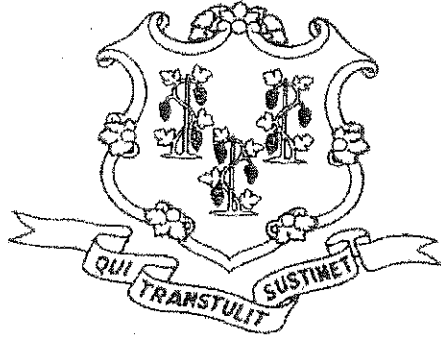


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2016

Name of Facility (as licensed) Trinity Hill Care Center, LLC	
Address (No. & Street, City, State, Zip Code) 151 Hillside Avenue, Hartford, CT 06016	
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 checked="" type="checkbox"/> NurseFac-Aids	
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH 2222-C	RHNS	NurseFac-Aids AIDS	Medicare Provider 07-5268
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Medicaid Provider Numbers:	CCNH 9555	RHNS	ICF-IID 49553
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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) Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2016	Page 1	of 37
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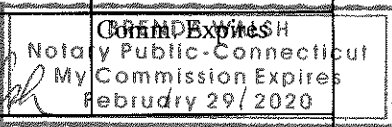
**Administrator's/Owner's Certification**

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Trinity Hill Care Center, LLC [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specific 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
			<i>Chris S. Wright</i>		2/10/17
Printed Name (Administrator) George Kingston			Printed Name (Owner) Chris Wright		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)		
<i>Brenda Walsh</i>	<i>CT</i>	<i>2/10/17</i>	<i>Brenda Walsh</i>		
Address of Notary Public <i>341 Bidwell St, Manchester, CT 06040</i>					

(Notary Seal)

**General Information**

Name of Facility (as licensed) <i>Trinity Hill Care Center LLC</i>	License No. <i>2222-C</i>	Report for Year Ended <i>9/30/2016</i>	Page <i>1</i>	of <i>37</i>
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**Administrator's/Owner's Certification**

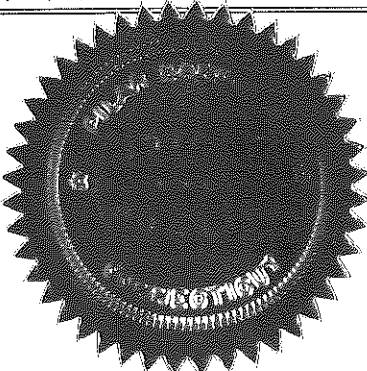
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for *Trinity Hill Care Center* [facility name], for the cost report period beginning \_\_\_\_\_ and ending \_\_\_\_\_, 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) <i>G. W. Kingston</i>		Date <i>2/10/17</i>	Signed (Owner)	Date
Printed Name (Administrator) <i>George W. Kingston</i>			Printed Name (Owner)	
Subscribed and Sworn to before me: <i>GEORGE W. KINGSTON</i>	State of <i>CONNECTICUT</i>	Date <i>2-10-17</i>	Signed (Notary Public) <i>Pilar Sandoval</i>	Comm. Expires <i>AUG 31, 2019</i>
Address of Notary Public <i>20 FAIRFAX AV. WEST HARTFORD CT-06119</i>				



**PILAR SANDOVAL**  
**NOTARY PUBLIC**  
 MY COMMISSION EXPIRES AUG. 31, 2019

State of Connecticut  
**Department of Social Services**  
 55 Farmington Avenue, Hartford, Connecticut 06105

<b>Data Required for Real Wage Adjustment</b>		Page 1A	of 37
Name of Facility Trinity Hill Care Center, LLC		Period Covered:	From 10/1/2015 To 9/30/2016
Address of Facility 151 Hillside Avenue, Hartford, CT 06016			
Report Prepared By iCare		Phone Number 860-570-2140	Date 2/15/2016
Item	Total	CCNH	RHNS NurseFac- Aids
1. Dietary wages paid	\$		
2. Laundry wages paid	\$		
3. Housekeeping wages paid	\$		
4. Nursing wages paid	\$		
5. All other wages paid	\$		
6. <b>Total Wages Paid</b>	<b>\$</b>		
7. Total salaries paid	\$		
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	<b>\$</b>		

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 860-951-1060		Report for Year Ended 9/30/2016	Page 2	of 37
Name of Facility (as shown on license) Trinity Hill Care Center, LLC		Address (No. & Street, City, State, Zip) 151 Hillside Avenue, Hartford, CT 06016		
License Numbers:	CCNH 2222-C	RHNS	NurseFac-Aids AIDS	Medicare Provider No. 07-5268
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 checked="" type="checkbox"/> NurseFac-Aids				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" 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.				
<b>Administrator</b>				
Name of Administrator George Kingston		Nursing Home Administrator's License No.:	1327	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

**General Information and Questionnaire**  
**Partners/Members**

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2016	Page 3	of 37
Legal Name of Partnership/LLC Trinity Hill Care Center, LLC		Business Address 151 Hillside Avenue, Hartford, CT 06016		State(s) and/or Town(s) in Which Registered CT	
Name of Partners/Members	Business Address	Title		% Owned	
V. Robert Salazar	2500 18th Street, Suite 200, Denver, CO 80211	Member		31.3	
David Sebbag	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		21.4	
Ari Krausz	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		21.3	
Solomon Melamed	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		1	
Christopher Wright	341 Bidwell Street, Manchester, Ct 06040	Member		5	
Premier First Investors	245 S. Benton Street, Lakewood, CO 80226	Member		10	
Global World Investors	245 S. Benton Street, Lakewood, CO 80226	Member		10	







