State of Connecticut

15-13

Annual Report of Long-Term Care Facility
Cost Year 2015

Name of Facility (as licensed) Northbridge Healthcare Center
Address (No. & Street, City, State, Zip Code) 2875 Main Street Bridgeport, CT 06606
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Report for Year Beginning	Report for Year Ending
10/1/2014	9/30/2015

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-MR
	2183C		

For Department Use Only

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

MYERS AND STAUFFER LLC
CERTIFIED PUBLIC ACCOUNTANTS

December 11, 2013

Mr. Michael E. Mosier
Chief Financial Officer
Athena Health Care Systems
135 South Road
Farmington, CT 06032

Subject: Alternative Annual Report Approval

Dear Mr. Mosier:

This letter is a follow-up to your verbal approval regarding your request for alternative annual report utilization. We have reviewed your request for approval of the Athena Health Care Systems version of the 2013 Annual Report for the State of Connecticut. Based on our review, your version of the annual report has been approved.

It is not necessary to request approval on an annual basis. This approval will remain in effect until modifications have been made to the Annual Report by the Department of Social Services. The provider community will be notified should such changes occur. At that time, you will be required to submit a new request for approval based on the modified annual report.

Should you have any questions, please feel free to contact me at (860) 687-0790.

Sincerely,

Brittany L. Hester

Brittany L. Hester, Administrative Assistant

CC: Claudette B. Pickens, CPA
CC: Chris Lavigne

7 Waterside Crossing, Ste 202 | Windsor, CT 06095
PH 860.687.0790 | PH 855.716.9377 | FX 860.687.0810
www.mslc.com

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General Information

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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Northbridge Healthcare Center [facility name] for the cost report period beginning October 01, 2014 and ending September 30, 2015, 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 penalities 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
	2-10-16		2-10-16
Printed Name (Administrator) **Erica Roman**		Printed Name (Owner) **Lawrence Santilli**	
Subscribed and Sworn to before me: State of Conn	Date 2/10/16	Signed (Notary Public)	Comm. Expires 03/31/20
Address of Notary Public		76 Christine Drive Southington CT. 06489	

(Notary Seal)

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State of Connecticut
Department of Social Services
25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility **Northbridge Healthcare Center**	Period Covered:		From **10/1/2014**	To **9/30/2015**
Address of Facility **2875 Main Street Bridgeport, CT 06606**				
Report Prepared By **Athena Health Care Associates, Inc**	Phone Number **(860) 751-3900**		Date **2/11/2016**	

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

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-336-0232	**09/30/15**	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)	Medicare Provider No.
	2183C			**07-5413**

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

☐ PROPRIETORSHIP ☐ LLC ☐ PARTNERSHIP ☑ PROFIT CORP. ☐ NON-PROFIT CORP. ☐ GOVERNMENT ☐ TRUST

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Erica Roman	**001948**

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

Name	License No.:
Not Applicable	

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General Information and Questionnaire
Partners/Members

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

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

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General Information and Questionnaire
Corporate Owners

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Northbridge Health Care Center, Inc	**2875 Main St, Bridgeport, CT 06606**	**CT**

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Lawrence G. Santilli	**2875 Main St, Bridgeport, CT 06606**	**President**	**589.493**
Debra M Soucey	**2875 Main St, Bridgeport, CT 06606**	**Secretary**	
Michael E. Mosier	**2875 Main St, Bridgeport, CT 06606**	**Treasurer**	**40**
Names of Stockholders Owning at Least 10% of Shares			
Custodians for Lawrence E Santilli	**2875 Main St, Bridgeport, CT 06606**		**110.307**

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General Information and Questionnaire
Individual Proprietorship

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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

Not Applicable

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ☐ Yes ☑ No — If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties: Yes	No	%**	Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
Laurel Ridge Health Care Center	642 Danbury Road Ridgefield, CT 06877	☑	☐	>98%	Bank Charges	PG 16, m13	$6,932	$6,932
Athena Captive LLC	135 South Road, Farmington, CT 06032	☑	☐	>98%	Workers Comp Captive	Pg 15, ln 1a	$368,096	$368,096
Northbridge Landord LLC	135 South Road, Farmington, CT 06062	☑	☐	>98%	Lease of facility	Pg 22, ln 9 and 10b, Pg 27, ln 14a	$1,063,259	$1,063,259
Shady Knoll	41 Skokorat Street, Seymour, CT 06483	☑	☐	>98%	Swap interest allocation	Pg 26, 12A	$5,879	$5,879
Athena Health Care Services Inc. 401(K) Plan	135 South Road, Farmington, CT 06032	☑	☐	>98%	Facility participates in a group 401(K) plan			
Litchfield Woods Health Care	255 Roberts Street, Torrington, CT	☑	☐	>98%	reimbursement of legal fees	pg 15, Ln 1e	$5,077	$5,077
Athena Health Care		☐	☑		See attached			
Beacon Brook Health Care	89 Weid Drive, Naugatuck, CT	☑	☐	>98%	Reimbursement of cable expense	pg 20, Ln 5j	$664	$664
		☐	☐					

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.

