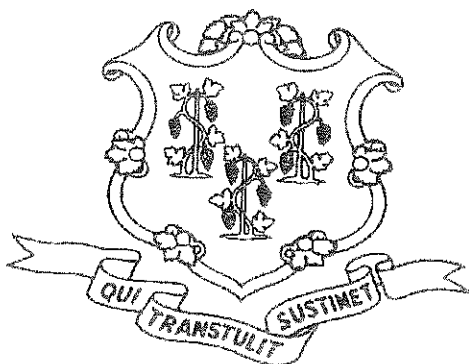


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2015

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 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	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

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

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 9/30/2015	Page 1	of 37
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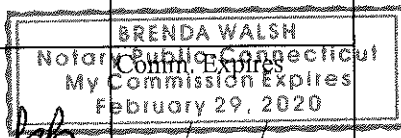
Administrator's/Owner's Certification

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, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator) <i>George Kingston</i>		Date 2/10/16	Signed (Owner) <i>Chris Wright</i>		Date 2/10/16
Printed Name (Administrator) George Kingston			Printed Name (Owner) Chris Wright		
Subscribed and Sworn to before me: <i>George Kingston</i>	State of CT	Date 2/10/16	Signed (Notary Public) <i>Brenda Walsh</i>		
Address of Notary Public 341 Bidwell Street, Manchester, CT 06040					

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Trinity Hill Care Center, LLC		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility 151 Hillside Avenue, Hartford, CT 06016				
Report Prepared By Denise MacKinnon		Phone Number 860-570-2140 ext 15	Date	
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. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-951-1060		Report for Year Ended 9/30/2015	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.				
Administrator				
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 9/30/2015	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	

General Information and Questionnaire Related Parties*

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2015	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No

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

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No				
See Attached		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				
		<input type="radio"/>	<input type="radio"/>				

* Use additional sheets if necessary.
 ** Provide the percentage amount of revenue received from non-related parties.

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 CSP-4 Rev. 10/2005

Related Parties*

Name of Facility		License No.	Report for Year Ended	Page	of	
Trinity Care Center, LLC			9/3/2015	4	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 #	Actual Cost to the Related Party
		Yes	No %**			
Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040			Shared Employees		(11,025) 11,025
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105			Shared Employees		(15,980) 15,980
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088			Laundry Services	19 3	-
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088			Shared Employees		(75,853) 75,853
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032			Bank Fees	16 M	796 (796)
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032			Shared Employees		(4,742) 4,742
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088			Laundry Services	19 3	-
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088			Shared Employees		(36,815) 36,815
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450			Shared Employees		(28,701) 28,701
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		(8,676) 8,676
Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002			Shared Employees		(5,221) 5,221
Secure Care Center LLC	60 West Street, Rocky Hill, CT 06067			Shared Employees		(5,417) 5,417
Touchpoints therapy	171 Main St. East Windsor, CT 06088			OT/PT/ST	13 5,8,10	370,528 (370,528)
Bidwell Realty, LLC	341 Bidwell St. Manchester, CT 06040			Building Lease & Rent	22,22,27 10,9,14	1,563,332 (1,563,332)
iCare Management, LLC	341 Bidwell St. Manchester, CT 06040			Postage & Legal	16, 15 M.E.	30,942 (30,942)
iCare Health Management, LLC	341 Bidwell St. Manchester, CT 06040			Shared EEs not part of mgmt agmt Management Services, Direct	20 51	111,891 (111,891)
				Management Services, Indirect	20 51	137,681 (137,681)
				Management Services, Administrative	16 M12	48,915 (48,915)
						284,522 (284,522)
						-
						-
						-
						-
All 9 Care Centers, mgmt co, ready, 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 9/30/2015	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

- In the preparation of this Report, were all costs allocated as required? Yes No If "No," explain fully why such allocation was not made.
- Explain the allocation of related company expenses and attach copy of appropriate supporting data.
- Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.) Yes No If "No," explain fully why such allocation was not made.

