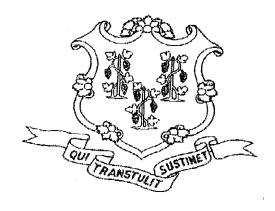
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2015

						RECE	IVED		
Name of Facility (as									:
Health Care Investors		****	•			MAR 1	7 2016		
Address (No. & Stree							, ,		
55 Tunxis Ave Bloom	nfield, CT 0600	2				DEPT OF SOCI	AL SERVICES	3	
Type of Facility					OFF	ICE OF CON AN	D RATE SET	INGS	
Chronic and C Nursing Home	Convalescent e only (CCNH)		Rest Home wit Supervision on (RHNS)	_	; 	(Specify)			
Report for Year Begi 10/1/2014	•		Report for Yea 9/30/2015	r Ending			,		
License Numbers:		CCNH 2095-C	RHNS		(Specify)		Medicare F 07-529		er
Medicaid Provider N	umbers:	CC	CNH	RI	HNS		ICF-MR		
For Department Use	e Only								
Sequence Number Assigned	Signed and Notarized	Date Received	Sequence N Assign		Signed	and Notarized	d Date F	Receive	ed
									•

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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 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 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 (Ówner)	
			Benjamin Z Fischman	
Subscribed and Sworn	State of	Date /	Signed (Notary Public)	Comm. Expires
to before me: Cheshere	Q+	3/15/19	a Martenand	131,19
Address of Notary Public	γ_{\star}	11 0 - 11	1110	
921 Marion all +	Witsell	le, CT06	Donna Mar	le Patenaude

(Notary Seal)

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

State of Connecticut Department of Social Services

25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjus	tm	ent		Page	of
				1A	37
Name of Facility		Period Cov	ered:	From	То
Health Care Investors Inc. d/b/a Alexandria Manor				10/1/2014	9/30/2015
Address of Facility					
55 Tunxis Ave Bloomfield, CT 06002					
Report Prepared By		Phone Nun		Date	
Alexnadria Manor		203-250-20	030		
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

	ſ	Pho	ne No. of Fac	ility	Report for Ye	ar Ended	Page	of
		860-	-242-0703		9/30/2015		2	37
Name of Facility (as shown on license)			Address (No	. & S	Street, City, Sto	ite, Zip)		
Health Care Investors Inc. d/b/a Alexandria Manor			55 Tunxis A	ve B	loomfield, CT	06002		
CCN	H		RHNS		(Specify)			Provider No.
License Numbers: 2095-C	}						07-5291	
Type of Facility (Check appropriate box(es))								
Chronic and Convalescent Nursing Home only (CCNH)			Home with Nervision only			(Specify)		
Type of Ownership (Check appropriate box)								
Proprietorship O LLC O Partnersh	ip	0	Profit Corp.		Non-Profit Cor	- -	Government	O Trust
If this facility opened or closed during report year pro	vide:			Date	Opened	Date Clo	sed	
Has there been any change in ownership			·-·			<u> </u>	····	
or operation during this report year?		0	Yes	•	No	If "Yes,"	explain fully	/.
Administrator								
Name of Administrator					Nursing He			
William Pond					Administrat		1520	
					License 1	Vo.:	********	
Other Operators/Owners who are assistant administra	itors (full	or part time) o	of thi				
Name					License 1	No.:		•
		,						

General Information and Questionnaire Partners/Members

Name of Facility		License No.	Report for Y	ear Ended	Page of
Health Care Investors Inc. d/b/a	Alexandria Manor	2095-C	9/30/2015		3 37
Legal Name of Parti	nership/LLC		Address	j.	or Town(s) in Registered
Health Care Investors Inc d/b/a	Alexandria Manor	55 Tunxis Ave Bloomfield,CT			
Name of Partners/Members	Business A	Address		Title	% Owned
Benjamin Fischman			President		51%
Samuel Strasser			Vice Preside	ent	6%
Joseph Grun			Secretary/Ti	easurer	6%

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year I	∃nded	Page	of
Health Care Investors Inc. d/b/a Alexandria M		9/30/2015		3A	37
If this facility is owned or operated as a corpo	ration, provide th	e following informa	tion:		
Legal Name of Corporation		ess Address	State(s) in Whi	ch Incorp	orated
				No. C	1
Name of Directors, Officers	Busin	ess Address	Title	No. Sl Held by	
				Heid by	/ Басн
	1				
				<u></u>	
	1				
				<u> </u>	-
					_
Names of Stockholders Owning at Least 10%					
of Shares					
	-				
				_	
			,		
			·		
	4		•	1	

General Information and Questionnaire Individual Proprietorship

Name of Facility Health Care Investors Inc. d/b/a Alexandria Mano	License No. 2095-C	Report for Year Ended 9/30/2015	Page 3B	of 37
If this facility is owned or operated as an individual				31
	ner(s) of Facility			
				<u></u>
			····	
	Manual Control of the			
			Mariana di	
			<u></u>	
	<u></u>			

State of Connecticut

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General Information and Questionnaire Related Parties*

Name of Facility Health Care Investors In	Name of Facility Health Care Investors Inc. d/b/a Alexandria Manor	License No. 2095	No. 2095-C	Report for Year Ended 9/30/2015		Page 4	of 37
Are any individuals receinmantage ability to contr	Are any individuals receiving compensation from the facility related through marriage ability to control ownershin family or business association?	acility rela	ated through	Vec O No	If "Yes," provide the Name/Address and	he Name/Add	If "Yes," provide the Name/Address and
النسانية، مالية ما مالية	or, criticality, tenting of contra	000		3	month of the month	וומרוטוו טוו דמ	go 11 of the report.
Are any individuals or α including the rental of pr	Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility,	or servic to this fa	es, cility,				
related through family as association to any of the	related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?	, control, of this fa	or business cility?	O Yes O No	If "Yes," provide the following information:	he following	information:
		Also	Provides		Indicate Where		
		Goods	Goods/Services to		Costs are Included		
Name of Related	Business	Non-R	Non-Related Parties	Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	%** ON	Provided	Page # / Line #	Reported	Related Party
Benjamin Fischman, Affinity Heaith Care Mgt	Benjamin Fischman, Affinity 221 East 33rd St New York , NY Heaith Care Mgt 10016	0	•	Management of Operations	Pg 16 Line M12	358,524	358,524
Benjamin Fischman, Affinity Health Care Mgt	Benjamin Fischman, Affinity 221 East 33rd St New York, NY Health Care Mgt 10016	0	0	Consolidated Pension-NonUnion	Pg 15 Line 1a7		
Joseph Grun & Harold Rubin, Gerimedix	3741 Ocean Ave Brooklyn, NY 11224	0	0	99% Medical Supplies	Various	171,293	Unknown
Alexandria Manor Associates LLC	Alexandria Manor Associates 1781 Highland Ave Cheshire, CT LLC	0	•	Real estate	Pg 22 Line 9	423,412	423,412
Blair Manor		0	•	None	N/A	N/A	N/A
Douglas Manor		0	•	None	N/A	N/A	N/A
Ellis Manor		0	•	None	N/A	N/A	N/A
		0	0				
		0	0				

^{*} 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	License No) .	Report for Year Ended	Page of
Health Care Investors Inc. d/b/a Alexandria Mar	2095-0	2	9/30/2015	5 37
If the facility is licensed as CDH and/or RCH or	provides A	IDS or TBI	services with special Medicai	d rates, costs
must be allocated to CCNH and RHNS as follow	vs:			
Item			Method of Allocation	1
Dietary		Number of	meals served to residents	
Laundry		Number of	pounds processed	
Housekeeping		Number of	square feet serviced	
		Number of	hours of routine care provided	by EACH
Nursing		employee c	lassification, i.e., Director (or	Charge Nurse),
			Nurses, Licensed Practical Nu	irses, Aides and
		Attendants		
Direct Resident Care Consultants		Number of	hours of resident care provide	d by EACH
		specialist ((See listing page 13)	
Maintenance and operation of plant		Square feet		
Property costs (depreciation)		Square feet		
Employee health and welfare		Gross salaı		
Management services			e cost center involved	
All other General Administrative expenses	<u></u>	Total of Di	rect and Allocated Costs	
The preparer of this report must answer the following	wing quest	ions applica	ble to the cost information pro	vided.
1. In the preparation of this Report, were all	• Yes	O No	If "No," explain fully why su	ch allocation was
costs allocated as required?	O 165	0 140	not made.	
Explain the allocation of related company exp	enses and a	ttach copy	of appropriate supporting data	•
3. Did the Facility appropriately allocate and se				me cost centers?
(e.g., Assisted Living, Home Health, Outpation	ent Services	, Adult Day	Care Services, etc.)	
	• Yes	O No	If "No," explain fully why su	ch 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	ar Ended		Page of
Health Care Investors Inc. d/b/a Alexandria Manor	Aanor		2095-C	9/30/2015			6 37
	Related * to	d * to					
	Owners,	ers,					
	Operators,	tors,				Annual	
	Officers	ers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Claimed
Ricoh America	0	•	Copier	01/01/02		4,673	4,673
Crystal Rock	0	•	Water Coolers	01/01/94		2,501	2,501
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					

Is a Mileage Log Book Maintained for All Leased Vehicles?

