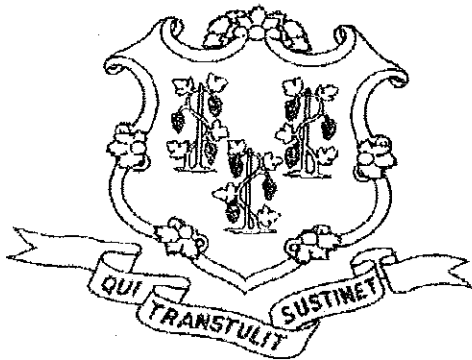
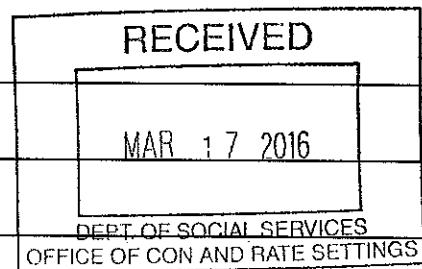


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015



Name of Facility (as licensed) Health Care Investors Inc. d/b/a Alexandria Manor	
Address (No. & Street, City, State, Zip Code) 55 Tunxis Ave Bloomfield, CT 06002	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 2095-C	RHNS	(Specify)	Medicare Provider 07-5291
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-MR
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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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Health Care Investors Inc. d/b/a Alexandria Manor	2095-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 IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Health Care Investors Inc. d/b/a Alexandria 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.

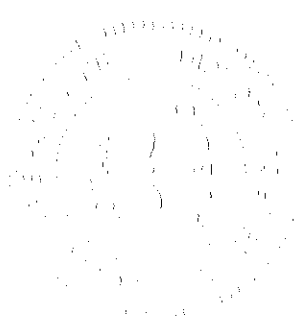
I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the 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
					3-14-2016
Printed Name (Administrator)			Printed Name (Owner)		
			Benjamin Z. Fischman		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires	
Cheshire	CT	3/15/14		1/31/19	
Address of Notary Public					
921 Marion Ave Plainville, CT 06449					

Donna Marie Patenaude
 NOTARY PUBLIC
 State of Connecticut
 My Commission Expires 1/31/2019

(Notary Seal)



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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Health Care Investors Inc. d/b/a Alexandria Manor	Period Covered:	From 10/1/2014	To 9/30/2015	
Address of Facility 55 Tunxis Ave Bloomfield, CT 06002				
Report Prepared By Alexnadria 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.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-242-0703		Report for Year Ended 9/30/2015	Page 2	of 37
Name of Facility (as shown on license) Health Care Investors Inc. d/b/a Alexandria Manor		Address (No. & Street, City, State, Zip) 55 Tunxis Ave Bloomfield, CT 06002		
License Numbers:	CCNH 2095-C	RHNS	(Specify)	Medicare Provider No. 07-5291
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input checked="" type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator William Pond		Nursing Home Administrator's License No.:	1520	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire Corporate Owners

Name of Facility Health Care Investors Inc. d/b/a Alexandria M	License No. 2095-C	Report for Year Ended 9/30/2015	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10% of Shares			

General Information and Questionnaire Related Parties*

Name of Facility Health Care Investors Inc. d/b/a Alexandria Manor	License No. 2095-C	Report for Year Ended 9/30/2015	Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input checked="" type="radio"/> Yes <input type="radio"/> No						
If "Yes," provide the following information:						
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		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	<input type="radio"/>	<input checked="" type="radio"/>	Pg 16 Line M12	358,524	358,524
Benjamin Fischman, Affinity Health Care Mgt	221 East 33rd St New York, NY 10016	<input type="radio"/>	<input checked="" type="radio"/>	Pg 15 Line 1a7		
Joseph Grun & Harold Rubin, Gerimedix	3741 Ocean Ave Brooklyn, NY 11224	<input checked="" type="radio"/>	<input type="radio"/>	Various	171,293	Unknown
Alexandria Manor Associates LLC	1781 Highland Ave Cheshire, CT 06410	<input type="radio"/>	<input checked="" type="radio"/>	Pg 22 Line 9	423,412	423,412
Blair Manor		<input type="radio"/>	<input checked="" type="radio"/>	N/A	N/A	N/A
Douglas Manor		<input type="radio"/>	<input checked="" type="radio"/>	N/A	N/A	N/A
Ellis Manor		<input type="radio"/>	<input checked="" type="radio"/>	N/A	N/A	N/A
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			

* Use additional sheets if necessary.

** Provide the percentage amount of revenue received from non-related parties.

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility Health Care Investors Inc. d/b/a Alexandria Ma	License No. 2095-C	Report for Year Ended 9/30/2015	Page 5	of 37
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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 <i>(See listing page 13)</i>
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.

