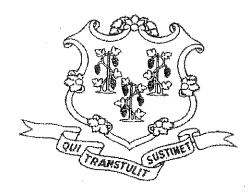
State of Connecticut



Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as l	icensed)						
Trinity Hill Care Cent	ter, LLC						
Address (No. & Stree	t, City, State, Z	ip Code)					
151 Hillside Avenue,	Hartford, CT 0	6016					
Type of Facility							
Chronic and C Nursing Home			Rest Home wit Supervision on (RHNS)	_	☑	NurseFac-Aic	ls
Report for Year Begi 10/1/2015	nning	***************************************	Report for Year 9/30/2016	r Ending			
License Numbers:		CCNH 2222-C	RHNS	Nι	urseFac-Aid AIDS	ls M	edicare Provider 07-5268
Medicaid Provider N	umbers:	CC 9555	CNH	RH	INS	IC	CF-IID 49553
For Department Us	e Only						
Sequence Number Assigned	Signed and Notarized	Date Received	Sequence N Assign		Signed a	nd Notarized	Date Received

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General Information

— — — — — — — — — — — — — — — — — — —				
Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2016	1	37

Administrator's/Owner's Certification

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

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

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

I have read this Report and hereby certify that the information provided is true and correct to the best of n 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) Nui X MM		Date 3/16/11	
Printed Name (Administrator)		(Printed Name (Owner)		, ,	
George Kingston			Chris Wright			
T.					withten this major and the same a	nerthelitenanthiliting.
Subscribed and Sworn	State of	Date	Signed (Notary Public)	\$1	Confinio Expines H	
to before, me: 1) (unda Walsh	CT	2/10/17	Bunda Wal	_/) My	y Public-Connectic Commission Expires ebrudry 29/2020	;
Address of Notary Public		<i>()</i>	•	THE COLUMN		manemani
34) Bidwell	St. Ma	nchest	er, CT 0604	D		

(Notary Seal)

General	Inform	ation
LAPHEFAL		инин

Name of Facility (as licensed)	License No.	/ ·	Leport for Year Ende	ed Page of 37
Frimily Hill Cyse (enter LIC			1/2015018	5 1 37
Administra	tor's/Owner	's Certificati	on	·
MISREPRESENTATION OR FALSIFICA' COST REPORT MAY BE PUNISHABLE FEDERAL LAW.				
I HEREBY CERTIFY that I have read the a Cost Report and supporting schedules prepa cost report period beginning and that to the best of my knowledge and be	ared for Trial	ty Hill Con and ending _	r Cr.4 [facility na	ame], for the
the books and records of the provider(s) in a				
I hereby certify that I have directed the preparation of Resident Statistics, Statements of Reported E this Facility in accordance with the Reporting Respecified above. I have read this Report and hereby certify the knowledge under the penalty of perjury. I at this Report as a basis for securing reimburse incurred to provide resident care in this Facility in the penalty of perjury and the penalty of perjury. I at this Report as a basis for securing reimburse incurred to provide resident care in this Facility in the penalty of penalt	xpenditures, Statequirements of state the information certify that the ement for Title ility. All suppositions are supposited to the supposition of the supposition o	tements of Reven the State of Conno- tion provided is t all salary and no XIX and/or oth- orting records fo	ues and the related Ba ecticut for the year end rue and correct to the on-salary expenses pa er State assisted resing the expenses record	lance Sheet of ded as e best of my resented in dents were ded have
Signed (Administrator)	Date 2/11/12	Signed (Owner)	Date
Printed Name (Administrator)	710114	Printed Name (Owner)	
George W. Kingston				
Subscribed and Sworn State of	Date	Signed (Notary	Public)	Comm. Expires
to before me: GEORGE W.KINGSTON ONVECTION	2-10-17	Adar Low	anl	AUG , 31 , 2019
Address of Notary Public 20 FAIR FOX AU. 10 FST HONGFOR CC-OG119	4	/		

STATE OF THE STATE

PILAR SANDOVAL MOTARY PUBLIC MY COMMISSION EXPIRES AUG. 31, 2019

State of Connecticut Department of Social Services

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page	of
				1A	37
Name of Facility		Period Cov	ered:	From	То
Trinity Hill Care Center, LLC				10/1/2015	9/30/2016
Address of Facility					
151 Hillside Avenue, Hartford, CT 06016				T	
Report Prepared By		Phone Nun		Date	
iCare		860-570-2	140	2/15/2016	
Item		Total	CCNH	RHNS	NurseFac- Aids
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. 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

	Pho	ne No. of Fac	ility	Report for Yea	ır Ended	Page	of
	860	-951-1060		9/30/2016		2	37
Name of Facility (as shown on license)		,		Street, City, Sta		<u> </u>	
Trinity Hill Care Center, LLC		:.h-,		nue, Hartford, (CT 0601		
CCNH		RHNS	1	NurseFac-Aids		Į.	Provider No.
License Numbers: 2222-C			AID	<u>s</u> .		07-5268	
Type of Facility (Check appropriate box(es))	_						
Chronic and Convalescent Nursing Home only (CCNH)		t Home with lervision only			NurseFa	c-Aids	
Type of Ownership (Check appropriate box)							
O Proprietorship O LLC O Partnership	0	Profit Corp.		Non-Profit Cor		Government	O Trust
If this facility opened or closed during report year provid	le:		Date	e Opened	Date Clo	osed	:
Has there been any change in ownership							v
or operation during this report year?	0	Yes	•	No	If "Yes,"	explain full	у.
Administrator				I No. 1 TI			
Name of Administrator				Nursing Ho Administrat	I .	1327	
George Kingston				License 1	I .	1327	
Other Operators/Owners who are assistant administrator	rs (full	or part time)	of thi				
Name				License I	No.:		
						, , , , , , , , , , , , , , , , , , ,	

General Information and Questionnaire Partners/Members

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C	Report for Y 9/30/2016	Year Ended	Page of 3 37
Legal Name of Par Trinity Hill Care Center, LLC	inership/LLC	Business 151 Hillside A Hartford, CT	Address venue,	` '	or Town(s) in egistered
Name of Partners/Members	Business Ad	idress		Title	% Owned
V. Robert Salazar	2500 18th Street, Suite CO 80211	200, Denver,	Member		31.3
David Sebbag	245 South Benton Stree Lakewood, CO 80226	et, Suite 100,	Member		21.4
Ari Krausz	245 South Benton Stre Lakewood, CO 80226	et, Suite 100,	Member		21.3
Solomon Melamed	245 South Benton Stre Lakewood, CO 80226	et, Suite 100,	Member		1
Christopher Wright	341 Bidwell Street, Ma 06040	anchester, Ct	Member		5
Premier First Investors	245 S. Benton Street, I 80226	Lakewood, CO	Member		10
Global World Investors	245 S. Benton Street, I 80226	Lakewood, CO	Member		10
1					

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year End	led	Page of
Trinity Hill Care Center, LLC	2222-C	9/30/2016		3A 37
If this facility is owned or operated as a corpo				
Legal Name of Corporation	Busines	s Address	State(s) in Which	ch Incorporated
Name of Directors, Officers	Busines	s Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10% of Shares				
		- Landa Company		

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General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2016	3B	37
If this facility is owned or operated as an individu			ation:	
Ov	wner(s) of Facility			
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
				-
		M - M - M - M - M - M - M - M - M - M -		
		And the Prince of the Control of the		
·				
		AMMONINE TOTAL		

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Related Parties*

Times care		2	2222-C	9/3/2016		4	3/
		Also	Also Provides		Indicate Where		
Name of Related Individual or Company	Business Address	Goods/S Relat Yes	Goods/Services to Non- Related Parties Yes No %**	n Description of Goods/Services Provided	Costs are included in Annual Report Page # / Line #	Cost	Actual Cost to me Related Party
Bidwell Care Center,	333 Bidwell St. Manchester, CT 06040			Shared Employees		(28,718)	28,718
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105			Shared Employees		(29,470)	29,470
int Care	171 Main St. East Windsor, CT 06088			Laundry Services	19 3		
int Care	171 Main St. East Windsor, CT 06088			Shared Employees		(23,601)	23,601
Care	20 Scott Swamp Rd. Farmington, CT 06032			Bank Fees	16 M	519	(675)
Sare	20 Scott Swamp Rd. Farmington, CT 06032			Shared Employees		(11,958)	11,958
Care	96 Prospect Hill Rd. East Windsor, CT 06088			Laundry Services	19 3		1
Care	96 Prospect Hill Rd. East Windsor, CT 06088			Shared Employees		(25,601)	25,601
e Center, Springs)	33 Roy St. Meriden, CT 06450			Shared Employees		(20,553)	20,553
Trinity Hill Care	151 Hillside Ave. Hartford, CT 06106			Shared Employees		ŀ	E.
e e	m 25			Shared Employees		(48,271)	48,271
Care	140 Park Ave. Bloomfield, CT 06002			Shared Employees		(25,288)	25,288
Center	60 West Street, Rocky Hill, CT 06067			Shared Employees		(4,233)	4,233
hooints therapy	171 Main St. East Windsor, CT 06088			OT/PT/ST	13 5,8,10	340,257	(340,257)
	341 Bidwell St. Manchester, CT 06040			Building Lease & Rent	22,22,27 10,9,14	1,561,539	(1,561,539)
Ü	341 Bidwell St. Manchester, CT 06040			Postage & Legal	16, 15 M.E	İ	(22,207)
	341 Bidwell St. Manchester, CT 06040			Shared EEs not part of mgmt agmt			(137,296)
				Management Services, Direct Management Services, Indirect	20 5	35,132	(35,132)
				Management Services, Administrative	16 M		(445,323)
							1
							,
All 9 Care Centers							
mgmt co, realty cos				Share Common 401k, Pension and Insurance plans, courier, legal and various other services	surance plans, courier	, legal and vari	ous other services