Northbridge Healthcare

Name of Related Individual or Company	Address	Also Provides Goods/Services To Non-Related Parties YES	No	%	Description of Goods/Services Provided	Indicate Where Costs Are Included in Annual Report Page #/Line #	Cost Reported	Actual Cost to the Related Party
Athena Health Care Assoc. Inc.	135 South Road Farmington, CT 06032	X		>98%	MDS Nurse Consultant, Legal, Office Supplies, staff appreciation, Pension Fees, Gift Certificates, Business Promotion, Management Fees, Lobbying, Bank Charges Data Processing Fees, Repairs & Maintenance, Insurance, Furniture & Equipment, Temp Help-Therapy	Pg. 13 ln 11a2, Pg 15 ln 1e, 1g, 1a7; Pg 16 ln l2, m3, L6, m12, m13 Pg. 22 ln 6a, Pg. 27 ln 14a, Pg. 31 ln B6, Pg 13, ln 11 Pg 15, Ln 1a5 Pg 13, ln B5a	$799,731	$388,821
Athena Health Care Assoc. Inc.	135 South Road Farmington, CT 06032	X		>98%	Health Insurance	pg 15, Line 1a5	$1,208,490	$1,208,490

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General Information and Questionnaire
Basis for Allocation of Costs

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

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

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

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

Not Applicable

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

Not Applicable

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

☐ Yes ☐ No If "No," explain fully why such allocation was not made.

Not Applicable:No Non-Nursing Home Cost Centers

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General Information and Questionnaire
Leases (Excluding Real Property)

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

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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**	**05/17/06**	**automatic renewal**	**$1,953**	**$1,953**
Leaf, 1720A Crete Street, Moberly, MO 65270	☐	☑	**Copier**	**03/04/13**	**48 months**	**$18,999**	**$18,999**
Hewlett Packard Financial Services, PO Box 402582, Atlanta, GA	☐	☑	**PCC equipment**	**08/15/13**	**60 months**	**$7,975**	**$7,975**
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Is a Mileage Log Book Maintained for All Leased Vehicles ? **Not Applicable - No Vehicles** ☐ Yes ☐ No **Total** *** $28,927

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

** Attach copies of newly acquired leases.

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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The records of this facility for the period covered by this report were maintained on the following basis:

☑ Accrual ☐ Cash ☐ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 **Dworkin, Hillman, Lamorte**	**Four Corporate Drive, Suite 488, Shelton, CT 06484**
2 **Marcum LLP**	**555 Long Wharf Drive, Shelton, CT**
3 **Dopkins & Co**	**200 International Dr, Buffalo, NY**
4	

Services Provided by This Firm (*describe fully*)

1	**2015 Audit, Year End Financials & Tax Return**	$ 14,000
2	**Medicare Cost Report Preparation: Disallowed**	$ 2,650
3	**Key Bank Audit: Disallowed**	$ 1,912
4		$ -

Charge for Services Provided: **$18,562**

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 **Murtha Cullina LLP**	**860-240-6000**
2 **Day Pitney**	**973-966-8186**
3 **Shipman & Goodwin**	**860-251-5000**
4 **Schiff Hardin**	**312-258-5500**
5 **Bridgeport Probate**	

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

1 **185 Asylum St. Hartford, CT 06103**
2 **PO Box 416234, Boston, MA 02241**
3 **One Constitution Plaza, Hartford, CT 06103**
4 **6600 Sears Tower, Chicago, IL 60606**
5 **Bridgeport, CT**

Services Provided by This Firm (*describe fully*)

1	**Secretary of state annual /Audit letter $873 Allow; Misc Matters $7201:Disallow**	$ 8,074
2	**Vendor Dispute (Disallowed)**	$ 73,944
3	**Misc Employee Matters: Disallowed**	$ 6,802
4	**Key Bank audit;Disallowed**	$ 5,077
5	**Conservatorship: Disallowed**	$ 204

Charge for Services Provided: **$94,101**

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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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period.....	145	145			145	145			145	145		
B. On last day of THIS report period.....	145	145			145	145			145	145		
2. Number of Residents												
A. As of midnight of PREVIOUS report period.....	135	135			138	138			135	135		
B. As of midnight of THIS report period.....	141	141			141	141			141	141		
3. Total Number of Days Care Provided During Period												
A. Medicare.....	6,528	6,528			4,911	4,911			1,617	1,617		
B. Medicaid (Conn.).....	42,812	42,812			32,175	32,175			10,637	10,637		
C. Medicaid (other states).....												
D. Private Pay.....	881	881			581	581			300	300		
E. State SSI for RCH.....												
F. Other (Specify) Managed Care	660	660			553	553			107	107		
G. Total Care Days During Period (3A thru F).....	50,881	50,881			38,220	38,220			12,661	12,661		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days.....	664	664			527	527			137	137		
B. Other Bed Reserve Days.....												
5. ***Total Resident Days*** **(3G + 4A + 4B).....**	51,545	51,545			38,747	38,747			12,798	12,798		

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Schedule of Resident Statistics (Cont'd)

