State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed) Health Care Assurance, LLC d/b/a Douglas Manor		
Address (No. & Street, City, State, Zip Code) 103 North Road Windham, CT 06280		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	693-C			07-5291

Medicaid Provider Numbers:	CCNH	RHNS	ICF-MR

For Department Use Only

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

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General Information

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Health Care Assurance, LLC d/b/a Douglas Manor	693-C	9/30/2015	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 Health Care Assurance, LLC d/b/a Douglas Manor [facility name], for the cost report period beginning October 1, 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 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) James Lopez			Printed Name (Owner) Benjamin Z. Fischman	
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
25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Health Care Assurance, LLC d/b/a Douglas Manor	Period Covered:		From 10/1/2014	To 9/30/2015
Address of Facility 103 North Road Windham, CT 06280				
Report Prepared By Douglas Manor	Phone Number 203-250-2030		Date	

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
860-423-4636	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Health Care Assurance, LLC d/b/a Douglas Manor	103 North Road Windham, CT 06280

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	693-C			07-5291

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.:
James Lopez	1047

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

Name	License No.:

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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
Health Care Assurance, LLC d/b/a Douglas M	693-C	9/30/2015	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
Health Care Assurance, LLC d/b/a Douglas Manor	103 North Road Windham, CT 06280	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Benjamin Fischman		Managing Memb	56%
Samuel Strasser		Member	6%
Names of Stockholders Owning at Least 10% of Shares			
Benjamin Fischman		Managing Memb	56%
Samuel Strasser		Member	6%
Toby Hersh		Member	16%
Chow Ju-Fa Chen		Member	16%

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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

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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	%**				
Benjamin Fischman, Affinity Health Care Mgt	221 East 33rd St New York , NY 10016	○	⊙		Management of Operations	Pg 16 Line m.11	286,438	286,438
Benjamin Fischman, Affinity Health Care Mgt	221 East 33rd St New York , NY 10016	○	⊙		Consolidated Pension-NonUnion	Pg 15 Line 7	N/A	N/A
Joseph Grun & Harold Rubin, Gerimedix	3741 Ocean Ave Brooklyn, NY 11224	⊙	○	99%	Medicaid Supplies	Various	198,762	Unknown
Assurance Health Care Assoc, LLC	1781 Highland Ave Cheshire, CT 06410	○	⊙		Real estate	Pg 22 Line 9	550,696	550,696
Alexandria, Blair and Ellis Manor		○	⊙		None	N/A	N/A	N/A
		○	⊙					
		○	○					
		○	○					
		○	○					

* 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
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
Citicorp/Advanced Copy	○	⊙	Copy Machine	05/15/97	monthly	7,225	7,225
Pitney Bowes	○	⊙	Postage Machine	05/29/97	monthly	3,593	3,593
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 10,818

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

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General Information and Questionnaire
Accounting Basis

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Genovese & Wonneberger, LLC	Cheshire, CT
2	
3 Whittlesey and Hadley PC	Hartford CT
4	

Services Provided by This Firm (*describe fully*)

1	Monthly Accounting / Financial Management	$ 48,185
2		$
3	HUD Audit	$ 9,400
4		$
		Charge for Services Provided $ 57,585

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

⊙ Yes ○ No — Pg 15, Line 1.d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 See Attached Page 7A	
2	
3	
4	
5	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	See Attached Page 7A	$ 76,703
2		$
3		$
4		$
5		$
		Charge for Services Provided $ 76,703

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

⊙ Yes ○ No — Pg 15, Line 1.e

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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	90	90			90	90			90	90		
B. On last day of THIS report period	90	90			90	90			90	90		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	89	89			89	89			81	81		
B. As of midnight of THIS report period	79	79			85	85			79	79		
3. Total Number of Days Care Provided During Period												
A. Medicare	6,125	6,125			4,607	4,607			1,518	1,518		
B. Medicaid (Conn.)	16,125	16,125			12,365	12,365			3,760	3,760		
C. Medicaid (other states)												
D. Private Pay	5,153	5,153			3,757	3,757			1,396	1,396		
E. State SSI for RCH												
F. Other (Specify)	2,640	2,640			2,003	2,003			637	637		
G. Total Care Days During Period (3A thru F)	30,043	30,043			22,732	22,732			7,311	7,311		
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)**	30,043	30,043			22,732	22,732			7,311	7,311		

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Schedule of Resident Statistics (Cont'd)