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No	•	Report for Year Ended	Page	of		
Trinity Hill Care Center, LLC	2222-C	·	9/30/2016	5	37		
If the facility is licensed as CDH and/or RCH or	provides A	IDS or TBI	services with special Medicaid	rates, cc	osts		
must be allocated to CCNH and RHNS as follow	ws:						
Item			Method of Allocation				
Dietary		Number of	meals served to residents				
Laundry			pounds processed				
Housekeeping			square feet serviced				
		1	hours of routine care provided	•			
Nursing			lassification, i.e., Director (or	_			
			Nurses, Licensed Practical Nu	rses, Aide	es and		
		Attendants					
Direct Resident Care Consultants			hours of resident care provided	d by EAC	CH		
			(See listing page 13)				
Maintenance and operation of plant		Square feet	The state of the s				
Property costs (depreciation)		Square feet					
Employee health and welfare		Gross salaı					
Management services			e cost center involved				
All other General Administrative expenses		<u> </u>	rect and Allocated Costs				
The preparer of this report must answer the following	owing quest	ons applica					
1. In the preparation of this Report, were all	• Yes	O No	If "No," explain fully why suc	h allocati	ion was		
costs allocated as required?			not made.				
2. Explain the allocation of related company ex	penses and a	ttach copy	of appropriate supporting data.	,			
3. Did the Facility appropriately allocate and se				ne cost ce	enters?		
(e.g., Assisted Living, Home Health, Outpati	ent Services	, Adult Day	Care Services, etc.)				
	• Yes	O No	If "No," explain fully why suc not made.	sh allocati	ion was		

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General Information and Questionnaire Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals

οţ 37 Amount Claimed 12,134 13,114 10,297 628 -2,391Page Amount of Lease Annual 12,134 10,764 12,823 Term of Report for Year Ended Lease 60 Months yr with automatic 48 months Month to month % 0 9/30/2016 Lease** Date of 05/18/10 06/01/10 03/05/14 04/16/13 O Yes Description of Items Leased Omnistim Electrotherapy and Omnisound Therapeutic Ultrasound Equipment Time Clocks and Payroll Punch Equip 2222-C License No. Postage Rental Copier 2 N Related * to 0 0 0 Operators, 0 0 0 0 0 0 0 Owners, Officers Yes 0 0 0 0 0 0 0 0 0 0 Reno, should not be included in these amounts. Neopost USA Inc, 25880 Network Place, Chicago, IL Name and Address of Lessor Augusta, GA 30909 GE Capital C/O Ricoh USA, P.O.Box 41564, Trinity Hill Care Center, LLC 4850 Joule Street, Suite A-1 ADP, Inc., One ADP Drive MS-100, Accelerated Care Plus Corp. Philadelphai, PA 19101 Name of Facility

Is a Mileage Log Book Maintained for All Leased Vehicles?

33,782

Total ***

* 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.

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General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended	-	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2016		7	37
The records of this facility for the	period covered by this repo	ort were maintained on the following basis:			
	Modified Cash				
Is the accounting basis for this					
11	Yes	If "No," explain.			
previous period? O	No				
				and the state of t	
Independent Accounting Firm			4 6		
Name of Accounting Firm		Address (No. & Street, City, State, Zip Coo		0.51.00	
1 O'Connor, Davies LLP		100 Great Meadow Road, Ste 401, Wo	ethersfield, CT	06109	
2 3					
4					
Services Provided by This Firm (d					,,.,
1 Taxes, financial statements, accounting	ng support		\$	3,533	
2			\$		
3			\$		
4			\$		
			Charge for	Services Pr	rovided
			\$	3,533	
Are These Charges Reflected in the Expen	diture Portion of This Report? I	f Yes, Specify Expense Classification and Line No.			
O Yes O No	15D				
Legal Services Information					
Name of Legal Firm or Independen	nt Attorney	The state of the s	Telephone	Number	
1 iCare Health Management, LI			860-570-21		
2 Starble and Harris			860-678-77	75	
3 Durant Nichols / Robinson &	Cole, LLP		860-275-82	.00	
	oitration , Various Arbitrat	ion, Murtha Cullina, Jackson Lewis))			
5 Starble and Harris, iCare Hea	lth Management LLC		860-678-77	75 & 860-	570-2140
Address (No. & Street, City, State	, Zip Code)				
1 341 Bidwell Street, Manches	ter CT				
2 32 Main Street, Avon, CT					
3 280 Trumbull St, Hartford, C	T				
4					
5 32 Main Street, Avon, CT &		hester CT			
Services Provided by This Firm (a	lescribe fully)				
1 Lease and contract issues, general leg			\$	20,628	
2 Lease and contract issues, general leg	gal advice, union funds advice		\$	1,926	
3 Employment law, arbitrations, contra	act negotiations	-	\$	25,505	
4 Employment Arbitrations, healthcare	law		\$	9,734	
5 Conservatorships		4	\$	5,180	
			Charge for	Services Pr	rovided
			\$	62,974	
Are These Charges Reflected in the Expen		f Yes, Specify Expense Classification and Line No.			
⊙ Yes O No	15E				

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Schedule of Resident Statistics

Name of Bacility			License No	γ			Report fo	r Year Ende	q		Page	Jo
Trinity Hill Care Center, LLC			22	2222-C			9/30/201	9/30/2016			, ∞	37
					H	eriod 10/	Period 10/1 Thru 6/30	30		Period 7/1 Thru 9/30	Thru 9/3	0
		Total	Total	Total								
	Total All	CCNH	RHNS	NurseFac-				NurseFac-				NurseFac-
	Levels	Level	Level	Aids	Total	CCNH	RHNS	Aids	Total	CCNH	RHNS	Aids
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	144	114		30	144	114		30	441	114		30
B. On last day of THIS report period	144	114		30	44	114		30	144	114		30
2. Number of Residents												
A. As of midnight of PREVIOUS report period	139	110		29	139	110		29	140	113		27
B. As of midnight of THIS report period	143	114		29	140	113		77	143	114		29
3. Total Number of Days Care Provided During Period												
A. Medicare	1,560	1,144		416	1,245	998		379	315	278	- Annual	37
B. Medicaid (Conn.)	48,180	38,560		9,620	35,681	28,650		7,031	12,499	9,910		2,589
C. Medicaid (other states)												
D. Private Pay	77	77			T	1			76	76		
E. State SSI for RCH												
F. Other (Specify) Insurance	25	25			25	25						
G. Total Care Days During Period (3A thru F)	49,842	39,806		10,036	36,952	29,542		7,410	12,890	10,264		2,626
4. Total Number of Days Not Included in Figures in 3G												
for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	49,842	39,806		10,036	36,952	29,542		7,410	12,890	10,264		2,626

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Schedule of Resident Statistics (Cont'd)