**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		
Health Care Investors Inc. d/b/a Alexandria Manor		2095-C	9/30/2015	6	37		
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Ricoh America	<input type="radio"/>	<input checked="" type="radio"/>	Copier	01/01/07		4,673	4,673
Crystal Rock	<input type="radio"/>	<input checked="" type="radio"/>	Water Coolers	01/01/94		2,501	2,501
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
				<input type="radio"/> Yes	<input checked="" type="radio"/> No	Total ***	7,174

Is a Mileage Log Book Maintained for All Leased Vehicles ?

* 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.

General Information and Questionnaire
Accounting Basis

Name of Facility Health Care Investors Inc. d/b/a Al	License No. 2095-C	Report for Year Ended 9/30/2015	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis: <input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> 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 Whittlesey & Hadley PC		Hartford, CT		
3				
4				
Services Provided by This Firm (<i>describe fully</i>)				
1 Monthly Accounting / Financial Oversight				\$ 48,285
2 HUD financials				\$ 9,400
3				\$
4				\$
			Charge for Services Provided	
			\$ 57,685	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. <input checked="" type="radio"/> Yes <input type="radio"/> 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 (<i>No. & Street, City, State, Zip Code</i>)				
1				
2				
3				
4				
5				
Services Provided by This Firm (<i>describe fully</i>)				
1 See Attached Page 7A				\$ 22,783
2				\$
3				\$
4				\$
5				\$
			Charge for Services Provided	
			\$ 22,783	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. <input checked="" type="radio"/> Yes <input type="radio"/> No Pg 15, Line 1.e				

Alexandria Manor
Medicaid Cost Report 9/30/2015

Legal	Vendor	Address	Description of Serv	Amount	Amt Disallow	Reason
Legal General:						
	Murtha Cullina	1100 Asylum St Hartford CT 06104		\$ 119	\$ (119)	insufficient description
				\$ 119	\$ (119)	<input checked="" type="checkbox"/>
Legal - Resident						
	Hertzmark Crean & Lahey, LLP	76 Center Street, Waterbury CT 06702	Resident dept collection	\$ 4,942	\$ (4,942)	collections
				\$ -	\$ -	
				\$ 4,942	\$ (4,942)	
Legal Labor						
	Durant, Nichols, Houston, Hodgson & Cortese - Costa, PC	1057 Broad Street, Bridgeport, CT 06604	Union negotiations City notices and correspondence with S Clark	\$ 995		
	Durant, Nichols, Houston, Hodgson & Cortese - Costa, PC	1057 Broad Street, Bridgeport, CT 06604	Issues related to layoffs and settlement negotiations	\$ 2,578		
	Durant, Nichols, Houston, Hodgson & Cortese - Costa, PC	1057 Broad Street, Bridgeport, CT 06604	Prepare settlement agreement with 1199	\$ 8,858		
	Durant, Nichols, Houston, Hodgson & Cortese - Costa, PC	1057 Broad Street, Bridgeport, CT 06604		\$ 300		
				\$ 12,731	\$ -	<input checked="" type="checkbox"/>
Legal Expense						
	Durant, Nichols, Houston, Hodgson & Cortese - Costa, PC	1057 Broad Street, Bridgeport, CT 06604		\$ 100	\$ (100)	insufficient support
	Durant, Nichols, Houston, Hodgson & Cortese - Costa, PC	1057 Broad Street, Bridgeport, CT 06604		\$ 350	\$ (350)	insufficient support
	Durant, Nichols, Houston, Hodgson & Cortese - Costa, PC	1057 Broad Street, Bridgeport, CT 06604		\$ 150	\$ (150)	insufficient support
	Durant, Nichols, Houston, Hodgson & Cortese - Costa, PC	1057 Broad Street, Bridgeport, CT 06604	Investigation regarding termination of employee	\$ 1,298		
	Ward, Frederick	433 South Main Street, Hartford, CT 06110	Arbitration for Union matter	\$ 675		
	Durant, Nichols, Houston, Hodgson & Cortese - Costa, PC	1057 Broad Street, Bridgeport, CT 06604	Union negotiations	\$ 2,418		
				\$ 4,991	\$ (600)	
			Grand Total:	\$ 22,782	\$ (5,660)	<input type="checkbox"/>

Schedule of Resident Statistics

Name of Facility Health Care Investors Inc. d/b/a Alexandria Manor	License No. 2095-C	Report for Year Ended 9/30/2015				Page 8	of 37
		Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)		
1. Certified Bed Capacity							
A. On last day of PREVIOUS report period		120	120				
B. On last day of THIS report period		120	120				
2. Number of Residents							
A. As of midnight of PREVIOUS report period		106	106				
B. As of midnight of THIS report period				95			
3. Total Number of Days Care Provided During Period							
A. Medicare		3,009	3,009				
B. Medicaid (Conn.)		30,259	30,259				
C. Medicaid (other states)							
D. Private Pay		1,130	1,130				
E. State SSI for RCH							
F. Other (Specify)		3,096	3,096				
G. Total Care Days During Period (3A thru F)		37,494	37,494				
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)		37,494	37,494	28,765	8,729	8,729	

