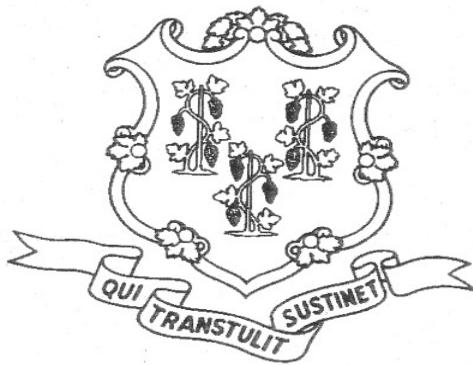


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2020

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		
Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS)	<input checked="" type="checkbox"/> NurseFac-Aids
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020	

License Numbers:	CCNH 2222-C	RHNS	NurseFac-Aids AIDS	Medicare Provider 07-5268
------------------	----------------	------	-----------------------	------------------------------

Medicaid Provider Numbers:	CCNH 9555	RHNS	ICF-IID 49553
----------------------------	--------------	------	------------------

### For Department Use Only

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

**General Information**

Name of Facility (as licensed) Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020	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, 2019 and ending September 30, 2020, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)	Date	Signed (Owner)	Date	
Printed Name (Administrator) Yong Crandall		Printed Name (Owner) Chris Wright		
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public				

(Notary Seal)

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**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 10/1/2019	To 9/30/2020
Address of Facility 151 Hillside Avenue, Hartford, CT 06016			
Report Prepared By iCare Management, LLC	Phone Number 860-570-2140	Date 2/15/2021	
Item	Total	CCNH	RHNS
1. Dietary wages paid	\$		NurseFac-Aids
2. Laundry wages paid	\$		
3. Housekeeping wages paid	\$		
4. Nursing wages paid	\$		
5. All other wages paid	\$		
6. <b>Total Wages Paid</b>	\$		
7. Total salaries paid	\$		
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$		

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility	Report for Year Ended	Page	of
860-951-1060	9/30/2020	2	37

Name of Facility (as shown on license)	Address (No. & Street, City, State, Zip)		
Trinity Hill Care Center, LLC	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 <input checked="" type="checkbox"/> 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	Nursing Home Administrator's License No.:	2046
Yong Crandall		
Other Operators/Owners who are assistant administrators (full or part time) of this facility.		
Name	License No.:	

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-3 Rev. 10/2005

**General Information and Questionnaire  
Partners/Members**

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020	Page of 3   37
Legal Name of Partnership/LLC		Business Address	State(s) and/or Town(s) in Which Registered
Trinity Hill Care Center, LLC		151 Hillside Avenue, Hartford, CT 06016	CT
Name of Partners/Members	Business Address	Title	% Owned
V. Robert Salazar	2500 18th Street, Suite 200, Denver, CO 80211	Member	31.3
David Sebag	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

# **General Information and Questionnaire**

## **Corporate Owners**

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2020	3A	37

If this facility is owned or operated as a corporation, provide the following information:

# **General Information and Questionnaire**

## **Individual Proprietorship**

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

## **General Information and Questionnaire**

### **Related Parties\***

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.				
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the following information:				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
See Attached		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.

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

### **Related Parties\***

Name of Facility Trinity Care Center, LLC		License No. 2222-C		Report for Year Ended 9/30/2020				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		Cost Reported	Actual Cost to the Related Party
		Yes	No	%**		Page # / Line #			
Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040				Shared Employees			(18,618)	18,618
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105				Shared Employees			(13,184)	13,184
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088				Shared Employees			(20,297)	20,297
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032				Shared Employees			(17,520)	17,520
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088				Shared Employees			(2,089)	2,089
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450				Shared Employees			(23,923)	23,923
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			(7,078)	7,078
Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002				Shared Employees			(17,728)	17,728
Secure Care Center LLC	60 West Street, Rocky Hill, CT 06067				Shared Employees			9,216	(9,216)
Universal Healthcare Holdings, LLC	5 Greenwood Street, Hartford, CT 06106				Shared Employees			(7,324)	7,324
Touchpoints at Homecare LLC	1838 Silas Deane Hwy, Rocky Hill, CT 06067				Shared Employees			-	-
Elevate Counseling Services LLC	341 Bidwell St. Manchester, CT 06040				Shared Employees			-	-
Touchpoints Therapy LLC	341 Bidwell St. Manchester, CT 06040				OT/PT/ST	13 5,8,10		221,914	(221,914)
Realty	N/A				Workers Comp Direct Treatments				
iCare Management, LLC	341 Bidwell St. Manchester, CT 06040				Building Lease & Rent	22,22,27	10,9,14		-
iCare Health Management, LLC	341 Bidwell St. Manchester, CT 06040				iCare Helt-Legal, Postage, Emp Recruitment & Marketing, Equipment Rental	16, 15, 22	M,E, 6f	10,527	(10,527)
					Shared EEs not part of mgmt agmt			249,759	(249,759)
					Management Services, Direct	20 5j		177,787	(177,787)
					Management Services, Indirect	20 5j		35,234	(35,234)
					Management Services, Administrative	16 M12		418,485	(418,485)
All 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 9/30/2020	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist ( <i>See listing page 13</i> )
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