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CSP-7 Rev. 6/95

**General Information and Questionnaire
Accounting Basis**

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2015	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? Yes 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	\$ 3,712
2	\$
3	\$
4	\$
Charge for Services Provided	
	\$ 3,712

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 1 iCare Health Management, LLC 2 Starble and Harris 3 Durant Nichols / Robinson & Cole, LLP 4 Various others (American Arbitration , Various Arbitration, Murtha Cullina,Robinson) 5 Starble and Harris, iCare Health Management LLC	Telephone Number 860-570-2140 860-678-7775 860-275-8200
--	--

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	\$ 29,739
2 Lease and contract issues, general legal advice, union funds advice	\$ 11,653
3 Employment law, arbitrations, contract negotiations	\$ 21,144
4 Employment Arbitrations, healthcare law	\$ 7,904
5 Collections	\$ 418
Charge for Services Provided	
	\$ 70,859

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

- Yes No 15E

Schedule of Resident Statistics

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2015						Page 8	of 37
		Period 10/1 Thru 6/30		Period 7/1 Thru 9/30		Total	NurseFac- Aids		
		Total CCNH Level	Total RHNS Level	Total CCNH	Total RHNS				
1. Certified Bed Capacity									
A. On last day of PREVIOUS report period	144	114	30	144	114	144	30	30	
B. On last day of THIS report period	144	114	30	144	114	144	30	30	
2. Number of Residents									
A. As of midnight of PREVIOUS report period	141	112	29	141	112	142	29	26	
B. As of midnight of THIS report period	139	110	29	142	116	139	26	29	
3. Total Number of Days Care Provided During Period									
A. Medicare	1,038	787	251	692	601	346	91	160	
B. Medicaid (Conn.)	49,771	39,288	10,483	37,283	29,305	12,488	7,978	2,505	
C. Medicaid (other states)									
D. Private Pay									
E. State SSI for RCH									
F. Other (Specify) INSURANCE	71	71		68	68	3			
G. Total Care Days During Period (3A thru F)	50,880	40,146	10,734	38,043	29,974	12,837	8,069	2,665	
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)	50,880	40,146	10,734	38,043	29,974	12,837	8,069	2,665	

Schedule of Resident Statistics (Cont'd)

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2015	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)	(1)	(2)	(3)				

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

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

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

Item	Medicare		Medicaid		Self-Pay			Other State Assisted	
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	NurseFac-Aids	R.C.H.	ICF-MR
No. of Residents	3		107				29		
Per Diem Rate									
a. One bed rm.									
b. Two bed rms.	562.00		279.00				312.00		
c. Three or more bed rms.									

7. Total Number of Physical Therapy Treatments

	TOTAL	CCNH	RHNS	NurseFac-Aids
A. Medicare - Part B	875	689		186
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	4,786	3,771		1,015
C. Other	1,503	1,184		319
D. Total Physical Therapy Treatments	7,164	5,645		1,519

8. Total Number of Speech Therapy Treatments

	TOTAL	CCNH	RHNS	NurseFac-Aids
A. Medicare - Part B	103	81		22
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	301	237		64
C. Other	165	130		35
D. Total Speech Therapy Treatments	569	448		120.64

9. Total Number of Occupational Therapy Treatments

	TOTAL	CCNH	RHNS	NurseFac-Aids
A. Medicare - Part B	1,371	1,080		291
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	5,268	4,151		1,117
C. Other	1,269	1,000		269
D. Total Occupational Therapy Treatments	7,908	6,231		1,677

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Trinity Hill Care Center, LLC	2222-C	9/30/2015	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	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)	97,460	1,390			48,730	695
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	144,189	6,968			72,095	3,484
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	60,686	1,475			15,970	388
c. Dietary Workers	425,293	20,761			111,919	5,464
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	224,806	13,080			112,403	6,540
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	32,001	1,353			16,001	677
b. Other Maintenance Workers	23,605	1,536			11,803	768
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	104,199	5,698			27,421	1,500
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	163,300	2,835			81,650	1,418
b. RN						
1. Direct Care	379,341	9,015			262,771	6,630
2. Administrative**	195,015	6,101			97,508	1,605
c. LPN						
1. Direct Care	1,009,467	33,763			202,502	6,601
2. Administrative**						
d. Aides and Attendants	1,551,307	90,807			505,933	27,724
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	72,064	5,080			58,113	3,414
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	66,254	2,894			75,437	2,719
n. Marketing						
o. Other (Specify)						
See Attached Schedule	100,357	5,490			35,968	1,613
<i>A-13. Total Salary Expenditures</i>	4,649,345	208,248			1,736,222	71,240