Schedule of Resident Statistics (Cont'd)

Name of Facility Health Care Investors Inc. d/b/a Alexandria M			License No. 2095-C			Report for Year Ended 9/30/2015			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> 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			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	(Specify)			
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	5		81		3		6						
Per Diem Rate													
a. One bed rm.	RUGs 777.94		249.79		390.00		375.00						
b. Two bed rms.	RUGs 199.21				370.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								1,307	1,307				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								754	754				
C. Other								9,507	9,507				
D. <i>Total Physical Therapy Treatments</i>								11,568	11,568				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								377	377				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								45	45				
C. Other								746	746				
D. <i>Total Speech Therapy Treatments</i>								1,168	1,168				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								1,522	1,522				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								851	851				
C. Other								8,934	8,934				
D. <i>Total Occupational Therapy Treatments</i>								11,307	11,307				

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Health Care Investors Inc. d/b/a Alexandria Manor	2095-C	9/30/2015	10	37		
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes		<input type="radio"/> 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)	102,565	2,134				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	211,731	9,362				
5. Dietary Service						
a. Head Dietitian	25,357	622				
b. Food Service Supervisor	62,376	2,206				
c. Dietary Workers	451,252	23,990				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	241,744	16,527				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	49,261	2,295				
b. Other Maintenance Workers	19,065	1,349				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	94,967	3,877				
9. Barber and Beautician Services						
10. Protective Services	40,406	2,400				
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	158,798	3,997				
b. RN						
1. Direct Care	851,568	21,086				
2. Administrative**	165,365	5,323				
c. LPN						
1. Direct Care	892,041	29,846				
2. Administrative**						
d. Aides and Attendants	1,782,609	106,904				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	97,010	4,355				
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	59,309	2,118				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	29,988	1,908				
A-13. Total Salary Expenditures	5,335,412	240,299				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
50505062 S & W - NURS MED REC	\$ 29,988	1,908				
-	\$ -	-				
-	\$ -	-				
-	\$ -	-				
Total	\$ 29,988	1,908	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
54006190 PURCH SERV - IV NURS	\$ 7,863	105				
	\$ -	-				
-	\$ -	-				
-	\$ -	-				
Total	\$ 7,863	105	\$ -	-	\$ -	-

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

Name of Facility		License No.		Report for Year Ended		Page	of			
Health Care Investors Inc. d/b/a Alexandria Manor		2095-C		9/30/2015		11	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 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.

**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 Investors Inc. d/b/a Alexandria Manor		2095-C		9/30/2015		12	37					
Name	Salary Paid		CCNH	RHNS	(Specify)	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS										
Section III - Administrators***												
William Pond	102,565						Facility Administrator	2,134	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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Health Care Investors Inc. d/b/a Alexandria Manor	2095-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	4,320	96				
3. Pharmacist	9,024	120				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	282,366	3,547				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	56,000	317				
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	62,160	793				
b. Other						
10. Occupational Therapist						
a. Resident Care	316,468	3,572				
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	7,863	105				
B-13 Total Fees Paid in Lieu of Salaries	738,201	8,550				

* 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.

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 Investors Inc. d/b/a Alexandria Manor		2095-C		9/30/2015	14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
United Health Resource	Dental	<input type="radio"/>	<input checked="" type="radio"/>			
Omicare	Pharmacy, IV Nurse	<input type="radio"/>	<input checked="" type="radio"/>			
Foremost Rehab	PT, OT, ST	<input type="radio"/>	<input checked="" type="radio"/>			
Wilfred Eloba MD	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
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		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			

* Use additional sheets if necessary.
 ** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Health Care Investors Inc. d/b/a Alexandria Manor	2095-C	9/30/2015	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 229,060	229,060		
2. Disability Insurance	\$ 4,088	4,088		
3. Unemployment Insurance	\$ 65,756	65,756		
4. Social Security (F.I.C.A.)	\$ 407,734	407,734		
5. Health Insurance	\$ 807,620	807,620		
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 2,098	2,098		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 219,276	219,276		
8. Uniform Allowance	\$ 38,588	38,588		
9. Other (<i>Specify</i>) See Attached Schedule	\$ 40,384	40,384		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$			
d. Accounting and Auditing	\$ 57,685	57,685		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 22,783	22,783		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 11,802	11,802		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 39,780	39,780		
2. Cellular Phones	\$ 4,414	4,414		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 711,211	711,211		
Subtotal	\$ 2,662,279	2,662,279		

* 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**

Health Care Investors Inc. d/b/a Alexandria Manor
9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
70008045 UNION TRAINING FUND	\$ 27,857		
70008007 DENTAL INSURANCE	\$ 12,527		
Total	\$ 40,384	\$ -	\$ -