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

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	18	36		12		13		
Per Diem Rate								
a. One bed rm.	RUGs 772.52	243.81		395.00		390.00		
b. Two bed rms.	RUGs 193.52			370.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	2,081	2,081		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	2,202	2,202		
C. Other	18,692	18,692		
D. ***Total Physical Therapy Treatments***	22,975	22,975		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	414	414		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	61	61		
C. Other	586	586		
D. ***Total Speech Therapy Treatments***	1,061	1,061		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,616	1,616		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	1,668	1,668		
C. Other	16,095	16,095		
D. ***Total Occupational Therapy Treatments***	19,379	19,379		

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Report of Expenditures - Salaries & Wages

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

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	102,087	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	190,146	10,156				
5. Dietary Service						
a. Head Dietitian	15,043	406				
b. Food Service Supervisor	55,998	2,094				
c. Dietary Workers	326,501	22,343				
6. Housekeeping Service						
a. Head Housekeeper	28,662	2,035				
b. Other Housekeeping Workers	188,081	12,777				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	50,382	2,227				
b. Other Maintenance Workers	31,824	1,781				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	94,211	6,155				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	175,089	4,242				
b. RN						
1. Direct Care	573,450	16,087				
2. Administrative**	178,058	5,088				
c. LPN						
1. Direct Care	946,261	33,798				
2. Administrative**						
d. Aides and Attendants	1,238,808	82,734				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	92,031	4,423				
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	69,761	3,271				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	21,670	1,050				
A-13. Total Salary Expenditures	4,378,063	212,753				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
50505062 S & W - NURS MED REC	$ 21,670	1,050				
-	$ -	-				
-	$ -	-				
-	$ -	-				
Total	$ 21,670	1,050	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
54006190 PURCH SERV - IV NURS	$ 2,009	27				
	$ -	-				
-	$ -	-				
-	$ -	-				
Total	$ 2,009	27	$ -	-	$ -	-

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

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Health Care Assurance, LLC d/b/a Douglas Manor	693-C	9/30/2015	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
James Lopez	102,087			Std	Facility Administrator	2,086	A2	None	NA	NA
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
Health Care Assurance, LLC d/b/a Douglas Manor	693-C	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						
2. Dentist						
3. Pharmacist	7,643	102				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	459,929	5,744				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	28,700	286				
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	25,002	333				
b. Other						
10. Occupational Therapist						
a. Resident Care	330,286	4,845				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	2,009	27				
B-13 Total Fees Paid in Lieu of Salaries	853,569	11,337				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
		○	⊙	
Omnicare	Pharmacy, IV	○	⊙	
Foremost Rehab	PT, OT, ST	○	⊙	
Peter Jones MD	Medical Director	○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	○	
		○	○	
		○	○	
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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
Health Care Assurance, LLC d/b/a Douglas Manc	693-C	9/30/2015	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	195,133	195,133		
2. Disability Insurance	$	21,223	21,223		
3. Unemployment Insurance	$	64,825	64,825		
4. Social Security (F.I.C.A.)	$	333,128	333,128		
5. Health Insurance	$	539,914	539,914		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	2,034	2,034		
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	15,974	15,974		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	57,585	57,585		
e. Legal (*Services should be fully described on Page 7)*	$	76,703	76,703		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	27,263	27,263		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	37,033	37,033		
2. Cellular Phones	$	1,505	1,505		
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	$	489,787	489,787		
Subtotal	$	1,862,107	1,862,107		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
	$ -		
70008007 DENTAL INSURANCE	$ 15,974		
Total	$ 15,974	$ -	$ -

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
Health Care Assurance, LLC d/b/a Douglas Manor	693-C	9/30/2015	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,862,107	1,862,107		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$	344	344		
2. Holiday Parties for Staff	$	2,713	2,713		
3. Gifts to Staff and Residents	$	1,380	1,380		
4. Employee Travel	$	278	278		
5. Education Expenses Related to Seminars and Conventions	$	2,445	2,445		
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*)	$	4,983	4,983		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	3,615	3,615		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	1,241	1,241		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	1,534	1,534		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	1,536	1,536		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	1,550	1,550		
10. Contributions*** See Attached Schedule	$				
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	151,273	151,273		
12. Administrative Management Services**	$	286,438	286,438		
13. Other (*Specify*) See Attached Schedule	$	35,077	35,077		
C-14 Total Administrative & General Expenditures	$	2,356,514	2,356,514		