* 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 9/30/2015		Name and Address of All Other Employment**	Page 11	of 37
		CCNH	RHNS			
Name	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Total Hours Worked	Compensation Received
Section I - Operators/Owners						
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).						

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include all employment worked during the cost year.

**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 9/30/2015		Page 12	of 37		
Name	Salary Paid			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						
Section III - Administrators***									
George Kingston	97,460		48,730	same as employees less union funds	2,086	A2			
				same as employees less union funds		A2			
				same as employees less union funds		A2			
Section IV - Assistant Administrators									

*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include all other employment worked during the cost year.

*** If more than one Administrator is reported, include dates of employment for each.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Trinity Hill Care Center, LLC	2222-C	9/30/2015	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	NurseFac-Aids	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian	3,598	80			947	21
2. Dentist						
3. Pharmacist	5,777	168			1,520	45
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	132,920	1,462			35,763	393
b. Other						
6. Social Worker	15,838	284			4,168	75
7. Recreation Worker	5,011	35+Cable			1,319	35+Cable
8. Physicians						
a. Medical Director (entire facility)	35,625	253			74,367	596
b. Utilization Review (Title 18 and 19 only) monthly meeting	1,000				263	
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	17,262	177			4,543	47
9. Speech Therapist						
a. Resident Care	24,488	295			6,589	79
b. Other						
10. Occupational Therapist						
a. Resident Care	132,146	1,607			35,555	432
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	724					
2. Administrative***	(97,220)	(1,985)			(25,584)	(522)
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides	(1,151)	(80)				
d. Other						
12. Other (Specify) See Attached Schedule	41,564	817			10,985	205
B-13 Total Fees Paid in Lieu of Salaries	317,583	3,077			150,434	1,370

* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

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

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

Report of Expenditures
Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis*

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C		Report for Year Ended 9/30/2015	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Omnicare	Pharmacy Consulting	<input type="radio"/>	<input checked="" type="radio"/>			
Tocuhpoints Therapy	Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Healthdrive Physician Services	Audiology, Dental and Podiatry	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Tress	HIV Med Dr	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Johnson Fielding III	Asst Med Dir	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Lindenberg Leslie	Med Dir	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2015	15	37
Item	Total	CCNH	RHNS	NurseFac-Aids
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 232,793	169,497		63,296
2. Disability Insurance	\$			
3. Unemployment Insurance	\$			
4. Social Security (F.I.C.A.)	\$ 612,421	445,905		166,516
5. Health Insurance	\$ 1,082,627	788,263		294,364
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 356,602	259,643		96,959
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 46,563	33,903		12,660
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 55,535	43,760		11,774
d. Accounting and Auditing	\$ 3,712	2,938		773
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 70,859	56,097		14,762
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 13,208	10,457		2,752
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 31,001	24,542		6,459
2. Cellular Phones	\$ 3,156	2,499		658
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 252	200		53
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	\$ 1,064,222	838,593		225,629
Subtotal	\$ 3,572,950	2,676,296		896,654

* 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
9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	NurseFac-Aids
UNION TRAINING	\$ 33,903		\$ 12,660
Total	\$ 33,903	\$ -	\$ 12,660