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Health Care Investors Inc. d/b/a Alexandria Manor	2095-C	9/30/2015	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	2,662,279	2,662,279		
l. Travel and Entertainment				
1. Resident Travel and Entertainment	\$ 984	984		
2. Holiday Parties for Staff	\$ 522	522		
3. Gifts to Staff and Residents	\$ 78	78		
4. Employee Travel	\$ 298	298		
5. Education Expenses Related to Seminars and Conventions	\$			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$			
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 4,288	4,288		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 3,538	3,538		
4. Fund-Raising***	\$			
5. Medical Records	\$ 2,957	2,957		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 2,397	2,397		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 2,052	2,052		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$ 598	598		
10. Contributions*** See Attached Schedule	\$			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 174,036	174,036		
12. Administrative Management Services**	\$ 358,524	358,524		
13. Other (<i>Specify</i>) See Attached Schedule	\$ 53,353	53,353		
C-14 Total Administrative & General Expenditures	\$ 3,265,904	3,265,904		

* 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)
80007810 ADVERTISING - PROMO	\$ 999		
ADVERTISING - COMM. AWARENESS	\$ (240)		
80007540 PROMOTIONAL	\$ 2,779		
Total Other Advertising	\$ 3,538	\$ -	\$ -

Schedule of Dues

Description	CCNH	RIINS	(Specify)
	\$ -		
CAHCF-Annual Membership Dues	\$ 2,052		
	\$ -		
	\$ -		
	\$ -		
Total Dues	\$ 2,052	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RIINS	(Specify)
	\$ -		
LICENSES & FEES - DIETARY	\$ 460		
70008042 EMPLOYEE INQUIRIES	\$ 1,851		
80007450 LICENSES & FEES	\$ 553		
80007900 BANK SERVICE FEES	\$ 132		
85005533 COMPUTER HARDWARE MAI	\$ 4,166		
	\$ -		
80007950 UNALLOWED EXPENSES	\$ 4,895		
PRIOR YEAR EXPENSE	\$ 370		
90009710 FINES & PENALTIES	\$ 38,555		
90009910 INT-FEDERAL/STATE TAX	\$ 1,859		
51005292 UNION NEGOTIATIONS	\$ 400		
80008530 SALES & USE TAX	\$ 112		
	\$ -		
	\$ -		
Total Other Administrative and General	\$ 53,353	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Health Care Investors Inc. d/b/a Alexandri	2095-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	358,524	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.

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 Investors Inc. d/b/a Alexandria Manor		2095-C	9/30/2015		18	37
Item	Total	CCNH	RHNS	(Specify)		
2. Dietary						
a. In-House Preparation & Service						
1. Raw Food	\$ 286,320	286,320				
2. Non-Food Supplies	\$ 33,112	33,112				
3. Other (Specify) _____	\$ _____					
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 283	283				
c. Management Services**	\$ _____					
d. Other (Specify) _____	\$ _____					
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 319,715	319,715				
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)		
G. Resident Meals: Total no. of meals served per day:*	308	308				
H. Is cost of employee meals included in 2E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No				
I. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify cost.	
L. Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			If yes, specify cost.	
O. Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

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 Investors Inc. d/b/a Alexandria Manor		2095-C	9/30/2015	19	37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$			
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.			
		Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.			
		Amt. \$			
4. Repair and/or purchase of linens.***		Lbs.			
		Amt. \$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	41,749	41,749	
c. Management Services**		\$			
d. Other (Specify)		\$			
3E. Total Laundry Expenditures (3a + b + c + d)		\$	41,749	41,749	
3F. Laundry Questionnaire					
G.	Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

**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 Investors Inc. d/b/a Alexandria Mar		2095-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 (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	31,121	31,121		
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$	88,102	88,102		
c.	Management Services*	\$				
d.	Other (<i>Specify</i>) Minor Furniture and Equipment	\$	119	119		
4E.	Total Housekeeping Expenditures (4a + b + c + d)	\$	119,342	119,342		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from	\$	267,859	267,859		
b.	Medicine Cabinet Drugs	\$	68,582	68,582		
c.	Medical and Therapeutic Supplies	\$	116,042	116,042		
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	41,477	41,477		
f.	X-rays and Related Radiological Procedures***	\$	2,994	2,994		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	34,080	34,080		
i.	Recreation	\$	11,311	11,311		
j.	Other (Specify)**** See Attached Schedule	\$	229,585	229,585		
5K.	Total Resident Care Expenditures (5a - 5j)	\$	771,930	771,930		

