State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

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 10/1/2015	Report for Year Ending 9/30/2016	

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	9/30/2016	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, 2015 and ending September 30, 2016, 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 10/1/2015	To 9/30/2016
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	9/30/2016	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

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	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	9/30/2016	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

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

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

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Benjamin Fischman, Affinity Health Care Mgt	221 East 33rd St New York , NY 10016	○	⊙		Management of Operations	Pg 16 Line m.11	301,829	301,829
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	140,273	Unknown
Assurance Health Care Assoc, LLC	1781 Highland Ave Cheshire, CT 06410	○	⊙		Real estate	Pg 22 Line 9	534,463	534,463
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	1,947	1,947
Pitney Bowes	○	⊙	Postage Machine	05/29/97	monthly	1,661	1,661
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total ***** 3,608

* 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 Wonneberger Business Soultions	Cheshire, CT
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Monthly Accounting / Financial Management	$ 11,840
2		$
3		$
4		$
	Charge for Services Provided	$ 11,840

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	$ 73,650
2		$
3		$
4		$
5		$
	Charge for Services Provided	$ 73,650

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	79	79			79	79			79	79		
B. As of midnight of THIS report period	75	75			75	75			75	75		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,256	5,256			3,629	3,629			1,627	1,627		
B. Medicaid (Conn.)	15,356	15,356			11,436	11,436			3,920	3,920		
C. Medicaid (other states)												
D. Private Pay	5,543	5,543			4,248	4,248			1,295	1,295		
E. State SSI for RCH												
F. Other (Specify)	2,349	2,349			2,066	2,066			283	283		
G. Total Care Days During Period (3A thru F)	28,504	28,504			21,379	21,379			7,125	7,125		
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)**	28,504	28,504			21,379	21,379			7,125	7,125		

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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	17	41		14		3		
Per Diem Rate								
a. One bed rm.	RUGs 772.52	251.59		405.00		390.00		
b. Two bed rms.	RUGs 193.52			385.00				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,983	3,983		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	266	266		
C. Other	17,831	17,831		
D. ***Total Physical Therapy Treatments***	22,080	22,080		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	277	277		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	10	10		
C. Other	1,169	1,169		
D. ***Total Speech Therapy Treatments***	1,456	1,456		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,255	2,255		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	254	254		
C. Other	15,952	15,952		
D. ***Total Occupational Therapy Treatments***	18,461	18,461		

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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)	102,291	2,091				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	225,627	11,072				
5. Dietary Service						
a. Head Dietitian	16,217	414				
b. Food Service Supervisor	51,839	2,101				
c. Dietary Workers	360,275	21,524				
6. Housekeeping Service						
a. Head Housekeeper	22,342	2,122				
b. Other Housekeeping Workers	194,773	11,618				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	46,448	2,135				
b. Other Maintenance Workers	33,403	1,817				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	91,144	5,418				
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	188,548	4,196				
b. RN						
1. Direct Care	550,769	14,560				
2. Administrative**	179,699	4,378				
c. LPN						
1. Direct Care	966,382	33,190				
2. Administrative**						
d. Aides and Attendants	1,170,075	70,416				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	92,993	4,210				
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	55,609	2,686				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	22,015	1,050				
A-13. Total Salary Expenditures	4,370,449	194,998				

* 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**
5050-5062 S & W - NURS MED REC	$ 22,015	1,050				
-	$ -	-				
-	$ -	-				
-	$ -	-				
Total	$ 22,015	1,050	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
5400-6190 PURCH SERV - IV NURS	$ 5,100	68				
	$ -	-				
-	$ -	-				
-	$ -	-				
Total	$ 5,100	68	$ -	-	$ -	-

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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	9/30/2016	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	102,291			Std	Facility Administrator	2,091	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	9/30/2016	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	7,836	104				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	465,330	5,520				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	32,700	272				
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	40,383	538				
b. Other						
10. Occupational Therapist						
a. Resident Care	313,889	4,615				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides	6,638	255				
d. Other						
12. Other (Specify)						
See Attached Schedule	5,100	68				
B-13 Total Fees Paid in Lieu of Salaries	871,876	11,372				