Name of Facil	lity			Licen	se No.				Report	for Year	Ended		Page	of
Trinity Hill C	are Cen	ter, LLC	7	22	22-C				-	9/30/201	6		9	37
			<u></u>	• • • • • • • • • • • • • • • • • • • •										
4. Were the	ere any o	hanges	in the certified b	ed ca	pacity du	ring t	he repo	rt yea	r?	0	Yes	•	No	
If "YES"	, provid	e the fo	llowing informat	ion:										
			f Change		Cł	ange	in Bed	s		Car	pacity Afte	er Change		
Date of			NurseFac-Aids		Lost			Gaine	4					
Date of	CCIVII	KILIN	Transcr up Trias		LOSI							NurseFac-		İ
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Aids	Reason fo	or Change
	(1)	(2)	(5)	(1)	(~)	(5)	(1)	(4)	(0)	001111	101110	11145	***************************************	. Jg.
						,								
	•	-	in certified bed o	-		the r	eport ye	ear (as	report	ed in item	14 above)	provide the nun	iber of	
RESID	ENT DA	YS for	90 days followin	g the	change,								A 	
			Change in Re	esider	t Days					CC	NH	RHNS	NurseF	ac-Aids
1st chan	ge				·									
2nd char														
3rd chan	ge													
4th chan														
6. Number	of Resid	lents an	d Rates on Septe	mber			ar							
			Medicare		Medi	caid				Se	elf-Pay		Other Stat	e Assisted
											i			
												NurseFac-		
	Item		CCNH	C	CNH	R.	HNS	CO	CNH	RI	INS	Aids	R.C.H.	ICF-MR
No. of R	esidents	5	Medicare - CCNH		CCNH							нг∨		
Per Dien	n Rate													
a. One t	oed rm.													
b. Two	bed rms													
c, Three	or mor	e		1										
bed i	rms.		555.84		283,58							306.06	<u> </u>	
										ļ				NurseFac-
			al Therapy Treat	ments						TO	TAL	CCNH	RHNS	Aids
		re - Par									1,041	831		210
В,			lusive of Part B)											
			e Treatments											
		torative	Treatments				·				6,436	5,140		1,296
	Other	Dlava!	Thousan To	94 C = c -d						ļ	2,004	1,600 7,572		404 1,909
			Therapy Treati		· · · · · · · · · · · · · · · · · · ·						9,481	7,372		1,909
		r Speecr are - Par	Therapy Treatn	ients							194	155		39
			lusive of Part B)								194	100		39
ъ,			ce Treatments											
			Treatments								282	225		57
C	Other	totative.	Treatments								116	93		23
		Speech	Therapy Treatm	ents	•					!	592	473		119
			ational Therapy		nents									
		are - Par									715	571		144
			lusive of Part B))										
]			ce Treatments								ontensional State of		por collective transition in the least one collective and the second of the least o	
			Treatments								3,562	2,845		717
	Other										1,557	1,243		314
D	Total (Эссира	tional Therapy T	reatr	nents						5,834	4,659		1,175

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CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.		Report for Year		Page	of
Trinity Hill Care Center, LLC	2222-C		9/30/2016		10	37
Are time records maintained by all individuals receiving con	mpensation?	0	Yes	0	No	
			Total Cost a	nd Hours		
			10441 0031 4	la Hours		ſ
					NurseFac-	
Item	CCNH	Hours	RHNS	Hours	Aids	Hours
A. Salaries and Wages*						
Operators/Owners (Complete also Sec. I						
of Schedule A1)	20000072000007000700070	Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market			Commence of the Commence of th	
Administrator(s) (Complete also Sec. III						
of Schedule A1)	119,652	1,394			30,167	697
Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	190,433	7,697			48,013	3,848
5. Dietary Service						
a. Head Dictitian	60.614	1 / 5 /			10 220	124
b. Food Service Supervisor c. Dietary Workers	69,614 437,657	1,656 21,160		 	18,320 115,173	
6. Housekeeping Service	437,037	21,100			112,173	الادول
a. Head Housekeeper						
b. Other Housekeeping Workers	214,894	12,524			107,447	6,262
7. Repairs & Maintenance Services	21,,05 (
a. Engineer or Chief of Maintenance	32,069	1,352			16,034	670
b. Other Maintenance Workers	23,330	1,521			11,665	760
8. Laundry Service						
a. Supervisor						ļ
b. Other Laundry Workers	100,213	5,503			25,266	1,44
Barber and Beautician Services						ļ
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants 12. Professional Care of Residents						
1	170 165	2,792			44,919	1,39
a. Directors and Assistant Director of Nurses b. RN	178,165	2,192			44,515	1,37
1. Direct Care	355,933	8,322			242,377	6,17
2. Administrative**	288,713				72,791	
c. LPN		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
1. Direct Care	1,055,939	34,875	A CONTRACTOR OF THE PROPERTY O		219,319	8,19
2. Administrative**					T.	
d. Aides and Attendants	1,558,619	89,430			551,938	32,46
e. Physical Therapists						
f. Speech Thorapists						
g. Occupational Therapists		и см.	ļ	1	140 001	3,56
h. Recreation Workers		5,574			140,821	. 3,30
i, Physicians					1	
Medical Director Utilization Review	-					
3. Resident Care***		 				+
4. Other (Specify)						
(openy)						
j. Dentists						
k. Pharmacists						
1. Podiatrists						
m. Social Workers/Case Management	83,312	3,239			69,596	5 2,94
n. Marketing						
o. Other (Specify)						
See Attached Schedule	117,659				29,665	
A-13. Total Salary Expenditures	4,826,202	210,013	<u> </u>	1	1,743,511	78,02

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

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

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

Schedule of Other Salaries and Wages (Page 10)

	CC	NH	R	HNS	NurseFa	c-Aids
Position	\$	Hours	\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$ 4,096	207			\$ 1,033	54
MEDICAL RECORDS SALARIES	\$ 62,341	2,914			\$ 15,718	767
CENTRAL SUPPLY SALARIES	\$ 51,222	2,525			\$ 12,914	842
			A Section Control			
			NEW YORK			
			Name (Sec.			
			X III C			
		100000000000000000000000000000000000000				
						VIEW CONTRACTOR
Total	\$ 117,659	5,646	s -		\$ 29,665	1,663

Schedule of Other Fees (Page 13)

	C	CNH	RH	INS	NurseFa	ac-Aids
Service	\$	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ (25,380)	(1,114)			\$ (6,399)	(281
ADMISSIONS C/S LABOR	\$ 33,173	601			\$ 8,364	158
CENTRAL SUPPLY CONTRACT SERVICE	\$ (33,258	(1,062)			\$ (8,385)	(268)
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ 79,207	2,484			\$ 19,970	654
RESPIRATORY THERAPY CONTRACT SERVICES	\$ 3,595	80			\$ 906	20
		yers or ending				
			42.000 (0.000)			
						ja Jasabakan kepi
Total	\$ 57,337	988	\$		\$ 14,456	283

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*

		7	Assistan	t Administra	Assistant Administrators and Other Related Falues	Relate	d raines			
Name of Facility				License No.		Report for	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC				2222-C	Libertage	9/30/2016			11	37
		Salary Paid	. pi							
12.0				Fringe Benefits and/or Other		Total	Line Where	177	Total	
Name	CCNH	RHNS	NurscFac- Aids	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours	Compensation Received
Section I - Operators/Owners								ii. Assilan ja ja ja ja ja ja ja ja ja ja ja ja ja		
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).						4000				
] : _ _ ,				- 42 - 41 - 42 - 44 - 45 - 44 - 45 - 44 - 45 - 45					

^{*} 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,

sistant Administrators and Other Related Parties*

		7	Assistant	Administra	Assistant Administrators and Other Related Parties*	Related	Parties*			***************************************
Name of Facility (as licensed)				License No.		Report for Year Ended	ear Ended		Page	of
Trinity Hill Care Center, LLC				2222-C		9/30/2016		The state of the s	12	37
		Salary Paid	-							THE SECTION OF THE SE
				Fringe Benefits and/or Other			Line Where		Total	
Name	CCNH	RHINS	NurseFac- Aids	Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section III - Administrators***										
				same as						
George Kingston	119,652		30,167	employees less 30,167 union funds	Administrator	2,091 A2	A2			
				same as						
				employees less	Administrator		42			
				same as						
				employees less union funds	Administrator		A2			
Section IV - Assistant Administrators								17.70		
							1			

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

^{**} Include all other employment worked during the cost year.

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

Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility Trinity Hill Care Center, LLC	License No. 2222		Report for Y 9/30/2016		Page 13	of 37
			Total Cost a	and Hours		
					NurseFac-	
Item	CCNH	Hours	RHNS	Hours	Aids	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary	10000				2.7	
(For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	7,979	170			2,012	43
4. Podiatrist	and the second s		CONTRACTOR CONTRACTOR AND CONTRACTOR CONTRAC			
5. Physical Therapy						
a. Resident Care	189,487	1,991				502
b. Other						
6. Social Worker		269			18,089	71
7. Recreation Worker	4,148	35+Cable			1,046	35+Cable
8. Physicians						
a. Medical Director (entire facility)	35,939	243			74,053	593
b. Utilization Review						
(Title 18 and 19 only) monthly meeting	479	4			121	1
c. Resident Care**						
d. Administrative Services facility						
Infection Control Committee (Quarterly meetings)			İ			
2. Pharmaceutical Committee						
(Quarterly meetings)						
3. Staff Development Committee						
(Once annually)						
e. Other (Specify)	10.404	104			4.661	40
Physician Care Contract Services	18,486	184			4,661	48
9. Speech Therapist	20.262	0.15				0.0
a. Resident Care	30,263	317				80
b. Other						
10. Occupational Therapist	112 402	1011				305
a. Resident Care	113,492	1,211			<u> </u>	303
b. Other						
11. Nurses and aides and attendants a. RN	100	70.0				
ł	2.001					
1. Direct Care 2. Administrative***	3,981 (113,204)	(2,412)		-	(28,541)	(635)
b. LPN	(1(3,204)	(2,412)			(20,041)	(055)
Direct Care Administrative***					 	
		(143)			(4,525)	1
c. Aides d. Other	<u> </u>	(1-53)			(-74.2-2-1)	
12. Other (Specify)						
See Attached Schedule	57,337	988			14,456	283
B-13 Total Fees Paid in Lieu of Salaries	348,387	2,822			81,370	1,292
* Do not include in this section management consultants or services which			12 1 1 1	1 1 6		1 1,2072