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

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

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

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

Item	Medicare: CCNH	Medicaid: CCNH	RHNS	Self-Pay: CCNH	RHNS	(Specify)	Other State Assisted: R.C.H.	ICF-MR
No. of Residents	10	118		4		9		
Per Diem Rate								
a. One bed rm.	533.74	253.92		442.00		388.24		
b. Two bed rms.	533.74	253.92		422.00		388.24		
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	6,282	6,282		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	3,949	3,949		
2. Restorative Treatments				
C. Other	16,196	16,196		
D. ***Total Physical Therapy Treatments***	26,427	26,427		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	436	436		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	348	348		
2. Restorative Treatments				
C. Other	1,102	1,102		
D. ***Total Speech Therapy Treatments***	1,886	1,886		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	4,222	4,222		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	3,680	3,680		
2. Restorative Treatments				
C. Other	16,206	16,206		
D. ***Total Occupational Therapy Treatments***	24,108	24,108		

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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

Item	Total Cost and Hours					
	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	118,604	2,254				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	239,248	11,146				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	61,325	2,091				
c. Dietary Workers	586,535	33,702				
6. Housekeeping Service						
a. Head Housekeeper	47,191	2,088				
b. Other Housekeeping Workers	262,374	19,970				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	66,136	2,143				
b. Other Maintenance Workers	35,771	2,172				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	140,845	9,966				
9. Barber and Beautician Services						
10. Protective Services	10,074	961				
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	159,841	3,137				
b. RN						
1. Direct Care	906,059	23,552				
2. Administrative**	448,821	15,890				
c. LPN						
1. Direct Care	1,091,352	42,181				
2. Administrative**						
d. Aides and Attendants	2,011,728	137,145				
e. Physical Therapists	492,689	15,328				
f. Speech Therapists	61,940	1,597				
g. Occupational Therapists	364,733	10,069				
h. Recreation Workers	247,908	13,118				
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	264,049	10,152				
n. Marketing						
o. Other (Specify)						
A-13. Total Salary Expenditures	7,617,223	358,662				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

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

Schedule of Physician: Other Fees (Page 13)

Service	$ CCNH	Hours CCNH	$ RHNS	Hours RHNS	$ (Specify)	Hours (Specify)
Medical Staff Meetings	$ 150	1				
Total	$ 150	1	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

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

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Not Applicable										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
Not Applicable										

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

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

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

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Dane Walton (10/1/2014-5/29/2015)	76,454			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	1,552	A2			
Erica Roman (5/30/2015-9/30/2015)	42,150			Health & life insurances, Payroll Taxes	Day to day operations of the nursing home facility.	702	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**		**9/30/2015**		13	37
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	29,861	814				
2. Dentist	15,747	79				
3. Pharmacist	10,787	156				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	128,080	2,185				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	36,000	190				
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)						
See Attached Schedule	150	1				
9. Speech Therapist						
a. Resident Care	301	1				
b. Other						
10. Occupational Therapist						
a. Resident Care	4,254					
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***	12,293	24				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	237,473	3,450				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	**2183C**	**9/30/2015**	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
St Vincent's Medical Center 2800 Main St Bridgeport CT 06606	Physician Services	☐	☑	
Talent Achievement Group, 23945 Calabasa Rd, Suite 114, Calabasas, CA 91302	Nurse placement fee	☐	☑	
Access Therapies, PO Box 823461, Philadelphia, PA 19182	Physical Therapy Staff	☐	☑	
Omnicare/Value Health Care Services, Inc 525 Knotter Drive Cheshire, CT 06410	Pharmacy Services	☐	☑	
SDX Dysphagia Experts, 21 Waterville Rd, Avon, CT 06001	Speech therapy	☐	☑	
Athena Health Care Systems 135 South Road, Farmington, CT 06032	MDS fill-in	☑	☐	Common Owners
Dr. Adrian Klufas, 3715 Main Street, Bridgeport, CT 06606	Medical Staff	☐	☑	
HealthDrive Dental Practices, 1 Prestige Dr., Meriden, CT 06450	Dentist	☐	☑	
Dr. Vasudha Vallabhneni, 3180 Main St., Bridgeport, CT 06606	Medical Director	☐	☑	
Margaret Rose 217 Hickory St Bridgeport CT 06610	Dietician	☐	☑	
Pinnacle Rehab, PO Box 8317, Clearwater, FLA	Occupational therapy	☐	☑	
Advanced Payroll Funding d/b/a Rehability Care, PO Box 823461, Philadelphia, PA 19182-3461	Physical Therapy	☐	☑	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

* 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**	**9/30/2015**	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation.....	$	368,096	368,096		
2. Disability Insurance.....	$				
3. Unemployment Insurance.....	$	163,240	163,240		
4. Social Security (F.I.C.A.).....	$	567,678	567,678		
5. Health Insurance.....	$	1,087,266	1,087,266		
6. Life Insurance (employees only)					
(not-owners and not-operators).....	$				
7. Pensions (Non-Discriminatory)	$	32,530	32,530		
(not-owners and not-operators).....					
8. Uniform Allowance.....	$				
9. Other (*Specify*).....	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*.....	$	149,419	149,419		
d. Accounting and Auditing.....	$	18,562	18,562		
e. Legal (*Services should be fully described on Page 7)*	$	94,101	94,101		
f. Insurance on Lives of Owners and Operators (*Specify*)*.....	$				
g. Office Supplies.....	$	64,718	64,718		
h. Telephone and Cellular Phones.....					
1. Telephone & Pagers.....	$	43,683	43,683		
2. Cellular Phones.....	$	4,591	4,591		
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	$	946,257	946,257		
Subtotal	$	3,540,141	3,540,141		