<p>1. In the preparation of this Report, were all costs allocated as required?</p>	<input checked="" type="radio"/> Yes <input type="radio"/> No	<p>If "No," explain fully why such allocation was not made.</p>         
<p>2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.</p>         		
<p>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.)</p> <p style="text-align: center;"><input checked="" type="radio"/> Yes    <input type="radio"/> No    If "No," explain fully why such allocation was not made.</p>         		

## General Information and Questionnaire

### Leases (Excluding Real Property)

**Operating Leases** - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

Name of Facility		License No.		Report for Year Ended			Page	of
Trinity Hill Care Center, LLC		2222-C		9/30/2020			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers			Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
		Yes	No					
Accelerated Care Plus Corp. Joule Street, Suite A-1	4850 Reno, NV	<input type="radio"/>	<input checked="" type="radio"/>	Omnistim Electrotherapy and Omnisound Therapeutic Ultrasound Equipment	05/18/10	automatic annual	3,435	3,435
ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909		<input type="radio"/>	<input checked="" type="radio"/>	Time Clocks and Payroll Punch Equip	06/01/10	automatic renewals	8,272	8,272
GE Capital C/O Wells Fargo, P.O.Box 41564, Philadelphia, PA 19101		<input type="radio"/>	<input checked="" type="radio"/>	Copier	03/05/14	automatic renewals	10,237	10,237
Neopost USA Inc, 25880 Network Place, Chicago, IL 60673		<input type="radio"/>	<input checked="" type="radio"/>	Postage Rental	04/16/13	Month to month	714	714
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		<b>Total ***</b>	22,658	

\* 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 Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

⊕ Accrual      ○ Cash      ○ Modified Cash

Is the accounting basis for this

period the same as for the previous period?

- Ye
- No

If "No," explain.

## **Independent Accounting Firm**

Name of Accounting Firm 1 O'Connor, Davies LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 100 Great Meadow Road, Ste 401, Wethersfield, CT 06109
--	---

**Services Provided by This Firm (*describe fully*)**

1	Taxes, financial statements, accounting support	\$	8,379
2		\$	
3		\$	
4		\$	
		Charge for Services Provided	
		\$	8,379

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

Yes       No      15D

## **Legal Services Information**

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

- 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 (*describe fully*)**

1	Lease and contract issues, general legal advice, Labor Law	\$	4,076
2	Lease and contract issues, general legal advice, union funds advice	\$	
3	Employment law, arbitrations, contract negotiations	\$	
4	Employment Arbitrations, healthcare law & Conservatorships	\$	3,489
5	Collections	\$	276
		Charge for Services Provided	
		\$	7,841

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

Yes       No

## Schedule of Resident Statistics

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C			Report for Year Ended 9/30/2020				Page 8 of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total NurseFac- Aids	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	NurseFac- Aids	Total	CCNH	RHNS	NurseFac- Aids
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	144	114		30	144	114		30				
B. On last day of THIS report period	144	114		30					144	114		30
2. Number of Residents												
A. As of midnight of PREVIOUS report period	141	111		30	141	111		30				
B. As of midnight of THIS report period	131	103		28					131	103		28
3. Total Number of Days Care Provided During Period												
A. Medicare	1,486	1,486			1,147	1,147			339	339		
B. Medicaid (Conn.)	46,083	36,751		9,332	35,064	27,774		7,290	11,019	8,977		2,042
C. Medicaid (other states)												
D. Private Pay												
E. State SSI for RCH												
F. Other (Specify) Insurance												
G. Total Care Days During Period (3A thru F)	47,569	38,237		9,332	36,211	28,921		7,290	11,358	9,316		2,042
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												
<b>5. Total Resident Days (3G + 4A + 4B)</b>	<b>47,569</b>	<b>38,237</b>		<b>9,332</b>	<b>36,211</b>	<b>28,921</b>		<b>7,290</b>	<b>11,358</b>	<b>9,316</b>		<b>2,042</b>

## Schedule of Resident Statistics (Cont'd)

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?  Yes  No  
If "YES", provide the following information:

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

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

1st change	Change in Resident Days			CCNH	RHNS	NurseFac-Aids
	2nd change	3rd change	4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	NurseFac-Aids	R.C.H.	ICF-MR
No. of Residents	2	101				24		
Per Diem Rate								
a. One bed rm.	539.00	292.85				318.58		
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	NurseFac-Aids
		1,293	1,039		254
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		936	752		184
2. Restorative Treatments		2,400	1,929		471
C. Other		3,927	3,157		770
D. <b>Total Physical Therapy Treatments</b>		8,556	6,877		1,679

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		88	71		17
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		503	404		99
2. Restorative Treatments		254	254		
C. Other		497	350		147
D. <b>Total Speech Therapy Treatments</b>		1,342	1,079		263

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		2,462	1,979		483
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments		984	791		193
2. Restorative Treatments		1,416	1,138		278
C. Other		3,130	2,516		614
D. <b>Total Occupational Therapy Treatments</b>		7,992	6,424		1,568

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended		Page	of		
		9/30/2020		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		
A. Salaries and Wages*							
1. Operators/Owners (Complete also Sec. I of Schedule A1)							
2. Administrator(s) (Complete also Sec. III of Schedule A1)	129,148	1,398			31,520 699		
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)							
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	247,190	11,251			123,595 5,625		
5. Dietary Service							
a. Head Dietitian							
b. Food Service Supervisor	89,057	1,656			21,735 436		
c. Dietary Workers	457,235	21,140			111,591 5,563		
6. Housekeeping Service							
a. Head Housekeeper							
b. Other Housekeeping Workers	238,449	13,090			119,224 6,545		
7. Repairs & Maintenance Services							
a. Engineer or Chief of Maintenance	1,067				533		
b. Other Maintenance Workers	25,275	1,426			12,638 713		
8. Laundry Service							
a. Supervisor							
b. Other Laundry Workers	98,007	4,964			49,003 2,482		
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	158,136	2,944			79,068 1,472		
b. RN							
1. Direct Care	334,019	6,866			239,285 6,143		
2. Administrative**	220,533	5,171			110,266 2,585		
c. LPN							
1. Direct Care	1,132,966	34,000			216,696 8,056		
2. Administrative**							
d. Aides and Attendants	1,846,731	94,433			309,193 18,031		
e. Physical Therapists							
f. Speech Therapists							
g. Occupational Therapists							
h. Recreation Workers	175,931	6,998			42,937 1,842		
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	118,487	4,454			37,769 1,599		
n. Marketing							
o. Other (Specify)							
See Attached Schedule	77,446	4,152			18,901 1,390		
A-13. Total Salary Expenditures	5,349,676	213,940			1,523,955 63,180		

\* 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)**

**Schedule of Other Fees (Page 13)**

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 Trinity Hill Care Center, LLC			License No. 2222-C		Report for Year Ended 9/30/2020			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	NurseFac- Aids							
<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)				License No.		Report for Year Ended			Page	of
Trinity Hill Care Center, LLC				2222-C		9/30/2020			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	NurseFac-Aids							
<b>Section III - Administrators***</b>										
George Kingston	92,898		31,520	same as employees less union funds	Administrator	1,616	A2			
Dennis Billings	36,250			same as employees less union funds	Administrator	480	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
	2222-C	9/30/2020		13	37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	NurseFac-Aids
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist					
3. Pharmacist	21,794	209			5,319
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	91,093	1,745			
b. Other					
6. Social Worker	12,799	146			3,124
7. Recreation Worker	2,701	35+Cable			1,351
8. Physicians					
a. Medical Director (entire facility)	54,000	268			64,992
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**					
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
Physician Care Contract Services	13,091	21			3,195
9. Speech Therapist					
a. Resident Care	24,392	467			
b. Other					
10. Occupational Therapist					
a. Resident Care	106,429	2,039			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	130,163	1,357			
2. Administrative***	(82,586)	(1,398)			
b. LPN					
1. Direct Care	154,534	1,914			
2. Administrative***					
c. Aides	121,772	1,304			
d. Other					
12. Other (Specify)					
See Attached Schedule	155,600	3,329			70,091
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	805,782	11,400			148,071
					2,390

\* 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\*

\* Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

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

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020	Page 15	of 37	
Item		Total	CCNH	RHNS	NurseFac- Aids
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 162,749	126,654			36,095
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 570,391	443,888			126,504
5. Health Insurance	\$ 1,098,873	855,161			243,713
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 381,127	296,599			84,528
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 46,657	36,309			10,348
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 204,940	204,940			
d. Accounting and Auditing	\$ 8,379	6,735			1,644
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 7,841	6,303			1,538
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 20,584	13,723			6,861
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 20,995	16,876			4,119
2. Cellular Phones	\$ 2,599	2,089			510
i. Appraisal ( <i>Specify purpose and attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$ (0)	(0)			(0)
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	\$ 962,169	773,413			188,757
<b>Subtotal</b>	\$ 3,487,304	2,782,688			704,615