* 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
Health Care Assurance, LLC d/b/a Douglas Manor	693-C	9/30/2016	14	37

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	9/30/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	168,073	168,073		
2. Disability Insurance	$	17,935	17,935		
3. Unemployment Insurance	$	59,392	59,392		
4. Social Security (F.I.C.A.)	$	311,884	311,884		
5. Health Insurance	$	486,880	486,880		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	1,916	1,916		
7. Pensions (Non-Discriminatory)	$	228	228		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	11,927	11,927		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$				
d. Accounting and Auditing	$	11,840	11,840		
e. Legal (*Services should be fully described on Page 7)*	$	73,650	73,650		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	25,358	25,358		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	48,080	48,080		
2. Cellular Phones	$	1,739	1,739		
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	$	477,701	477,701		
Subtotal	$	1,696,603	1,696,603		

* 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)
	$ -		
7000-8007 DENTAL INSURANCE	$ 11,927		
Total	$ 11,927	$ -	$ -

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	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,696,603	1,696,603		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	3,005	3,005		
3. Gifts to Staff and Residents	$	20	20		
4. Employee Travel	$	999	999		
5. Education Expenses Related to Seminars and Conventions	$	1,427	1,427		
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*)	$	718	718		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	1,338	1,338		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	1,176	1,176		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,113	2,113		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	350	350		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	629	629		
10. Contributions***	$				
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	129,839	129,839		
12. Administrative Management Services**	$	301,829	301,829		
13. Other (*Specify*)	$	25,245	25,245		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,165,291	2,165,291		

* 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)
	$ -		
8000-7540 PROMOTIONAL	$ 1,338		
Total Other Advertising	$ 1,338	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	$ -		
CAHCF-Annual Membership Dues	$ 350		
	$ -		
-	$ -		
-	$ -		
Total Dues	$ 350	$ -	$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	$ -		
6200-7450 LICENSE & FEE DIET	$ 400		
7000-8042 EMPLOYEE INQUIRIES	$ 2,136		
8000-7450 LICENSES & FEES	$ 1,787		
8000-7900 BANK SERVICE FEES	$ 513		
-	$ -		
	$ -		
	$ -		
8000-7955 PRIOR YEAR EXPENSE	$ 7,750		
9000-9710 FINES & PENALTIES	$ 12,659		
	$ -		
-	$ -		
-	$ -		
-	$ -		
Total Other Administrative and General	$ 25,245	$ -	$ -

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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 Dougl	693-C	9/30/2016	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	301,829	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	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	203,721	203,721		
2. Non-Food Supplies	$	31,107	31,107		
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)	$	234,828	234,828		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	234	234		

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	9/30/2016	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. $	4,999	4,999		
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	$	15,423	15,423		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	20,422	20,422		

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	9/30/2016	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.	$	48,606	48,606		
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)		$	48,606	48,606		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	384,126	384,126		
Drugs Charged to Medicare and Contract						
b. Medicine Cabinet Drugs		$	28,861	28,861		
c. Medical and Therapeutic Supplies		$	51,231	51,231		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	33,730	33,730		
f. X-rays and Related Radiological Procedures***		$	2,588	2,588		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	48,289	48,289		
i. Recreation		$	6,497	6,497		
j. Other (Specify)****		$	125,508	125,508		
See Attached Schedule						
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	680,830	680,830		

* 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)
	$ -		
5100-6000 NURSING SUPPLIES	$ 9,143		
5100-6080 MINOR EQUIPMENT - NSG	$ 9,522		
5100-6100 NON-CHARGE MED SUPPL	$ 90,703		
5100-6101 NON-CHARGE MED-ENTNL	$ 4,843		
5100-6103 PERSONAL CARE SUPPL	$ 11,297		
	$ -		
	$ -		
	$ -		
	$ -		
-			
Total Other Resident Care	$ 125,508	$ -	$ -