Schedule of Other Taxes

Description	CCNH	RHNS	NurseFac-Aids
Total	\$ -	\$ -	\$ -

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	9/30/2015		16	37
Item	Total	CCNH	RHNS	NurseFac-Aids	
Subtotals Brought Forward:	3,572,950	2,676,296		896,654	
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 6,629	5,248		1,381	
5. Education Expenses Related to Seminars and Conventions	\$ 5,061	3,988		1,073	
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 1,875	1,485		391	
7. Other (<i>Specify</i>) See Attached Schedule	\$ 669	530		139	
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 5,631	4,458		1,173	
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 6,616	5,238		1,378	
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	\$ 1,220	966		254	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 9,777	7,740		2,037	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 373	295		78	
10. Contributions*** See Attached Schedule	\$ 538	426		112	
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 117,996	92,979		25,017	
12. Administrative Management Services**	\$ 284,523	224,200		60,322	
13. Other (<i>Specify</i>) See Attached Schedule	\$ 25,887	20,472		5,415	
C-14 Total Administrative & General Expenditures	\$ 4,039,745	3,044,320		995,425	

* 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	RIINS	NurseFac-Aids
MEALS	\$ 530		\$ 139
Total Other Travel and Entertainment	\$ 530	\$ -	\$ 139

Schedule of Other Advertising

Description	CCNH	RHNS	NurseFac-Aids
COMMUNICATIONS SPECIAL EVENTS	\$ 5,238		\$ 1,378
Total Other Advertising	\$ 5,238	\$ -	\$ 1,378

Schedule of Dues

Description	CCNH	RHNS	NurseFac-Aids
Dues			
CAHCF Dues	\$ 7,740.03		\$ 2,036.85
OTHER DUES			
Total Dues	\$ 7,740	\$ -	\$ 2,037

Schedule of Contributions

Description	CCNH	RIINS	NurseFac-Aids
CHARITABLE CONTRIBUTIONS	\$ 426		\$ 112
Total Contributions	\$ 426	\$ -	\$ 112

Schedule of Other Administrative and General

Description	CCNH	RHNS	NurseFac-Aids
SOCIAL SERVICE SUPPLIES	\$ 948		\$ 249
SOC SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 4,136		\$ 1,088
EMPLOYEE RELATIONS	\$ 5,130		\$ 1,350
EMPLOYEE RELATIONS-OTHER	\$ 25		\$ 7
PERMITS & LICENSES	\$ 2,106		\$ 554
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 6,389		\$ 1,681
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ 1,488		\$ 392
LATE FEES	\$ 354		\$ 93
Rounding	\$ (105)		\$ 0
Total Other Administrative and General	\$ 20,472	\$ -	\$ 5,415

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Trinity Hill Care Center, LLC	2222-C	9/30/2015	17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
iCare Management, LLC/iCare Health Management, LLC	284,523	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	137,681	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	48,915	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	9/30/2015		18	37
Item		Total	CCNH	RHNS	NurseFac-Aids	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 292,023	194,682			97,341
2.	Non-Food Supplies	\$ 41,411	32,632			8,780
3.	Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 24,639	16,426			8,213
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$ (1,132)	(892)			(240)
c. Management Services**		\$				
d. Other (Specify) _____ DIETARY MINOR EQUIPMENT		\$ 5,751	4,532			1,219
2E. Total Dietary Expenditures (2a + b + c + d)		\$ 362,694	247,380			115,313
2F. Dietary Questionnaire		Total	CCNH	RHNS	NurseFac-Aids	
G. Resident Meals: Total no. of meals served per day:*		504	416		88	
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No						
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify amt.				
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.				
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify amt.				
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify cost.				
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No		If yes, specify amt.				
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)						