^{*} 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 Y 9/30/2016	ear Ended	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Operato	* to Owners, ers, Officers		nation of Rela	
Omnicare	Pharmacy Consulting	Yes O	No •			
Tocuhpoints Therapy	Therapy			Common Own	erchin	
		•	0			
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	•	0	Common Own	ership	
Healthdrive Physician Services	Audiology, Dental and Podiatry	0	•			
Dr Tress	HIV Med Dr	0	0			
Dr Johnson Fielding III	Asst Med Dir	0	0			
Dr Lindenberg Leslie	Med Dir	0	0			
		0	0			
, , , , , , , , , , , , , , , , , , ,		0	0			
		0	0			
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		0	0			
		0	0			
		0	0			

^{*} Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

Annual Report of Long-Term Care Facility CSP-15 Rev. 10/2005

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Ye	ar Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	 9/30/2016		15	37
And the second s			<u></u>		
					NurseFac-
Item		Total	CCNH	RHNS	Aids
Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation		\$ 205,128	163,824		41,304
2. Disability Insurance		\$			
3. Unemployment Insurance		\$			
4. Social Security (F.I.C.A.)		\$ 639,679	510,875		128,803
5. Health Insurance		\$ 1,047,266	836,393		210,874
6. Life Insurance (employees only)	•••		46.6		
(not-owners and not-operators)		\$			
7. Pensions (Non-Discriminatory)		\$ 388,001	309,875		78,126
(not-owners and not-operators)					
8. Uniform Allowance		\$ 			
9. Other (Specify)		\$ 46,997	37,534		9,463
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and		\$ what have a second a december of corons and comment and confirm	~*************		Company (1997)
Profit Sharing Plans for Owners and					
Operators (Discriminatory)*		A 4 4 2 3		1	
c. Bad Debts*		\$ 74,876	74,876		
d. Accounting and Auditing		\$ 3,533	2,822		711
e. Legal (Services should be fully described	on Page 7)	\$ 62,974	50,293		12,680
f. Insurance on Lives of Owners and		\$			
Operators (Specify)*					
g. Office Supplies		\$ 17,152	13,698		3,454
h. Telephone and Cellular Phones	1				
1. Telephone & Pagers		\$ 23,438	18,718		4,719
2. Cellular Phones		\$ 3,521	2,812		709
i. Appraisal (Specify purpose and		\$ 412			100
attach copy)*					
j. Corporation Business Taxes (franchise ta		\$	2		
k. Other Taxes (Not related to property - Se	e Page 22)				
1. Income*		\$ 			
2. Other (Specify)		\$			
See Attached Schedule					
3. Resident Day User Fee		\$ 1,047,679	836,722		210,957
Subtotal		\$ 3,560,243	2,858,443		701,801

^{*} Facility should self-disallow the expense on Page 28 of the Cost Report.

*** DO NOT Include Holiday Parties / Awards / Gifts to Staff

Trinity Hill Care Center, LLC 9/30/2016

Attachment Page 15

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

			Nurser ac-
Description	CCNH	RHNS	Aids
Total	\$ -	\$ -	\$ -

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

Name of Facility	License No.	I	Report for Y	ear Ended	Page	of
Trinity Hill Care Center, LLC	2222-C		9/30/2016		16	37
		T				
						NurseFac-
Item		-	Total	CCNH	RHNS	Aids
Subtota	ls Brought Forward	l:	3,560,243	2,858,443		701,801
I. Travel and Entertainment						
Resident Travel and Entertainment		\$				400 A CONTRACTOR OF THE PROPERTY OF THE PROPER
2. Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$				
4. Employee Travel		\$	5,493	4,387		1,106
5. Education Expenses Related to Seminars and	d Conventions	\$	4,178	3,337		841
6. Automobile Expense (not purchase or depre		\$	3,955	3,158		796
7. Other (Specify)		\$	242	193		49
See Attached Schedule						
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expenses	s)	\$	5,447	4,350		1,097
2. Advertising Telephone Directory (all such e	xpenses)***	\$				
3. Advertising Other (Specify)***		\$	4,440	3,546		894
See Attached Schedule		9389				
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service	is supplied	\$	nan a zamar wama Merekarek da ingakarek da ing			
directly and not by contract or fee for service	e)***	area con a				
7. Postage		\$	1,595	1,274		321
* 8. Dues and Membership Fees to Professional		\$	10,367	8,279	mentalisas (Albanis (2,087
Associations (Specify)		011040110			-	
See Attached Schedule		1000000				
8a. Dues to Chamber of Commerce & Other Non-A	Allowable Org.***	\$				
9. Subscriptions		\$				
10, Contributions***		\$	932	744		188
See Attached Schedule						
11. Services Provided by Contract (Specify and	Complete	\$	121,121	96,732		24,388
Schedule C-2, Page 21 for each firm or ind	lividual)					
12. Administrative Management Services**		\$	426,519	340,637		85,882
13. Other (Specify)		\$	26,653	21,287		5,366
See Attached Schedule			10			
C-14 Total Administrative & General Expenditures		\$	4,171,184	3,346,368		824,817

^{*} Do not include Subscriptions, which should go in item 9.

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

^{***} Facility should self-disallow the expense on Page 28 of the Cost Report.

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	NurseFac- Aids
MEALS	\$ 193		\$ 49
			New York
	HINNEY!		A DESCRIPTION
	Property and the say	AND THE	
	111111111111111111111111111111111111111		AHANI BU
	Agranda Ser		114,743,744,74
Total Other Travel and Entertainment	\$ 193	\$ -	\$ 49

Schedule of Other Advertising

			NurseFac-
Description	CCNH	RHNS	Àids
COMMUNICATIONS SPECIAL EVENTS	\$ 3,546		\$ 894
Total Offier Advertising	\$ 3,546	\$	\$ 894

Schedule of Dues

Description	CCNH	RHNS	NurseFac- Alds
ALTCFM			
CAHCF Dues	\$ 8,151.66		\$ 2,055,22
OTHER DUES	\$ 128		\$ 32
		1.500.000.000	
	\$100 MARKET		NAME OF THE PARTY
Total Dues	\$ 8,279	3 **********	\$ 2,087

Schedule of Contributions

Description	CCNH	RHNS	Nurselfac- Aids
contributions	\$ 744		\$ 188
Total Contributions	\$ 744	\$	\$ 188

Schedule of Other Administrative and General

Description	CCNH	RHNS	NurseFac- Aids
SOCIAL SERVICE SUPPLIES	\$ 144		\$ 36
SOC SVC MINOR EQUIPMENT	\$		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 1,215	The Section	\$ 306
EMPLOYEE RELATIONS	\$ 9,864	1500 1000	\$ 2,487
EMPLOYEE RELATIONS-OTHER	\$		\$
PERMITS & LICENSES	\$ 1,961		\$ 495
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 7,766	Several Several Se	\$ 1,958
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ 145		\$ 37
LATE FEES	\$ 188		\$ 47
Rounding	\$ 4		\$ -
Total Other Administrative and General	\$ 21,287	\$	\$ 5,366

Schedule C-1 - Management Services*

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

^{*} In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.