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

(Carry Subtotals forward to next page)

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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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**	**9/30/2015**	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		3,540,141	3,540,141		
l. Travel and Entertainment					
1. Resident Travel and Entertainment.....	$				
2. Holiday Parties for Staff.....	$	9,599	9,599		
3. Gifts to Staff and Residents.....	$	25,890	25,890		
4. Employee Travel.....	$	4,386	4,386		
5. Education Expenses Related to Seminars and Conventions	$	7,312	7,312		
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*).....	$	2,550	2,550		
2. Advertising Telephone Directory (*all such expenses*)***	$	1,214	1,214		
3. Advertising Other (*Specify*)***..... See Attached Schedule	$	29,730	29,730		
4. Fund-Raising***.....	$				
5. Medical Records.....	$	(124)	(124)		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***.....	$				
7. Postage.....	$	9,407	9,407		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	9,843	9,843		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions.....	$	512	512		
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**.....	$	479,709	479,709		
13. Other (*Specify*) See Attached Schedule	$	151,788	151,788		
C-14 Total Administrative & General Expenditures	$	4,271,957	4,271,957		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	$ 29,730		
Total Other Advertising	$ 29,730	$ -	$ -

Schedule of Dues

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

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Lobbying Fees	$ 4,856		
Employee Physicals & background checks	$ 18,580		
Bank Fees	$ 6,960		
Payroll Processing Fees	$ 25,149		
Data Processing Fees	$ 34,807		
Licenses	$ 1,361		
Medicaid Applications	$ 8,750		
compliance consulting	$ 51,325		
Total Other Administrative and General	$ 151,788	$ -	$ -

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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 #
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	$656,946	Contract Attached to a Prior Year	See Below
Allocation of the Above	$433,584 $105,111 $118,250	Admin/Gen 66% Indirect 16% Direct 18%	Pg 16, Line 12 Pg 18, Line 2C Pg 20, Line 5J
Athena Health Care Assoc., Inc 135 South Road Farmington, CT 06032	$46,124	Admin/Gen - Other Expense	Pg 16, Line 12

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

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C. Expenditures Other Than Salaries (cont'd) - Dietary Basis for Allocation of Costs

(See Note on Page 5)

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	**2183C**	**9/30/2015**	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food.....	$	306,056	306,056		
2. Non-Food Supplies.....	$	51,478	51,478		
3. Other (*Specify*)_____	$	583	583		
Dishes = $583					
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**.....	$	105,111	105,111		
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	463,228	463,228		
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*		418	418		
H. Is cost of employee meals included in 2E?		☑ Yes	☐ No		
I. Did you receive revenue from employees?		☐ Yes	☑ No	If yes, specify amount.	
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?		☑ Yes	☐ No	If yes, specify cost. = $2820	
L. Is any revenue collected from these people?		☐ Yes	☑ No	If yes, specify amount.	
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?		☐ Yes	☑ No	If yes, specify cost.	
O. Is any revenue collected from employees?		☐ Yes	☑ No	If yes, specify amount.	
P. 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.

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

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CSP-19 Rev. 9/2002

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**	**9/30/2015**	19 | 37

Item		Total	CCNH	RHNS	(Specify)
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. $	15,687	15,687		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**.....	$				
d. Other (*Specify*) **Supplies = $8,693**	$	8,693	8,693		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	24,380	24,380		

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

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

*** 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**	**9/30/2015**	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	43,393	43,393		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$				
c. Management Services*.....		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)....		$	43,393	43,393		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy.....		$				
2. Purchased from **Omni Care**		$	416,737	416,737		
b. Medicine Cabinet Drugs.....		$	24,020	24,020		
c. Medical and Therapeutic Supplies.....		$	335,713	335,713		
d. Ambulance/Limousine***.....		$	2,178	2,178		
e. Oxygen						
1. For Emergency Use.....		$				
2. Other***.....		$	45,040	45,040		
f. X-rays and Related Radiological Procedures***.....		$	11,718	11,718		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***.....		$	18,931	18,931		
i. Recreation.....		$	14,449	14,449		
j. Other (Specify)**** See Attached Schedule		$	180,585	180,585		
5K. ***Total Resident Care Expenditures*** (5a - 5j).....		$	1,049,371	1,049,371		

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

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Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Management Fee Direct	$ 118,250		
Medical Equip Rentals-Medicaid	$ 5,374		
Physical Therapy Supplies	$ 41,341		
Occupational Therapy Supplies	$ 229		
Oxygen Concentrator Rentals	$ 4,113		
Cable TV Fees	$ 9,897		
Medical Equip Rentals-Other	$ 1,381		
Total Other Resident Care	$ 180,585	$ -	$ -