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Related Parties\*

Name of Facility Trinity Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2016	Page 4	of 37					
					Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties	Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #
Bidwell Care Center, LLC		333 Bidwell St. Manchester, CT 06040			Shared Employees		(28,718)		28,718
Chelsea Place Care Center, LLC		25 Lorraine St. Hartford, CT 06105			Shared Employees		(29,470)		29,470
Chestnut Point Care Center, LLC		171 Main St. East Windsor, CT 06088		19	Laundry Services	3			-
Chestnut Point Care Center, LLC		171 Main St. East Windsor, CT 06088			Shared Employees		(23,601)		23,601
Farmington Care Center, LLC		20 Scott Swamp Rd. Farmington, CT 06032			Bank Fees	16 M	675		(675)
Farmington Care Center, LLC		20 Scott Swamp Rd. Farmington, CT 06032			Shared Employees		(11,958)		11,958
Kettle Brook Care Center, LLC		96 Prospect Hill Rd. East Windsor, CT 06088		19	Laundry Services	3			-
Kettle Brook Care Center, LLC		96 Prospect Hill Rd. East Windsor, CT 06088			Shared Employees		(25,601)		25,601
Meriden Care Center, LLC (Silver Springs)		33 Roy St. Meriden, CT 06450			Shared Employees		(20,553)		20,553
Trinity Hill Care Center, LLC		151 Hillside Ave. Hartford, CT 06106			Shared Employees				-
Westside Care Center, LLC		349 Bidwell St. Manchester, CT 06040			Shared Employees		(48,271)		48,271
Wintonbury Care Center, LLC		140 Park Ave. Bloomfield, CT 06002			Shared Employees		(25,288)		25,288
Secure Care Center LLC		60 West Street, Rocky Hill, CT 06087			Shared Employees		(4,233)		4,233
Touchpoints therapy		171 Main St. East Windsor, CT 06088		13	OT/PT/ST	5, 8, 10	340,257		(340,257)
Bidwell Realty, LLC		341 Bidwell St. Manchester, CT 06040		22, 22, 27	Building Lease & Rent	10, 9, 14	1,561,539		(1,561,539)
iCare Management, LLC		341 Bidwell St. Manchester, CT 06040		16, 15	Postage & Legal	M, E	22,207		(22,207)
iCare Health Management, LLC		341 Bidwell St. Manchester, CT 06040			Shared FEs not part of mgmt agmt		137,296		(137,296)
					Management Services, Direct	20	153,787		(153,787)
					Management Services, Indirect	20	35,132		(35,132)
					Management Services, Administrative	16	445,323		(445,323)
									-
									-
									-
									-
All 9 Care Centers, mgmt co, realty cos					Share Common 401k, Pension and Insurance plans, courier, legal and various other services				

\* 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 Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2016	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item	Method of Allocation			
Dietary	Number of meals served to residents			
Laundry	Number of pounds processed			
Housekeeping	Number of square feet serviced			
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants			
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (See listing page 13)			
Maintenance and operation of plant	Square feet			
Property costs (depreciation)	Square feet			
Employee health and welfare	Gross salaries			
Management services	Appropriate cost center involved			
All other General Administrative expenses	Total of Direct and Allocated Costs			
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <input checked="" type="radio"/> Yes <input type="radio"/> 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.)				
<input checked="" type="radio"/> Yes <input type="radio"/> No      If "No," explain fully why such allocation was not made.				



**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2016	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    If "No," explain. <input type="radio"/> No		
<b>Independent Accounting Firm</b>				
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)		
1 O'Connor, Davies LLP		100 Great Meadow Road, Ste 401, Wethersfield, CT 06109		
2				
3				
4				
Services Provided by This Firm ( <i>describe fully</i> )				
1 Taxes, financial statements, accounting support		\$		3,533
2		\$		
3		\$		
4		\$		
				Charge for Services Provided
				\$ 3,533
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    15D				
<b>Legal Services Information</b>				
Name of Legal Firm or Independent Attorney			Telephone Number	
1 iCare Health Management, LLC			860-570-2140	
2 Starble and Harris			860-678-7775	
3 Durant Nichols / Robinson & Cole, LLP			860-275-8200	
4 Various others (American Arbitration , Various Arbitration, Murtha Cullina,Jackson Lewis))				
5 Starble and Harris, iCare Health Management LLC			860-678-7775 & 860-570-2140	
Address ( <i>No. &amp; Street, City, State, Zip Code</i> )				
1 341 Bidwell Street, Manchester CT				
2 32 Main Street, Avon, CT				
3 280 Trumbull St, Hartford, CT				
4				
5 32 Main Street, Avon, CT & 341 Bidwell Street, Manchester CT				
Services Provided by This Firm ( <i>describe fully</i> )				
1 Lease and contract issues, general legal advice, Labor Law		\$		20,628
2 Lease and contract issues, general legal advice, union funds advice		\$		1,926
3 Employment law, arbitrations, contract negotiations		\$		25,505
4 Employment Arbitrations, healthcare law		\$		9,734
5 Conservatorships		\$		5,180
				Charge for Services Provided
				\$ 62,974
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    15E				