Total ***

0 0

O Yes

* 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	License No.	Report for Year Ended		Page	of
Health Care Investors Inc. d/b/a Ale	2095-C	9/30/2015		7	37
The records of this facility for the p	period covered by this report	were maintained on the following basis:			
O Accrual O Cash O	Modified Cash				÷
Is the accounting basis for this					
12	Yes	If "No," explain.			
previous period?	No				
Independent Accounting Firm					
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code))		
1 Genovese & Wonneberger, LL	.C	Cheshire, CT			
2 Whittlesey & Hadley PC		Hartford, CT			
3					
4					
Services Provided by This Firm (de	escribe fully)				
1 Monthly Accounting / Financial Overs	sight		\$	48,285	
2 HUD financials		÷	\$	9,400	
3			\$		
4			\$		
			Charge fo	r Services Pi	rovided
			\$	57,685	
Are These Charges Reflected in the Expend	liture Portion of This Report? If Ye	s, Specify Expense Classification and Line No.		,	
⊙ Yes O No	Pg 15, Line 1.d				
Legal Services Information					
Name of Legal Firm or Independen	nt Attorney		Telephone	e Number	
1 See Attached Page 7A					
2 3					
3					
4					
5	7:- (-1-)		L		
Address (No. & Street, City, State,	zip Coae)				
1 2					
3					
4					
5					
Services Provided by This Firm (de	escribe fully)				
1 See Attached Page 7A			\$	22,783	
2			\$		
3			\$		
4			\$		
5			\$		
	·		Charge fo	r Services Pi	rovided
			\$	22,783	
Are These Charges Reflected in the Expend	diture Portion of This Report? If Yo	s, Specify Expense Classification and Line No.			
⊙ Yes O No	Pg 15, Line 1.e				
O 103 O 110					

Alexandria Manor Medicaid Cost Report 9/30/2015

	-		~				
Total Tota	Legal			:		Page 7A	
169 169		Address	Uescription of Sry	Amour		Amt Disallow	Reason
199 199					:	: :	
76 Centrer Street, Waterbury CT 06/702		Teo Asylum Schamord Ct Certus				\$ (119)	insufficent description
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76 Center Sireel, Waterbury CT 06702 resident bear collection \$ 4,942 105 Broad Sireel, Bridgeport, CT 06604 Confessionation \$ 2,578 1057 Broad Sireel, Bridgeport, CT 06604 Confessionation with S Cark \$ 2,578 1057 Broad Sireel, Bridgeport, CT 06604 Confessionation of the second confession of the second conf							
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76 Center Street, Waterbury CT 06/02 Nessident vect collection \$ 4,942 1067 Broad Street, Endgeport, CT 06604 Union negotaenons \$ 4,942 1067 Broad Street, Endgeport, CT 06604 Carrespondence with Sclark ordered with Sclark sequencing \$ 2,578 1067 Broad Street, Endgeport, CT 06604 Issues relations and street, Endgeport, CT 06604 Issues relations \$ 8,858 1067 Broad Street, Endgeport, CT 06604 Issues relations \$ 100 1067 Broad Street, Endgeport, CT 06604 International Sequence \$ 100 1067 Broad Street, Endgeport, CT 06604 International Sequence \$ 100 1067 Broad Street, Endgeport, CT 06604 International Sequence \$ 100 1067 Broad Street, Endgeport, CT 06604 International Sequence \$ 12,731 1067 Broad Street, Endgeport, CT 06604 International Sequence \$ 12,731 1067 Broad Street, Endgeport, CT 06604 International Sequence \$ 1,298 107 Broad Street, Endgeport, CT 06604 International Sequence \$ 1,298 107 Broad Street, Endgeport, CT 06604 International Sequence \$ 1,298 107 Broad Street, Endgeport, CT 06604 International Sequence \$ 1,298	<u>Legal - Resident</u>				+-+		J
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1057 Broad Street, Entigeport, CT 06604 Captoring and settlement regotations \$ 9.95 1057 Broad Street, Entigeport, CT 06604 Captoring and settlement regotations and settlement regotations \$ 8,858 1057 Broad Street, Entigeport, CT 06604 with 1199 1058 Broad Street, Entigeport, CT 06604 with 1199 1059 Broad Street, Entigeport, CT 06604 with 1199 1050 Broad Street, Entigeport, CT 06604 with 1199 1050 Broad Street, Entigeport, CT 06604 with 1199 1051 Broad Street, Entigeport, CT 06604 with 1199 1052 Broad Street, Entigeport, CT 06604 with 1199 1053 Broad Street, Entigeport, CT 06604 with 1199 1054 Broad Street, Entigeport, CT 06604 with 1199 1055 Broad Street, Entigeport, CT 06604 with 1199 1057 Broad Street, Entigeport, CT 06604 with 1199 1058 Broad Street, Entigeport, CT 06604 with 1199 1059 Broad Street, Entigeport, CT 06604 with 1199 1050 Broad Street, Entigeport, CT 06604 with 1199 1050 Broad Street, Entigeport, CT 06604 with 1199 1051 Broad Street, Entigeport, CT 06604 with 1199 1052 Broad Street, Entigeport, CT 06604 with 1199 1052 Broad Street, Entigeport, CT 06604 with 1199 1054 Broad Street, Entigeport, CT 06604 with 1199 1057 Broad Street, Entigeport, CT 06604 with 1199 1058 Broad Street, Entigeport, CT 06604 with 1199 1058 Broad Street, Entigeport, CT 06604 with 1199 1058 Broad Street, Entigeport, CT 06604 with 1199 1059 Broad Street, Entigeport, CT 06604 with 1199 1059 Broad Street, Entigeport, CT 06604 with 1199 1059 Broad Street, Entigeport, CT 06604 with 1199 1050 Broad Street, Entigeport, CT 06604 with 1199 1059 Broad Street, Entigeport, CT 06604 with 1199 1059 Broad Street, Entigep					1		
1057 Broad Street, Bridgeport, CT O6604 Cargon regionations 5 2,578 1057 Broad Street, Bridgeport, CT O6604 Settlement ingoitations 5 8,858 1057 Broad Street, Bridgeport, CT O6604 With 1199 1057 Broad Street, Bridgeport, CT O6604 Reminitation of employee 5 1,298 1057 Broad Street, Bridgeport, CT O6604 Reminitation of employee 5 1,298 1057 Broad Street, Bridgeport, CT O6604 Reminitation of employee 5 1,298 1057 Broad Street, Bridgeport, CT O6604 Reminitation of employee 5 1,298 1057 Broad Street, Bridgeport, CT O6604 Reminitation of employee 5 2,418 1057 Broad Street, Bridgeport, CT O6604 Reminitation of employee 5 2,418						\$ (4,942)	
1057 Broad Street, Bridgeport, CT 06604 Cayon negoriations \$ 2,578 1057 Broad Street, Bridgeport, CT 06604 Settlement negotiations \$ 8,858 1057 Broad Street, Bridgeport, CT 06604 With 1199 With 1199 With 1199 1057 Broad Street, Bridgeport, CT 06604 With 1199 With 1199 1057 Broad Street, Bridgeport, CT 06604 With 1199 With 1199 1057 Broad Street, Bridgeport, CT 06604 With 1199 With 1199 1057 Broad Street, Bridgeport, CT 06604 With 1199 With 1199 1057 Broad Street, Bridgeport, CT 06604 With 1199 With 1199 With 1199 1057 Broad Street, Bridgeport, CT 06604 With 1199	<u>Legal Labor</u>						
1057 Broad Street, Bridgeport, CT 06604 correspondence with S Clark \$ 2,578 1057 Broad Street, Bridgeport, CT 06604 with 1199 settlement registering for settlement agreement \$ 3.00 1057 Broad Street, Bridgeport, CT 06604 with 1199 settlement agreement \$ 3.00 1057 Broad Street, Bridgeport, CT 06604 with 1199 \$ 12,731 1057 Broad Street, Bridgeport, CT 06604 with 1199 \$ 12,731 1057 Broad Street, Bridgeport, CT 06604 with 1199 \$ 350 1057 Broad Street, Bridgeport, CT 06604 with 1199 \$ 1,298 1057 Broad Street, Bridgeport, CT 06604 with 1199 1058 Bridger With 1199 1058 Bridger With 1199 1057 Broad Street, Bridgeport, CT 06604 with 1199	Durant, Nichols, Houston, Hodgson & Cortese - Costa, PC		Union hegotiations		395		
1057 Broad Street, Bridgeport, CT 06604 settlement negotiations \$ 8,858 1057 Broad Street, Bridgeport, CT 06604 with 1199 1057 Broad Street, Bridgeport, CT 06604 with 1199 1057 Broad Street, Bridgeport, CT 06604 with 1199 1057 Broad Street, Bridgeport, CT 06604 remination of employee \$ 12,731 1057 Broad Street, Bridgeport, CT 06604 remination of employee \$ 1,298 1057 Broad Street, Bridgeport, CT 06604 remination of employee \$ 1,298 1057 Broad Street, Bridgeport, CT 06504 remination of employee \$ 1,298 1057 Broad Street, Bridgeport, CT 06504 remination of employee \$ 2,418 1057 Broad Street, Bridgeport, CT 06504 remination of employee \$ 2,418			Cayon notices and correspondence with S Clark		78		
1057 Broad Street, Bridgeport, CT 06604 with 199 8,858 1057 Broad Street, Bridgeport, CT 06604 with 199 8,800 1057 Broad Street, Bridgeport, CT 06604 with 199 8,12,731 1057 Broad Street, Bridgeport, CT 06604 1057 Broad Street, Bridgeport, CT 0660			Issues related to layofts and		2		
1057 Broad Street, Bridgeport, CT 06604 With 1199 and Street, Bridgeport, CT 06604 With 1199 and Street, Bridgeport, CT 06604 With 1199 and Street, Bridgeport, CT 06604 with and Street			settlement negotiations	ŀ	358		
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1057 Broad Street, Britgsport, CT Ubsouk 1057 Broad Street, Britgsport, CT Ubsouk 1057 Broad Street, Britgsport, CT 06504 1057 Broad Street, Britgsport, CT 06504 1057 Broad Street, Britgsport, CT 06504 1057 Broad Street, Britgsport, CT Ubsouk 1058 Broad Street, Britgsport, CT Ubsouk 1059 Broad Street, Britgsport, CT Ubsouk 1059 Broad Street, Britgsport, CT Ubsouk 1050 Broad Street, Broad Street				-			7
1037 Broad Street, Britigaport, CT 06604 1057 Broad Street, Bridgaport, CT 06700 1057	Legal Expense						
1057 Broad Street, Bridgepont, CT 06604 hweetigateon of employee \$ 1,298 has south real Street, Bridgepont, CT 06604 termination of employee \$ 1,298 has south real Street, Bridgepont, CT 06707 Aroltation of employee \$ 2,418	Direct Nichole Househop Hodgeon & Cortace - Costs Do					(400)	to constant
1057 Broad Street, Bridgeport, CT 06504 termination of employee \$ 1,298 403 South Main St West Plaintvict, CT 06504 termination of employee \$ 1,298 1007 Broad Street, Bridgeport, CT 06504 Termination of employee \$ 2,418 1007 Broad Street, Bridgeport, CT 06504 Union negotiations \$ 2,418	Durant, Nichols, Houston, Hodgson & Cortese - Costa, P.C.				1	(350)	insufficient support
1057 Broad Street, Bridgeport, CT 06604 Eministric S 1,298 1057 Broad Street, Bridgeport, CT 06604 Chromomegorianoms S 2,418 1057 Broad Street, Bridgeport, CT Up604 Union hegorianoms S 2,418	Durant, Nichols, Houston, Hodgson & Cortese - Costa, PC	-			Ì.		insufficient support
1057 Erroad Street, Bringsport, CT Up6TV Writhfatch Orlinon megoriations \$ 2,418			investigation regarding termination of employee		863		
Sse - Costa, PC Tour chad street, bringspirit, or bodget	Ward, Frederick	•	Arbitrator for Oniton matter		375		
\$ 4,991	Durant, Nichols, Houston, Hodgson & Cortese - Costa, PC		Union negotiations		138		
\$ 4,991							
						(009) \$	
\$ 22.782			Grand Total:			\$ (5,660)	