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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)	Pg	Line
ADP	Hartford Region, Richmond, VA	☐	☑		Payroll Services	21,640			16	m13
CWPM	25 Norton Place, PO Box 415, Plainville, CT 06062	☐	☑		Rubbish Removal	28,966			22	6f
Omnicare/Value Health Care	525 Knotter Drive Cheshire, CT 06410	☐	☑		Pharmacy	446,525			20	5
Parziale Landscaping	1800 Huntington Rd, Stratford, CT 06614	☐	☑		Landscaping and Snow removal	14,384			22	6f
Harmony Health Care	430 Boston St.STE 104, Topsfield, MA 01983	☐	☑		Compliance consulting	31,325			16	m13
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							
		☐	☐							

* 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**	**9/30/2015**			22 | 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	86,969	86,969		
b. Heat	$	78,950	78,950		
c. Light & Power	$	172,523	172,523		
d. Water	$	101,606	101,606		
e. Equipment Lease (*Provide detail on page 6*)	$	28,927	28,927		
f. Other (*itemize*)	$	84,365	84,365		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	553,340	553,340		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	1,225	1,225		
b. Building & Building Improvements	$	109,376	109,376		
c. Non-Movable Equipment	$	116,324	116,324		
d. Movable Equipment	$	91,276	91,276		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	318,201	318,201		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$	5,084	5,084		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	5,084	5,084		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	732,165	732,165		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	232,526	232,526		
c. Personal property taxes	$	28,562	28,562		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,316,538	1,316,538		

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

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Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Groundskeeping	$ 9,681		
Rubbish Removal	$ 28,966		
Snow Removal	$ 13,007		
Supplies	$ 32,711		
Total Other Repairs and Maintenance	$ 84,365	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	2183C	9/30/2015	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	78,891		78,891	77,779	S/L	Various	537	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	20,632		20,632		S/L	Various	688	
A-4. Subtotal								1,225
B. **Building and Building Improvements**								
1. Acquired prior to this report period	2,141,554		2,141,554	1,365,204	S/L	Various	109,375	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								109,375
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	860,838		860,838	403,422	S/L	Various	112,792	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	35,320		35,320		S/L	Various	3,532	
C-4. Subtotal								116,324

	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	2014	1,319,033		1,319,033	865,396	S/L	Various	87,038	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)			9	2015	62,978		62,978		S/L	Various	4,238	
D-3. Subtotal												91,276
E. *Total Depreciation*												318,200

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Feb-15	concrete work	$ 20,632	15	$ 688	
Total additions for Land Improvements		$ 20,632		$ 688	*
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:					
various	generator design work	$ 14,320	5	$ 1,432	
various	generator electrical work	$ 21,000	5	$ 2,100	
Total additions for Non-Movable Equipment		$ 35,320		$ 3,532	*
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	Cost	Useful Life	Depreciation	
Additions:					
Oct-14	Dryer assembly	$ 3,901	10	$ 194	
Oct-14	42" TV w/wall mount	$ 871	5	$ 87	
Nov-14	Blender/mixer	$ 1,797	10	$ 90	
Dec-14	Wound Vac	$ 18,888	10	$ 944	
Jan-15	overbed tables	$ 6,269	15	$ 209	
Feb-15	laptop	$ 534	3	$ 89	
Apr-15	mattresses	$ 3,636	5	$ 364	
Apr-15	32" TV w/wall mounts	$ 2,206	5	$ 221	
May-15	32" TV w/wall mounts	$ 2,206	5	$ 221	
Jun-15	mattresses	$ 1,620	5	$ 162	
Aug-15	32" TV w/wall mounts	$ 2,206	5	$ 221	
Jul-15	electric range	$ 550	10	$ 28	
Oct-14	computer conversion	$ 904	3	$ 151	
Sep-15	Dryer assembly	$ 6,045	10	$ 302	
Sep-15	40" tv	$ 1,066	5	$ 107	
Sep-15	ice maker	$ 3,814	10	$ 191	
Sep-15	laptop	$ 586	3	$ 98	
Sep-15	computer conversion	$ 1,245	3	$ 208	
Sep-15	computer conversion	$ 1,050	3	$ 175	
Sep-15	office chairs	$ 3,584	10	$ 179	
Total additions for Movable Equipment		$ 62,978		$ 4,238	*
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:					
Total additions for Leasehold Improvements		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvements		$ -		$ -	**

*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**	**9/30/2015**	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**	3	2012		27,509	27,509				
3. **Finance Fees-Key Bank**	6	2007	5 yrs	247,750	247,750	SL	0		
B-4. Subtotal									
C. **Leasehold Improvements and Other** (Specify)									
1. Acquired prior to this report period	9	2014	Various	1,612,549	714,408	SL	Var	5,083	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	9	2015	Various				Var		
C-4. Subtotal									5,083
D. ***Total Amortization***									5,083

* 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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Supplemental Page

Amortization Schedule - Detail of Leasehold Improvements & Other

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	**2183C**	**9/30/2015**	24A	37