**Schedule of Resident Statistics**

	Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2016						Page 8	of 37
			Period 10/1 Thru 6/30			Period 7/1 Thru 9/30				
			Total All Levels	Total CCNH Level	Total RHNS Level	Total NurseFac-Aids	Total	CCNH		
1. Certified Bed Capacity										
A. On last day of PREVIOUS report period	144	114		30	144	114	30	144	114	30
B. On last day of THIS report period	144	114		30	144	114	30	144	114	30
2. Number of Residents										
A. As of midnight of PREVIOUS report period	139	110		29	139	110	29	140	113	27
B. As of midnight of THIS report period	143	114		29	140	113	27	143	114	29
3. Total Number of Days Care Provided During Period										
A. Medicare	1,560	1,144		416	1,245	866	379	315	278	37
B. Medicaid (Conn.)	48,180	38,560		9,620	35,681	28,650	7,031	12,499	9,910	2,589
C. Medicaid (other states)										
D. Private Pay	77	77			1	1		76	76	
E. State SSI for RCH										
F. Other (Specify) Insurance	25	25			25	25				
G. Total Care Days During Period (3A thru F)	49,842	39,806		10,036	36,952	29,542	7,410	12,890	10,264	2,626
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)	49,842	39,806		10,036	36,952	29,542	7,410	12,890	10,264	2,626



**Report of Expenditures - Salaries & Wages**

Name of Facility	License No.	Report for Year Ended	Page	of		
Trinity Hill Care Center, LLC	2222-C	9/30/2016	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	NurseFac-Aids	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	119,652	1,394			30,167	697
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	190,433	7,697			48,013	3,848
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	69,614	1,656			18,320	436
c. Dietary Workers	437,657	21,160			115,173	5,568
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	214,894	12,524			107,447	6,262
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	32,069	1,352			16,034	676
b. Other Maintenance Workers	23,330	1,521			11,665	760
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	100,213	5,503			25,266	1,448
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	178,165	2,792			44,919	1,396
b. RN						
1. Direct Care	355,933	8,322			242,377	6,173
2. Administrative**	288,713	7,330			72,791	1,929
c. LPN						
1. Direct Care	1,055,939	34,875			219,319	8,193
2. Administrative**						
d. Aides and Attendants	1,558,619	89,430			551,938	32,468
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers		5,574			140,821	3,566
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	83,312	3,239			69,596	2,944
n. Marketing						
o. Other (Specify) See Attached Schedule	117,659	5,646			29,665	1,663
<i>A-13. Total Salary Expenditures</i>	4,826,202	210,013			1,743,511	78,028

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

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2016		Line Where Claimed on Page 10	Name and Address of All Other Employment**	Page 11	of 37
		CCNH	RHNS				
Name		Salary Paid		Total Hours Worked	Total Hours Worked	Total Hours Worked	Compensation Received
		NurseFac- Aids	Fringe Benefits and/or Payments (describe fully)				
<b>Section I - Operators/Owners</b>							
<b>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).</b>							

\* 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\***

Name of Facility (as licensed) Trinity Hill Care Center, LLC	License No. 2222-C		Report for Year Ended 9/30/2016				Page 12	of 37
	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
CCNH	RHNS	NurseFac-Aids						
<b>Section III - Administrators***</b>								
George Kingston	119,652		30,167	same as employees less union funds	Administrator	2,091 A2		
			same as employees less union funds	Administrator	A2			
			same as employees less union funds	Administrator	A2			
<b>Section IV - Assistant Administrators</b>								

\*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		
Trinity Hill Care Center, LLC	2222-C	9/30/2016	13	37		
<b>Total Cost and Hours</b>						
Item	CCNH	Hours	RHNS	Hours	NurseFac-Aids	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian						
2. Dentist						
3. Pharmacist	7,979	170			2,012	43
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	189,487	1,991				502
b. Other						
6. Social Worker		269			18,089	71
7. Recreation Worker	4,148	35+Cable			1,046	35+Cable
8. Physicians						
a. Medical Director (entire facility)	35,939	243			74,053	593
b. Utilization Review (Title 18 and 19 only) monthly meeting	479	4			121	1
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) Physician Care Contract Services	18,486	184			4,661	48
9. Speech Therapist						
a. Resident Care	30,263	317				80
b. Other						
10. Occupational Therapist						
a. Resident Care	113,492	1,211				305
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	3,981					
2. Administrative***	(113,204)	(2,412)			(28,541)	(635)
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides		(143)			(4,525)	
d. Other						
12. Other (Specify) See Attached Schedule	57,337	988			14,456	283
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>348,387</b>	<b>2,822</b>			<b>81,370</b>	<b>1,292</b>

\* 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.



**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2016	15	37
Item	Total	CCNH	RHNS	NurseFac-Aids
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 205,128	163,824		41,304
2. Disability Insurance	\$			
3. Unemployment Insurance	\$			
4. Social Security (F.I.C.A.)	\$ 639,679	510,875		128,803
5. Health Insurance	\$ 1,047,266	836,393		210,874
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 388,001	309,875		78,126
8. Uniform Allowance	\$			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 46,997	37,534		9,463
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 74,876	74,876		
d. Accounting and Auditing	\$ 3,533	2,822		711
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 62,974	50,293		12,680
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 17,152	13,698		3,454
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 23,438	18,718		4,719
2. Cellular Phones	\$ 3,521	2,812		709
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	\$ 1,047,679	836,722		210,957
<b>Subtotal</b>	\$ 3,560,243	2,858,443		701,801

\* 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**

Trinity Hill Care Center, LLC  
9/30/2016

Attachment Page 15

**Schedule of Other Employee Benefits**

Description	CCNH	RHNS	NurseFac-Aids
UNION TRAINING	\$ 37,534		\$ 9,463
<b>Total</b>	\$ 37,534	\$ -	\$ 9,463