* 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	\$ 1,163		
51006080 MINOR EQUIPMENT - NSG	\$ 9,718		
51006100 NON-CHARGE MED SUPPL	\$ 109,627		
51006101 NON-CHARGE MED-ENTNL	\$ 15,964		
51006103 PERSONAL CARE SUPPL	\$ 10,877		
54605349 NURSING REN EQ-MEDA	\$ 82,236		
	\$ -		
	\$ -		
	\$ -		
	\$ -		
	\$ -		
	\$ -		
	\$ -		
	\$ -		
	\$ -		
	\$ -		
	\$ -		
	\$ -		
	\$ -		
	\$ -		
	\$ -		
	\$ -		
Total Other Resident Care	\$ 229,585	\$ -	\$ -

**Report of Expenditures
 Schedule C-2 - Individuals or Firms Providing Services by Contract ***

Name of Facility Health Care Investors Inc. d/b/a Alexandria Manor		License No. 2095-C	Report for Year Ended 9/30/2015	Page of 21 37						
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Pg	Line
		Yes	No							
State of Connecticut DSS		<input type="radio"/>	<input checked="" type="radio"/>		Eligibility Worker	34,069				16 m11
Healthcare Services		<input type="radio"/>	<input checked="" type="radio"/>		Laundry Services	41,749				19 3b
Healthcare Services		<input type="radio"/>	<input checked="" type="radio"/>		Housekeeping Service	85,395				20 4b
USA Hauling		<input type="radio"/>	<input checked="" type="radio"/>		Trash Removal	19,519				22 6f
ADP		<input type="radio"/>	<input checked="" type="radio"/>		Payroll Time and Attendance system	23,759				16 m11
MDI Achieve Software		<input type="radio"/>	<input checked="" type="radio"/>		Software	13,334				16 m11
Healthcare Management Solutions		<input type="radio"/>	<input checked="" type="radio"/>		Maintenance/Support Billing and AR Processing	97,496				16 m11
Property Management		<input type="radio"/>	<input checked="" type="radio"/>		Snow Removal	15,967				22 6f
Kone Inc		<input type="radio"/>	<input checked="" type="radio"/>		Elevator Service	14,096				22 6f
Red Hawk Fire & Sec.		<input type="radio"/>	<input checked="" type="radio"/>		Fire and Alarm Service	33,467				22 6f
Stericycle		<input type="radio"/>	<input checked="" type="radio"/>		Medical Waste Removal	28,669				23 6f
Digital Media		<input type="radio"/>	<input checked="" type="radio"/>		Satelite TV	15,642				22 6f
Andrea's Mechanical		<input type="radio"/>	<input checked="" type="radio"/>		Sewer services/Grease trap services	13,514				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).

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

Name of Facility		License No.	Report for Year Ended		Page	of
Health Care Investors Inc. d/b/a Alexandria M		2095-C	9/30/2015		22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 55,010	55,010				
b. Heat	\$ 33,131	33,131				
c. Light & Power	\$ 135,657	135,657				
d. Water	\$ 31,699	31,699				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 7,174	7,174				
f. Other (<i>itemize</i>)	\$ 180,488	180,488				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 443,159	443,159				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 18	18				
b. Building & Building Improvements	\$ 300,545	300,545				
c. Non-Movable Equipment	\$ 489	489				
d. Movable Equipment	\$ 7,356	7,356				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 308,408	308,408				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$ 8,673	8,673				
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 8,673	8,673				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 423,412	423,412				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 162,961	162,961				
c. Personal property taxes	\$ 5,390	5,390				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 908,844	908,844				

* 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	\$ 19,519		
85005430 CONTRACT SERV - SNOW	\$ 15,967		
85005495 CONTRACT SERV - SEWER	\$ 13,514		
85005420 CNTRCT SERV MAINT	\$ 3,752		
85005425 CONTRACT SERV - LAWN	\$ 9,981		
85005435 CNTRCT SRV GENERATOR	\$ 593		
85005440 CNTRCT SRV ELEVATOR	\$ 14,096		
85005445 CONTRACT SERV - ALARM	\$ 19,229		
85005451 CONTRACT SERV SPRINK	\$ 13,096		
	\$ -		
85005452 ONTRCT SRV FIRE PROT	\$ 14,238		
85005460 CONTRACT SERV - HVAC	\$ 9,804		
85005466 CNTRCT SRV-FAC NET	\$ 2,424		
63005510 MEDICAL WASTE REMOVAL	\$ 28,669		
85006540 CABLE TV	\$ 15,642		
85006550 SATTELITE TV	\$ (36)		
	\$ -		
Total Other Repairs and Maintenance	\$ 180,488	\$ -	\$ -

Health Care Investors Inc. d/b/a Alexandria 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:				
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

Amortization Schedule*

Name of Facility Health Care Investors Inc. d/b/a Alexandria Manor	Date of Acquisition		Length of Amortization	License No. 2095-C	Report for Year Ended 9/30/2015		Page 24	of 37
	Month	Year			Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**		
A. Organization Expense								
1. Deferred Acquisitions					354,431	147,777	8,673	
2.								
3.								
A-4. Subtotal								8,673
B. Mortgage Expense								
1.								
2.								
3.								
B-4. Subtotal								
C. Leasehold Improvements and Other								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								
D. Total Amortization								8,673

* 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.