C. **Leasehold Improvements** (Specify)									
1. Acquired prior to this report period	9	2014	Various	61,565	6,214	SL	Vario	5,083	
2. Disposals (attach schedule)									
3. Acquired during this report period	9	2015							
C-4. Subtotal.....									5,083
C. **Other** (Specify)									
1. Bed License Purchase	9	1997	None	525,000	237,708	None			
2. Goodwill	9	1997	None	1,025,984	470,486	None			
C-4. Subtotal.....									
Total Acquired prior to this report period	9	2014	Various	1,612,549	714,408	SL	Var	5,083	
Total Disposals									
Total Acquired during this report period	9	2015	Various				Var		

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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	9/30/2015	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	03/29/12			
c. Interest Rate for the Cost Year	3.22%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	8,800,000			
f. Principal balance outstanding as of 9/30/2015	8,170,719			
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**	**9/30/2015**			26 | 37
Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage.....	$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage.....	$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage.....	$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage.....	$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount.....	$				
2. Loan Origination Date.....					
3. Interest Rate %.....					
4. Term.....					
5. CHEFA Interest Expense.....					
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)	$				

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	**2183C**	**9/30/2015**	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment..... $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*)..... $	7,796	7,796		
A. Item **Generator** / Rate / Amount -				
Lender **Webster Capital Finance**				
Address of Lender **5 FarmGlen Blvd Farmington, CT**				
B. Item / Rate / Amount -				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)..... $	7,796	7,796		
12. D. Other Interest Expense (*Specify*)..... $	120,203	120,203		
Vender Interest = $18,259; Key Bank Term Loan Int & Fees = $43,075; Key Bank Line of Credit = $58,869				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D).....$	127,999	127,999		
14. Insurance				
a. Insurance on Property (buildings only)..... $	103,101	103,101		
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)... $	103,101	103,101		
15. ***Total All Expenditures (A-13 thru C-14)*****.....** $	15,808,003	15,808,003		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2015	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs..... $				
2.			Salaries not related to Resident Care.... $				
3.	10	A12g	Occupational Therapy..... $	364,733	364,733		
4.	Var	Var	Other - See attached Schedule..... $	3,582	3,582		
Page 13 - Professional Fees							
5.			Resident Care Physicians **..... $				
6.	13	B10a	Occupational Therapy..... $	4,254	4,254		
7.			Other - See attached Schedule..... $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits..... $				
9.	15	1c	Bad Debts..... $	149,419	149,419		
10.	15	1d&e	Accounting & Legal..... $	97,790	97,790		
11.			Telephone..... $				
12.	15	1h2	Cellular Telephone..... $	3,871	3,871		
13.			Life insurance premiums on the life of Owners, Partners, Operators..... $				
14.	16	13	Gifts, flowers and coffee shops..... $	25,890	25,890		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees..... $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative.... $				
17.			Automobile Expense (e.g. personal use). $				
18.	16	m2&3	Unallowable Advertising *..... $	30,944	30,944		
19.			Income Tax / Corporate Business Tax... $				
20.			Fund Raising / Contributions..... $				
21.	16	m12	Unallowable Management Fees..... $	271,200	271,200		
	18	2e	$	65,746	65,746		
	20	5j	$	73,964	73,964		
22.			Barber and Beauty..... $				
23.	Var	Var	Other - See attached Schedule..... $	71,891	71,891		
Page 18 - Dietary Expenditures							
24.	18	2a1	Meals to employees, guests and others who are not residents..... $	2,820	2,820		
Page 19 - Laundry Expenditures							
25.	19	3d	Laundry services to employees, guests and others who are not residents..... $				
Page 20 - Housekeeping Expenditures							
26.	20	4d	Housekeeping services to employees and others who are not residents..... $				
			Subtotal (Items 1 - 26) $	1,166,104	1,166,104		

(Carry Subtotal forward to next page)

* All except "Help Wanted".

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	A4	Marketing Salaries & Benefits	3,582		
Total Other Salaries Adjustment			$ 3,582	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Charges	6,960		
16	M13	Lobbying Fees	4,856		
16	M13	Medicaid Applications	8,750		
16	M13	Compliance Consulting	51,325		
Total Other A&G Adjustments			$ 71,891	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	**2183C**	**9/30/2015**	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	1,166,104	1,166,104		
Page 20 - Resident Care Supplies***							
27.	20	5a1&2	Prescription Drugs..... $	416,737	416,737		
28.	20	5d	Ambulance/Limousine..... $	2,178	2,178		
29.	20	5f	X-rays, etc..... $	11,718	11,718		
30.	20	5h	Laboratory..... $	18,931	18,931		
31.	20	5c	Medical Supplies..... $	19,297	19,297		
32.	20	5e2	Oxygen (non emergency)..... $	45,040	45,040		
33.	20	5j	Occupational Therapy..... $	229	229		
34.	Var	Var	Other - See Attached Schedule..... $	1,381	1,381		
Page 22 - Maintenance and Property							
35.	Var	Var	Excess Movable Equipment Depreciation See Attached Schedule..... $	4,409	4,409		
36.			Depreciation on Unallowable Motor Vehicles..... $				
37.			Unallowable Property and Real Estate Taxes..... $				
38.			Rental of Building Space or Rooms..... $				
39.			Other - See Attached Schedule..... $				
Page 27 - Insurance							
40.			Mortgage Insurance..... $				
41.			Property Insurance..... $				
Other - Miscellaneous							
42.			Research or Experimental Activities..... $				
43.	20	5j	Radio and Television Revenue..... $	6,297	6,297		
44.			Vending Machine Revenue..... $				
45.			Purchase Discounts and Allowances..... $				
46.			Duplications of functions or services.... $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest..... $				
48.	30	IV5	Interest Income on Accounts Rec..... $	175	175		
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule..... $				
Not For Profit Providers Only							
50.	Var	Var	Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule..... $				
51.			***Total Amount of Decrease (Items 1 - 50)*** ..... $	1,692,496	1,692,496		