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

C. Expenditures Other Than Salaries (cont'd) - Laundry Basis for Allocation of Costs
(See Note on Page 5)

Name of Facility		License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC		2222-C	9/30/2015		19	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. \$	909	716		193
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)		\$	52,726	41,547		11,178
c. Management Services**		\$				
d. Other (Specify) LAUNDRY SUPPLIES		\$	57	45		12
3E. Total Laundry Expenditures (3a + b + c + d)		\$	53,692	42,308		11,383
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	9/30/2015		20	37
Item			Total	CCNH	RHNS	NurseFac-Aids
4.	Housekeeping	Sq. Ft. Served by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt.	\$ 18,069	14,238		3,831
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Served by Personnel				
		Amt.	\$ 40,075	31,578		8,496
c.	Management Services*		\$			
d.	Other (<i>Specify</i>) HOUSEKEEPING MINIR EQUIPMENT		\$			
4E.	Total Housekeeping Expenditures (4a + b + c + d)		\$ 58,144	45,816		12,327
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy		\$			
	2. Purchased from OMNICARE PHARMACY		\$ 47,704	45,644		2,059
b.	Medicine Cabinet Drugs		\$ 13,804	10,877		2,927
c.	Medical and Therapeutic Supplies		\$ 66,303	52,246		14,057
d.	Ambulance/Limousine***		\$ 25,070	19,755		5,315
e.	Oxygen					
	1. For Emergency Use		\$ 1,812	1,428		384
	2. Other***		\$			
f.	X-rays and Related Radiological Procedures***		\$ 484	382		103
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$			
h.	Laboratory***		\$ 2,825	2,226		599
i.	Recreation		\$			
j.	Other (<i>Specify</i>)**** See Attached Schedule		\$ 290,830	229,201		61,629
5K.	Total Resident Care Expenditures (5a - 5j)		\$ 448,832	361,759		87,073

* 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	\$ 270		\$ 73
NURSING MINOR EQUIP	\$ 5,696		\$ 1,533
MEDICAL RECORDS SUPPLIES	\$ (933)		\$ (251)
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATIONS - DIRECT	\$ 108,491		\$ 29,190
NON-COVERED PPS DR. VISITS	\$ -		\$ -
RESIDENT CARE SUPPLIES	\$ 278		\$ 75
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 6,629		\$ 1,744
PERSONAL CARE SUPPLIES	\$ 6,024		\$ 1,621
INCONTINENCY SUPPLIES	\$ 27,098		\$ 7,291
VACCINE RESIDENTS	\$ 564		\$ 152
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	\$ 18,477		\$ 4,971
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 29		\$ 8
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ -		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ 357		\$ 96
IV THERAPY SUPPLIES	\$ 10,102		\$ 2,718
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 4,119		\$ 1,108
ACTIVITIES SUPPLIES	\$ 2,579		\$ 694
ACTIVITIES MINOR EQUIPMENT	\$ 878		\$ 236
MANAGEMENT ALLOCATION - INDIRECT	\$ 38,544		\$ 10,371
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ -		\$ -
Total Other Resident Care	\$ 229,201	\$ -	\$ 61,629

**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 9/30/2015	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***			Page 21	of 37	
			Yes	No			CCNH	RHNS	NurseFac- Aids			Pg
Name of Individual or Company	Address											
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020		<input type="radio"/>	<input type="radio"/>	VENDOR	Housekeeping Services	39,708			20	4b	
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020		<input type="radio"/>	<input type="radio"/>	VENDOR	Laundry Services	52,584			19	3b	
Eagle Elevator			<input type="radio"/>	<input type="radio"/>	VENDOR	Elevator Contract	6,126			22	6F	
Bioserve, Inc.			<input type="radio"/>	<input type="radio"/>	VENDOR	Medical Waste Stow	5,227			22	6F	
The Brickman Group/ Stevan Infante			<input type="radio"/>	<input type="radio"/>	VENDOR	Removal/Landscaping	17,032			22	6F	
All Waste Inc			<input type="radio"/>	<input type="radio"/>	VENDOR	Trash removal	35,537			22	6F	
American HealthTech			<input type="radio"/>	<input type="radio"/>	VENDOR	Software Maintenance Contract	10,504			16	M11	
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290		<input type="radio"/>	<input type="radio"/>	VENDOR	Payroll Services	51,737			16	M11	
National Datacare Corp			<input type="radio"/>	<input type="radio"/>	VENDOR	Resident Trust Software	2,516			16	M11	
Prime Care Technology services			<input type="radio"/>	<input type="radio"/>	VENDOR	Computer Consulting Services	20,470			16	M11	
Priority Express			<input type="radio"/>	<input type="radio"/>	VENDOR	Courier Services	5,388			16	M11	
Point Right Inc			<input type="radio"/>	<input type="radio"/>	VENDOR	Nursing Software	4,680			16	M11	
			<input type="radio"/>	<input type="radio"/>	VENDOR							
			<input type="radio"/>	<input 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	License No.	Report for Year Ended			Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2015			22	37
Item	Total	CCNH	RHNS	NurseFac-Aids		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 32,633	25,714		6,919		
b. Heat	\$ 75,624	50,416		25,208		
c. Light & Power	\$ 81,762	54,508		27,254		
d. Water	\$ 55,793	37,195		18,598		
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 37,351	24,901		12,450		
f. Other (<i>itemize</i>)	\$ 182,016	121,755		60,261		
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 465,179	314,489		150,689		
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 17,437	17,437				
c. Non-Movable Equipment	\$ 459	306		153		
d. Movable Equipment	\$ 49,736	39,374		10,362		
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 67,632	57,117		10,515		
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 49,531	33,021		16,510		
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 49,531	33,021		16,510		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,223,303	815,535		407,768		
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 278,724	185,816		92,908		
c. Personal property taxes	\$ 26,267	20,795		5,472		
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,645,456	1,112,284		533,173		