State of Connecticut

Annual Report of Long-Term Care Facility CSP-8 Rev. 9/2002

Schedule of Resident Statistics

Name of Facility			License No.	lo.			Report fo	Report for Year Ended	, z		Page	of
Health Care Investors Inc. d'b/a Alexandria Manor			20	2095-C			9/30/201.	5			8	37
					I	eriod 10/	Period 10/1 Thru 6/30	30		Period 7/1 Thru 9/30	Thru 9/3)
	Total All	Total CCNH	Total RHNS	Total								
	Levels	Level	Level	(Specify)	Total	CCNH	RHINS	(Specify)	Total	CCNH	RHINS	(Specify)
 Certified Bed Capacity 												
A. On last day of PREVIOUS report period	120	120			120	120			120	120		
B. On last day of THIS report period	120	120			120	120			120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	106	106			901	106						
B. As of midnight of THIS report period		1/4-1-2		-	95	95						
3. Total Number of Days Care Provided During Period												
A. Medicare	3,009	3,009			2,419	2,419			290	590		
B. Medicaid (Conn.)	30,259	30,259			22,908	22,908			7,351	7,351		
C. Medicaid (other states)												
D. Private Pay	1,130	1,130			887	887			243	243		
E. State SSI for RCH												
F. Other (Specify)	3,096	3,096			2,551	1,551			545	545		
G. Total Care Days During Period (3A thru F)	37,494	37,494			28,765	28,765			8,729	8,729		
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	28,765			8,729	8,729	•	

Annual Report of Long-Term Care Facility

CSP-9 Rev. 9/2002

Schedule of Resident Statistics (Cont'd)

Name of Faci	lity			Lice	nse No.				Report	for Year	Ended		Page	of
Health Care I	nvestors	inc. d/t	o/a Alexandria N	20	095-C					9/30/201	.5		9	37
	•	_	in the certified b		pacity du	ring t	he repo	ort yea	ır?	0	Yes	•	No	
	T.		ſ Change		Cł	ange	in Bed	s		Ca	pacity Aft	er Change		
Date of	CCNH	RHNS			Lost		1	Gaine	d d					
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason f	or Change
							ļ							
	 							-						
[_	in certified bed of 90 days following		-	the r	eport y	ear (as	s report	ed in iten	n 4 above)	provide the nur	mber of	
			Change in R	esider	nt Days					CC	NH	RHNS	(Spe	ecify)
1st chan														
2nd char 3rd chan														·····
4th chan														· · · · · ·
		dents an	d Rates on Septe	mber	30 of Co	st Ye	ar					l .	L	
			Medicare		Medi					Se	lf-Pay		Other Sta	te Assisted
								l						
3.1 CD	ltem		CCNH		CNH	RI	HNS	CC	CNH	RH	INS	(Specify)	R.C.H.	ICF-MR
No. of R Per Dien		š į	5		81				3	**		6		
a. One b			RUGs 777.94	2000	249,79	rate a re		1450.00	390.00			375.00		
b. Two			RUGs 199.21						370,00					
c. Three	e or mor	e :												
bed i	rms.							<u> </u>				·		-
A.	Medica	are - Par			.						TAL 1,307	CCNH 1,307	RHNS	(Specify)
В.		-	lusive of Part B)											
			e Treatments Treatments								754	754		
C.	Other	torative	Treatments								9,507	9,507		
		Physical	Therapy Treati	nents							11,568	11,568		
			Therapy Treatn	ents										
		are - Par							·····		377	377		
В.			lusive of Part B) to Treatments							100 Miles	10 11 12 W			
			Treatments								45	45		, , , , , , , , , , , , , , , , , , , ,
C.	Other										746	746		
		Speech T	Therapy Treatm	ents							1,168	1,168		
			ational Therapy	Freatr	nents									
		are - Par								4-13-14-14-14-14-14-14-14-14-14-14-14-14-14-	1,522	1,522		
В.			lusive of Part B) the Treatments											
			Treatments								851	851		
	Other										8,934	8,934		
D.	Total C	Occupat	ional Therapy T	reatr	nents						11,307	11,307		

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.		Report for Yea		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 co	mpensation?	•	Yes	0	No	
			Total Cost a	nd Hours	······································	
			Accessor			
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
Operators/Owners (Complete also Sec. I						
of Schedule A1) 2. Administrator(s) (Complete also Sec. III						
	100.565	2 124				
of Schedule A1) 3. Assistant Administrator (Complete also Sec. IV	102,565	2,134		N. Company		\$4644 Berendara
of Schedule A1) 4. Other Administrative Salaries (telephone						
operator, cierks, receptionists, etc.)	211,731	9,362				
5. Dietary Service	2(1,731	7,302				
a. Head Dietitian	25,357	622				
b. Food Service Supervisor	62,376					
c. Dietary Workers	451,252	23,990				
Housekeeping Service						
 a. Head Housekeeper 						
b. Other Housekeeping Workers	241,744	16,527		UNIVERSAL CONTRACTOR		772
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		-		
Barber and Beautician Services	54,507	3,617		<u> </u>		
10. Protective Services	40,406	2,400				
11. Accounting Services		2,100				
a. Head Accountant	2000-00220-00220-0020	0384400040840090900400				
b. Other Accountants						
12. Professional Care of Residents						
 a. Directors and Assistant Director of Nurses 	158,798	3,997				
b. RN		7.				
Direct Care	851,568					
2. Administrative**	165,365	5,323				Y
c. LPN						
1. Direct Care	892,041	29,846				
Administrative** d. Aides and Attendants	1.782.609	106 904				
e. Physical Therapists	1,762,009	100,904				
f. Speech Therapists						
g. Occupational Therapists	-					
h. Recreation Workers	97,010	4,355				
i. Physicians						
Medical Director	:				E-BBC CO-LOCALIS AND SOMEW BLAND WHIN BOTTE VALUE	
Utilization Review						
3. Resident Care***				20000		######################################
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
1. Podiatrists						
m. Social Workers/Case Management	59,309	2,118				
n. Marketing	militaria in ingga mili ana taona na mana		TALLS AND			an begin of the latter and the latte
o. Other (Specify)	20,000	1.000				
See Attached Schedule	29,988	1,908				
А-13. Total Salary Expenditures	5,335,412	240,299	<u> </u>	L		