* 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)
ADVERTISING - PROMOTIONAL	$ 106		
80007540 PROMOTIONAL	$ 3,509		
Total Other Advertising	$ 3,615	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	$ -		
CAHCF-Annual Membership Dues	$ 1,536		
	$ -		
-	$ -		
-	$ -		
Total Dues	$ 1,536	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Account Not Used	$ -		
Total Contributions	$ -	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	$ -		
	$ -		
	$ -		
80007450 LICENSES & FEES	$ 2,648		
80007900 BANK SERVICE FEES	$ 233		
-	$ -		
80008550 FINES & PENALTIES	$ 493		
	$ 64		
80007955 PRIOR YEAR EXPENSE	$ 17,062		
90009710 FINES & PENALTIES	$ 14,413		
	$ 164		
-	$ -		
-	$ -		
-	$ -		
Total Other Administrative and General	$ 35,077	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Health Care Assurance, LLC d/b/a Dougla	693-C	9/30/2015	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Affinity Health Care Mgt, Inc	286,438	Oversight of Operations including , Accounting, Purchasing, Human Resources, Payroll and Policy Review	Page 16/M12

*** 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
Health Care Assurance, LLC d/b/a Douglas Manor	693-C	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	213,541	213,541		
2. Non-Food Supplies	$	23,660	23,660		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	237,201	237,201		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	247	247		

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
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.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
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 amt.
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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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
Health Care Assurance, LLC d/b/a Douglas Manor	693-C	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. $	4,263	4,263		
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. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*) Laundry Supplies, Chemicals, Minor equip	$	12,490	12,490		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	16,753	16,753		

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 amt.
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 amt.
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
Health Care Assurance, LLC d/b/a Douglas Ma	693-C	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.	$	54,949	54,949		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	5,222	5,222		
c. Management Services*		$				
d. Other (*Specify*)		$	(753)	(753)		
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	59,418	59,418		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Drugs Charged to Medicare and Contract		$	382,651	382,651		
b. Medicine Cabinet Drugs		$	34,488	34,488		
c. Medical and Therapeutic Supplies		$	53,765	53,765		
d. Ambulance/Limousine***		$	1,114	1,114		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	35,665	35,665		
f. X-rays and Related Radiological Procedures***		$	2,241	2,241		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	49,016	49,016		
i. Recreation		$	10,830	10,830		
j. Other (Specify)**** See Attached Schedule		$	119,659	119,659		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	689,429	689,429		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
	$ -		
51006000 NURSING SUPPLIES	$ 7,546		
51006080 MINOR EQUIPMENT - NSG	$ 7,140		
51006100 NON-CHARGE MED SUPPL	$ 88,416		
51006101 NON-CHARGE MED-ENTNL	$ 295		
51006103 PERSONAL CARE SUPPL	$ 14,231		
	$ -		
RESIDENT ITEMS	$ 1,200		
55006080 MINOR MEDICAL EQUIP	$ 831		
	$ -		
-			
Total Other Resident Care	$ 119,659	$ -	$ -

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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
Health Care Assurance, LLC d/b/a Douglas Manor	693-C	9/30/2015	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
State of Connecticut DSS		○	⊙		Eligibility Worker	29,855			16	m11
ADP		○	⊙		Payroll Processing	22,667			16	m11
Waste Management		○	⊙		Trash Removal	19,479			22	6f
The Corridor Group		○	⊙		AR and Billing	76,122			16	m11
MDI Achieve		○	⊙		Software Maintenance and Support	16,171			16	m11
		○	⊙							
		○	⊙							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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
Health Care Assurance, LLC d/b/a Douglas M	693-C	9/30/2015	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	33,595	33,595		
b. Heat	$	59,863	59,863		
c. Light & Power	$	93,219	93,219		
d. Water	$	5,829	5,829		
e. Equipment Lease (*Provide detail on page 6*)	$	10,818	10,818		
f. Other (*itemize*)	$	65,786	65,786		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	269,110	269,110		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	237,148	237,148		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	5,066	5,066		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	242,214	242,214		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$	27,747	27,747		
b. Mortgage Expense	$				
c. Leasehold Improvements	$	37,547	37,547		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	65,294	65,294		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	550,696	550,696		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	92,614	92,614		
c. Personal property taxes	$	5,262	5,262		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	956,080	956,080		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
63005500 TRASH REMOVAL	$ 19,479		
85005430 CONTRACT SERV - SNOW	$ 7,373		
	$ -		
85005420 CNTRCT SERV MAINT	$ 3,752		
	$ -		
85005435 CNTRCT SRV GENERATOR	$ 2,725		
85005440 CNTRCT SRV ELEVATOR	$ 8,609		
85006050 WATER MAINT TESTING	$ 5,652		
85005445 CONTRACT SERV - ALARM	$ 1,191		
85005451 CONTRACT SERV SPRINK	$ 5,319		
85005452 ONTRCT SRV FIRE PROT	$ 3,156		
	$ -		
85005466 CNTRCT SRV-FAC NET	$ 2,424		
90009220 RENT - OFFSITE STORAG	$ 1,473		
85006550 SATTELITE TV	$ 4,740		
	$ (107)		
	$ -		
Total Other Repairs and Maintenance	$ 65,786	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Health Care Assurance, LLC d/b/a Douglas Manor	693-C	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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	7,021,487		7,021,487	3,015,178			234,931	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	54,318		54,318				2,217	
B-4. Subtotal								237,148
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	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					691,737		691,737	667,013			5,066	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					7,601						380	
D-3. Subtotal												5,446
E. ***Total Depreciation***												242,594