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	NurseFac-Aids
PLANT SUPPLIES	\$ 8,004		\$ 4,002
PLANT CONTRACT SERVICE LABOR	\$ -		\$ -
ELEVATOR CONTRACT SERVICE	\$ 6,193		\$ 3,097
FIRE/SPRINKLER CONTRACT SERVICE	\$ 4,956		\$ 2,478
LANDSCAPING CONTRACT SERVICE	\$ 6,037		\$ 3,019
SNOW REMOVAL CONTRACT SERVICE	\$ 5,317		\$ 2,659
TRASH REMOVAL CONTRACT SERVICE	\$ 23,691		\$ 11,846
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ -		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 59,548		\$ 29,774
PLANT MINOR EQUIPMENT	\$ 5,406		\$ 2,703
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ 2,603		\$ 685
RENT OTHER	\$ -		\$ -
Total Other Repairs and Maintenance	\$ 121,755	\$ -	\$ 60,261

Amortization Schedule*

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C		Report for Year Ended 9/30/2015		Page 24	of 37				
	Date of Acquisition Month	Year	Length of Amortization	Cost to Be Amortized			Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year
A. Organization Expense										
1.										
2.										
3.										
A-4. Subtotal										
B. Mortgage Expense										
1.										
2.										
3.										
B-4. Subtotal										
C. Leasehold Improvements and Other										
1. Acquired prior to this report period							556,615		297,990	
2. Disposals (attach schedule)										45,908
3. Acquired during this report period (attach schedule)										
C-4. Subtotal							82,018			3,623
D. Total Amortization										
										49,531
										49,531

* 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 9/30/2015	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	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					

Part B - Owner and Related Parties

1st Mortgage 2nd Mortgage 3rd Mortgage 4th Mortgage

1. Financing				
a. Type of Financing (e.g., fixed, variable)	HUD fixed			
b. Date Mortgage Obtained	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 09/30/2015	3,943,842			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

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

Name of Facility		License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC		2222-C	9/30/2015		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. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended			Page	of
Trinity Hill Care Center, LLC		2222-C		9/30/2015			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 (<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>)				\$	416	329	87	
INTEREST								
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	416	329	87	
14. Insurance								
a. Insurance on Property (buildings only)				\$	6,650	4,433	2,217	
b. Insurance on Automobiles				\$	3,110	2,462	648	
c. Insurance other than Property (as specified above)								
1. Umbrella (<i>Blanket Coverage</i>)				\$	54,654	43,268	11,386	
2. Fire and Extended Coverage				\$				
3. Other (<i>Specify</i>)				\$	2,791	2,210	582	
14d. Total Insurance Expenditures (14a + b + c)				\$	67,205	52,373	14,832	
15. Total All Expenditures (A-13 thru C-14)				\$	13,994,945	10,187,987	3,806,958	