\* 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**

Attachment Page 15

## **Schedule of Other Employee Benefits**

## Schedule of Other Taxes

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

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

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020		Page 16	of 37
Item		Total	CCNH	RHNS	NurseFac- Aids
	<b><i>Subtotals Brought Forward:</i></b>	3,487,304	2,782,688		704,615
I. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$	318	256		62
4. Employee Travel	\$	2,821	2,268		553
5. Education Expenses Related to Seminars and Conventions	\$	1,245	1,001		244
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$				
7. Other ( <i>Specify</i> ) See Attached Schedule	\$	279	224		55
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$	12,179	9,790		2,389
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	13,658	10,979		2,679
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	\$	2,288	1,839		449
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	9,777	7,859		1,918
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	660	531		129
10. Contributions*** See Attached Schedule	\$	1,511	1,215		296
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$	151,343	100,896		50,448
12. Administrative Management Services**	\$	418,485	336,387		82,098
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	20,056	16,122		3,934
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$	4,121,923	3,272,052		849,871

\* 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	\$ 224		\$ 55
<b>Total Other Travel and Entertainment</b>	<b>\$ 224</b>	<b>\$ -</b>	<b>\$ 55</b>

**Schedule of Other Advertising**

Description	CCNH	RHNS	NurseFac-Aids
COMMUNICATIONS SPECIAL EVENTS	\$ 10,979		\$ 2,679
<b>Total Other Advertising</b>	<b>\$ 10,979</b>	<b>\$ -</b>	<b>\$ 2,679</b>

**Schedule of Dues**

Description	CCNH	RHNS	NurseFac-Aids
ALTCFM			
CAHCF Dues	\$ 7,730		\$ 1,887
OTHER DUES	\$ 129		\$ 31
<b>Total Dues</b>	<b>\$ 7,859</b>	<b>\$ -</b>	<b>\$ 1,918</b>

**Schedule of Contributions**

Description	CCNH	RHNS	NurseFac-Aids
CONTRIBUTIONS	\$ 1,215		\$ 296
<b>Total Contributions</b>	<b>\$ 1,215</b>	<b>\$ -</b>	<b>\$ 296</b>

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	NurseFac-Aids
SOCIAL SERVICE SUPPLIES	\$ -		\$ -
SOC SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 690		\$ 168
EMPLOYEE RELATIONS	\$ 230		\$ 56
EMPLOYEE RELATIONS-OTHER	\$ 90		\$ 22
PERMITS & LICENSES	\$ 1,930		\$ 471
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 2,761		\$ 674
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ 7,999		\$ 1,952
LATE FEES	\$ 518		\$ 126
INTERNET EXPENSES	\$ 1,901		\$ 464
Rounding	\$ 3		
<b>Total Other Administrative and General</b>	<b>\$ 16,122</b>	<b>\$ -</b>	<b>\$ 3,934</b>

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

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020	Page of 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	418,485	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	177,787	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	35,234	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
		9/30/2020		18   37
Item	Total	CCNH	RHNS	NurseFac-Aids
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 291,775	234,535		57,240
2. Non-Food Supplies	\$ 42,246	33,958		8,288
3. Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 13,120	10,546		2,574
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ (20,264)	(16,289)		(3,975)
c. Other (Specify) _____ DIETARY MINOR EQUIPMENT	\$ 5,850	4,702		1,148
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 332,727</b>	<b>267,453</b>		<b>65,274</b>
2E. Dietary Questionnaire	Total	CCNH	RHNS	NurseFac-Aids
F. Resident Meals: Total no. of meals served per day:*	391	391		
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
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 meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.	
K. Is any revenue collected 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)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.	
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.	
O. 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.

## 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 9/30/2020		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. \$	277	184		92
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 ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$	52,821	35,214		17,607
c. Other ( <i>Specify</i> ) LAUNDRY MINOR EQUIPMENT	\$	324	216		108
<b>3D. Total Laundry Expenditures (3a + b + c )</b>	\$	<b>53,421</b>	<b>35,614</b>		<b>17,807</b>
3E. Laundry Questionnaire					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. 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 3D.