Health Care Assurance, LLC d/b/a Douglas Manor
9/30/2015

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:					
11/28/2014	Boiler repair	$ 7,445	15	$ 414	
11/11/2014	Excavation for Propane tank	$ 2,925	15	$ 179	
1/2/2015	Gas Strains and Clean Boilers	$ 2,857	10	$ 214	
1/23/2015	Parts for Boiler Repair	$ 1,210	10	$ 81	
5/26/2015	New Boiler	$ 39,881	10	$ 1,329	
Total additions for Building Improvements		$ 54,318		$ 2,217	*
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	Cost	Useful Life	Depreciation	
Additions:					
3/31/2014	Door Alarm System	$ 7,601	10	$ 380	
Total additions for Movable Equipment		$ 7,601		$ 380	*
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 Improvement		$ -		$ -	*
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
Health Care Assurance, LLC d/b/a Douglas Manor	693-C	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. Deferred Acquisitions			20	45,924	39,991			2,296	
2. Deferred Financing Costs				763,954	324,503			25,451	
3.									
A-4. Subtotal									27,747
B. **Mortgage Expense**									
1.									
2. Deferred Financing Costs-Working C	10	2006	22 month	13,610	13,610	SL			
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period				1,126,389	490,603			37,547	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									37,547
D. ***Total Amortization***									65,294

* 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
Health Care Assurance, LLC d/b/a Do	693-C	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	5/15/97
2. Date Structure Completed	12/10/2001
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	05/15/97
5. Total Licensed Bed Capacity	90
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

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 Fixed			
b. Date Mortgage Obtained	10/2002			
c. Interest Rate for the Cost Year	4.38%			
d. Term of Mortgage (number of years)	40			
e. Amount of Principal Borrowed	9,638,600			
f. Principal balance outstanding as of _____				
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
Health Care Assurance, LLC d/b/a Dc	693-C	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
Health Care Assurance, LLC d/b/a	693-C	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*) $				
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*) $	110,928	110,928		
See Attachment Page 27A				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	110,928	110,928		
14. Insurance				
a. Insurance on Property (buildings only) $				
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	18,329	18,329		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $	45,231	45,231		
See Attachment Page 27A				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	63,560	63,560		
15. ***Total All Expenditures (A-13 thru C-14)*** $	9,990,625	9,990,625		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Health Care Assurance, LLC d/b/a Douglas Manor	693-C	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.			Occupational Therapy $				
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $	330,286	330,286		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.			Accounting & Legal $	77,817	77,817		
11.			Telephone $				
12.			Cellular Telephone $	785	785		
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
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.			Unallowable Advertising * $	3,615	3,615		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $	35,052	35,052		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	63,613	63,613		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	511,168	511,168		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