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equip Rental	1,381		
Total Other Ancillary Costs			$ 1,381	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	7d	Move Equipment Depreciation Carryforward AJE	4,409		
Total Excess Movable Equipment Depreciation			4,409		

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

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

Northbridge Healthcare Center
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Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Northbridge Healthcare Center	2183C	9/30/2015	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	19,076,712	19,076,712		
b. Medicaid Room and Board Contractual Allowance **	$	(8,063,076)	(8,063,076)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents (*all inclusive*)	$	1,780,387	1,780,387		
b. Medicare Room and Board Contractual Allowance **	$	555,861	555,861		
4. a. Private-Pay Residents and Other	$	1,865,764	1,842,594	23,170	
b. Private-Pay Room and Board Contractual Allowance **	$	(51,124)	(51,124)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	238,188	238,188		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(238,188)	(238,188)		
c. Prescription Drugs - Non-Medicare	$	184,743	184,743		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(184,743)	(184,743)		
2. a. Medical Supplies - Medicare	$	4,797	4,797		
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	793,378	793,378		
b. Physical Therapy - Medicare Contractual Allowance **	$	(633,390)	(633,390)		
c. Physical Therapy - Non-Medicare	$	493,412	493,412		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(493,412)	(493,412)		
4. a. Speech Therapy - Medicare	$	113,058	113,058		
b. Speech Therapy - Medicare Contractual Allowance **	$	(83,520)	(83,520)		
c. Speech Therapy - Non-Medicare	$	113,492	113,492		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(113,492)	(113,492)		
5. a. Occupational Therapy - Medicare	$	683,815	683,815		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(584,131)	(584,131)		
c. Occupational Therapy - Non-Medicare	$	497,473	497,473		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(497,473)	(497,473)		
6. a. Other (*Specify*) - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$	7,658	7,658		
III *Total Resident Revenue* (Section I.thru Section II.)	$	15,466,189	15,443,019	23,170	
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)*	$	175	175		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	222	222		
8. Other (*Specify*)	$	8,775	8,775		
V. Total Other Revenue (1 thru 8)	$	9,172	9,172		
VI. Total All Revenue (III + V)	$	15,475,361	15,452,191	23,170	

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

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

Schedule of Other Resident Revenue - Medicare

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp Page Ref	Description	CCNH	RHNS	(Specify)
N/A	Retroactives	$ 7,658		
Total Other Resident Revenue		$ 7,658	$ -	$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
Pg 31, Ln A2	Interest on Accts Rec	N/A	$ 175		
Total Interest Income			$ 175	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
n/a	Bad Debt Recoveries	$ 8,775		
Total Other Revenue		$ 8,775	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	**2183C**	**9/30/2015**	31	37

Account			Amount
Assets			
A. Current Assets			
1. Cash (*on hand and in banks*)			$ 101,425
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			$ 1,409,333
3. Other Accounts Receivable (Excluding Owners or Related Parties)			$
4 Inventories			$ 34,906
5. Prepaid Expenses			$ 134,793
a. Prepaid Insurance		134,793	
b.			
c.			
d.			
6. Interest Receivable			$
7. Medicare Final Settlement Receivable			$
8. Other Current Assets (*itemize*)			$ 268,314
A/R Related Party Facilities		268,314	
A-9. ***Total Current Assets*** (Lines A1 thru 8)			$ 1,948,771
B. Fixed Assets			
1. Land			$
2. Land Improvements	*Historical Cost	99,523	$ 20,519
	Accd. Depreciation	(79,004) Net	
3. Buildings	*Historical Cost	2,141,550	$ 666,975
	Accd. Depreciation	(1,474,575) Net	
4. Leasehold Improvements	*Historical Cost	61,565	$ 50,268
	Accd. Depreciation	(11,297) Net	
5. Non-Movable Equipment	*Historical Cost	896,157	$ 376,412
	Accd. Depreciation	(519,745) Net	
6. Movable Equipment	*Historical Cost	1,360,875	$ 404,204
	Accd. Depreciation	(956,671) Net	
7. Motor Vehicles	*Historical Cost		$
	Accd. Depreciation	Net	
8. Minor Equipment-Not Depreciable			$
9. Other Fixed Assets (*itemize*)			$ 21,136
Equipment Carry Forward Adjustment		21,136	
		-	
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)			$ 1,539,514