\*\*\* 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 Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020		Page 20	of 37
Item		Total	CCNH	RHNS	NurseFac- Aids
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 31,036	20,691		10,345
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
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.	\$ 43,433	28,955		14,478
C. Other ( <i>Specify</i> )	\$				
HOUSEKEEPING MINOR EQUIPMENT					
<b>4D. Total Housekeeping Expenditures (4a + b + c)</b>	\$	74,469	49,646		24,823
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from PHARMACY	\$	133,418	133,418		
b. Medicine Cabinet Drugs	\$	10,117	8,133		1,985
c. Medical and Therapeutic Supplies	\$	100,684	80,932		19,752
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$	1,852	1,852		
2. Other***	\$				
f. X-rays and Related Radiological Procedures***	\$	859	859		
g. Dental ( <i>Not dentists who should be included under             salaries or fees</i> )	\$				
h. Laboratory***	\$	16,274	16,274		
i. Recreation	\$				
j. Direct Management Services*	\$	177,787	142,909		34,878
k. Indirect Management Services*	\$	35,234	28,322		6,912
l. Other ( <i>Specify</i> )**** See Attached Schedule	\$	133,336	99,746		33,590
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	609,562	512,445		97,117

\* 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	\$ 41,464		\$ 10,120
NURSING MINOR EQUIP	\$ 311		\$ 76
MEDICAL RECORDS SUPPLIES	\$ (363)		\$ (88)
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
NON-COVERED PPS DR. VISITS	\$ 623		\$ 152
RESIDENT CARE SUPPLIES	\$ 72		\$ 18
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 10,115		\$ 2,469
PERSONAL CARE SUPPLIES	\$ 185		\$ 45
INCONTINENCY SUPPLIES	\$ -		\$ -
VACCINE RESIDENTS	\$ 756		\$ -
PATIENT SPECIAL NEEDS	\$ -		\$ -
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	\$ 18,179		\$ 9,090
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 4,983		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ -		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ -		\$ -
IV THERAPY SUPPLIES	\$ 16,741		\$ 8,370
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 1,081		\$ 541
ACTIVITIES SUPPLIES	\$ 2,867		\$ 1,434
ACTIVITIES MINOR EQUIPMENT	\$ 1,233		\$ 616
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ 1,498		\$ 749
STRIKE COSTS NON REIMBURSABLE	\$ -		\$ -
COVID NON REIMBURSABLE	\$ -		\$ -
<b>Total Other Resident Care</b>	<b>\$ 99,746</b>	<b>\$ -</b>	<b>\$ 33,590</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 9/30/2020				Page of 21   37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	NurseFac-Aids	Pg	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Housekeeping Services	39,887			20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Laundry Services	52,821			19	3b
Eagle Elevator		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Elevator Contract	6,125			22	6F
Bioserve, Inc.		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Medical Waste	1,622			22	6F
Brightview Landscapes LLC/Stevan Infante		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Snow Removal/Landscaping	15,169			22	6F
All Waste Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Trash removal	35,122			22	6F
American HealthTech		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Software Maintenance Contract	16,655			16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Payroll Services	47,928			16	M11
National Datacare Corp		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Resident Trust Software	2,992			16	M11
Prime Care Technology services		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Computer Consulting Services	42,764			16	M11
Priotiry Express		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Courier Services	2,982			16	M11
Point Right Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Nursing Software	4,680			16	M11
Facility Complain		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Plant Contract Services	148,450			22	6F
		<input type="radio"/>	<input checked="" type="radio"/>	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 Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020			Page 22	of 37
Item		Total	CCNH	RHNS	NurseFac-Aids	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 52,054	34,702				17,351
b. Heat	\$ 40,990	27,327				13,663
c. Light & Power	\$ 74,012	49,341				24,671
d. Water	\$ 77,125	51,416				25,708
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 22,658	18,213				4,445
f. Other ( <i>itemize</i> )	\$ 299,241	199,494				99,747
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 566,080	380,494				185,586
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 23,564	18,941				4,623
c. Non-Movable Equipment	\$ 459	369				90
d. Movable Equipment	\$ 57,302	46,060				11,241
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 81,325	65,370				15,954
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 52,762	42,411				10,351
d. Other ( <i>Specify</i> )	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$ 52,762	42,411				10,351
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,360,151	1,093,319				266,832
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 278,886	185,924				92,962
c. Personal property taxes	\$ 34,526	23,017				11,509
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 1,807,651	1,410,043				397,608

\* 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	\$ 11,214		\$ 5,607
PLANT CONTRACT SERVICE LABOR	\$ 9,774		\$ 4,887
ELEVATOR CONTRACT SERVICE	\$ 4,084		\$ 2,042
FIRE/SPRINKLER CONTRACT SERVICE	\$ 4,405		\$ 2,203
LANDSCAPING CONTRACT SERVICE	\$ 4,442		\$ 2,221
SNOW REMOVAL CONTRACT SERVICE	\$ 5,671		\$ 2,835
TRASH REMOVAL CONTRACT SERVICE	\$ 23,415		\$ 11,707
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ 3,843		\$ 1,922
PLANT CONTRACT SERVICE OTHER	\$ 125,094		\$ 62,547
PLANT MINOR EQUIPMENT	\$ 5,004		\$ 2,502
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ 2,548		\$ 1,274
RENT OTHER	\$ -		\$ -
<b>Total Other Repairs and Maintenance</b>	<b>\$ 199,494</b>	<b>\$ -</b>	<b>\$ 99,747</b>