^{*} 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)

	CC	NH	RH	INS	(Spe	cify)
Position	\$	Hours	\$	Hours	8	Hours
50505062 S & W - NURS MED REC	\$ 29,988	1,908		San	1.148/11.2547.15	
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						TO MALILIA DE
				711 el 141 el 2016 e 1418, liber 80	1 - 20 0 A 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
Fotal	\$ 29,988	1,908	\$		\$	

Schedule of Other Fees (Page 13)

		CC	NH	RH	INS	(Spe	eify)
Service		\$	Hours	\$	Hours	\$	Hours
54006190 PURCH SERV - IV NURS	\$	7,863	105				
	\$		4.5				raiteatha i
* * * * * * * * * * * * * * * * * * *	\$	•				tere to teres.	
-	\$		1000				
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	 -						
	-				rings kapa Made		
					1 1 1 1 1 1 1 1 1 1		
	\vdash						1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Total	\$	7,863	105	\$ -		\$ -	

State of Connecticut Annual Report of Long-Term Care Facility CSP-11 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

Name of Facility		,	112215547		icense No Remort for Vest Ended	Renort for	Renort for Year Ended		Рясе	J.C
וימוווט טו ז מכוווני)				בירכוואר זיים.		TOT TION	ו כמו דיות כת		1 age	3
Health Care Investors Inc. d/b/a Alexandria Manor	Jexandria 🛚	víanor		2095-C		9/30/2015			11	37
		Salary Paid	đ							
				Fringe Benefits and/or Other		Total	Line Where		Total	
Name	CCNH	RHINS	(Specify)	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
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.

State of Connecticut Annual Report of Long-Term Care Facility CSP-12 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties*

		7	Assistan	t Administra	Assistant Administrators and Utner Kelated Parties*	Related	rarues			
Name of Facility (as licensed)				License No.		Report for Year Ended	ear Ended		Page	of
Health Care Investors Inc. d/b/a Alexandria Manor	exandria M	lanor		2095-C		9/30/2015			12	37
		Salary Paid	đ						:	
-				rringe Benefits and/or Other					Total	•
Name	CCNH	RHNS	(Specify)	Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section III - Administrators***										
William Pond	102,565			Std	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.

Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

B. Report of Ex		68 - 1 1 01				
Name of Facility	License No.		Report for Y	ear Ended	Page	of
Health Care Investors Inc. d/b/a Alexandria Manor	2095)-C	9/30/2015		13	37
	ļ	<u> </u>	Total Cost	and Hours		I
	~~~				(0.10)	
<u>Item</u>	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary			10 7 2			
(For all such services complete Schedule B1)						
1. Dietitian	1 220	0.6	•			
2. Dentist	4,320	96				
3. Pharmacist	9,024	120				
4. Podiatrist						
5. Physical Therapy	202.244	2.547				
a. Resident Care	282,366	3,547				
b. Other 6. Social Worker						
7. Recreation Worker 8. Physicians						
•	56,000	317		54 A.E.B. 64 A.E.		
a. Medical Director (entire facility) b. Utilization Review	56,000	317				
(Title 18 and 19 only) monthly meeting c. Resident Care**						
d. Administrative Services facility						
Infection Control Committee	125 00 E 2 - 1 S C C C	66141-6-6-4				Salah Persentah
(Quarterly meetings)						
2. Pharmaceutical Committee		······································				1
(Quarterly meetings)						
Staff Development Committee     (Once annually)						
e. Other (Specify)						
c. Other (openly)						
9. Speech Therapist						
a. Resident Care	62,160	793	See a de red had sancia			
b. Other	02,100	775				
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	en constituente de la casa de la c				CONTRACTOR OF THE PROPERTY OF	- LOUIS OF THE SECTION OF THE SECTIO
2. Administrative***						
c. Aides						
d. Other			,			
12. Other (Specify)						
See Attached Schedule	7,863	105		- Annual Control of the Control of t		1 10 cm / 104 100 177 ( 134 134 134 134 134 134 134 134 134 134
B-13 Total Fees Paid in Lieu of Salaries	738,201	8,550				
	4					

^{*} 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 Health Care Investors Inc. d/b/a Alexandri	License No. a Manor 2095-C		Report for Ye 9/30/2015	ear Ended	Page 14	of 37
Name & Address of Individual	Full Explanation of Service		to Owners, rs, Officers	Expla	nation of Relat	ionship
United Health Resource	Dental	0	0	· · · · · · · · · · · · · · · · · · ·		
Omnicare	Pharmacy, IV Nurse	0	0		·**	
Foremost Rehab	PT, OT, ST	0	•			T/******
Wilfred Eloba MD	Medical Director	0	0			
		0	0			
		0	0			
		0	•			
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^{*} 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 Y	ear Ended	Page	of
Health Care Investors Inc. d/b/a Alexandria Mano 2095-C		9/30/2015		15	37
	T				
Item		Total	CCNH	RHNS	(Specify)
Administrative and General					
a. Employee Health & Welfare Benefits	ľ				
1. Workmen's Compensation	\$	229,060	229,060		
2. Disability Insurance	\$	4,088	4,088		
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)	\$	219,276	219,276		
(not-owners and not-operators)					
8. Uniform Allowance	\$	38,588	38,588		
9. Other ( <i>Specify</i> )	\$	40,384	40,384		
See Attached Schedule	ľ				
b. Personal Retirement Plans, Pensions, and	\$				
Profit Sharing Plans for Owners and					
Operators (Discriminatory)*					
• • • • • • • • • • • • • • • • • • • •	ľ			100	
c. Bad Debts*	\$				
d. Accounting and Auditing	\$	57,685	57,685		
e. Legal (Services should be fully described on Page 7)	\$	22,783	22,783		
f. Insurance on Lives of Owners and	\$				
Operators ( <i>Specify</i> )*	Ì				
g. Office Supplies	\$	11,802	11,802		Secretary and the Secretary Secretary Secretary Secretary
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	39,780	39,780	CONTRACT CONTRACTOR CONTRACTOR	
2. Cellular Phones	\$	4,414	4,414		
i. Appraisal (Specify purpose and	\$	,			
attach copy)*					
	į				
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	\$	711,211	711,211		
Subtotal	\$	2,662,279	2,662,279		
* Eggility should yelf-disallow the expense on Page 28 of the Cost Report		2,002,219		tals forward t	

^{*} 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

Health Care Investors Inc. d/b/a Alexandria Manor 2095-C  Item  Subtotals Brought Forwa  1. Travel and Entertainment	rd:	9/30/2015 Total	CCNH	16	37
Subtotals Brought Forwa	rd:	Total	CCNII		
Subtotals Brought Forwa	rd:	Total	CCMII		
Subtotals Brought Forwa	rd:	Total	COMIT		
<del></del>	rd:		CUNIT	RHNS	(Specify)
1 Travel and Entertainment		2,662,279	2,662,279		
i. Frayor and Emericannion					
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 (not purchase or depreciation)	\$				
7. Other ( <i>Specify</i> )	\$				
See Attached Schedule				Z-1-1	
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (all such expenses)	\$	4,288	4,288		AND STREET STREET
2. Advertising Telephone Directory (all such expenses )***	\$	• •			
3. Advertising Other (Specify)***	\$	3,538	3,538		
See Attached Schedule					
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	\$	2,052	2,052		
Associations (Specify)					
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	598	598		
10. Contributions***	\$				
See Attached Schedule					
11. Services Provided by Contract (Specify and Complete	\$	174,036	174,036	- contract of the control of the con	And the second s
Schedule C-2, Page 21 for each firm or individual)					
12. Administrative Management Services**	\$	358,524	358,524		
13. Other (Specify)	\$	53,353	53,353	····	
See Attached Schedule					
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	C	CNH	RHI	NS	(Specify)
-	\$	-			
	L				
	<u> </u>				
	<u> </u>		ļ		
			<u> </u>		
	-		<u> </u>		
Total Other Travel and Entertainment			4		
Total Other Travel and Entertainment	3	-	<u> </u>	-	· -

### Schedule of Other Advertising

Description	C	CNH	RHNS		(Specify)
80007810 ADVERTISING - PROMO	. \$	999			
ADVERTISING - COMM. AWARENESS	\$	(240)			
80007540 PROMOTIONAL	\$	2,779			
Total Other Advertising	\$	3,538	\$	- [	s -

### Schedule of Dues

Description		CCNH	RI	INS	(S	pecify)
	\$	-				
CAHCF-Annual Membership Dues	\$	2,052				
	\$	-				
-	\$	-				
-	\$	-				
	l					
	L					
<del></del>			l			
					I	
					L	
Total Dues	\$	2,052	s		\$	-

### Schedule of Contributions

Description	CCNH	R	HNS	(Spe	cify)
_	\$ -				
Total Contributions	\$ -	\$		\$	-

### Schedule of Other Administrative and General

Description	CCNII	RHNS	(Specify)
	\$ -		
LICENSES & FEES - DIETARY	\$ 460		
70008042 EMPLOYEE INQUIRIES	\$ 1,851		
80007450 LICENSES & FEES	\$ 553		T
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	\$ i,859		
51005292 UNION NEGOTIATIONS	\$ 400		}
80008530 SALES & USE TAX	\$ 112		
	. \$ -		
	\$		
Fotal 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 Alexandr	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)

Nan	ne of Facility	·	License	No.	Repo	ort for Ye	ear Ended	Page	of
Hea	th Care Investors Inc. d/b/a Alexandria Manor			2095-C	9/	30/2015		18	37
	Item			Total	C	CNH	RHNS	(S ₁	pecify)
2.	Dietary a. In-House Preparation & Service								
	1. Raw Food		\$	286,320	Spirit Married	286,320			
	2. Non-Food Supplies		\$			33,112			
	3. Other (Specify)		_ \$				- 16 (E) - 17 (E) - 18 (E)		
-	b. Purchased Services (by contract other		\$	283		283		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	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)		\$	319,715		319,715			
2F.	Dietary Questionnaire			Total	C	CNH	RHNS	(S	pecify)
G.	Resident Meals: Total no. of meals served per	day	/:*	308		308			
H.	Is cost of employee meals included in 2E?	<del>_</del>	Yes	1	No		1		
I.	Did you receive revenue from employees?	0	Yes	•	No		If yes, specify amt.	·	
J.	Where is the revenue received reported in the	Cos	t Report	? (Page/Line I	tem)				
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	0	Yes	•	No		If yes, specify cost.		
L.	Is any revenue collected from these people?	0	Yes	•	No		If yes, specify amt.		
M.	Where is the revenue received reported in the	Cos	t Report	? (Page/Line I	tem)				
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	0	Yes	•	No		If yes, specify cost.		
O.	Is any revenue collected from employees?	0	Yes	•	No		If yes, specify amt.		
P.	Where is the revenue received reported in the	Cos	t Report	? (Page/Line I	tem)				
t									

^{*} 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 Health Care Investors Inc. d/b/a Alexandria Manor			No. 095-C	Report for Y 9/30/2015	ear Ended	Page	of 37
						<u> </u>	
	Item		Total	CCNH	RHNS	(Spec	rify)
3.	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies,	Lbs.					
	gowns and other resident care items washed, ironed, and/or processed.***	Amt. 5					
	Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.					
	processed.***	Amt. \$					
	3. Personal clothing of residents	Lbs.					
	washed, ironed, and/or processed.***	Amt. \$					
	4. Repair and/or purchase of linens.***	Lbs.					
		Amt. \$					
	b. Purchased Services (by contract other	\$	41,749	41,749			
	than through Management Services)						
	(Complete Schedule C-2 att. Page 21)						
	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? O	Yes	•	No	If yes, specify cost.		
Н.	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			

^{*} 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		1	Rep	ort for Year E	nded	Page	of
Health Care Inve	estors Inc. d/b/a Alexandria Mar	2095-C	<u> </u>	9/30/2015		20	37
	Item			Total	CCNH	RHNS	(Specify)
4. Housekeepi	_	Sq. Ft. Serviced					
a. In-Hous		by Personnel					
_	plies - Cleaning ( <i>Mops,</i> ls, brooms, etc.)	Amt.	\$	31,121	31,121		
b. Purchas	ed Services (by contract other	Sq. Ft. Serviced					
than th	rough Management Services)	by Personnel					
_	ete Schedule C-2 att. se 21 )	Amt.	\$	88,102	88,102		
	ment Services*	I	\$				
d. Other (S			\$	119	119		
	or Furniture and Equipment						
	sekeeping Expenditures (4a +	b+c+d)	\$	119,342	119,342	The second secon	
5. Resident Ca	are (Supplies)**						