**Schedule of Other Taxes**

Description	CCNH	RHNS	NurseFac-Aids
<b>Total</b>	\$ -	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2016		16	37
Item	Total	CCNH	RHNS	NurseFac-Aids	
<b>Subtotals Brought Forward:</b>	3,560,243	2,858,443		701,801	
<b>l. Travel and Entertainment</b>					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 5,493	4,387		1,106	
5. Education Expenses Related to Seminars and Conventions	\$ 4,178	3,337		841	
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$ 3,955	3,158		796	
7. Other ( <i>Specify</i> ) See Attached Schedule	\$ 242	193		49	
<b>m. Other Administrative and General Expenses</b>					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$ 5,447	4,350		1,097	
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$ 4,440	3,546		894	
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 1,595	1,274		321	
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 10,367	8,279		2,087	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$ 932	744		188	
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$ 121,121	96,732		24,388	
12. Administrative Management Services**	\$ 426,519	340,637		85,882	
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 26,653	21,287		5,366	
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 4,171,184	3,346,368		824,817	

\* 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	NurseFac-Aids
MEALS	\$ 193		\$ 49
<b>Total Other Travel and Entertainment</b>	<b>\$ 193</b>	<b>\$ -</b>	<b>\$ 49</b>

Schedule of Other Advertising

Description	CCNH	RHNS	NurseFac-Aids
COMMUNICATIONS SPECIAL EVENTS	\$ 3,546		\$ 894
<b>Total Other Advertising</b>	<b>\$ 3,546</b>	<b>\$ -</b>	<b>\$ 894</b>

Schedule of Dues

Description	CCNH	RHNS	NurseFac-Aids
ALTCFM			
CAHCF Dues	\$ 8,151.66		\$ 2,055.22
OTHER DUES	\$ 128		\$ 32
<b>Total Dues</b>	<b>\$ 8,279</b>	<b>\$ -</b>	<b>\$ 2,087</b>

Schedule of Contributions

Description	CCNH	RHNS	NurseFac-Aids
contributions	\$ 744		\$ 188
<b>Total Contributions</b>	<b>\$ 744</b>	<b>\$ -</b>	<b>\$ 188</b>

Schedule of Other Administrative and General

Description	CCNH	RHNS	NurseFac-Aids
SOCIAL SERVICE SUPPLIES	\$ 144		\$ 36
SOC SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 1,215		\$ 306
EMPLOYEE RELATIONS	\$ 9,864		\$ 2,487
EMPLOYEE RELATIONS-OTHER	\$ -		\$ -
PERMITS & LICENSES	\$ 1,961		\$ 495
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 7,766		\$ 1,958
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ 145		\$ 37
LATE FEES	\$ 188		\$ 47
Rounding	\$ 4		\$ -
<b>Total Other Administrative and General</b>	<b>\$ 21,287</b>	<b>\$ -</b>	<b>\$ 5,366</b>

**Schedule C-1 - Management Services\***

Name of Facility	License No.	Report for Year Ended	Page of
Trinity Hill Care Center, LLC	2222-C	9/30/2016	17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
iCare Management, LLC/iCare Health Management, LLC	426,519	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	169,095	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	38,629	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j

\* 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
Trinity Hill Care Center, LLC	2222-C	9/30/2016	18	37
Item	Total	CCNH	RHNS	NurseFac-Aids
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 270,484	216,021		54,464
2. Non-Food Supplies	\$ 37,209	29,457		7,752
3. Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 20,915	16,704		4,211
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 525	416		109
c. Management Services**	\$			
d. Other (Specify) _____ DIETARY MINOR EQUIPMENT	\$ 7,730	6,173		1,556
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 336,864</b>	<b>268,771</b>		<b>68,093</b>
2F. Dietary Questionnaire	Total	CCNH	RHNS	NurseFac-Aids
G. Resident Meals: Total no. of meals served per day:*	492	410		82
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 Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2016	Page 19	of 37
Item		Total	CCNH	RHNS	NurseFac-Aids
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. \$	507	405	102
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)		\$	52,587	41,998	10,589
c. Management Services**		\$			
d. Other (Specify) LAUNDRY SUPPLIES		\$	292	233	59
3E. <b>Total Laundry Expenditures</b> (3a + b + c + d)		\$	53,386	42,636	10,750
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
Trinity Hill Care Center, LLC		2222-C	9/30/2016		20	37
Item			Total	CCNH	RHNS	NurseFac-Aids
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	23,695	15,797		7,898
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. \$	39,450	26,300		13,150
c.	Management Services*	\$				
d.	Other ( <i>Specify</i> )	\$				
HOUSEKEEPING MINOR EQUIPMENT						
4E.	<b>Total Housekeeping Expenditures</b> (4a + b + c + d)	\$	63,145	42,097		21,048
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from OMNICARE PHARMACY	\$	76,836	76,836		
b.	Medicine Cabinet Drugs	\$	11,139	8,896		2,243
c.	Medical and Therapeutic Supplies	\$	69,670	55,642		14,029
d.	Ambulance/Limousine***	\$				
e.	Oxygen					
1.	For Emergency Use	\$	1,764	1,764		
2.	Other***	\$				
f.	X-rays and Related Radiological Procedures***	\$	949	949		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h.	Laboratory***	\$	4,967	4,967		
i.	Recreation	\$				
j.	Other (Specify)**** See Attached Schedule	\$	382,369	295,799		86,570
5K.	<b>Total Resident Care Expenditures</b> (5a - 5j)	\$	547,694	444,853		102,841