## Depreciation Schedule

**Schedule of Land Improvements Acquired during this report period**

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

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

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

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

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

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

\*\*Ties to Page 23, Line C2

**Schedule of Movable Equipment Acquired during this report period**

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

**Schedule of Leasehold Improvements Acquired during this report period**



**Amortization Schedule\***

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C		Report for Year Ended 9/30/2020			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
<b>A-4. Subtotal</b>									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
<b>B-4. Subtotal</b>									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period				917,009	534,538			51,157	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				26,333				1,606	
<b>C-4. Subtotal</b>									52,762
<b>D. Total Amortization</b>									52,762

\* 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 9/30/2020	Page 25	of 37
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#### 11. Property Questionnaire

##### Part A

Is the property either owned by the Facility  
or leased from a Related Party?\*

Yes

No

If "Yes," complete Part B.  
If "No," complete Part C.

\*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed	04/01/99			
3. If NOT Original Owner, Date of Purchase	04/01/99			
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	144			
6. Square Footage	51,572			
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)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of				

##### Complete if Mortgage was Refinanced During Current Cost Year

g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

##### Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
Summit Trinity Hill SNF, LLC	151 Hillside Ave, Hartford, CT	08/09/17	15 year with 2	\$1,368,000 yr 1

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 9/30/2020			Page 26	of 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 9/30/2020			Page 27	of 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 ( <i>Specify</i> )	\$					
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 ( <i>Specify</i> )	\$	2,064	1,659			405
INTEREST						
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)	\$	2,064	1,659			405
14. Insurance						
a. Insurance on Property (buildings only)	\$	8,227	5,485			2,742
b. Insurance on Automobiles	\$	5,040	3,360			1,680
c. Insurance other than Property (as specified above)						
1. Umbrella ( <i>Blanket Coverage</i> )	\$	64,223	42,815			21,408
2. Fire and Extended Coverage	\$					
3. Other ( <i>Specify</i> )	\$	7,116	4,744			2,372
Other insurance, crime						
14d. <b>Total Insurance Expenditures</b> (14a + b + c)	\$	84,606	56,404			28,202
15. <b>Total All Expenditures</b> (A-13 thru C-14)	\$	15,479,985	12,141,267			3,338,718

## **D. Adjustments to Statement of Expenditures**

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C	Report for Year Ended 9/30/2020		Page 28	of 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.	15	c	Bad Debts	\$ 204,940	204,940		
10.			Accounting	\$			
10a.			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.	16	m3	Unallowable Advertising *	\$ 13,658	10,979		2,679
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 10,596	8,517		2,079
			<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)			\$ 229,193	224,435			4,758

\* 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	NurseFac-Aids
<b>Total Other Salaries Adjustment</b>			\$ -	\$ -	\$ -

### **Schedule of Fees Adjustments**

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

## **Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
16a		PENALTIES	\$ 7,999		\$ 1,952
16a		LATE FEES	\$ 518		\$ 126
16a		PRIOR PERIOD EXPENSES			
		rounding			
		Provider User Fee for Medicare days	\$ -		\$ -
<b>Total Other A&amp;G Adjustments</b>			\$ 8,517	\$ -	\$ 2,079

State of Connecticut

**Annual Report of Long-Term Care Facility**

CSP-29 Rev. 9/2018

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

Name of Facility			License No.	Report for Year Ended		Page	of
Item No.	Page No.	Line No.	2222-C	9/30/2020		29	37
				Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
		Item Description					
		Subtotals Brought Forward		\$ 229,193	224,435		4,758
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$			
28.	20	5d	Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 859	859		
30.	20	5h	Laboratory	\$ 16,274	16,274		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 776	623		152
<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.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation	\$			
			Unallowable Building Interest - See Attached Schedule	\$			
49.	<b>Total Amount of Decrease (Items 1 - 48)</b>		\$ 247,102	242,192			4,910

\*\*\* 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**

### **Schedule of Excess Movable Equipment Depreciation**

### **Schedule of Other Property Adjustments**

## **Schedule of Other - Indirect Adjustments**

Attachment Page 29

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 Other - Miscellaneous Administrative Adjustments**