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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	9/30/2016	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	12,867			16	m11
ADP		○	⊙		Payroll Processing	23,086			16	m11
Waste Management		○	⊙		Trash Removal	18,379			22	6f
The Corridor Group		○	⊙		AR and Billing	72,868			16	m11
MDI Achieve		○	⊙		Software Maintenance and Support	15,545			16	m11
Stericycle		○	⊙		Medical Waste Removal	12,150			22	6f
		○	⊙							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Health Care Assurance, LLC d/b/a Douglas M	693-C	9/30/2016	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	19,744	19,744		
b. Heat	$	43,835	43,835		
c. Light & Power	$	97,309	97,309		
d. Water	$	9,176	9,176		
e. Equipment Lease (*Provide detail on page 6*)	$	3,608	3,608		
f. Other (*itemize*)	$	75,876	75,876		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	249,548	249,548		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	243,467	243,467		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	3,130	3,130		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	246,597	246,597		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$	27,747	27,747		
b. Mortgage Expense	$				
c. Leasehold Improvements	$	17,129	17,129		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	44,876	44,876		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	534,463	534,463		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	86,713	86,713		
c. Personal property taxes	$	5,397	5,397		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	918,046	918,046		

* 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)
6300-5500 TRASH REMOVAL	$ 18,379		
8500-5430 CONTRACT SERV - SNOW	$ 1,788		
	$ 12,150		
8500-5420 CNTRCT SERV MAINT	$ 3,750		
	$ 500		
8500-5435 CNTRCT SRV GENERATOR	$ 5,396		
8500-5440 CNTRCT SRV ELEVATOR	$ 8,814		
8500-6050 WATER MAINT TESTING	$ 5,267		
8500-5445 CONTRACT SERV - ALARM	$ 4,477		
8500-5451 CONTRACT SERV SPRINK	$ 3,510		
8500-5452 ONTRCT SRV FIRE PROT	$ 916		
	$ 350		
8500-5466 CNTRCT SRV-FAC NET	$ 2,424		
9000-9220 RENT - OFFSITE STORAG	$ 2,057		
8500-6550 SATTELITE TV	$ 6,558		
8500-6540 CABLE TV	$ (460)		
	$ -		
Total Other Repairs and Maintenance	$ 75,876	$ -	$ -

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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	9/30/2016	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	7,075,805		7,075,805	3,252,326			243,467	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								243,467
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	672,459			3,130	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												3,130
E. ***Total Depreciation***												246,597

Health Care Assurance, LLC d/b/a Douglas Manor
9/30/2016

Schedule of Land Improvements Acquired during this report period

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

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

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

***Ties to Page 23, Line B3**
****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

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

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Movable Equipment		$ -		$ -	*
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	9/30/2016	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	42,287			2,296	
2. Deferred Financing Costs				763,954	349,954			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	528,150			17,129	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									17,129
D. ***Total Amortization***									44,876

* 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	9/30/2016	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	9/30/2016	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	9/30/2016	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*) $	45,733	45,733		
See Attachment Page 27A				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	45,733	45,733		
14. Insurance				
a. Insurance on Property (buildings only) $				
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	17,026	17,026		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $	54,384	54,384		
See Attachment Page 27A				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	71,410	71,410		
15. ***Total All Expenditures (A-13 thru C-14)*** $	9,677,039	9,677,039		

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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	9/30/2016	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 $	313,889	313,889		
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
10.			Accounting & Legal $	73,650	73,650		
11.			Telephone $				
12.			Cellular Telephone $	1,019	1,019		
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 * $	1,338	1,338		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $	50,443	50,443		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	36,293	36,293		
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) $	476,632	476,632		