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

Name of Facility Health Care Investors Inc. d/b/a Alexar	License No. 2095-C	Report for Year Ended 9/30/2015	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description		Total			
1. Date Land Purchased					
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity		120			
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		11/01/97			
c. Interest Rate for the Cost Year		4.38%			
d. Term of Mortgage (number of years)		40			
e. Amount of Principal Borrowed					
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.

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

Name of Facility		License No.	Report for Year Ended		Page	of
Health Care Investors Inc. d/b/a Alexa		2095-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)

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

Name of Facility	License No.	Report for Year Ended	Page	of		
Health Care Investors Inc. d/b/a Ale	2095-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) \$ 108,700 108,700						
See Attachment Page 27A						
13. Total All Interest Expense (12B7 + 12C3 + 12D) \$ 108,700 108,700						
14. Insurance						
a. Insurance on Property (buildings only) \$						
b. Insurance on Automobiles \$						
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage) \$ 16,865 16,865						
2. Fire and Extended Coverage \$						
3. Other (Specify) \$ 99,215 99,215						
See Attachment Page 27A						
14d. Total Insurance Expenditures (14a + b + c) \$ 116,080 116,080						
15. Total All Expenditures (A-13 thru C-14) \$ 12,169,036 12,169,036						

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Health Care Investors Inc. d/b/a Alexandria Manor			2095-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	\$ 316,468	316,468		
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$			
10.			Accounting & Legal	\$ 24,461	24,461		
11.			Telephone	\$			
12.			Cellular Telephone	\$ 3,694	3,694		
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 *	\$ 3,538	3,538		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$ 27,701	27,701		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 80,569	80,569		
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)				\$ 456,431	456,431		

* 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)
		TRAVEL - PARKING & TOLLS		\$ 6		
		80007400 DUES - A&G		\$ 2,052		
		80007521 OFFICE MEALS		\$ 522		
		80007530 EMPLOYEE GIFTS		\$ 78		
		80007950 UNALLOWED EXPENSES		\$ 4,895		
		PRIOR YEAR EXPENSE		\$ 370		
		85005468 CNTRCT SRV ELIG WORK		\$ 34,069		
		90009710 FINES & PENALTIES		\$ 38,555		
		80007509 TRAVEL - TAXI FARES-		\$ 22		
			-			
			-			
		Total Other A&G Adjustments		\$ 80,569	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Health Care Investors Inc. d/b/a Alexandria Manor			2095-C	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 456,431	456,431		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$ 267,859	267,859		
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$ 1,379	1,379		
30.			Laboratory	\$ 34,080	34,080		
31.			Medical Supplies	\$ 20,016	20,016		
32.			Oxygen (non emergency)	\$ 41,477	41,477		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 157,830	157,830		
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	\$ 5,559	5,559		
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)			\$ 984,631	984,631		

*** 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.

Health Care Investors Inc. d/b/a Alexandria Manor
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
		54605346 P.S. CONSOL BILLING A	\$ 1,583		
		54605347 NURSING RENT EQ-CNT	\$ 34,884		
		54605348 Rental Equip-Medicare	\$ 28,250		
		51006103 PERSONAL CARE SUPPL	\$ 10,877		
		54605349 NURSING REN EQ-MEDA	\$ 82,236		
			\$ -		
			\$ -		
		Total Other Ancillary Costs	\$ 157,830	\$ -	\$ -

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	\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
			\$ -		
		90009700 INTEREST - VENDORS	\$ 3,700		
		90009910 INT-FEDERAL/STATE TAX	\$ 1,859		
			\$ -		
			\$ -		
		Total Other Adjustments	\$ 5,559	\$ -	\$ -