### Schedule of Other - Direct Adjustments

## Schedule of Unallowable Building Interest

				age 29
<b>Total Unallowable Building Interest</b>	\$ -	\$ -	\$ -	

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**F. Statement of Revenue**

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020			Page 30   37
Item		Total	CCNH	RHNS	NurseFac-Aids
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 13,672,842	10,784,786			2,888,055
b. Medicaid Room and Board Contractual Allowance **	\$				
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,052,192	832,985			219,207
b. Medicare Room and Board Contractual Allowance **	\$				
4. a. Private-Pay Residents and Other	\$				
b. Private-Pay Room and Board Contractual Allowance **	\$				
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 104,425	104,425			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (104,425)	(104,425)			
c. Prescription Drugs - Non-Medicare	\$ 42,747	36,985			5,762
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (42,747)	(36,985)			(5,762)
2. a. Medical Supplies - Medicare	\$ 807	807			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (807)	(807)			
c. Medical Supplies - Non-Medicare	\$ 16,938	13,501			3,437
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (16,938)	(13,501)			(3,437)
3. a. Physical Therapy - Medicare	\$ 68,775	68,775			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (46,088)	(46,088)			
c. Physical Therapy - Non-Medicare	\$ 122,699	105,665			17,034
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (122,699)	(105,665)			(17,034)
4. a. Speech Therapy - Medicare	\$ 7,449	7,449			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (5,920)	(5,920)			
c. Speech Therapy - Non-Medicare	\$ 43,510	37,421			6,089
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (43,510)	(37,421)			(6,089)
5. a. Occupational Therapy - Medicare	\$ 89,964	89,964			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (42,943)	(42,943)			
c. Occupational Therapy - Non-Medicare	\$ 97,139	83,744			13,396
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (97,139)	(83,744)			(13,396)
6. a. Other ( <i>Specify</i> ) - Medicare	\$				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 63,376	63,376			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 14,859,647	11,752,385			3,107,262
<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 ( <i>Specify</i> )	\$ 8,081	8,081			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 836,936	836,936			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 845,017	845,017			
<b>VI. Total All Revenue</b> (III +V)	\$ 15,704,663	12,597,401			3,107,262

\* 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	NurseFac-Aids
	Lab Medicare	\$ 4,920		
	Lab Medicare CA	\$ (4,920)		
	Oxygen Medicare	\$ -		
	Oxygen Medicare CA	\$ -		
	Equipment rental	\$ -		
	Equipment rental CA	\$ -		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds Medicare	\$ -		
	Therapy Beds Medicare CA	\$ -		
	Radiology Medicare	\$ 816		
	Radiology Medicare CA	\$ (816)		
	IV Therapy	\$ 7,200		
	IV Therapy CA	\$ (7,200)		
	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	NurseFac-Aids
	Lab	12,123		
	Lab CA	(12,123)		
	Oxygen	\$ 450	\$ 132	
	Oxygen CA	\$ (450)	\$ (132)	
	Equipment rental	\$ -		
	Equipment rental CA	\$ -		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds	\$ -		
	Therapy Beds CA	\$ -		
	Radiology	\$ 729		
	Radiology CA	\$ (729)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose Testing	\$ -		
	Glucose Testing CA	\$ -		
	IV therapy	\$ 26,083	\$ 2,210	
	IV therapy CA	\$ (26,083)	\$ (2,210)	
	Flu shot revenue	\$ -		
	Outpatient therapy	\$ -		
	prior period revenue	\$ (5,063)		
	Optum B	\$ 150,182		
	Optum B CA	\$ (68,782)		
	C/A VBP	\$ (12,961)		
	rounding	\$ (0)		
	<b>Total Other Resident Revenue</b>	<b>\$ 63,376</b>	<b>\$ -</b>	<b>\$ -</b>

## Interest Income

## Account

Page Ref	Account	Balance	CCNH	RHNS	NurseFac-Aids
	INTEREST INCOME	\$ 8,081			
	<b>Total Interest Income</b>	<b>\$ 8,081</b>	<b>\$ -</b>	<b>\$ -</b>	

## Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	NurseFac-Aids
	MEALS	\$ -		
	TELEVISION INCOME	\$ -		
	OTHER INCOME: DMHAS OPERATING REVENUE	\$ -		
	OTHER INCOME: DMHAS ORGANIZATIONAL REV	\$ -		
	OTHER INCOME: DEFERRED REVENUE	\$ -		
	MEDICARE COVID STIMULUS REVENUE	\$ -		
	MEDICAID COVID REVENUE	\$ 820,219		
	CONCESSIONS / VENDING INCOME	\$ -		
	RESIDENT LATE FEE REVENUE	\$ -		
	RESIDENT ATTORNEY FEE REVENUE	\$ -		
	TELEPHONE INCOME	\$ -		
	OTHER INCOME	\$ 128		
	OPTUM DIVIDENDS REVENUE	\$ 16,589		
	OPTUM OUTLIERS	\$ -		
	<b>Total Other Revenue</b>	<b>\$ 836,936</b>	<b>\$ -</b>	<b>\$ -</b>