\* 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	NurseFac- Aids
NURSING ADMIN SUPPLIES	\$ 65		\$ 16
NURSING MINOR EQUIP	\$ 8,657		\$ 2,183
MEDICAL RECORDS SUPPLIES	\$ (124)		\$ (31)
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATIONS - DIRECT	\$ 135,047		\$ 34,048
NON-COVERED PPS DR. VISITS	\$ -		\$ -
RESIDENT CARE SUPPLIES	\$ 346		\$ 87
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 11,697		\$ 2,949
PERSONAL CARE SUPPLIES	\$ 6,525		\$ 1,645
INCONTINENCY SUPPLIES	\$ 22,069		\$ 5,564
VACCINE RESIDENTS	\$ 9,736		\$ -
PATIENT SPECIAL NEEDS	\$ 15		\$ -
PHYSICAL THERAPY SUPPLIES	\$ -		\$ -
PHYSICAL THERAPY EQUIPMENT RENT	\$ -		\$ -
PHYSICAL THERAPY MINOR EQUIPMENT	\$ -		\$ -
OCCUPATIONAL THERAPY SUPPLIES	\$ -		\$ -
OCCUPATIONAL THERAPY EQUIP RENTAL	\$ -		\$ -
OCCUPATIONAL THERAPY MINOR EQUIP	\$ -		\$ -
SPEECH THERAPY SUPPLIES	\$ -		\$ -
SPEECH THERAPY EQUIPMENT RENT	\$ -		\$ -
SPEECH THERAPY MINOR EQUIPMENT	\$ -		\$ -
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 27,539		\$ 7,247
EQUIPMENT RENTAL- AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 4,370		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ 63		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ -		\$ -
IV THERAPY SUPPLIES	\$ 25,732		\$ 6,772
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 3,088		\$ 1,544
ACTIVITIES SUPPLIES	\$ 3,499		\$ 882
ACTIVITIES MINOR EQUIPMENT	\$ 5,749		\$ 1,449
MANAGEMENT ALLOCATION - INDIRECT	\$ 30,851		\$ 7,778
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ -		\$ 14,215
STRIKE COSTS NON REIMBURSABLE	\$ 877		\$ 221
<b>Total Other Resident Care</b>	<b>\$ 295,799</b>	<b>\$ -</b>	<b>\$ 86,570</b>

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

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2016	Total Cost/Page Ref.***				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	NurseFac-Aids	Pg Line
		Yes	No						
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	<input type="checkbox"/>	<input type="checkbox"/>	VENDOR	Housekeeping Services	39,817			20 4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	<input type="checkbox"/>	<input type="checkbox"/>	VENDOR	Laundry Services	52,728			19 3b
Eagle Elevator		<input type="checkbox"/>	<input type="checkbox"/>	VENDOR	Elevator Contract	6,126			22 6F
Bioserve, Inc.		<input type="checkbox"/>	<input type="checkbox"/>	VENDOR	Medical Waste Snow	4,632			22 6F
The Brickman Group/ Stevan Infante		<input type="checkbox"/>	<input type="checkbox"/>	VENDOR	Snow Removal/Landscaping	13,272			22 6F
All Waste Inc		<input type="checkbox"/>	<input type="checkbox"/>	VENDOR	Trash removal Software Maintenance Contract	35,298			22 6F
American Health Tech		<input type="checkbox"/>	<input type="checkbox"/>	VENDOR	Contract	10,623			16 M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	<input type="checkbox"/>	<input type="checkbox"/>	VENDOR	Payroll Services	55,546			16 M11
National Datacare Corp		<input type="checkbox"/>	<input type="checkbox"/>	VENDOR	Resident Trust Software Computer Consulting Services	2,613			16 M11
Prime Care Technology services		<input type="checkbox"/>	<input type="checkbox"/>	VENDOR	Services	22858.79			16 M11
Priority Express		<input type="checkbox"/>	<input type="checkbox"/>	VENDOR	Courier Services	5,203			16 M11
Point Right Inc		<input type="checkbox"/>	<input type="checkbox"/>	VENDOR	Nursing Software	4,680			16 M11
		<input type="checkbox"/>	<input type="checkbox"/>	VENDOR					
		<input type="checkbox"/>	<input type="checkbox"/>	VENDOR					

\* 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
Trinity Hill Care Center, LLC	2222-C	9/30/2016			22	37
Item	Total	CCNH	RHNS	NurseFac-Aids		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 36,276	28,972		7,304		
b. Heat	\$ 65,783	43,856		21,928		
c. Light & Power	\$ 89,587	59,724		29,862		
d. Water	\$ 57,371	38,247		19,124		
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 33,782	26,980		6,802		
f. Other ( <i>itemize</i> )	\$ 169,700	124,260		45,439		
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 452,498</b>	<b>322,039</b>		<b>130,459</b>		
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 20,096	16,050		4,047		
c. Non-Movable Equipment	\$ 459	366		92		
d. Movable Equipment	\$ 43,867	35,034		8,833		
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 64,422</b>	<b>51,450</b>		<b>12,972</b>		
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 51,756	41,334		10,421		
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 51,756</b>	<b>41,334</b>		<b>10,421</b>		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,223,304	976,984		246,320		
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 278,724	222,601		56,123		
c. Personal property taxes	\$ 28,851	23,042		5,809		
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 1,647,056</b>	<b>1,315,411</b>		<b>331,645</b>		