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility		License No.		Report for Year Ended		Page	of
Health Care Investors Inc. d/b/a Alexandi		2095-C		9/30/2015		30	37
Item	Total	CCNH	RHNS	(Specify)			
I. Resident Room, Board & Routine Care Revenue							
1. a. Medicaid Residents (<i>CT only</i>)	\$ 11,843,118	11,843,118					
b. Medicaid Room and Board Contractual Allowance **	\$ (4,084,275)	(4,084,275)					
2. a. Medicaid (<i>All other states</i>)	\$						
b. Other States Room and Board Contractual Allowance **	\$						
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,438,545	1,438,545					
b. Medicare Room and Board Contractual Allowance **	\$ 239,032	239,032					
4. a. Private-Pay Residents and Other	\$ 1,158,731	1,158,731					
b. Private-Pay Room and Board Contractual Allowance **	\$ (189,610)	(189,610)					
II. Other Resident Revenue							
1. a. Prescription Drugs - Medicare	\$ 134,956	134,956					
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (133,151)	(133,151)					
c. Prescription Drugs - Non-Medicare	\$ 67,979	67,979					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (67,869)	(67,869)					
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	\$ 184,838	184,838					
b. Physical Therapy - Medicare Contractual Allowance **	\$ (135,281)	(135,281)					
c. Physical Therapy - Non-Medicare	\$ 102,741	102,741					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (102,199)	(102,199)					
4. a. Speech Therapy - Medicare	\$ 67,576	67,576					
b. Speech Therapy - Medicare Contractual Allowance **	\$ (38,032)	(38,032)					
c. Speech Therapy - Non-Medicare	\$ 23,765	23,765					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (23,699)	(23,699)					
5. a. Occupational Therapy - Medicare	\$ 226,491	226,491					
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (180,671)	(180,671)					
c. Occupational Therapy - Non-Medicare	\$ 96,980	96,980					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (96,500)	(96,500)					
6. a. Other (<i>Specify</i>) - Medicare	\$ 25,736	25,736					
b. Other (<i>Specify</i>) - Non-Medicare	\$ (370)	(370)					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 10,558,831	10,558,831					
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 (<i>Specify</i>)	\$ 17,396	17,396					
6. Private Duty Nurses' Fees	\$						
7. Barber, Coffee, Beauty and Gift shops	\$						
8. Other (<i>Specify</i>)	\$ 11,729	11,729					
V. Total Other Revenue (1 thru 8)	\$ 29,125	29,125					
VI. Total All Revenue (III + V)	\$ 10,587,956	10,587,956					

* 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)
	40604025 REV-IV THERAPY-EVER A	\$ 2,750		
	40604100 REV-IV THERAPY MED A	\$ 9,607		
	42504025 REV-LAB-EVERCARE A	\$ 1,336		
	42504028 REV-LAB-EVERCARE B	\$ -		
	42504150 REV - LAB MCR PART B	\$ 12,326		
	42504100 REV - LAB MEDICARE	\$ 1,305		
	42004100 REV - X-RAY MEDICARE	\$ 16,391		
	42004025 REV-X-RAY-EVERCARE A	\$ 411		
	47504025 ANCI LL ALLOW-EVER A	\$ (1,855)		
	47504028 ANCI LL ALLOW EVER B	\$ 289		
	47504100 ANCI LL ALLOW MED A	\$ (16,623)		
	47504150 ANCI LL ALLOW - PRT B	\$ (201)		
Total Other Resident Revenue - Medicare		\$ 25,736	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	42504050 REV - LAB CONTRACT	\$ 6,205		
	40604050 REV - IV THERAPY CONT	\$ 14,461		
	43004200 REV - PHARMACY MD CD	\$ 1,580		
	REV - LAB MEDICAID	\$ 178		
	47504060 ANCI LLARY ALLOW INS1	\$ (433)		
	40604200 REV IV THERAPY MED CD	\$ 1,728		
	47504050 ANCI LL ALLOW CNT	\$ (20,632)		
	47504200 ANCI LL ALLOW MD CD	\$ (3,457)		
Total Other Resident Revenue		\$ (370)	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
		-	\$ -		
	49004700 INTEREST INCOME		\$ 5,623		
	PENSION REFUND-NOT ELIGIBLE		\$ (1,189)		
	49004900 DIVIDEND INCOME		\$ 12,962		
Total Interest Income			\$ 17,396	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	49004600 MISCELLANEOUS REVENUE	\$ 11,729		
Total Other Revenue		\$ 11,729	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Health Care Investors Inc. d/b/a Alexan	2095-C	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	(95,231)
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	930,960
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	526,165
4. Inventories			\$	37,750
5. Prepaid Expenses			\$	73,843
a. SEE PAGE 31A	73,843			
b. _____				
c. _____				
d. _____				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	43,468
12101000 Exchange-BofA Debit c	5,805			
12102000 Exchange - Pullman &	12,269			
12100000 EXCHANGE ACCOUNT	25,394			
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,516,955
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 _____		\$	
	Accum. Depreciation _____	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost 355,961		\$	(7,100)
	Accum. Depreciation 363,061	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

B-10. Total Fixed Assets (Lines B1 thru 9)			\$	(7,100)

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

(Carry Total forward to next page)