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

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)
		80007400 DUES - A&G	$ (2,303)		
		80007520 EMPLOYEE PARTY	$ 395		
		80007521 OFFICE MEALS	$ 2,318		
		80007530 EMPLOYEE GIFTS	$ 1,380		
		80008550 FINES & PENALTIES	$ 493		
		80007955 PRIOR YEAR EXPENSE	$ 17,062		
		85005468 CNTRCT SRV ELIG WORK	$ 29,855		
		90009710 FINES & PENALTIES	$ 14,413		
		-	$ -		
		-	$ -		
		-	$ -		
		-	$ -		
Total Other A&G Adjustments			$ 63,613	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Health Care Assurance, LLC d/b/a Douglas Manor	693-C	9/30/2015	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	511,168	511,168		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $	382,651	382,651		
28.			Ambulance/Limousine $				
29.			X-rays, etc $	2,241	2,241		
30.			Laboratory $	34,154	34,154		
31.			Medical Supplies $	9,540	9,540		
32.			Oxygen (non emergency) $	35,385	35,385		
33.			Occupational Therapy $	1,893	1,893		
34.			Other - See Attached Schedule $	30,915	30,915		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
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.			Radio and Television Revenue $				
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.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $	5,928	5,928		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			***Total Amount of Decrease (Items 1 - 50)*** $	1,013,875	1,013,875		

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

Attachment Page 29

Health Care Assurance, LLC d/b/a Douglas Manor
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		54605346 P.S. CONSOL BILLING A	$ 16,684		
			$ -		
			$ -		
		51006103 PERSONAL CARE SUPPL	$ 14,231		
		-	$ -		
		-	$ -		
		-	$ -		
		-	$ -		
		-	$ -		
Total Other Ancillary Costs			$ 30,915	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

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)
		90009700 INTEREST - VENDORS	$ 5,426		
		90009910 INT-FEDERAL/STATE TAX	$ 502		
		-	$ -		
		-	$ -		
Total Other Adjustments			$ 5,928	$ -	$ -

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
Health Care Assurance, LLC d/b/a Dougl	693-C	9/30/2015	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	6,213,766	6,213,766		
b. Medicaid Room and Board Contractual Allowance **	$	(2,352,059)	(2,352,059)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,536,229	2,536,229		
b. Medicare Room and Board Contractual Allowance **	$	686,697	686,697		
4. a. Private-Pay Residents and Other	$	3,050,887	3,050,887		
b. Private-Pay Room and Board Contractual Allowance **	$	(171,074)	(171,074)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	289,351	289,351		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(289,351)	(289,351)		
c. Prescription Drugs - Non-Medicare	$	90,146	90,146		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(88,368)	(88,368)		
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	428,194	428,194		
b. Physical Therapy - Medicare Contractual Allowance **	$	(376,433)	(376,433)		
c. Physical Therapy - Non-Medicare	$	126,385	126,385		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(124,248)	(124,248)		
4. a. Speech Therapy - Medicare	$	64,747	64,747		
b. Speech Therapy - Medicare Contractual Allowance **	$	(41,704)	(41,704)		
c. Speech Therapy - Non-Medicare	$	8,745	8,745		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(8,698)	(8,698)		
5. a. Occupational Therapy - Medicare	$	564,809	564,809		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(509,835)	(509,835)		
c. Occupational Therapy - Non-Medicare	$	124,723	124,723		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(122,519)	(122,519)		
6. a. Other *(Specify)* - Medicare	$	8,568	8,568		
b. Other *(Specify)* - Non-Medicare	$	(1,573)	(1,573)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	10,107,385	10,107,385		
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)*	$	74	74		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	2,413	2,413		
V. Total Other Revenue (1 thru 8)	$	2,487	2,487		
VI. Total All Revenue (III +V)	$	10,109,872	10,109,872		

* *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)
	40604100 REV IIV THERAPY MED A	$ 2,498		
	42004100 REV - X-RAY MEDICARE	$ 593		
	42504100 REV - LAB MEDICARE	$ 8,297		
	47504100 ANCILL ALLOW MED A	$ (2,820)		
	47504150 ANCILL ALLOW - PRT B	$ -		
		$ -		
Total Other Resident Revenue - Medicare		$ 8,568	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	42504050 REV - LAB CONTRACT	$ 2,482		
	40604050 REV - IV THERAPY CONT	$ 3,080		
	47504060 ANCILLARY ALLOW INS1	$ (1,843)		
	42004050 REV - X-RAY CONTRACT	$ 158		
	47504050 ANCILL ALLOW CNT	$ (5,607)		
	47504200 ANCILL ALLOW MDCD	$ -		
	40604000 REV - IV THERAPY PVT	$ 157		
	47504000 ANCILLARY ALLOW PRIV	$ -		
	-			
Total Other Resident Revenue		$ (1,573)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	49004700 INTEREST INCOME		$ 66		
	49004730 INT INCOME - MED A		$ 8		
			$ -		
	-		$ -		
Total Interest Income			$ 74	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	49004600 MISCELLANEOUS REVENUE	$ 2,413		
		$ -		
	-			
Total Other Revenue		$ 2,413	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Health Care Assurance, LLC d/b/a Dou	693-C	9/30/2015	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ (10,320)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,624,741
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 3,792,578
4 Inventories				$ 28,716
5. Prepaid Expenses				$ 177,558
a. SEE PAGE 31A		177,558		
b.				
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (41,527)
12101000 Exchange-BofA Debit c		(3,422)		
12102000 Exchange - Pullman &		19,976		
12100000 EXCHANGE ACCOUNT		(70,623)		
15900000 CONSTRUCTION IN PROGR		12,542		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 5,571,746
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	1,126,389		$ 598,239
	Accum. Depreciation	528,150	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	691,737		$ 19,278
	Accum. Depreciation	672,459	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 617,517