* 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)
		8000-7400 DUES - A&G	$ -		
		8000-7520 EMPLOYEE PARTY	$ 332		
		8000-7521 OFFICE MEALS	$ 2,673		
		8000-7511 TRAVEL PARKING & TOLL	$ 12		
		-	$ -		
		8000-7955 PRIOR YEAR EXPENSE	$ 7,750		
		8500-5468 CNTRCT SRV ELIG WORK	$ 12,867		
		9000-9710 FINES & PENALTIES	$ 12,659		
		-	$ -		
		-	$ -		
		-	$ -		
		-	$ -		
Total Other A&G Adjustments			$ 36,293	$ -	$ -

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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	9/30/2016	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	476,632	476,632		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $	384,126	384,126		
28.			Ambulance/Limousine $				
29.			X-rays, etc $	2,588	2,588		
30.			Laboratory $	22,945	22,945		
31.			Medical Supplies $	9,163	9,163		
32.			Oxygen (non emergency) $	33,730	33,730		
33.			Occupational Therapy $	885	885		
34.			Other - See Attached Schedule $	26,843	26,843		
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 $	1,983	1,983		
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)*** $	958,895	958,895		

*** 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
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		5460-5346 P.S. CONSOL BILLING A	$ 5,033		
			$ 5,913		
			$ -		
		5100-6103 PERSONAL CARE SUPPL	$ 11,297		
		5400-6180 IV THERAPY - MEDICARE	$ 4,600		
		-	$ -		
		-	$ -		
		-	$ -		
		-	$ -		
Total Other Ancillary Costs			$ 26,843	$ -	$ -

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)
		9000-9700 INTEREST - VENDORS	$ 1,983		
		-	$ -		
		-	$ -		
		-	$ -		
Total Other Adjustments			$ 1,983	$ -	$ -

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	9/30/2016	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	5,970,047	5,970,047		
b. Medicaid Room and Board Contractual Allowance **	$	(2,092,814)	(2,092,814)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,179,770	2,179,770		
b. Medicare Room and Board Contractual Allowance **	$	727,807	727,807		
4. a. Private-Pay Residents and Other	$	3,093,938	3,093,938		
b. Private-Pay Room and Board Contractual Allowance **	$	(178,500)	(178,500)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	267,427	267,427		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(267,427)	(267,427)		
c. Prescription Drugs - Non-Medicare	$	85,550	85,550		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(83,819)	(83,819)		
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	$	464,138	464,138		
b. Physical Therapy - Medicare Contractual Allowance **	$	(367,472)	(367,472)		
c. Physical Therapy - Non-Medicare	$	147,548	147,548		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(143,473)	(143,473)		
4. a. Speech Therapy - Medicare	$	78,021	78,021		
b. Speech Therapy - Medicare Contractual Allowance **	$	(67,011)	(67,011)		
c. Speech Therapy - Non-Medicare	$	8,704	8,704		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(8,155)	(8,155)		
5. a. Occupational Therapy - Medicare	$	549,957	549,957		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(496,065)	(496,065)		
c. Occupational Therapy - Non-Medicare	$	135,692	135,692		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(131,414)	(131,414)		
6. a. Other *(Specify)* - Medicare	$	13,861	13,861		
b. Other *(Specify)* - Non-Medicare	$	301	301		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	9,886,611	9,886,611		
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)*	$	87	87		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	1,370	1,370		
V. Total Other Revenue (1 thru 8)	$	1,457	1,457		
VI. Total All Revenue (III +V)	$	9,888,068	9,888,068		

* *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)
	4060-4100 REV IIV THERAPY MED A	$ 18,547		
	4200-4100 REV - X-RAY MEDICARE	$ 10,141		
	4250-4100 REV - LAB MEDICARE	$ 8,510		
	4750-4100 ANCILL ALLOW MED A	$ (23,337)		
	4750-4150 ANCILL ALLOW - PRT B	$ -		
		$ -		
Total Other Resident Revenue - Medicare		$ 13,861	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	4250-4050 REV - LAB CONTRACT	$ 1,914		
	4060-4050 REV - IV THERAPY CONT	$ 13,327		
	4750-4060 ANCILLARY ALLOW INS1	$ -		
	4200-4050 REV - X-RAY CONTRACT	$ 10		
	4750-4050 ANCILL ALLOW CNT	$ (14,950)		
		$ -		
		$ -		
		$ -		
	-			
Total Other Resident Revenue		$ 301	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	4900-4700 INTEREST INCOME		$ 87		
			$ -		
			$ -		
	-		$ -		
Total Interest Income			$ 87	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Purchase Agreement-Rebate	$ 1,267		
	Overpayment Farmington Grp	$ 103		
	-			
Total Other Revenue		$ 1,370	$ -	$ -