a. Prescrip	tion Drugs***						
1. Ow	n Pharmacy		\$	CO CONTROL OF A CO	a contration which is the model contration to the contration of th	SECTION TO SECURITY OF SECURITY SECTIONS.	
2. Pur	chased from		\$	267,859	267,859		
b. Medicin	e Cabinet Drugs		\$	68,582	68,582		
c. Medical	and Therapeutic Supplies		\$	116,042	116,042		
d. Ambula	nce/Limousine***		\$				
e. Oxygen							
	Emergency Use		\$				
2. Oth	er***		\$	41,477	41,477		
	and Related Radiological		\$	2,994	2,994		
Procedu	· · · · · · · · · · · · · · · · · · ·						
	Not dentists who should be incl	luded under	\$		V-61-0/100000-07-0/1000-100-6	TOTAL PROPERTY AND ADDRESS OF THE PARTY OF T	
**	or fees)						
h. Laborat			\$	34,080	34,080		
i. Recreati			\$	11,311	11,311		
	Specify)****		\$	229,585	229,585		THE PERSON TO COMPANY AND ADDRESS OF THE PERSON ADDRESS OF THE
	Attached Schedule						
5K. Total Resid	lent Care Expenditures (5a - 5	<u>j)</u>	\$	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		
	\$ -		
	\$ -		
	\$ -		
	\$ -		
<u> </u>	\$ -		
	\$ -		
	\$ -		
-	\$ -		
-	\$ -		
	\$ -		
-	\$ -		
	\$ -		
	\$ -		
Total Other Resident Care	\$ 229,585	\$ -	\$ -

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

Name of Facility Health Care Investors Inc. d/b/a Alexandria Manor	a Alexandria Manor			License No. 2095-C	Report for Year Ended 9/30/2015	7			Page of 21   37
		Related ** to Owners, Operators, Officers	to Owners, Officers				Fotal Cost	Total Cost/Page Ref.***	*
Name of Individual or Company	Address	Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Pg Line
State of Connecticut DSS		0	•		Eligibility Worker	34,069			16 m11
Healthcare Services		0	0		Laundry Services	41,749			19/3b
Healthcare Services	1	0	•		Housekeeping Service	85,395			20 4b
USA Hauling		0	0		Trash Removal	615,61			22 6f
АDP		0	0		Payroll Time and Attendance system	23,759			16 m11
MDI Achieve Software		0	0		Software Maintenance/Support	13,334			16 m11
Healthcare Management Solutions		0	0		Billing and AR Processing	97,496			16 m11
Property Management		0	0		Snow Removal	15,967			22 6f
Kone Inc		0	•		Elevator Service	14,096			22 6f
Red Hawk Fire & Sec.		0	•		Fire and Alarm Service	33,467			22 6f
Stericyle		0	•		Medical Waste Removal	28,669			23 6f
Digital Media		0	•		Satelite TV	15,642			22 6f
Andrea's Mechanical		0	0		Sewer services/Grease trap services	13,514			22 6f
		0	0						

^{*} 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	) <b>.</b>	Report for Ye	ear Ended		Page	of
Health Care Investors Inc. d/b/a Alexandria M 2095-C	3	9/30/2015			22	37
Item		Total	CCNH	RHNS	(Sp	ecify)
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 (Provide detail on page 6)	\$	7,174	7,174			
f. Other (itemize)	\$	180,488	180,488			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	443,159	443,159			
7. Depreciation (complete schedule page 23*)						
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 (Complete att. Schedule Page 24*)						
a. Organization Expense	\$	8,673	8,673			*
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (Specify)	\$		·			
*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. <i>Total Property Expenses</i> (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		
	\$	ugh a r		
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)		
	\$	jaku j		
Total Other Repairs and Maintenance	\$	180,488	\$	\$

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Depreciation Schedule

					a chresners servents					
Name of Facility			License No.			Report for Year Ended	nded		Page	Jo
Health Care Investors Inc. d/b/a Alexandria Manor	anor		2095-C	 		9/30/2015			23	37
			Historical Cost	Less		Accumulated Depreciation to	Method of			
,			Exclusive of	Salvage	Cost to Be	Beginning of		Useful	Depreciation	£
Property Item	***************************************		Land	Value	Depreciated	Year's Operations	Depreciation	Life	tor this Year	lotais
A. Land Improvements	,									
<ol> <li>Acquired prior to this report period</li> </ol>			1,640		1,640	1,621			18	
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	schedule)									
A-4. Subtotal										18
B. Building and Building Improvements										
1. Acquired prior to this report period			9,534,530		9,534,530	5,428,667		***	300,545	
2. Disposals (attach schedule)	***************************************					***************************************				
3. Acquired during this report period (attach schedule)	schedule)									
										300,545
C. Non-Movable Equipment										
1. Acquired prior to this report period			29,205		29,205	11,223			489	
3. Acquired during this report period (attach schedule)	schedule)									
C-4. Subtotai										489
	Is a mileage									
Ħ	logbook maintained? A	Date of Acquisition	Historical Cost	Less		Accumulated Depreciation to	Method of			
			Exclusive of	<b>V</b> ,	Cost to Be	Begirning of	Computing	Useful	Depreciation	
	Yes No Month	th Year	Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
D. Movable Equipment 1. Motor Vehicles (Specify name, model and year of each vehicle)										
3.	A MANAGEMENT AND THE PROPERTY OF THE PROPERTY		The state of the s	For CAN INCAMANCE INCAMING AND		And the second s		Account A service below the service of the service		
b.										
ပ										
ď.		- 1								
2. Movable Equipment										
a. Acquired prior to this report period			355,961		355,961	355,705			7,356	
b. Disposais (attach schedule)										
c. Acquired during this report period										
(affach schedule)							T.	77		7301
D-5. Subloidi										4,356
t Iotal Depreciation										308,408

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:				
		2.00	4. 7	1. 51
			1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	
Fotal additions for Land Improvement	nts	\$ -		\$ -
Deletions:				
		l	1.	
Total deletions for Land Improvemen	nts	\$ -		\$ -

^{*}Ties to Page 23, Line A3

### Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
				7.5
Cotal additions for Building Im	provements	\$ -		\$ -
Deletions:				
				. "
Fotal deletions for Building Imp	provements	\$ -		\$ -

^{*}Ties to Page 23, Line B3

### Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of	Item	Cost	Useful Life	Depreciation
Additions:	· · · · · · · · · · · · · · · · · · ·				
		1			
Total additions for Non-Movab	le Equipment		\$ -		\$
Deletions:				· ·	
		······································			. "
Total deletions for Non-Movab	le Equipment		\$ -		\$ -

^{*}Ties to Page 23, Line C3

^{**}Ties to Page 23, Line A2

^{**}Ties to Page 23, Line B2

^{**}Ties to Page 23, Line C2

		<b>~</b> .	Useful	<b>.</b>
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
			11 14 14 14	
				7.7
				1. 1. 1.
				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
		-		
Cotal additions for Moyable Equipment		\$ -		\$ -
Deletions:				
		1 - 4 - 5		Transactive Lych
			et e e	
		2000	ing the profession	
Fotal 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:	пирточением		Ψ		Ψ
Total deletions for Leasehold	Improvement		\$ -		\$ -

^{*}Ties to Page 24, Line C3
**Ties to Page 24, Line C2

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# Amortization Schedule*

Nar	Name of Facility		License No.		Report for Year Ended	r Ended		Page	fo
He	Health Care Investors Inc. d/b/a Alexandria Manor	anor	2095-C	5-C	9/30/2015			24	37
					Accumulated				
		Date of			Amort. to	,			
		Acquisition			Beginning of	Basis for			
			Length of	Cost to Be	Year's	Computing	Rate	Amortization	
	Item	Month Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A.	Organization Expense								1 - 1
	1. Deferred Acquisitions			354,431	147,777			8,673	
	2.								
	3.								9.
A-4	A-4. Subtotal								8,673
B.	Mortgage Expense								
	-								
	2.								
	3.								
B-4	B-4. Subtotal								
ပ	Leasehold Improvements and Other								
	1. Acquired prior to this report period								
	2. Disposals (attach schedule)								
	3. Acquired during this report period								
	(attach schedule)		The state of the s		The county of th	A THE CONTRACT OF THE CONTRACT			
C-4	C-4. Subtotal								
Ö.	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; ORC. Remaining Life of Lease; ORD. Actual Life if owned by Related Party.

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

Part A  Is the property either owned by the Facility or leased from a Related Party?*  *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	of
Part A  Is the property either owned by the Facility or leased from a Related Party?*  *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	37
Part A  Is the property either owned by the Facility or leased from a Related Party?*  *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	
or leased from a Related Party?*  *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	
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	
1. Date Land Purchased 2. Date Structure Completed 3. If NOT Original Owner, Date of Purchase 4. Date of Initial Licensure	
Date Structure Completed     If NOT Original Owner, Date of Purchase     Date of Initial Licensure	
If NOT Original Owner, Date of Purchase     Date of Initial Licensure	
4. Date of Initial Licensure	
5 Total Licensed Ded Conseits	
5. Total Licensed Bed Capacity 120 6. Square Footage	
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	
k. Amount of Principal Borrowed  I. 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	l ease
Traple and Address of Losson Tropolsy Louised Date of Lease Term of Lease Attituda Attituda of	Louse

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 Yea	ar Ended		Page of
Health Care Investors Inc. d/b/a Alexa 2095-C		9/30/2015			26   37
		Total	CCNH	RHNS	(Specify)