* 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
Health Care Assurance, LLC d/b/a Dou	693-C	9/30/2015	32	37

Account				Amount
		Total Brought Forward:	$	6,189,263
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			$	
2. Land Improvements	*Historical Cost			
	Accum. Depreciation	Net	$	
3. Buildings	*Historical Cost	7,075,805		
	Accum. Depreciation	3,252,326 Net	$	3,823,479
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)			$	3,823,479
D. Investment and Other Assets				
1. Deferred Deposits			$	16,357
2. Escrow Deposits			$	
3. Organization Expense	*Historical Cost	809,460		
	Accum. Depreciation	392,241 Net	$	417,219
4. Goodwill (Purchased Only)			$	
5. Investments Related to Resident Care (*itemize*)			$	
6. Loans to Owners or Related Parties (*itemize*)			$	767,725
Name and Address	Amount	Loan Date		
See Page 32A	767,725			
7. Other Assets (*itemize*)			$	450,077
17000000 DEFERRED ACQUISITION		450,077		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$	1,651,378
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$	11,664,120

* 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
Health Care Assurance, LLC d/b/a Douglas M	693-C	9/30/2015	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
1.	Trade Accounts Payable				$ 2,862,042
2.	Notes Payable (*itemize*)				$ 475,264
	24877000 NOTE PAYABLE - METRO	6,250			
	24877500 NOTE PAYABLE HLTH CAP	414,104			
	24901000 NOTE PAYABLE-OMNICARE	55,357			
	24861000 NOTE PAY-JOHN DEERE	(447)			
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*)				$ 446,815
5.	Accrued Payroll (*Owners and/or Stockholders only*)				$
6.	Accrued Payroll Taxes Payable				$ 325,067
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*)				$ 1,104,472
			22650000 PAYROLL EM	3,917	
	23402500 ACCRUED PROVIDER T	1,072,596	25290000 STATE OF CT		
	24100000 PATIENT REFUND CLE	(132,706)	24800000 LOAN PAYAI	3,165	
	21050000 ACCRUED INTEREST	157,500	24961000 NOTE PAYAI		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 5,213,660

* 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
Health Care Assurance, LLC d/b/a Douglas	693-C	9/30/2015	34	37

Account	Amount
Total Brought Forward:	5,213,660
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*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 5,213,660

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

Name of Facility	License No.	Report for Year Ended	Page	of
Health Care Assurance, LLC d/b/a Do	693-C	9/30/2015	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$ 4,198,990
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	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	$ 4,198,990
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 2,132,223
	6. Gain or Loss for Period 10/1/2014 thru 9/30/2015	$ 119,247
	7. Total Net Worth	$ 2,251,470
C.	***Total Reserves and Net Worth***	$ 6,450,460
D.	***Total Liabilities, Reserves, and Net Worth***	$ 11,664,120

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Health Care Assurance, LLC d/b/a Doug	693-C	9/30/2015	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			$ 2,109,692
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 10,109,872
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 9,990,625
D.	Net Income or Deficit			$ 119,247
E.	Balance			$ 2,228,939
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
	Prior Period Adjustments	22,531		
F-3.	Total Additions			$ 22,531
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		$ 2,251,470

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Health Care Assurance, LLC d/b/a	693-C	9/30/2015	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Affinity Health Care Mgt

Addres Address	Phone Number
1781 Highland Ave Cheshire, CT	203-250-2030