Medicaid Cost Report: Cross Reference Report

Page	Name of Facility:	Year-End:	CCH Lic #	Page		
31	Alexandria Manor	9/30/2015	1015C	31		
Balance Sheet - Assets						
Line	Description	Adj	G/L Number	O/L Amount	Reclass	Adjusted Amount
A.5 Current Assets - Prepaid Expenses						
Page 31A						
	14100000 PREPAID INSURANCE - O		1410-0000	58,669		58,669
	14110000 PREPAID-RISK MANAGEME		1411-0000	1,333		1,333
	14200000 PREPAID TAXES		1420-0000	1,336		1,336
	14310000 PREPAID COMPUTER		1431-0000	8,337		8,337
	14340000 PREPAID-SOFTWARE NETW		1434-0000	1,092		1,092
	14550000 PREPAID POSTAGE MACHI		1455-0000	737		737
	14300000 PREPAID OTHER		1430-0000	-		-
	14330000 PREPAID COMPUTER SOFT		1433-0000	-		-
	14400000 PREPAID ALARM SERVICE		1440-0000	2,339		2,339
				-		-
				-		-
				-		-
				-		-
				-		-
	Subtotal			73,843		73,843

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Health Care Investors Inc. d/b/a Alexand	2095-C	9/30/2015	32	37
Account			Amount	
Total Brought Forward:			\$	1,509,855
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	1,640		
	Accum. Depreciation	1,640	Net	\$
3. Buildings				
	*Historical Cost	9,534,530		
	Accum. Depreciation	5,729,212	Net	\$ 3,805,318
4. Non-Movable Equipment				
	*Historical Cost	29,205		
	Accum. Depreciation	11,712	Net	\$ 17,493
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)			\$	3,822,811
D. Investment and Other Assets				
1. Deferred Deposits			\$	46,435
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	354,431		
	Accum. Depreciation	156,450	Net	\$ 197,981
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	(873,677)
Name and Address		Amount	Loan Date	
See Page 32A		(873,677)		
7. Other Assets (<i>itemize</i>)			\$	422,632
17000000 DEFERRED ACQUISITION		422,632		
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	(206,629)
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	5,126,037

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Health Care Investors Inc. d/b/a Alexandria Ma	2095-C	9/30/2015	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	3,511,152
2. Notes Payable (<i>itemize</i>)			\$	461,744
24877500 NOTE PAYABLE HLTH CAP				414,104
24901000 NOTE PAYABLE-OMNICARE				47,640
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)			\$	454,802
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	256,762
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable (<i>Current Portion</i>)			\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$	
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities (<i>itemize</i>)			\$	1,901,183
21950000 ACCRUED UNIFORM A			169,446	22650000 PAYROLL EI 9,020
23402500 ACCRUED PROVIDER			1,639,519	25290000 STATE OF C
24100000 PATIENT REFUND CLI			(69,994)	24800000 LOAN PAYA (4,113)
21050000 ACCRUED INTEREST			157,500	25600000 lease payable-l (195)
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	6,585,643

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Health Care Investors Inc. d/b/a Alexandria		License No. 2095-C	Report for Year Ended 9/30/2015	Page 34	of 37
Account				Amount	
Total Brought Forward:				6,585,643	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)				\$	
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$	

B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 6,585,643	

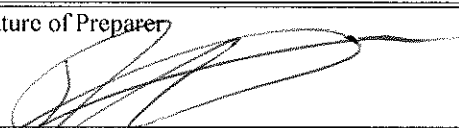
G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Health Care Investors Inc. d/b/a Alexar	2095-C	9/30/2015	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	3,912,946
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
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			\$	3,912,946
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(3,792,622)
6. Gain or Loss for Period	10/1/2014	thru	9/30/2015	\$ (1,581,080)
7. Total Net Worth			\$	(5,372,702)
C. Total Reserves and Net Worth			\$	(1,459,756)
D. Total Liabilities, Reserves, and Net Worth			\$	5,125,887

H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year Ended	Page	of
Health Care Investors Inc. d/b/a Alexandr		2095-C	9/30/2015	36	37
Account				Amount	
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			\$	(3,847,964)
B.	Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	10,587,956
C.	Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	12,169,036
D.	Net Income or Deficit			\$	(1,581,080)
E.	Balance			\$	(5,429,044)
F.	Additions				
	1. Additional Capital Contributed (<i>itemize</i>)				
	2. Other (<i>itemize</i>)				
	Prior Period Adjustments		56,342		
F-3.	Total Additions			\$	56,342
G.	Deductions				
	1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
	Name and Address (<i>No., City, State, Zip</i>)	Title	Amount		
	2. Other Withdrawings (<i>Specify</i>)			\$	
	Purpose	Amount			
	3. Total Deductions			\$	
H.	Balance at End of Period		09/30/15	\$	(5,372,702)

I. Preparer's/Reviewer's Certification

Name of Facility Health Care Investors Inc. d/b/a Alexandria	License No. 2095-C	Report for Year Ended 9/30/2015	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>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.</p>				
Signature of Preparer 		Title		Date Signed 3-15-2016
Printed Name of Preparer				
Affinity Health Care Mgt				
Address Address 1781 Highland Ave Cheshire, CT			Phone Number 203-250-2030	