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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	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ (37,105)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 2,027,937
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$ 28,716
5. Prepaid Expenses				$ 145,578
a. SEE PAGE 31A		145,578		
b.				
c.				
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$ (37,777)
1210-1000 Exchange-BofA Debit c		(6,422)		
1210-2000 Exchange - Pullman &		19,976		
1210-0000 EXCHANGE ACCOUNT		(63,873)		
1590-0000 CONSTRUCTION IN PROGR		12,542		
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,127,349
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		$ 581,110
	Accum. Depreciation	545,279	Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	691,737		$ 16,148
	Accum. Depreciation	675,589	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)				$ 597,258

* 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	9/30/2016	32	37

Account					Amount
			Total Brought Forward:	$	2,724,607
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	3,495,793	Net	$	3,580,012
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)				$	3,580,012
D. Investment and Other Assets					
1. Deferred Deposits				$	27,757
2. Escrow Deposits				$	
3. Organization Expense	*Historical Cost	809,460			
	Accum. Depreciation	419,988	Net	$	389,472
4. Goodwill (Purchased Only)				$	
5. Investments Related to Resident Care (*itemize*)				$	
6. Loans to Owners or Related Parties (*itemize*)				$	6,051,073
Name and Address	Amount	Loan Date			
See Page 32A	6,051,073				
7. Other Assets (*itemize*)				$	450,077
1700-0000 DEFERRED ACQUISITION		450,077			
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$	6,918,379
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$	13,222,998

* 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	9/30/2016	33	37

Account					Amount
Liabilities					
A.	Current Liabilities				
	1. Trade Accounts Payable				$ 4,382,432
	2. Notes Payable (*itemize*)				$ 463,950
	2487-7000 NOTE PAYABLE - METRO	6,250			
	2487-7500 NOTE PAYABLE HLTH CAP	414,104			
	2490-1000 NOTE PAYABLE-OMNICARE	44,043			
	2486-1000 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*)				$ 687,451
	5. Accrued Payroll (*Owners and/or Stockholders only*)				$
	6. Accrued Payroll Taxes Payable				$ 403,829
	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*)				$ 903,112
		(31,248)	2265-0000 PAYROLL E	5,813	
	2340-2500 ACCRUED PROVIDER	1,147,757	2340-0000 ACCRUED V	(11,000)	
	2410-0000 PATIENT REFUND CLI	(170,700)	2480-0000 LOAN PAYA	(49,176)	
	2105-0000 ACCRUED INTEREST	11,666	2496-1000 NOTE PAYA		
A-13.	***Total Current Liabilities*** (Lines A1 thru 12)				$ 6,840,774

* 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	9/30/2016	34	37

Account	Amount
Total Brought Forward:	6,840,774
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)	$ 6,840,774

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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	9/30/2016	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$ 3,932,098
	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	$ 3,932,098
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 2,239,097
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ 211,029
	7. Total Net Worth	$ 2,450,126
C.	***Total Reserves and Net Worth***	$ 6,382,224
D.	***Total Liabilities, Reserves, and Net Worth***	$ 13,222,998

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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	9/30/2016	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015			$ 2,251,470
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 9,888,068
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 9,677,039
D.	Net Income or Deficit			$ 211,029
E.	Balance			$ 2,462,499
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
	Prior Period Adjustments			(12,373)
F-3.	Total Additions			$ (12,373)
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*** 09/30/16			$ 2,450,126