\* 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**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>NurseFac-Aids</b>
PLANT SUPPLIES	\$ 4,591		\$ 2,295
PLANT CONTRACT SERVICE LABOR	\$ -		\$ -
ELEVATOR CONTRACT SERVICE	\$ 4,084		\$ 2,042
FIRE/SPRINKLER CONTRACT SERVICE	\$ 5,906		\$ 2,953
LANDSCAPING CONTRACT SERVICE	\$ 4,571		\$ 2,286
SNOW REMOVAL CONTRACT SERVICE	\$ 4,277		\$ 2,138
TRASH REMOVAL CONTRACT SERVICE	\$ 23,532		\$ 11,766
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ 64,904		\$ 16,364
PLANT CONTRACT SERVICE OTHER	\$ 4,095		\$ 2,047
PLANT MINOR EQUIPMENT	\$ 5,869		\$ 2,935
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ 2,432		\$ 613
RENT OTHER	\$ -		\$ -
<b>Total Other Repairs and Maintenance</b>	<b>\$ 124,260</b>	<b>\$ -</b>	<b>\$ 45,439</b>

State of Connecticut  
**Annual Report of Long-Term Care Facility**  
 CSP-23 Rev. 10/2006

**Depreciation Schedule**

Name of Facility		License No.		Report for Year Ended				Page	of
Trinity Hill Care Center, LLC		2222-C		9/30/2016				23	37
Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
									Is a mileage logbook maintained?
Yes	No	Month	Year						
<b>A. Land Improvements</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
A-4. Subtotal									
<b>B. Building and Building Improvements</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
B-4. Subtotal									
<b>C. Non-Movable Equipment</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Movable Equipment</b>									
1. Motor Vehicles (Specify name, model and year of each vehicle)									
a. Van Repair: Hillside Automotive Cex									
b.									
c.									
d.									
2. Movable Equipment									
a. Acquired prior to this report period									
b. Disposals (attach schedule)									
c. Acquired during this report period (attach schedule)									
D-3. Subtotal									
<b>E. Total Depreciation</b>									
							43,867	43,867	
							64,422	64,422	

Trinity Hill Care Center, LLC  
9/30/2016

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Land Improvements</b>		\$ -		\$ -
<b>Deletions:</b>				
<b>Total deletions for Land Improvements</b>		\$ -		\$ -

\*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
<b>Additions:</b>				
12/15/2015	Concrete Work	\$ 6,381	180	\$ 319
3/1/2016	Building Powerwashing	\$ 1,595	60	\$ 186
5/18/2016	Seal / repaint Metal roof	\$ 18,611	60	\$ 1,241
7/13/2016	Asphalt crack filling / sealing	\$ 9,050	60	\$ 302
<b>Total additions for Building Improvements</b>		\$ 35,638		\$ 2,048
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ -

\*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
<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ -
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ -

\*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
<b>Additions:</b>				
11/25/2015	BEDS: MEDLINE	\$ 12,751	60	\$ 2,125
4/12/2016	BEDS: MEDLINE	\$ 12,230	60	\$ 1,019
<b>Total additions for Movable Equipment</b>		<b>\$ 24,981</b>		<b>\$ 3,144 *</b>
<b>Deletions:</b>				
<b>Total deletions for Movable Equipment</b>		<b>\$ -</b>		<b>\$ - **</b>

\*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
<b>Additions:</b>				
10/16/2015	Upgrade Phone System- Comtech 21: Phase 2	\$ 12,783	120	\$ 1,172
9/1/2016	Upgrade Walk In Freezer- Proline	\$ 10,985	180	\$ -
7/29/2016	Upgrade 2 Rooftop AC Systems: Link Mechanical	\$ 22,402	120	\$ 373
<b>Total additions for Leasehold Improvement</b>		<b>\$ 46,170</b>		<b>\$ 1,545 *</b>
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		<b>\$ -</b>		<b>\$ - **</b>

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2016		Page 24	of 37
		Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**		
Item	Length of Amortization	Cost to Be Amortized	Date of Acquisition Month Year	Totals	
<b>A. Organization Expense</b>					
1.					
2.					
3.					
A-4. Subtotal					
<b>B. Mortgage Expense</b>					
1.		638,632		346,744	50,210
2.					
3.					
B-4. Subtotal					
<b>C. Leasehold Improvements and Other</b>					
1. Acquired prior to this report period					
2. Disposals (attach schedule)					
3. Acquired during this report period (attach schedule)		46,170			1,545
C-4. Subtotal					
<b>D. Total Amortization</b>					51,756
					51,756

\* 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 Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2016	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
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	04/01/99			
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase	04/01/99			
4. Date of Initial Licensure	04/01/99			
5. Total Licensed Bed Capacity	144			
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				
<b>Part B - Owner and Related Parties</b>	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD fixed			
b. Date Mortgage Obtained	05/30/13			
c. Interest Rate for the Cost Year	335.00%			
d. Term of Mortgage (number of years)	24			
e. Amount of Principal Borrowed	4,208,200			
f. Principal balance outstanding as of 9/30/2016	3,819,809			
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
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				
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
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
Trinity Hill Care Center, LLC		2222-C	9/30/2016			26	37
Item		Total	CCNH	RHNS	NurseFac-Aids		
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. <b>Total Building Interest Expense</b> (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
Trinity Hill Care Center, LLC		2222-C		9/30/2016			27	37
Item				Total	CCNH	RHNS	NurseFac-Aids	
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)				\$	3,458	2,762	696	
INTEREST								
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$	3,458	2,762	696	
14. Insurance								
a. Insurance on Property (buildings only)				\$	6,612	5,281	1,331	
b. Insurance on Automobiles				\$	3,680	2,939	741	
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)				\$	97,942	78,221	19,721	
2. Fire and Extended Coverage				\$				
3. Other (Specify)				\$	2,912	2,326	586	
Other insurance, crime								
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$	111,146	88,766	22,380	
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$	14,385,901	11,048,291	3,337,611	