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

N. T				i i age <i>5)</i>	D + C	V		Dean	- C
Name of Facility			cense		Report for Year Ended 9/30/2016			Page	of
1 rin	ity Hill Care Center, LLC	Care Center, LLC 2222-C 9/30/20		3016		18	37		
	Item			Total	CCNI	H RHI	NS	Nurse	Fac-Aids
2.	Dietary			100		400.00	Til.		
	a. In-House Preparation & Service			100000					
	1. Raw Food		\$	270,484	216,	021			54,464
	2. Non-Food Supplies		\$	37,209	29,	457			7,752
	3. Other (Specify)	_	\$	20,915	16,	704			4,211
	DIETARY SUPPLEMENTS								
	b. Purchased Services (by contract other	·····	\$	525		416			109
	than through Management Services)								
	(Complete Schedule C-2 att. Page 21)					100			
	c. Management Services**		\$						
	d. Other (Specify)		\$	7,730	6,	173			1,556
	DIETARY MINOR EQUIPMENT								
2E.	Total Dietary Expenditures $(2a + b + c + d)$		\$	336,864	268,	771			68,093
2F.	Dietary Questionnaire			Total	CCN	H RH	NS	Nurse	Fac-Aids
G.	Resident Meals: Total no. of meals served per da	ıy:*		492		410			82
Н.	Is cost of employee meals included in 2E?) Ye	es	•	No				
I.	Did you receive revenue from employees?) Ye	es	•	No	If yes, sp amt.	ecify		4.00
J,	Where is the revenue received reported in the Co	st Re	port	? (Page/Line I	tem)				
	Is cost of meals provided to persons other					If yes, sp	nosifi.		
K.	than employees or residents (i.e., Board) Ye	es	•	No	cost.	эсспу		
	Members, Guests) included in 2E?					cost.			
L.	Is any revenue collected from these people?) Ye	∍s	0	No	If yes, sp amt.	ecify		
M.	Where is the revenue received reported in the Co	st Re	eport	? (Page/Line I	tem)				
N.	Is cost of food (other than meals, e.g., snacks) Y			No	If yes, sp	pecify		
О,	Is any revenue collected from employees?) Y	es	0	No	If yes, sp amt.	pecify		
P.	Where is the revenue received reported in the Co	st Re	eport	? (Page/Line I	tem)				
	1		_	<u> </u>					

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

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

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

Name of Facility Trinity Hill Care Center, LLC		Licen	se No. 2222-C	Report for 9/30/201	Year Ended	Page of 19 37
11111	ry mit care center, LLC			7/30/201	<u> </u>	
	Item		Total	CCNH	RHNS	NurseFac-Aids
3.	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies,	Lbs.				
	gowns and other resident care items washed, ironed, and/or processed.***	Amt.		40	5	102
	Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.				
	processed.***	Amt.	\$			
	3. Personal clothing of residents	Lbs.				
	washed, ironed, and/or processed.***	Amt.	\$			
	4. Repair and/or purchase of linens.***	Lbs				
<u> </u>	b. Purchased Services (by contract other	Amt.	\$ 52,587	41,99	10	10,589
	than through Management Services) (Complete Schedule C-2 att. Page 21)		Φ 32,387	41,95		10,389
	c. Management Services**		\$			
	d. Other (Specify) LAUNDRY SUPPLIES		\$ 292			59
3E.	Total Laundry Expenditures $(3a+b+c+d)$		\$ 53,386	42,63	6	10,750
3F. G.	Laundry Questionnaire Is cost of employee laundry included in 3E? C	Yes	•	No	If yes, specify cost.	
H,	Did you receive revenue from employees?	Yes	0	No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost	Report	?	(Page/Lii	ne Item)	
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	Yes	0	No	If yes, specify cost.	
K.		Yes		No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost	Report	?	(Page/Li	ne 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)

			Repo	ort for Year E	nded	Page	of
Trinity Hill Care Center, LLC 2222-C		2222-C		9/30/2016		20	37
							NurseFac-
	Item			Total	CCNH	RHNS	Aids
4.	Housekeeping	Sq. Ft. Serviced					
	a. In-House Care	by Personnel					
	1. Supplies - Cleaning (<i>Mops</i> , pails, brooms, etc.)	Amt,	\$	23,695	15,797		7,898
	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel		1			
	(Complete Schedule C-2 att.	Amt.	\$	39,450	26,300		13,150
	Page 21)			,	,		
	c. Management Services*	,	\$				
	d. Other (Specify)		\$				
	HOUSEKEEPING MINOR EQUI	PMENT					
4E.	Total Housekeeping Expenditures (4a +		\$	63,145	42,097		21,048
5.	Resident Care (Supplies)**				Sec.		
	a. Prescription Drugs***						
	1. Own Pharmacy		\$				
	2. Purchased from		\$	76,836	76,836		
	OMNICARE PHARMACY				1 224		
	b. Medicine Cabinet Drugs		\$	11,139	8,896		2,243
	c. Medical and Therapeutic Supplies		\$	69,670	55,642		14,029
	d. Ambulance/Limousine***		\$				
	e. Oxygen						
	1. For Emergency Use		\$	1,764	1,764		
	2. Other***		\$				
	f. X-rays and Related Radiological		\$	949	949		
	Procedures***						
	g. Dental (Not dentists who should be inc	luded under	\$	***************************************	275 CHRISTON (1980) (1980) (1980) (1980) (1980) (1980) (1980) (1980) (1980) (1980) (1980) (1980) (1980) (1980)	18-4/	·
	salaries or fees)						
	h. Laboratory***		\$	4,967	4,967		
	i. Recreation		\$				
	j. Other (Specify)****		\$	382,369	295,799		86,570
	See Attached Schedule						100000000000000000000000000000000000000
5K.	Total Resident Care Expenditures (5a - 5	<u>ij) </u>	\$	547,694	444,853	<u> </u>	102,841

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

^{**} Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

^{***} Facility should self-disallow the expense on Page 29 of the Cost Report.

^{****} ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

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

Annual Report of Long-Term Care Facility CSP-21 Rev. 10/2001 State of Connecticut

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

Name of Facility Trinity Hill Care Center, LLC				License No. 2222-C	Report for Year Ended 9/30/2016	70			Page 21	of 37
		Related ** to Owners, Operators, Officers	o Owners,				Total Cost	Total Cost/Page Ref.***	,	
Name of Individual or Company	Address	Yes	N _o	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHINS	NurseFac- Aids	Pg I	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	0	0	VENDOR	Housekeeping Services	39,817			0	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	0	0	VENDOR	Laundry Services	52,728			19	35
Eagle Elevator		0	0	VENDOR	Elevator Contract	6,126			22	6F
Bioserve, Inc.		0	0	VENDOR	Medical Waste	4,632			22	6F
The Brickman Group/ Stevan Infante		0	0	VENDOR	Snow Removal/Landscaping	13,272			22	6F
All Waste Inc		0	0	VENDOR	Trash removal	35,298			22	6F
American Health Tech		0	0	VENDOR	Software Maintenance Contract	10,623			16	MII
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	0	0	VENDOR	Payroll Services	55,546	į		91	M11
National Datacare Corp		0	0	VENDOR	Resident Trust Software	2,613			16	M11
Prime Care Technologuy services		0	0	VENDOR	Computer Consulting Services	.22858.79			16	M11
Priotiry Express		0	0	VENDOR	Courier Services	5,203		:	16	M11
Point Right Inc		0	0	VENDOR	Nursing Software	4,680			16	MII
		0	0	VENDOR						
		0	0	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 Ye	ear Ended		Page of
Trinity Hill Care Center, LLC	2222-C	9/30/2016			22 37
Item		Total	CCNH	RHNS	NurseFac-Aids
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$	36,276	28,972		7,304
b. Heat	\$	65,783	43,856		21,928
c. Light & Power	\$	89,587	59,724		29,862
d. Water	\$	57,371	38,247		19,124
e. Equipment Lease (Provide detail on p	age 6) \$	33,782	26,980		6,802
f. Other (itemize)	\$	169,700	124,260		45,439
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a-	- 6f) \$	452,498	322,039		130,459
7. Depreciation (complete schedule page 23	*)				
a. Land Improvements	\$				
b. Building & Building Improvements	\$	20,096	16,050		4,047
c. Non-Movable Equipment	\$	459	366		92
d. Movable Equipment	\$	43,867	35,034		8,833
*7e. Total Depreciation Costs $(7a + b + c + d)$) \$	64,422	51,450		12,972
8. Amortization (Complete att. Schedule Page	ge 24*)				
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$	51,756	41,334		10,421
d. Other (Specify)	\$				
*8e. Total Amortization Costs (8a + b + c + c	1) \$	51,756	41,334		10,421
9. Rental payments on leased real property le	ess				
real estate taxes included in item 10b	\$	1,223,304	976,984		246,320
10. Property Taxes			-		
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$	278,724	222,601		56,123
c. Personal property taxes	\$	28,851	23,042		5,809
11. Total Property Expenses (7e + 8e + 9 +	10) \$	1,647,056	1,315,411		331,645

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

State of Connecticut
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Depreciation Schedule