12. Interest					(======================================
A. Building, Land Improvement & Non-Movable					
Equipment					
First Mortgage	\$				
Name of Lender	Rate			75 25 10 10	
Address of Lender					
2. Second Mortgage	\$				
Name of Lender	Rate		44		
Address of Lender					
3. Third Mortgage	\$			- # - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5	
Name of Lender	Rate	and the second			
Address of Lender					
4. Fourth Mortgage	\$				
Name of Lender	Rate		Part .		ic 27 1 dr. k
Address of Lender					
B. CHEFA Loan Information					
Original Loan Amount	\$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense			where the second se	and a second	
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$				
		(Carre	v Subtotals t	Commond to a	

(Carry Subtotals forward to next page)

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

Name of Facility Health Care Investors Inc. d/b/a Ale  20	No. 95-C		Report for Yo 9/30/2015	ear Ended		Page 27	of 37
Theatth Care investors inc. drora Aid 20	7J-C		7/30/2013			21	1
Item			Total	CCNH	RHNS	(Spec	rify)
	ototals Bro	ught Forward:		COIVII	Idino	(Spo.	01137
12. C. Movable Equipment							
Automotive Equipment		\$					
A. Item	Rate	Amount			0.00		
Lender							
Address of Lender							
2. Other (Specify)		\$					
A. Item	Rate	Amount					
Lender							
Address of Lender							
B. Item	Rate	Amount					
	1						
Lender	<u> </u>					- 1-1-	
		***************************************					
Address of Lender							
12. C. 3. Total Movable Equipment Inter	est						
Expense (C1 + 2)	<u> </u>	\$	<del></del>	100 700			
12. D. Other Interest Expense (Specify)		\$	108,700	108,700			
See Attachment Page 27A							
13. Total All Interest Expense (12B7 + 12	2C3 + 12D	) \$	108,700	108,700			
14. Insurance		<u> </u>		,,,,,			
a. Insurance on Property (buildings o	nly)	\$					
b. Insurance on Automobiles		\$					
c. Insurance other than Property (as s	pecified at	oove)					
1. Umbrella (Blanket Coverage)		\$	16,865	16,865			
Fire and Extended Coverage		\$					
3. Other (Specify)		\$	99,215	99,215		7577 St.	(pagangangangan)
See Attachment Page 27A							
141 7 417 7 7 7	Z 11		116 000	116.000			
14d. Total Insurance Expenditures (14a + 15. Total All Expenditures (A-13 thru C-		<u> </u>		116,080 12,169,036		-	
13. Iouai Au Expendiures (A-13 thru C-	14)	<u> </u>	12,109,036	12,109,036		<u> </u>	

## D. Adjustments to Statement of Expenditures

Name	of Fa	cility		Lie	cense No.	Report for Ye	ar Ended	Page	of
			stors Inc. d/b/a Alexandria Manor		2095-C	9/30/2015		28	37
					Total				•
Item	Page	Line			Amount of				
1 6	No.		Item Description		Decrease	CCNH	RHNS	(Sp	ecify)
			es and Wages						,
i.l			Outpatient Service Costs	\$					A control of the cont
2.			Salaries not related to Resident Care	\$					
3,			Occupational Therapy	\$					****
4.			Other - See attached Schedule	\$					
Page	13 - I	Profes	sional Fees						
5.			Resident Care Physicians **	\$	STATE STATE OF THE			HALL THE REST OF STREET	
6.			Occupational Therapy	\$	1····	316,468			
7.			Other - See attached Schedule	\$					
	s 15 &	16 -	Administrative and General		100				
8.		· ·	Discriminatory Benefits	\$					
9,			Bad Debts	\$					
10.			Accounting & Legal	\$		24,461			***************************************
11.			Telephone	\$					***************************************
12.			Cellular Telephone	\$	3,694	3,694			**********
13.			Life insurance premiums on the life	*				- 1	
			of Owners, Partners, Operators	\$					
14.			Gifts, flowers and coffee shops	\$					
15.			Education expenditures to colleges or						
			universities for tuition and related costs		14.5		4.0		
			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	\$	3,550	3,550			
20.			Fund Raising / Contributions	\$			<del></del>		······
21.			Unallowable Management Fees	\$	27,701	27,701			
22.			Barber and Beauty	\$	27,701	27,701	,- <u>,</u> -,		
23.			Other - See attached Schedule	\$	80,569	80,569			**************************************
1	18 - 1	)i <i>etar</i>	y Expenditures	Ψ	00,509	00,509			
24.	1 U = 1.	,,,,,,	Meals to employees, guests and others						
[ "			who are not residents	\$					
Page	19 _ 1	auna	ry Expenditures	Ψ.					
25.	17-1	26161111	Laundry services to employees, guests						
22.			and others who are not residents	\$					
Page	20 - 1	Tousa	keeping Expenditures	Ψ					
26.	40 - I	- CHOE	Housekeeping services to employees, guests						
۷٠,			and others who are not residents	\$					
		L	Subtotal (Items 1 - 26)	\$		456,431	<u> </u>		
		<u> </u>	Wanted".	Ψ	L	urrv Subtotal fe	7.		

^{*} 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)
			-	\$	u.		
		,	· <b>-</b>	\$	-		
				\$	<u> -</u>		
							1.00
		-					
Total Othe	r Salaries A	djustment		\$.	_	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	(	CCNH	RHNS	(Specify)
		-	\$	-		
		•	\$	-		
. " .			\$	· -		
						s tetral com Pari
			. 14		ergina inga salah Tagan dari	
Total Othe	r Fees Adj	ustments	\$	: 11 (1)	\$:	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description		CCNH	RIINS	(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	A.	<u> </u>
		85005468 CNTRCT SRV ELIG WORK	\$	34,069		
		90009710 FINES & PENALTIES	\$	38,555		
		80007509 TRAVEL - TAXI FARES-	\$	22	100	
		-			· · ·	
		-	1			
					1 j.s.	
•			1.	1		
Total Othe	er A&G Ad	justments	\$	80,569	\$ -	\$ -

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

Name	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				ense No.	Report for Y		Page	of
				1€	2095-C	9/30/2015	cai Eligeu	29	37
. icait	n Care	J HIVE	Store mo, arora rapadiana manoi		Total	7/30/2013		40	<i>J</i>
Item	Рапе	Line			Amount of				
	_		Item Description		Decrease	CCNH	RHNS	(Sne	cify)
110.	110.	110.		\$	456,431	456,431	KIIIO	(Gpc	ony)
Ρασρ	20 - B	?eside		Ψ	430,431	430,431			
	20-1	Carac		\$	267,859	267,859			
			· · · · · · · · · · · · · · · · · · ·	\$	207,000	207,005			
				\$	1,379	1,379	-		
			*	\$	34,080	34,080			
				\$	20,016	20,016			
				\$	41,477	41,477			
				\$					
				\$	157,830	157,830			
	22 - 1	Mainte		Ť		,			
			Excess Movable Equipment Depreciation						
				\$					
36.			T			100 100 100 100			
				\$	7,000 (000 ) 4 (000 ) 5 (000 ) 5 (000 )		2 57 10 10 10 1 10 10 10 10 10 10 10 10 10 1	CORE NILIPARION FILLS	122000 A (1290 MI20A
37.			L						
			,	\$	To describe the state of the second of the s	agast Lathuring to an high ingroup of the age, deligned by a left the first	akerdiri sisasia Hasiniya dila kabulan baran yana	OSCILIDA HORI GORAN MINISTRA ANTAN	of daile 27 at resident 21 th Acoustic
38.			Rental of Building Space or Rooms	\$			****		
39.				\$					
Page	27 - I	nsura	nce		4.6 5.6 5.0	and the fi			
40.			Mortgage Insurance	\$					
41.			Property Insurance	\$					
Othe.	r - Mis	scella	neous			100000			
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			300000			
			providers interest	\$					
48.			Interest Income on Accounts Rec	\$					Decision Variation A
49.			Other (include personnel and other						
			costs unrelated to resident care) - See						
	]	<u></u>	Attached Schedule	\$	5,559	5,559			voiled or the At
		ofit P	roviders Only		er ar en fûret da.				
50.			Building/Non Movable Eq. Depreciation		100000				
			Unallowable Building Interest -						
	<u> </u>		See Attached Schedule	\$					
51.	Total	Amo	unt 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.

#### 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	3, 34, 5 T A 194.	
		54605348 Rental Equip-Medicare	\$ 28,250		
		51006103 PERSONAL CARE SUPPL	\$ 10,877		
		54605349 NURSING REN EQ-MEDA	\$ 82,236		
			\$		
			\$ -		
					有为医生活的征
Total Othe	r Ancillar	y Costs	\$ 157,830	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description		CCNH	RHNS	(Specify)
						- 1 to 1 t
		·				
				, , , , , , , , , , , , , , , , , , , ,		
		·			48-34	
		.*				ay karilot ii r
Total Exce	ss Movabl	e Equipment Depreciation	111111	\$ -	\$	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description			CCN	H	RHNS	(Specify)
			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- 3	5	-	·	
	***************************************		r					
								+1 ++++ 1 <u>*</u> 1
							:	
	· · · · · ·							
				.:		.*.	garaga di s	
Total Othe	r Property	Adjustments		9	}.	-	\$ -	\$ -

Page Ref	Line Ref Description		CCNH		RHNS	(Specify)	
		•	\$				
		90009700 INTEREST - VENDORS	\$	3,700	14 15 14 1		
		90009910 INT-FEDERAL/STATE TAX	\$	1,859			
			\$	. "			
		-	\$	-	\$ 177.15		
				·		:	
Total Other Adjustments		\$	5,559	\$	\$ -		

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description		CCNH	RHNS	(Specify)
			•	\$ -		
						A LUMBAN
		,				
					1 77 47	
				•		
			 : 1			
			. 114			Boa Bhia
Total Una	llowable Bi	ilding Interest		\$	\$	\$

#### F. Statement of Revenue

F. Statement of Re					Page	
Name of Facility License No.		-	Report for Year Ended			of
Health Care Investors Inc. d/b/a Alexandi 2095-C		9/30/2015		<u> </u>	30	37
Item		Total	CCNH	RHNS	(Sp	ecify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$	11,843,118	11,843,118			
b. Medicaid Room and Board Contractual Allowance **	\$	(4,084,275)	(4,084,275)			
2. a. Medicaid (All other states)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (all inclusive)	\$	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				100		
1. a. Prescription Drugs - Medicare	\$	134,956	134,956		CONTRACTOR OF THE PROPERTY OF	
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 **	<del></del> \$	(67,869)	(67,869)			
a. Medical Supplies - Medicare	\$	(07,007)	(01,007)			
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)	<del></del>		
4. a. Speech Therapy - Medicare	\$					÷
b. Speech Therapy - Medicare Contractual Allowance **	\$	67,576	67,576			