### D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Trinity Hill Care Center, LLC			2222-C	9/30/2016	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$ 74,876	74,876		
10.			Accounting & Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
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 *	\$ 4,440	3,546		894
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 32,998	26,353		6,644
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 112,314	104,776		7,538

\* 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.



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

Name of Facility			License No.	Report for Year Ended	Page	of	
Trinity Hill Care Center, LLC			2222-C	9/30/2016	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
Subtotals Brought Forward				\$ 112,314	104,776		7,538
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$			
29.			X-rays, etc	\$ 949	949		
30.			Laboratory	\$ 4,967	4,967		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$			
<b>Page 22 - Maintenance and Property</b>							
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	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
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	\$			
<b>Not For Profit Providers Only</b>							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>51. Total Amount of Decrease (Items 1 - 50)</b>				\$ 118,231	110,692		7,538

\*\*\* 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.

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Trinity Hill Care Center, LLC  
9/30/2016

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
20	5J		-		-
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	-		
13	B9A	ST- Resident Care (for outpatient therapy - see schedule)	-		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	-		
<b>Total Other Ancillary Costs</b>			\$ -	\$ -	\$ -

**Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ -

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
20	4A1	Houskeeping Supplies (for Outpatient Therapy - see schedule)	\$ -		
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)	\$ -		
22	6B	Heat (for outpatient Therapy see schedule)	\$ -		
22	6C	Light and Power (for outpatient therapy see schedule)	\$ -		
22	6D	water (for outpatient therapy see schedule)	\$ -		
22	6A	Repair&Maint (for outpatient therapy see schedule)	\$ -		
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended			Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2016			30	37
Item	Total	CCNH	RHNS	NurseFac-Aids		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents (CT only)	\$ 14,046,671	10,941,264		3,105,407		
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (All other states)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (all inclusive)	\$ 882,925	698,982		183,943		
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 9,828	9,828				
b. Private-Pay Room and Board Contractual Allowance **	\$					
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 65,900	65,900				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (65,900)	(65,900)				
c. Prescription Drugs - Non-Medicare	\$ 13,394	8,225		5,169		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (13,394)	(8,225)		(5,169)		
2. a. Medical Supplies - Medicare	\$ 1,267	1,267				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (1,267)	(1,267)				
c. Medical Supplies - Non-Medicare	\$ 11,060	10,257		803		
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (11,060)	(10,257)		(803)		
3. a. Physical Therapy - Medicare	\$ 101,484	101,484				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (69,194)	(69,194)				
c. Physical Therapy - Non-Medicare	\$ 221,803	192,619		29,183		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (221,803)	(192,619)		(29,183)		
4. a. Speech Therapy - Medicare	\$ 30,199	30,199				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (12,417)	(12,417)				
c. Speech Therapy - Non-Medicare	\$ 26,337	21,661		4,676		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (26,337)	(21,661)		(4,676)		
5. a. Occupational Therapy - Medicare	\$ 73,170	73,170				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (53,588)	(53,588)				
c. Occupational Therapy - Non-Medicare	\$ 124,520	115,280		9,240		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (124,520)	(115,280)		(9,240)		
6. a. Other (Specify) - Medicare	\$					
b. Other (Specify) - Non-Medicare	\$ 105,612	105,612				
<b>III. Total Resident Revenue (Section I. thru Section II.)</b>	<b>\$ 15,114,691</b>	<b>11,825,342</b>		<b>3,289,349</b>		
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (Specify)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (Specify)	\$					
<b>V. Total Other Revenue (1 thru 8)</b>	<b>\$</b>					
<b>VI. Total All Revenue (III + V)</b>	<b>\$ 15,114,691</b>	<b>11,825,342</b>		<b>3,289,349</b>		

\* 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	NursePac-Aids
	Lab Medicare	\$ 7,733		
	Lab Medicare CA	\$ (7,733)		
	Oxygen Medicare	\$ 198		
	Oxygen Medicare CA	\$ (198)		
	Equipment rental	\$ -		
	Equipment rental CA	\$ -		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds Medicare	\$ -		
	Therapy Beds Medicare CA	\$ -		
	Radiology Medicare	\$ 140		
	Radiology Medicare CA	\$ (140)		
	IV Therapy	\$ 37,072		
	IV Therapy CA	\$ (37,072)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose testing	\$ -		
	Glucose testing CA	\$ -		
	Outpatient Therapy Medicare	\$ -		
	<b>Total Other Resident Revenue - Medicare</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	NursePac-Aids
	Lab	\$ -		
	Lab CA	\$ -		
	Oxygen	\$ 2,748		\$ 126
	Oxygen CA	\$ (2,748)		\$ (126)
	Equipment rental	\$ -		
	Equipment rental CA	\$ -		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds	\$ -		
	Therapy Beds CA	\$ -		
	Radiology	\$ -		
	Radiology CA	\$ -		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose Testing	\$ -		
	Glucose Testing CA	\$ -		
	IV therapy	\$ 13,610		\$ 681
	IV therapy CA	\$ (13,610)		\$ (681)
	Flu shot revenue	\$ -		
	Outpatient therapy	\$ -		
	prior period revenue	\$ 105,863		
	rounding	\$ (251)		
	<b>Total Other Resident Revenue</b>	<b>\$ 105,612</b>	<b>\$ -</b>	<b>\$ -</b>