			22 142 A	Dept common peaceuric	Ī					
Name of Facility			License No.			Report for Year Ended	nded		Page	of
Trinity Hill Care Center, LLC			2222-C).C		9/30/2016			23	37
			Historical			Accumulated				
			Cost	Less		Depreciation to	Method of			
			Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	
Property Item			Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
A. Land Improvements										
1. Acquired prior to this report period										
2. Disposals (attach schedule)									88460	
3. Acquired during this report period (attach schedule)	h schedule)									
A-4. Subtotal										
B. Building and Building Improvements										
1. Acquired prior to this report period			359,317	_	359,317	17,965			18,049	
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	th schedule)		35,638						2,048	
B-4. Subtotal								90		20,096
C. Non-Movable Equipment								•		
			7,990		7,990	4,473	****		459	
	h schedule)									
C-4. Subtotal										459
	Is a mileage logbook	Date of	Historical			Accumulated				
	maintained?	Acquisition	Cost	Less		Depreciation to	Method of		***************************************	
			Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation for This Vear	Totals
	Yes No	Month Year	Land	v atue	Depreciated	rears Operations	Depreciation	Trile	JOL LIUS I CAL	LOTAIS
D. Motor Vehicles (Specify name, mode)										
and year of each venicle)	×		9.580		9,580	2,105			2,296	
, o										
ن										
d.										
2. Movable Equipment										
a. Acquired prior to this report period			411,476		411,476	238,092			38,426	
b. Disposals (attach schedule)										
c. Acquired during this report period										
(attach schedule)			24,981						3,144	
D-3. Subtotal										43,867
E. Total Depreciation										64,422
	GIR CONTROL CONTROL CONTROL CONTROL CONTROL	PORTON SECRETARIO DE LA LANGUETA VIDRO DE LA COMPANSIONE	MASSA TANITRON OF THE PROPERTY	And Address of the Land Ad						

Useful

Trinity Hill Care Center, LLC 9/30/2016

Schedule of Land Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
				Harry Village
				distribution.
August Verger				
				white white
Total additions for	Land Improvements	S -		S -
Deletions:				
			1/3:303/4/4/4	
Total deletions for l	Land Improvements	\$		\$ -

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

		Life	Depreciation
Concrete Work	5 6,381	180	\$ 319
Building Powerwashing	\$ 1,595	60	\$ 186
Seal / repaint Metal roof	\$ 18,611	60	\$ 1,241
Asphalt crack filling / sealing	\$ 9,050	60	\$ 302
building Improvements	\$ 35,638		\$ 2,048
uilding Improvements	\$ -		\$ -
	Building Powerwashing Seal / repaint Mctal roof Asphalt crack filling / sealing Fuilding Improvements	Building Powerwashing \$ 1,595 Seal / repaint Metal roof \$ 18,611 Asphalt crack filling / sealing \$ 9,050 Building Improvements \$ 35,638	Building Powerwashing \$ 1,595 60 Seal / repaint Mctal roof \$ 18,611 60 Asphalt crack filling / sealing \$ 9,050 60 Building Improvements \$ 35,638

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreclation
Additions;				
Total additions for	Non-Movable Equipment	\$ -		\$ -
Deletions:				
		N. M. Walin	The Park N	
		The Hall		F 664 541 1134
Total deletions for	Non-Movable Equipment	S -		\$ -

^{*}Ties to Page 23, Line C3

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

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

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

Schedule of Movable Equipment Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:	-			
11/25/2015	BEDS: MEDLINE	\$ 12,751	60	\$ 2,125
4/12/2016	BEDS: MEDLINE	\$ 12,230	60	\$ 1,019
Total additions for	Moyable Equipment	\$ 24,981		\$ 3,144
Deletions:				
		Alexander (
				Name of Carl
		ARRIGINATION		
Total deletions for	Movable Equipment	\$ -		\$

^{*}Ties to Page 23, Line D2c **Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/16/2015	Upgrade Phone System- Comtech 21: Phase 2	\$ 12,783	120	\$ 1,172
9/1/2016	Upgrade Walk in Freezer- Proline	\$ 10,985	180	\$ -
7/29/2016	Upgrade 2 Rooftop AC Systems: Link Mechanical	\$ 22,402	120	\$ 373
Total additions for	Leasehold Improvement	\$ 46,170		\$ 1,545
Deletions:				
SEE SEASON				
Total deletions for	Leasehold Improvement	\$ -		\$ -

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

State of Connecticut Annual Report of Long-Term Care Facility CSP-24 Rev. 10/2006

Amortization Schedule*

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

* Straight-line method must be used. ** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.

B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year End	ded		Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2016			25	37
11. Property Questionnaire						
Part A						
	- Carille				TEUSZaa II aammiat	a Dout D
Is the property either owned by th	e racinty o	Yes	0		If "Yes," complete	
or leased from a Related Party?*					If "No," complete	Part C.
*If any owner or operator of this fac						
business association to any person or related party transaction.	r organization from whom b	uildings are leased, then i	t is considered a			
Description		Total				
Date Land Purchased		04/01/99				
Date Land 1 dremased Date Structure Completed		04/01/55				
3. If NOT Original Owner, Date	of Purchase	04/01/99				
4. Date of Initial Licensure	or r drendse	04/01/99				
5. Total Licensed Bed Capacity		144				
6. Square Footage		177			en and a second	
7. Acquisition Cost						
a. Land						
b. Building						
Part B - Owner and Related Pa	wting	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortga	апе
	THES	1st wortgage	Ziid Mortgage	ord Wortgage	4th Morego	ago
	vad veriebla)	HUD fixed	Inches Control			
a. Type of Financing (e.g., fb. Date Mortgage Obtained	xed, variable)	05/30/13				
c. Interest Rate for the Cost	Vacr	335.00%				
		333.00%				
d. Term of Mortgage (numb		4,208,200				
e. Amount of Principal Borr f. Principal balance outstand		3,819,809				
		3,819,809				
Complete if Mortgage was				42 40 5		
During Current Cost Ye		(10 m) (10 m) (10 m)				
g. Type of Financing (e.g., f	xed, variable)					
h. Date of Refinancing						
i. New Interest Rate	^ \					
j. Term of Mortgage (numb						
k. Amount of Principal Borr						
Principal Outstanding on				<u> </u>		
Part C - Arms-Length Leas		-		lm cr		CT
Name and Address of Lesso	or Pro	operty 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 Ye	ear Ended		Page	of
Trinity Hill Care Center, LLC	2222-C		9/30/2016			26 3	37
Iten	1		Total	CCNH	RHNS	NurseFac-A	Aids
12. Interest	1		10141	CONT	AGAND	1 (drijet de 1	IIOD
A. Building, Land Improve	ment & Non-Movable	>					
Equipment							
1. First Mortgage		\$					
Name of Lender		Rate					
Address of Lender				1989 (1982) 1980 (1981)			
2. Second Mortgage		\$					
Name of Lender		Rate					
Address of Lender							u i
3. Third Mortgage		Ş	3				auxacum arana
Name of Lender		Rate					it
Address of Lender	MAAN THREE T						
4. Fourth Mortgage		Ç	3	33.5		0.0000000000000000000000000000000000000	
Name of Lender		Rate					
Address of Lender		· "•					
B. CHEFA Loan Informat	ion						
1. Original Loan Amou	int	Ç	8				
2. Loan Origination Da	ate						
3. Interest Rate %							
4. Term							
5. CHEFA Interest Ex	pense			200000000000000000000000000000000000000			
12 B7. Total Building Interest Ex) 5					
The second secon	r (,,			rv Subtotals	forward to 1	pert nage)	

(Carry Subtotals forward to next page)

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

Name of Facility	License No.		Report for Ye	ear Ended		Page of
Trinity Hill Care Center, LLC	2222-C		9/30/2016			27 37
				······································		
It	em		Total	CCNH	RHNS	NurseFac-Aids
	Subtotals E	Brought Forward				
12. C. Movable Equipment						
1. Automotive Equipme	ent	S	3			
A. Item	Rate	e Amount				
Lender						
Address of Lender	arun(m-air-no					
2. Other (Specify)		9	S			
A, Item	Rate	e Amount				
Lender			1 1 2 4 1 2 1 1 2 1 1 1 1 1 1 1 1 1 1 1	P. 100 T. 201		
			_			
Address of Lender						
B. Item	Rate	e Amount				2.162.0
B. Item	Kan	Zanount		1		
Lender						
Address of Lender						100 mm
12. C. 3. Total Movable Equi	nment Interest					
Expense (C1 + 2)	pinoik intoroge	5	5			
12. D. Other Interest Expense	(Specify)		3,458	2,762		696
INTEREST	(1 35)					
			1000000000000			
13. Total All Interest Expense	(12B7 + 12C3 + 1)	2D) \$	3,458	2,762		696
14. Insurance						
a. Insurance on Property (6,612	5,281		1,331
b. Insurance on Automobi			3,680	2,939		741_
c. Insurance other than Pr						10 = 61
1. Umbrella (Blanket C			97,942	78,221		19,721
2. Fire and Extended C	overage		\$ 2.012	2.226		500
3. Other (Specify)		,	\$ 2,912	2,326		586
Other insurance, cri	me				100	
14d. Total Insurance Expenditu	ares (14a+b+c)		\$ 111,146	88,766		22,380
15. Total All Expenditures (A-			\$ 14,385,901	11,048,291		3,337,611