**G. Balance Sheet**

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$ 4,398,160	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 2,244,870	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$ 32,187	
5. Prepaid Expenses			\$ 355,477	
a. _____		275,599		
b. _____		77,751		
c. _____		2,127		
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$ (1,879,315)	
		57,875		
		(1,937,189)		
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 5,151,380	
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Depreciation	Net		
3. Buildings	*Historical Cost	394,955	\$ 262,638	
	Accum. Depreciation	132,317	Net	
4. Leasehold Improvements	*Historical Cost	943,343	\$ 356,042	
	Accum. Depreciation	587,300	Net	
5. Non-Movable Equipment	*Historical Cost	7,990	\$ 1,223	
	Accum. Depreciation	6,767	Net	
6. Movable Equipment	*Historical Cost	648,058	\$ 164,927	
	Accum. Depreciation	483,131	Net	
7. Motor Vehicles	*Historical Cost	13,085	\$ 1,071	
	Accum. Depreciation	12,014	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
Construction in Progress				
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$ 785,901	

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

(Carry Total forward to next page)

**Schedule of Prepaid Expenses Page 31 Line A5**

Page Ref Line Ref Description

Page REC	Line REC	Description	
<b>Total Prepaid Expenses</b>			\$ -

**Schedule of Other Current Assets (itemized) Page 31 Line A8**

**Page Ref Line Ref Description**

<b>Total Other Current Assets (Itemize)</b>		\$ -

**Schedule of Other Fixed Assets (Itemize) Page 31 Line B9**

Page Ref Line Ref Description

<b>Total Other Other Fixed Assets (Itemize)</b>		<b>\$</b>	<b>-</b>

**Schedule of Other Assets Page 32 Line D7**

**Page Ref Line Ref Description**

<b>Total Other Assets</b>		<b>\$</b>	<b>-</b>

**Schedule of Notes Payable (Itemize) Page 33 Line A2**

**Page Ref Line Ref Description**

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			\$ -

**Schedule of Other Current Liabilities (Itemize) Page 33 Line A12**

Page Ref Line Ref Description

<b>Total Other Current Liabilities (Itemize)</b>		\$ -

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

**Page Ref Line Ref Description**

<b>Total Other Current Liabilities (Itemize)</b>		<b>\$</b>	<b>-</b>

## G. Balance Sheet (cont'd)

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020	Page 32	of 37
Account		Amount		
		Total Brought Forward:		\$ 5,937,281
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements	*Historical Cost Accum. Depreciation	Net	\$	
3. Buildings	*Historical Cost Accum. Depreciation	Net	\$	
4. Non-Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
5. Movable Equipment	*Historical Cost Accum. Depreciation	Net	\$	
6. Motor Vehicles	*Historical Cost Accum. Depreciation	Net	\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	660,235
3. Organization Expense	*Historical Cost Accum. Depreciation	Net	\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	61,113
Patient Trust Funds	58,558			
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> )			\$	
See Schedule				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	721,347
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	6,658,628

\* 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
		9/30/2020	33	37
Account		Amount		
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable			\$	417,111
2. Notes Payable ( <i>itemize</i> ) Working Capital Line of Credit			\$	
See Schedule				
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> )			\$	322,933
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> )			\$	3,788,359
Related Party Payables				
Accrued Expenses				
Accrued Resident User Fees				
Accrued Workers Comp Expense				
A-13. <b>Total Current Liabilities</b> (Lines A1 thru 12)			\$	4,528,403

\* 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 9/30/2020	Page 34	of 37
Account				Amount
Total Brought Forward:				4,528,403
<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> )				\$ 58,558
Patient Trust Funds				58,558
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 58,558
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 4,586,960

## G. Balance Sheet (cont'd)

### Reserves and Net Worth

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020	Page 35	of 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			\$	1,845,990
6. Gain or Loss for Period	10/1/2019	thru	9/30/2020	\$ 224,678
7. Total Net Worth			\$	2,071,668
<b>C. Total Reserves and Net Worth</b>			\$	2,071,668
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	6,658,628

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Trinity Hill Care Center, LLC	2222-C	9/30/2020	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2019				\$		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 15,704,663		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 15,479,985		
D. Net Income or Deficit				\$ 224,678		
E. Balance				\$ 224,678		
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 (No., City, State, Zip)		Title	Amount			
2. Other Withdrawings ( <i>Specify</i> )				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. <b>Balance at End of Period</b>				\$ 224,678		

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

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2020	Page 37	of 37
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*Check appropriate category*

<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
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### Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
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Printed Name of Preparer
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iCare Management, LLC
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Address Address 341 Bidwell Street, Manchester, CT 06040	Phone Number 860-570-2140
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Contacted Person Regarding Additional Information Needed Regarding This Report Kartik Patel	Phone Number 860-570-2140
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Contact Email Address
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Kpatel@icarehn.com
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