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	NursePac-Aids
	#REF!		\$ -		
	<b>Total Interest Income</b>		<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Other Revenue

Page Ref	Description	CCNH	RFNS	NursePac-Aids
	MPALS	\$ -		
	TELEVISION INCOME	\$ -		
	CONCESSIONS / VENDING INCOME	\$ -		
	RESIDENT LATB FEE REVENUE	\$ -		
	RESIDENT ATTORNEY FEE REVENUE	\$ -		
	TELEPHONE INCOME	\$ -		
	OTHER INCOME	\$ -		
	OPTUM DIVIDENDS REVENUE	\$ -		
	<b>Total Other Revenue</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2016	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	315,967
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,509,548
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	32,187
5. Prepaid Expenses			\$	279,666
a. Prepaid Insurance	270,311			
b. Prepaid Property Taxes	7,240			
c. Prepaid Expenses Other	2,115			
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	(696,325)
Due From (to) Related Parties	147,020			
Other Owners reserves	(843,345)			
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	2,441,044
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Depreciation	Net		
3. Buildings	*Historical Cost	394,955	\$	356,894
	Accum. Depreciation	38,061	Net	
4. Leasehold Improvements	*Historical Cost	684,802	\$	286,303
	Accum. Depreciation	398,499	Net	
5. Non-Movable Equipment	*Historical Cost	7,990	\$	3,059
	Accum. Depreciation	4,932	Net	
6. Movable Equipment	*Historical Cost	436,457	\$	156,795
	Accum. Depreciation	279,663	Net	
7. Motor Vehicles	*Historical Cost	9,580	\$	5,179
	Accum. Depreciation	4,401	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	2,356
Construction in Progress	2,356			
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	810,584

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

(Carry Total forward to next page)

**G. Balance Sheet (cont'd)**

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2016	32	37
Account			Amount	
Total Brought Forward:			\$	3,251,628
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				
2. Land Improvements				
	*Historical Cost	_____	Net	\$
	Accum. Depreciation	_____		\$
3. Buildings				
	*Historical Cost	_____	Net	\$
	Accum. Depreciation	_____		\$
4. Non-Movable Equipment				
	*Historical Cost	_____	Net	\$
	Accum. Depreciation	_____		\$
5. Movable Equipment				
	*Historical Cost	_____	Net	\$
	Accum. Depreciation	_____		\$
6. Motor Vehicles				
	*Historical Cost	_____	Net	\$
	Accum. Depreciation	_____		\$
7. Minor Equipment-Not Depreciable				
C-8 <b>Total Leasehold or Like Properties</b> (C1 thru 7)				
D. Investment and Other Assets				
1. Deferred Deposits				
2. Escrow Deposits				
3. Organization Expense				
	*Historical Cost	_____	Net	\$
	Accum. Depreciation	_____		\$
4. Goodwill (Purchased Only)				
5. Investments Related to Resident Care ( <i>itemize</i> )				
	Patient Trust Funds	40,445		\$ 43,000
	Long Term Deposit - primecare	2,555		
6. Loans to Owners or Related Parties ( <i>itemize</i> )				
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)				
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)				

\* 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
Trinity Hill Care Center, LLC		2222-C	9/30/2016	33	37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	265,789
2. Notes Payable ( <i>itemize</i> )				\$	
Working Capital Line of Credit					
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> )				\$	299,443
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	
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> )				\$	865,336
Related Party Payables		428,392			
Accrued Expenses		43,712			
Accrued Resident User Fees		264,390			
Accrued Workers Comp Expense		128,842			
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				<b>\$</b>	<b>1,430,568</b>

\* 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 Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2016	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,430,568	
<b>Liabilities (cont'd)</b>					
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> )					\$
Patient Trust Funds		40,445			40,445
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)					\$ 40,445
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)					\$ 1,471,012

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

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2016	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
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			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	1,000
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	1,093,826
6. Gain or Loss for Period			\$	728,790
				10/1/2015 thru 9/30/2016
7. Total Net Worth			\$	1,823,615
<b>C. Total Reserves and Net Worth</b>			\$	1,823,615
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	3,294,628

### H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of	
Trinity Hill Care Center, LLC	2222-C	9/30/2016	36	37	
Account			Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2015			\$		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$ 15,114,691		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$ 14,385,901		
D. Net Income or Deficit			\$ 728,790		
E. Balance			\$ 728,790		
F. Additions					
1. Additional Capital Contributed ( <i>itemize</i> )					
2. Other ( <i>itemize</i> )					
F-3. Total Additions			\$		
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. <b>Balance at End of Period</b>			\$ 728,790		
09/30/16					

### I. Preparer's/Reviewer's Certification

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2016	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 checked="" type="checkbox"/> NurseFac-Aids		
<b>Preparer/Reviewer Certification</b>				
<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 <i>iCare Management LLC</i>	Title	Date Signed <i>2 / 14 / 17</i>		
Printed Name of Preparer  iCare Management, LLC				
Address Address  341 Bidwell Street, Manchester, CT 06040		Phone Number  860-570-2140		



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