D. Adjustments to Statement of Expenditures

	of Fa	_	Control II C	Lie	cense No.	Report for Yes 9/30/2016	ar Ended	Page	of 37
1 rm	унш	Care	Center, LLC	<u> </u>	2222-C	9/30/2016		28	31
т.	т	T 1.			Total				
	Page		Y. Y. Y.		Amount of	CONII	DIDIC	NurseFa	- A : d-
	No.		Item Description		Decrease	CCNH	RHNS	Nursera	c-Alus
	10 - 5		es and Wages						
1,			Outpatient Service Costs	\$			<u> </u>		
2.			Salaries not related to Resident Care	\$					
3.			Occupational Therapy	<u>\$</u> \$					
4.	12 1		Other - See attached Schedule	Ъ					
	13 - I	rojes	sional Fees	c h	- 10 m				
5.			Resident Care Physicians **	\$	1		- tooksake		
6.			Occupational Therapy	\$ \$	<u> </u>			<u> </u>	
<u>7.</u>	15.6	7.	Other - See attached Schedule	3					
	S 13 &		Administrative and General	<u>ф</u>					
8.			Discriminatory Benefits	\$		a. 0a.c			
9.			Bad Debts	\$		74,876			
10.			Accounting & Legal	\$					
11,			Telephone	\$					
12,			Cellular Telephone	\$					
13.			Life insurance premiums on the life	4	550 ALC TO 12 TO 15 W				
			of Owners, Partners, Operators	\$					
14.			Gifts, flowers and coffee shops	\$					
15.			Education expenditures to colleges or			45			
			universities for tuition and related costs						
			for owners and employees	\$					
16.			Travel for purposes of attending		Table 18 Charles				
			conferences or seminars outside the						
			continental U.S. Other out-of-state						
			travel in excess of one representative	\$					
17.			Automobile Expense (e.g. personal usc)	\$					
18.			Unallowable Advertising *	\$		3,546			894
19.			Income Tax / Corporate Business Tax	\$					
20.			Fund Raising / Contributions	\$					
21.			Unallowable Management Fees	\$					
22.			Barber and Beauty	\$					
23,			Other - See attached Schedule	\$	32,998	26,353			6,644
Page	18 - 1	Dietar	y Expenditures						
24.			Meals to employees, guests and others						
			who are not residents	\$					
Page	19 - 1	Launa	lry Expenditures						
25.			Laundry services to employees, guests						
			and others who are not residents	\$					Date of Page 1
Page	20 - I	House	keeping Expenditures						
26.			Housekeeping services to employees, guests						
			and others who are not residents	\$		100 C C C C C C C C C C C C C C C C C C	2000		· · · · · · · · · · · · · · · · · · ·
		J	Subtotal (Items 1 - 26)			104,776			7,538

^{*} All except "Help Wanted"

⁽Carry Subtotal forward to next page)

^{**} Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
Total Othe	r Salaries	Adjustment	\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
16		Management fee over cost	\$ -		\$ -
Total Other	r Fees Adj	ustments	\$ -	\$	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref Description	CCNH	RHNS	NurseFac-Aids
16a	PENALTIES	\$ 145		\$ 37
16a	LATE FEES	\$ 188		\$ 47
16a	PRIOR PERIOD EXPENSES			
	rounding	0		
11.00	Provider User Fee for Medicare days	26,019.91		6,560.21
Total Othe	r A&G Adjustments	\$ 26,353	\$	\$ 6,644

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

Name	e of Fa	acility	D. Adjustments to Statemen			Report for Y		Page		of
		-	Center, LLC	LIC	2222-C	9/30/2016	Cui Linded	29		7
******	Ly 11111	Care	Center, ELC	<u> </u>	Total	7/30/2010		47		
Itam	Page	Line			Amount of					
No.		No.	Item Description		Decrease	CCNH	RHNS	Nurse	Fac-A	ide
140.	140.	140.	Subtotals Brought Forward	\$	112,314	104,776	MIII	110130		538
Page	20 - 1	Reside	nt Care Supplies***	Ψ	112,517	104,770				330
27.	1	lesine	Prescription Drugs	\$						
28.			Ambulance/Limousine	-\$						
29.			X-rays, etc	\$	949	949				
30.			Laboratory	\$	4,967	4,967				
31.			Medical Supplies	\$						
32,	 		Oxygen (non emergency)	\$						
33.			Occupational Therapy	\$						
34.			Other - See Attached Schedule	\$						
	22 - 1	Mainte	enance and Property							
35.		T	Excess Movable Equipment Depreciation							
			See Attached Schedule	\$					4000 birthing	
36.			Depreciation on Unallowable							
			Motor Vehicles	\$	4.762.762.252.70.252.764.764.662.764.662.764.662.764.662.764.662.764.662.764.662.764.662.764.662.764.662.764.6	C. Same Market and Alexander of the second s	542-4011-07-2-31-0-400-0-5-5-0-7-100-		DVANORA AND BOSON	.,
37.			Unallowable Property and Real							
			Estate Taxes	\$	10000000000000000000000000000000000000	A 1995 (1995		Nan-sezaneza (Ne	MAN TOWN NOTION	
38.			Rental of Building Space or Rooms	\$						
39.			Other - See Attached Schedule	\$						
Page	27 - 1	nsura	ince							
40.			Mortgage Insurance	\$						
41.			Property Insurance	\$						
Othe	r - Mi	scella	neous							
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	\$						A-Samulat extensi
47.			Expenditures made for the protection,			0.00				
			enhancement or promotion of the			1000			4	
			providers interest	\$						
48.			Interest Income on Accounts Rec	\$						vacamia
49.			Other (include personnel and other					-		
			costs unrelated to resident care) - See							
	1		Attached Schedule	\$						
		rofit F	roviders Only							
50,			Building/Non Movable Eq. Depreciation							.,
			Unallowable Building Interest -						-	
			See Attached Schedule	\$						
51.	Total	l Amo	unt of Decrease (Items 1 - 50)	\$	118,231	110,692			7	,538

^{***} Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac- Aids
20	5J				
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	-		
13	B9A	ST- Resident Care (for outpatent therapy - see schedule)			
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)			
Total Othe	er Ancillar	y Costs	\$ -	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac- Aids
Total Exce	ess Movabl	e Equipment Depreciation	\$	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac- Aids
TVER SEE					
Total Othe	r Property	Adjustments	3	\$	\$

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 Othe	r Adjustn	ients	\$	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref Description	CCNH	RHNS	NurseFac- Aids
SPANSA AND				
Total Unal	lowable Building Interest	\$ -	\$ -	\$ -

F. Statement of Revenue

		F. Statement of Rev					T	
Name of Fa	-	License No.		Report for Y	ear Ended		Page	of
I rinity Hill	Care Center, LLC	2222-C	i	9/30/2016			30	37
		Item		Total	CCNH	RHNS	Nurse	Fac-Aids
I. Residen	it Room, Board & Routine	Care Revenue						
1. <u>a.</u> N	Medicaid Residents (CT only	ν)	\$	14,046,671	10,941,264			3,105,407
b. N	Aedicaid Room and Board C	Contractual Allowance **	\$					
2. <u>a.</u> N	Medicaid (All other states)	44	\$					
ъ. C	Other States Room and Boar	d Contractual Allowance **	\$.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Medicare Residents (all incl		\$	882,925	698,982	******		183,943
b. N	Medicare Room and Board (Contractual Allowance **	\$					
4. <u>a.</u> P	Private-Pay Residents and O	ther	\$	9,828	9,828		ļ	
ъ. P	rivate-Pay Room and Board	Contractual Allowance **	\$					
II. Other	Resident Revenue							
1. a. P	rescription Drugs - Medica	re	\$	65,900	65,900			
b. P	rescription Drugs - Medica	re Contractual Allowance **	\$	(65,900)	(65,900)			
c. P	Prescription Drugs - Non-Mo	edicare	\$	13,394	8,225			5,169
d. P	rescription Drugs - Non-Me	edicare Contractual Allowance **	\$	(13,394)	(8,225)			(5,169)
2. a. N	Medical Supplies - Medicard		\$	1,267	1,267		1	
b. N	Medical Supplies - Medicare	Contractual Allowance **	\$	(1.267)	(1,267)			
c. N	Medical Supplies - Non-Med	licare	\$	11,060	10,257			803
d. N	Medical Supplies - Non-Med	iicare Contractual Allowance **	\$	(H,0ĕ0)	(10,257)			(803)
3. a. F	Physical Therapy - Medicare	,	\$	101,484	101,484			
<u>b. F</u>	Physical Therapy - Medicare	Contractual Allowance **	\$	(69,194)	(69,194)			
c. F	Physical Therapy - Non-Med	licare	\$	221,803	192,619			29,183
d. F	Physical Therapy - Non-Med	licare Contractual Allowance **	\$	(221,803)	(192,619)			(29,183)
	Speech Therapy - Medicare		\$	30,199	30,199	ļ		
b. S	Speech Therapy - Medicare	Contractual Allowance **	\$	(12,417)	(12,417)			
	Speech Therapy - Non-Medi		\$	26,337	21,661			4,676
d. S	Speech Therapy - Non-Medi	care Contractual Allowance **	\$	(26.337)	(21,661)			(4,676)
	Occupational Therapy - Me		\$	73,170	73,170			
		dicare Contractual Allowance **	\$	(53,588)				
	Occupational Therapy - Nor		\$	124,520	115,280			9,240
		n-Medicare Contractual Allowance **	\$	(124,520)	(115,280)			(9,240)
6. <u>a. (</u>	Other (Specify) - Medicare		\$					
	Other (Specify) - Non-Medi		\$	105,612	105,612			
	Resident Revenue (Section	1. thru Section II.)	\$	15,114,691	11,825,342			3,289,349
IV. Other	r Revenue*							
1. Mea	als sold to guests, employee	s & others	\$			<u> </u>		
2. Ren	ital of rooms to non-residen	ts	\$					
3, Tele	ephone		\$					
	tal of Television and Cable	Services	\$					
	rest Income (Specify)		\$				-	
	ate Duty Nurses' Fees		\$			-	1	
	ber, Coffee, Beauty and Git	t shops	\$				ļ	
	er (Specify)	h.	\$				-	
V. Total C	Other Revenue (1 thru 8)		\$					
VI. Total	All Revenue (III+V)		\$	15,114,691	11,825,342			3,289,349

