (422,562)

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			$ 4,012,399

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

Page Ref	Line Ref	Description	
		Notes Pay-Procare CT	$ 89,853
		Related Party Notes	$ (1,707,549)
Total Other Current Liabilities (Itemize)			$ (1,617,696)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2024	32	37

	Account				Amount
			Total Brought Forward:	$	4,367,083
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	6,503,302 Net	$	495,767
	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)			$	888,993
D.	Investment and Other Assets				
	1. Deferred Deposits			$	
	2. Escrow Deposits			$	
	3. Organization Expense	*Historical Cost			
		Accum. Depreciation	Net	$	
	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*)			$	297,478
	See Schedule	297,478			
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)			$	(3,546,904)
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	1,709,172

* 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	9/30/2024	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 3,705,796
	2. Notes Payable (*itemize*)				$ (422,562)
	See Schedule			(422,562)	
	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*)				$ 453,322
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 500,295
	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*)				$ 4,012,399
	See Schedule			4,012,399	
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 8,249,250

* 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	9/30/2024	34	37

Account				Amount
			Total Brought Forward:	8,249,250
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*)				$ 179,306
Name and Address of Lender		Amount	Loan Date	
Related Party PROCARE NOTE PAYABLE		179,306		
4. Other Long-Term Liabilities (*itemize*)				$ (1,617,696)
See Schedule		(1,617,696)		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)				$ (1,438,390)
C. ***Total All Liabilities*** (Lines A-13 + B-5)				$ 6,810,860

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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	9/30/2024	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	$ 495,767
	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	$ 888,993
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$ 250,455
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (6,035,911)
	6. Gain or Loss for Period 10/1/2023 thru 9/30/2024	$ (206,225)
	7. Total Net Worth	$ (5,990,681)
C.	***Total Reserves and Net Worth***	$ (5,101,688)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 1,709,172

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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	9/30/2024	36 |	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2023			$ (5,784,454)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 16,350,168
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 16,556,393
D.	Net Income or Deficit			$ (206,225)
E.	Balance			$ (5,990,679)
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	Rounding			(2)
	ERC JE			
	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***	09/30/24		$ (5,990,681)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2024	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 in the Adjustments columns. 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 RoadFarmington, CT 06032	(860) 751-3900

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number

Contact Email Address