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D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Trinity Hill Care Center, LLC			2222-C	9/30/2015	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$	132,061	104,062	27,999
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$	55,535	43,760	11,774
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 *	\$	6,616	5,238	1,378
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$	18,702	14,724	3,979
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$	212,914	167,784	45,130

* 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
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
16		Management fee over cost	\$ 104,062		\$ 27,999
Total Other Fees Adjustments			\$ 104,062	\$ -	\$ 27,999

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
16a		PENALTIES	\$ 1,488		\$ 392
16a		LATE FEES	\$ 354		\$ 93
16a		PRIOR PERIOD EXPENSES			
		rounding	-104.56		
		Provider User Fee for Medicare days	12,986.17		3,494.01
Total Other A&G Adjustments			\$ 14,724	\$ -	\$ 3,979

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	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
Subtotals Brought Forward				\$ 212,914	167,784		45,130
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$ 25,070	19,755		5,315
29.			X-rays, etc	\$ 484	382		103
30.			Laboratory	\$ 2,825	2,226		599
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$			
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 241,293	190,147		51,146

*** 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.

Trinity Hill Care Center, LLC
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
20	5J	NON-COVERED PPS DR. VISITS	-		-
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)	-		
Total Other Ancillary Costs			\$ -	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
Total Other Property Adjustments			\$ -	\$ -	\$ -

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)	-		
Total Other Adjustments			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
Total Unallowable Building Interest			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2015		30	37
Item	Total	CCNH	RHNS	NurseFac-Aids	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 14,222,076	10,947,711		3,274,366	
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>)	\$ 595,525	471,458		124,068	
b. Medicare Room and Board Contractual Allowance **	\$				
4. a. Private-Pay Residents and Other	\$ 30,043	30,043			
b. Private-Pay Room and Board Contractual Allowance **	\$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 43,250	43,250			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (43,250)	(43,250)			
c. Prescription Drugs - Non-Medicare	\$ 26,022	24,236		1,786	
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (26,022)	(24,236)		(1,786)	
2. a. Medical Supplies - Medicare	\$ 134	134			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (134)	(134)			
c. Medical Supplies - Non-Medicare	\$ 6,032	5,338		694	
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (6,032)	(5,338)		(694)	
3. a. Physical Therapy - Medicare	\$ 72,290	72,290			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (47,361)	(47,361)			
c. Physical Therapy - Non-Medicare	\$ 165,834	144,245		21,590	
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (165,834)	(144,245)		(21,590)	
4. a. Speech Therapy - Medicare	\$ 24,151	24,151			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (15,076)	(15,076)			
c. Speech Therapy - Non-Medicare	\$ 30,701	19,205		11,496	
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (30,701)	(19,205)		(11,496)	
5. a. Occupational Therapy - Medicare	\$ 82,134	82,134			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (44,511)	(44,511)			
c. Occupational Therapy - Non-Medicare	\$ 181,059	165,557		15,501	
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (314,813)	(299,311)		(15,501)	
6. a. Other (<i>Specify</i>) - Medicare	\$				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 8,937	8,937			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 14,794,454	11,396,021		3,398,434	
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$				
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$				
V. Total Other Revenue (1 thru 8)	\$				
VI. Total All Revenue (III + V)	\$ 14,794,454	11,396,021		3,398,434	