· · · · · · · · · · · · · · · · · · ·		(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 (Specify) - Medicare	\$	25,736	25,736			
b. Other (Specify) - Non-Medicare	\$	(370)	(370)			
III. Total Resident Revenue (Section I, thru Section II.)	\$	10,558,831	10,558,831			ar'i S NA Calaballa a Francisco de la Paricio
IV. Other Revenue*						
<ol> <li>Meals sold to guests, employees &amp; others</li> </ol>	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (Specify)	\$	17,396	17,396			
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (Specify)	\$	11,729	11,729			
V. Total Other Revenue (1 thru 8)	\$	29,125	29,125			
VI. Total All Revenue (III +V)	\$					
A TORRING MERCHINE (TH + Y)	ψ	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 BY 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		1
	47504025 ANCILL ALLOW-EVER A	\$	(1,855)		
	47504028 ANCILL ALLOW EVER B	\$	289		
[	47504100 ANCILL ALLOW MED A	\$	(16,623)		
	47504150 ANCILL ALLOW - PRT B	S	(201)		
ļ					
Total Oth	r Resident Revenue - Medicare	\$	25,736	<u> </u>	

#### Schedule of Other Non-Medicare Resident Revenue

#### Related Exp

age Ref	Description	CCNH	RHNS	(Specify)
				<u> </u>
	42504050 REV - LAB CONTRACT	\$ 6,205		<u> </u>
	40604050 REV - IV THERAPY CONT	\$ 14,461		
	43004200 REV - PHARMACY MDCD	\$ 1,580		
	REV - LAB MEDICAID	\$ 178		
	47504060 ANCILLARY ALLOW INS1	\$ (433)		
	40604200 REV IV THERAPY MEDCD	\$ 1,728		ļ
	47504050 ANCILL ALLOW CNT	\$ (20,632)		
	47504200 ANCILL ALLOW MDCD	\$ (3,457)		
• •				
otal Othe	er Resident Revenue	\$ (370)	\$ -	s -

#### Interest Income

#### Account

Page Ref	Account	Batance	CCN	THL.	RHNS	(Spec	cify)
		-	\$				
	49004700 INTEREST INCOME		\$	5,623			
	PENSION REFUND-NOT ELIGIBLE		\$ (	1,189)			
	49004900 DIVIDEND INCOME		\$ 1	2,962			
Total Inte	rest Income		\$ 1	7,396	\$ -	\$	

#### Schedule of Other Revenue

Page Ref	Description	С	CNH	RHNS	(Specify)
					ļ
	49004600 MISCELLANEOUS REVENUE	\$	11,729		
<u> </u>					1
-					<u> </u>
	7				
Total Other	ет Кечепие	\$	11,729	\$ -	\$ -

## G. Balance Sheet

	Name of Facility		License No.	• • • • • • • • • • • • • • • • • • •			of
Healt	h C	are Investors Inc. d/b/a Alexa	n 2095-C	9/30/2015		31	37
		2701024	Account			Ar	nount
Asset							
A.	Cu	rrent Assets					
	1.	Cash (on hand and in banks				\$	(95,231
		Resident Accounts Receivab				\$	930,960
-		Other Accounts Receivable (	Excluding Owners o	r Related Parties)		\$	526,165
	4	Inventories				\$	37,750
	5.	Prepaid Expenses			8	\$	73,843
		a. SEE PAGE 31A		73,84	3		
		b	···		ST NEW MEN		
		·					
	_	d.			20	4	
	6.	Interest Receivable		SD 48 1 0 0		\$	
		Medicare Final Settlement R				\$	10.150
	8,	Other Current Assets ( <i>itemize</i> 12101000 Exchange-BofA Deb		5,80		\$	43,468
		12102000 Exchange - Pullman	&	12,20			
		12100000 EXCHANGE ACCO	NT	25,39			
	1201		4 0				
		tal Current Assets (Lines A1	thru 8)	1		\$	1,516,955
		xed Assets			1.	ds.	
		Land	411' · 10' ·			\$	
	2.	Land Improvements	*Historical Cost			\$	
	2	Duildings	Accum. Depreciate *Historical Cost	ion	Net	<u> </u>	
	3.	Buildings			<u> </u>	\$	
	1	Lagarhald Improvements	Accum. Depreciat  *Historical Cost	ion	Net	<u> </u>	
	4,	Leasehold Improvements			<del></del>	\$	
	5	Non Mayable Equipment	Accum. Depreciate *Historical Cost	ion	Net	\$	
	Э,	Non-Movable Equipment				Ф	
	6	Mayabla Equipment	Accum. Depreciat  *Historical Cost		Net	\$	(7.100)
	υ.	Movable Equipment		355,96 ion 363,06		Þ	(7,100)
	7	Motor Vehicles	Accum. Depreciate *Historical Cost	1011 303,00		\$	
	/٠	Wiotor Venicles	Accum, Depreciati	ion	— Net	Φ	
	Q	Minor Equipment-Not Depre		IOII		\$	
							<b></b>
	9.	Other Fixed Assets (itemize)			5	\$	
B-10.		Total Fixed Assets (Lines B	1 thru 9)			\$	(7,100)

^{*} Historical Costs must agree with Historical Cost reported in Schedules on (Carry Total forward to next page) Depreciation and Amortization (Pages 23 and 24).

### Medicaid Cost Report: Cross Reference Report

Page	Name of Facility:	Year End;	GCH Lie#	Page	
31	Alexandria Manor	9/30/2015	1015C	ente d <b>ar</b> estas l	
	Balance Sheet - Assets			ir dhieb se ish de k	
Line	Description	G/L Adj Number	O/L Amount	Reclass	Adjusted Amount
4.5	Current Assets - Prepaid Expenses				
age 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
		-	•		-
		-	-		-
		-	-		-
		-	=		-
		-			-
	Su	btotał	73,843	-	73,843

# G. Balance Sheet (cont'd)

Nam	ie of	Facility	License No.	Report for Year Ended	P	age of
Heal	lth C	Care Investors Inc. d/b/a Alexan	d 2095-C	9/30/2015	3	32   37
			Account			Amount
				Total Brought Forward:	\$	1,509,855
C.	Le	asehold or like property records	ed 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
	<ol> <li>Non-Movable Equip</li> </ol>	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 Deprec	iable		\$	
C-8	To	tal Leasehold or Like Propert	ies (C1 thru 7)		\$	3,822,811
D.	Inv	estment 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 Reside	ent Care (itemize)		\$	
	6.	Loans to Owners or Related P	arties (itemize)		\$	(873,677)
		Name and Address	Amount	Loan Date		
						Professional Control of Control o
		See Page 32A	(873,677)			
	7.	Other Assets (itemize)	\$	422,632		
		17000000 DEFERRED A	CQUISITION	422,632		
		tal Investments and Other Ass			\$	(206,629)
D-9.	To	tal 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 Faci	Name of Facility		License No.	Report for Year En	ded	Page	of
Health Care In	nvesi	ors Inc. d/b/a Alexandria Ma	2095-C	9/30/2015		33	37
			Account			Ar	nount
Liabilities							
Α.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable			\$		3,511,152
	2.	Notes Payable (itemize)			\$		461,744
		24877500 NOTE PAYABI	LE HLTH CAP	414,104			
		24901000 NOTE PAYABI	LE-OMNICARE	47,640			
	3.	Loans Payable for Equipme	ent (Current portion	) (itemize )	\$		
		Name of Lender	Purpose	Amount	Date Due		
					l.		
	4.	Accrued Payroll (Exclusive			\$		454,802
	5.	Accrued Payroll (Owners a		only)	\$		
	6.	Accrued Payroll Taxes Payr			\$		256,762
	7.	Medicare Final Settlement I	Payable		\$		
	8.	Medicare Current Financing	g Payable		\$		
	9.	Mortgage Payable (Current	t Portion)		\$		
	10.	Interest Payable (Exclusive	of Owner and/or Re	lated Parties)	\$		
	11.	Accrued Income Taxes*			\$		
	12.	Other Current Liabilities (it	temize)		\$		1,901,183
		21950000 ACCRUED UNIFORM	£ 169,4	146 22650000 PAYROLL EI	9,020		
		23402500 ACCRUED PROVIDER	1,639,	519 25290000 STATE OF C			
		24100000 PATIENT REFUND CL	[ (69,9	994) 24800000 LOAN PAYA	(4,113)		
1110		21050000 ACCRUED INTEREST		500 25600000 lease payable-	(195)		
A-13.	To	tal Current Liabilities (Line	es A1 thru 12)		\$		6,585,643

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

# G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year	Ended	Page		of
Health Care Investors Inc. d/b/a Alexandria	2095-C	9/30/2015		34		37
/	Account			———An	nount	
<del></del>		Total Broug	ht Forward:		6,585	,643
Liabilities (cont'd)						
B. Long-Term Liabilities						
<ol> <li>Loans Payable-Equipment (</li> </ol>	(itemize)		\$			
Name of Lender	Purpose	Amount	Date Due			
2. Mortgages Payable	<u></u>		\$			
3. Loans from Owners or Rela	eted Parties (itemize)	)	\$			
Name and Address of Lender	Amount	Loan D	25,636,000			
Traine and Francisco of Benedi	/ Milouit	Boun B				
4. Other Long-Term Liabilitie	(itemize)		\$			
, Other Bong 10111 Blacking	Ψ					
		***************************************				
B-5. Total Long-Term Liabilities (	Lines B1 thru 4)	н	\$	**************************************	Contract of the Contract of th	- Constitution
C. Total All Liabilities (Lines A-			\$		6,585	,643

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

	ne of Facility	License No.	1 -	Year Ended	Pag		
Hea	Ith Care Investors Inc. d/b/a Alexar		9/30/2015		35		
A.	Account Reserves				Amount		
23.	Reserve for value of leased la	nd		·	\$	3,912,946	
Reserve for depreciation value of leased buildings and appurtenances     to be amortized					\$		
	3. Reserve for depreciation valu	e of leased person	al property (Ed	quity)	\$		
	4. Reserve for leasehold real pro	perties on which f	air rental valu	e is based	\$		
	5. Reserve for funds set aside as	donor restricted		,	\$		
	6. Total Reserves				\$	3,912,946	
B.	Net Worth					•	
ļ	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	10/1/20	14 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 I	Net Worth			\$	5,125,887	

# H. Changes in Total Net Worth

Name	e of Facility	License No.	Report for Year	Ended	Page	of	
Healt	th 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.						10,587,956	
C.	Total Expenditures (From Statement of Expenditures Page 27)				\$	12,169,036	
D.	Net Income or Deficit				\$	(1,581,080)	
E.	Balance				\$	(5,429,044)	
F.	Additions						
	Additional Capital Contributed (	(itemize)					
	2. Other (itemize)						
Prior Period Adjustments 56,342							
F-3.	Total Additions				\$	56,342	
G.	Deductions					··· / ····	
	1. Drawings of Owners/Operators/	Partners (Specify)			\$		
	Name and Address (No., City,	State, Zip)	Title	Amount			
	2. Other Withdrawings (Specify)					4.0	
	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		License No.	Report for Year Ended	Page	of				
Health	Care Investors Inc. d/b/a Alexandria	2095-C	9/30/2015	37	37				
		Check appropriate category							
Ø	Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	□ (Specify)						
		Preparer/Reviewer Certifica	ition						
	I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.								
Signature of Preparery		Title	Date Signed	744-					
			3-15-20	76					
Printe	Name of Preparer								
Affinit	ry Health Care Mgt								
Addres Address			Phone Number						
1781 1	Highland Ave Cheshire, CT		203-250-2030						