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

(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**	**9/30/2015**	32	37

Account			Amount
		Total Brought Forward:	$ 3,488,285
C. Leasehold or like property recorded for Equity Purposes.			
1. Land			$ 393,226
2. Land Improvements	*Historical Cost.....		
	Accd. Depreciation	Net.....	$
3. Buildings	*Historical Cost.....	6,999,069	
	Accd. Depreciation	(4,403,579) Net.....	$ 2,595,490
4. Non-Movable Equipment	*Historical Cost.....		
	Accd. Depreciation	Net.....	$
5. Movable Equipment	*Historical Cost.....		
	Accd. Depreciation	Net.....	$
6. Motor Vehicles	*Historical Cost.....		
	Accd. Depreciation	Net.....	$
7. Minor Equipment-Not Depreciable			$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)			$ 2,988,716
D. Investment and Other Assets			
1. Deferred Deposits			$
2. Escrow Deposits			$
3. Organization Expense	*Historical Cost.....		
	Accd. Depreciation	Net.....	$
4. Goodwill (Purchased Only)			$ 625,498
5. Investments Related to Resident Care (*itemize*)			$
6. Loans to Owners or Related Parties (*itemize*)			$ (4,301,880)
Name and Address	Amount	Loan Date	
Investments-Related Party	(4,469,880)		
Loan Receivable-Shareholders	168,000		
7. Other Assets (*itemize*)			$ 198,776
Project Development	16,484		
Bed License Intangible	182,292		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$ (3,477,606)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ 2,999,395

* 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**	**9/30/2015**	33	37

Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				$ 990,154
2. Notes Payable (*itemize*)				$ 1,240,845
Due to Related Parties			30,000	
Key Bank Line of Credit			1,210,845	
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*)				$ 265,369
5. Accrued Payroll (*Owners and/or Stockholders only*)				$
6. Accrued Payroll Taxes Payable				$ 7,910
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*)				$ 6,323
11. Accrued Income Taxes*				$
12. Other Current Liabilities (*itemize*)				$ 266,996
Acc'd Operating Expenses			27,161	
Acc'd Expense - Sales Tax			2,036	
Provider Tax Due			237,799	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)				$ 2,777,597

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

(Carry Total forward to next page)

** Interest Bearing - Do Not Include in Return on Equity Calculation.

Northbridge Health Care
accd expenses
9/30/2015

9/30/2015		$14,000.00	audit accrual
9/30/2015	$	35,806.65	IBNR
9/30/2015		($2,964.89)	food rebate check
9/30/2015		$13,102.37	nursing supplies
9/30/2015		($189.18)	nursing supplies
9/30/2015		($32,593.68)	mgmt fee adjmt
		$27,161.27	

gl =	27161.27
diff	$0.00

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Northbridge Healthcare Center	**2183C**	**9/30/2015**	34	37

Account	Amount
Total Brought Forward:	2,777,597
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$ 195,647

Name of Lender	Purpose	Amount	Date Due
Webster Finance-generator	**Generator**	**195,647**	

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$ 76,873

Name and Address of Lender	Amount	Loan Date
Related Party	**76,873**	**03/29/12**

4. Other Long-Term Liabilities (*itemize*)		$ (152)
Key Bank Term Loan	**362,161**	
Related Party Notes	**(362,313)**	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 272,368
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 3,049,965

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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**	**9/30/2015**	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		$ 2,595,490
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		$ 2,988,716
B. **Net Worth**		
1. Owner's Capital		$
2. Capital Stock		$ 1,000
3. Paid-in Surplus		$ 250,455
4. Treasury Stock		$
5. Cumulated Earnings		$ (2,958,099)
6. Gain or Loss for Period	10/1/2014 thru 9/30/2015	$ (332,642)
7. Total Net Worth		$ (3,039,286)
C. ***Total Reserves and Net Worth***		$ (50,570)
D. ***Total Liabilities, Reserves, and Net Worth***		$ 2,999,395

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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**	**9/30/2015**	36	37

	Account		Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014		$ (2,431,110)
B.	Total Revenue (*From Statement of Revenue Page 30*)		$ 15,475,361
C.	Total Expenditures (*From Statement of Expenditures Page 27*)		$ 15,808,003
D.	Net Income or Deficit		$ (332,642)
E.	Balance		$ (2,763,752)
F.	Additions		
	1. Additional Capital Contributed (*itemize*)		
	SWAP Value Net Change	**680**	
		(285,045)	
	FF&E Adjustment 2015 conversion	**8,831**	
	2. Other (*itemize*)		
F-3.	Total Additions		$ (275,534)
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*** 09/30/15		$ (3,039,286)

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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**	**9/30/2015**	37	37

Check appropriate category		
CCNH	RHNS	Other (*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 appplicable 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
	CFO	2/12/16

Printed Name of Preparer

Athena Health Care Associates, Inc

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

Cost report forms generated by Athena Health Care Associates, Inc as approved in letter dated 12/11/13.