* 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	\$ 2,827		
	Lab Medicare CA	\$ (2,827)		
	Oxygen Medicare	\$ 6		
	Oxygen Medicare CA	\$ (6)		
	Equipment rental	\$ -		
	Equipment rental CA	\$ -		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds Medicare	\$ -		
	Therapy Beds Medicare CA	\$ -		
	Radiology Medicare	\$ 79		
	Radiology Medicare CA	\$ (79)		
	IV Therapy	\$ 13,930		
	IV Therapy CA	\$ (13,930)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose testing	\$ -		
	Glucose testing CA	\$ -		
	Outpatient therapy Medicare	\$ -		
	Total Other Resident Revenue - Medicare	\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RIINS	NurseFac-Aids
	Lab	\$ -		
	Lab CA	\$ -		
	Oxygen	\$ 1,452		\$ 246
	Oxygen CA	\$ (1,452)		\$ (246)
	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	\$ 15,661		\$ 2,009
	IV therapy CA	\$ (15,661)		\$ (2,009)
	Flu shot revenue	\$ 58		
	Outpatient therapy	\$ -		
	PRIOR YEAR ADJ - ANCILLARY & OTHER	\$ 8,879		
	rounding	\$ -		
	Total Other Resident Revenue	\$ 8,937	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	NurseFac-Aids
	INTEREST INCOME		\$ -		
	Total Interest Income		\$ -	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	NurseFac-Aids
	MEALS	\$ -		
	TELEVISION INCOME	\$ -		
	CONCESSIONS / VENDING INCOME	\$ -		
	RESIDENT LATE FEE REVENUE	\$ -		
	RESIDENT ATTORNEY FEE REVENUE	\$ -		
	TELEPHONE INCOME	\$ -		
	OTHER INCOME	\$ -		
	OPTUM DIVIDENDS REVENUE	\$ -		
	Total Other Revenue	\$ -	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	1,527,162
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,260,631
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	23,335
4. Inventories			\$	32,187
5. Prepaid Expenses			\$	303,842
a. Prepaid Insurance	290,786			
b. Prepaid Property Taxes	6,609			
c. Prepaid Expenses Other	6,447			
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(940,043)
Due From (to) Related Parties	129,480			
Other Owners reserves	(1,069,522)			
A-9. Total Current Assets (Lines A1 thru 8)			\$	3,207,114
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Depreciation	Net		
3. Buildings	*Historical Cost	345,217	\$	327,780
	Accum. Depreciation	17,437	Net	
4. Leasehold Improvements	*Historical Cost	638,632	\$	291,112
	Accum. Depreciation	347,521	Net	
5. Non-Movable Equipment	*Historical Cost	7,990	\$	3,517
	Accum. Depreciation	4,473	Net	
6. Movable Equipment	*Historical Cost	411,476	\$	173,384
	Accum. Depreciation	238,092	Net	
7. Motor Vehicles	*Historical Cost	6,889	\$	4,784
	Accum. Depreciation	2,105	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
Construction in Progress				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	800,577

* 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	9/30/2015	32	37
Account			Amount	
Total Brought Forward:			\$	4,007,691
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 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	43,000
Patient Trust Funds			40,445	
Long Term Deposit - primicare			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. Total Investments and Other Assets (Lines D1 thru 7)			\$	43,000
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	4,050,691

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

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G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC		2222-C	9/30/2015	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	292,270
2. Notes Payable (<i>itemize</i>)				\$	952,197
Working Capital Line of Credit					952,197
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>)				\$	296,557
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>)				\$	934,642
Related Party Payables			370,347		
Accrued Expenses			130,238		
Accrued Resident User Fees			262,561		
Accrued Workers Comp Expense			171,497		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	2,475,666

* 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 9/30/2015	Page 34	of 37
Account			Amount	
Total Brought Forward:			2,475,666	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
Patient Trust Funds		40,445	40,445	
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 40,445
C. Total All Liabilities (Lines A-13 + B-5)				\$ 2,516,111

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	9/30/2015	35	37
Account			Amount	
A. Reserves				
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. Net Worth				
1. Owner's Capital			\$	1,000
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	734,070
6. Gain or Loss for Period			\$	799,509
				10/1/2014 thru 9/30/2015
7. Total Net Worth			\$	1,534,579
C. Total Reserves and Net Worth			\$	1,534,579
D. Total Liabilities, Reserves, and Net Worth			\$	4,050,691

H. Changes in Total Net Worth

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2015	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	14,794,454
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	13,994,945
D. Net Income or Deficit			\$	799,509
E. Balance			\$	799,509
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. Balance at End of Period			\$	799,509
				09/30/15

I. Preparer's/Reviewer's Certification

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2015	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> NurseFac-Aids		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer 	Title VP Finance	Date Signed 2-11-16		
Printed Name of Preparer Denise MacKinnon				
Address Address 341 Bidwell Street, Manchester, CT 06040		Phone Number 860-570-2140 ext 15		