^{*} 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-Aid:
Lab Modicare	\$ 7,733	45-31-45-45-55-56	WHEN THE STATE
Lab Medicare CA	\$ (7,733)	Garage (say)	MARKAN
Oxygen Medicare	\$ 198	1.1.1.1.1.1.1.1.1.1.1	94 min (1974)
Oxygen Medicare CA	S (198)	alan kabupatèn	465,000
Equipment restal	\$	property (Sept.	
Equipment rental CA	S -		de desde Asianie.
Pen Therapy	5		
Pen Therapy CA	S	The state of the state of the	
Therapy Beds Medicare	5		
Therapy Beds Medicare CA	S	Barra Comment	and strategy
Radiology Medicare	S 140.		10 + 10 + 40 (20 4) (3)
Radiology Medicare CA	S (140)	16741161161161	
IV Thurspy	\$ 37,072		100000000000000000000000000000000000000
IV Therapy CA	S (37,072)		
Medical Transportation	S .	100000000000000000000000000000000000000	111111111111111111111111111111111111111
Medical Transportation CA	S		中华中华英语
Olucose testing	\$	agenticated a	Editor (
Olucose testing CA	S	A THE PERSON	
Outpatient therapy Medicare	\$		
	9 15 20 20 20 20 20	Service State of Services	a strategy is
Total Other Resident Revenue - Modicare	S	5	S

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNII	RHNS	NurseFac-Ald
	Lab			
11411	Lab CA	nagrinasignic	102-1541-1544	
1111	Oxygen	\$ 2,748	F1574139339	S 126
11-1-11	Oxygen CA	\$ (2,748)		\$ (126
11.0	Equipment rental	\$ 125,000		
1.0	Equipment rental CA	\$	F1000000000	distribution of
14 (14)	Pen Therapy	\$	100000000000000000000000000000000000000	Historica Historica
	Pen Therapy CA	5		
	Therapy Bods	5		i mining
50,000	Therapy Beds CA	S	NEED CONTRACT	Statistics and
44,119,93	Radiology	s -	Million Contracts	
313000	Radjology CA	s -	1000	
1111	Medical Transportation	S	100000000000000000000000000000000000000	a reconstitue de
	Medical Transportation.CA	S -	Section (Control of Control of Co	
, in this fire	Glucose Testing	S	Street (Street)	10.000
11111	Glucose Testing CA	2		A STATE OF STATE
	IV therapy	\$ 13,610	i francisco	\$ 681
5,5,550	IV therapy CA	S (13,610)	i propositiva	S (681
1111	Flu shot revenue	\$	Tribina (Albania	1 Markigher
2000	Outpatient therapy	S		and stage.
- 14.4	prior period revenue	5 105,863		
5.455.93		NEW STREET		g Agricus Austria
100	rounding	\$ (251)		1 19414111414
44.50		STATE OF THE		100000000000000000000000000000000000000
Fotal Oth	r Resident Revenue	\$ 105,612	2	\$ 1000

Interest Income

Account

Page Ref Account	Bahmee	CONH	RHNS	NurseFac-Alds
#REF!		s -	1	
			154 5 115	
		44.44.0	120	1 1
	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	11.5	1 1-1-1	
Total Interest Income		S	S -	S

Schedule of Other Revenue

Page Ref	Description	CCNII	RHNS	NorseFac-Aids
	MEALS	\$	ALC: HAVE	Adams Sign
	TELEVISION INCOME	s -		
	CONCESSIONS / VENDING INCOME	2		in and the
100	RESIDENT LATE FEE REVENUE	\$		and a substitution
7.77	RESIDENT ATTORNEY FEE REVENUE	5	Strategers.	Special Control
1.000	TBLEPHONE INCOME	\$	4044,0000	strike reservices
3.500	OTHER INCOME	5	ALC: N	10,000,000
	OPTUM DIVIDENDS REVENUE	\$	Attribute of profit	şissi ülemilişti
500 (0.5)			5111154441546	148/04/03/03
V. 111.				1,33,50,1-1-15.
				10,000
		2000	A STATE OF THE	
Tutal Othe	т Кеуелие	S	\$	5

G. Balance Sheet

Name of Facility		License No.		rt for Year Ended		Page	of
Trinity Hill Care Cen	ter, LLC	2222-C	9/30/	2016		31	37
		Account				An	nount
Assets							
A. Current Assets							
	and and in banks				\$		315,967
	······	le (Less Allowance			\$		2,509,548
3. Other Acco	ounts Receivable (Excluding Owners of	or Relate	d Parties)	\$		
4 Inventories					\$		32,187
Prepaid Ex	penses				\$		279,666
a. Prepaid	Insurance			270,311			
b. Prepaid	Property Taxes			7,240			
c. Prepaid	Expenses Other			2,115			
d.							
6. Interest Re	ceivable				\$		
7. Medicare F	inal Settlement R	eceivable			\$		
	ent Assets (itemiz	e)			\$		(696,325
	(to) Related Parties	L DE MUNICIPALITATION OF		147,020			
Other Ow	ners reserves			(843,345)	\dashv		
A-9. Total Current	Assets (Lines A1	thru 8)			\$		2,441,044
B. Fixed Assets							
1. Land					\$		
2. Land Impr	ovements	*Historical Cost			\$		
•		Accum. Deprecia	tion	Net			
3. Buildings		*Historical Cost		394,955	\$		356,894
0		Accum. Deprecia	tion	38,061 Net			
4. Leasehold	Improvements	*Historical Cost		684,802	\$		286,303
	•	Accum, Deprecia	tion	398,499 Net			
5. Non-Mova	ble Equipment	*Historical Cost		7,990	\$		3,059
	• •	Accum, Deprecia	tion	4,932 Net			
6. Movable E	quipment	*Historical Cost	-	436,457	\$		156,795
	* *	Accum, Deprecia	tion	279,663 Net			
7. Motor Veh	nicles	*Historical Cost		9,580	\$		5,179
		Accum. Deprecia	ition	4,401 Net			
8. Minor Equ	ipment-Not Depr			-	\$	4	
9. Other Fixe	d Assets (itemize)			\$		2,356
	ction in Progress			2,356			
B-10, Total Fixe	ed Assets (Lines I	R1 thru 9)			\$		810,584
D-10, Ivili Tixe	waynon (Duron I				ΙΨ		010,001

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

G. Balance Sheet (cont'd)

		Facility	License No.	Report for Year Ended		Page		of
Trini	ity H	Iill Care Center, LLC	2222-C	9/30/2016		32	3	7
			Account			Amo	unt	
				Total Brought Forward:	\$		3,251,62	28
C.	Le	asehold or like property record	led for Equity Purposes	•				
		Land			\$			
	2.	Land Improvements	*Historical Cost					
			Accum. Depreciation	ı Net	\$			
	3.	Buildings	*Historical Cost					
			Accum. Depreciation	n Net	\$			
	4.	Non-Movable Equipment	*Historical Cost					
			Accum, Depreciation	ı Net	\$			
	5.	Movable Equipment	*Historical Cost		_			
			Accum. Depreciation	n Net	\$			
	6.	Motor Vehicles	*Historical Cost					
			Accum. Depreciation	n Net	\$			
		Minor Equipment-Not Depre			\$			
C-8		tal Leasehold or Like Proper	ties (C1 thru 7)		\$			
D.		vestment and Other Assets						
		Deferred Deposits			\$			
		Escrow Deposits			\$			
	3.	Organization Expense	*Historical Cost		_			
<u> </u>		****	Accum, Depreciation	n Net	\$			
	4.	Goodwill (Purchased Only)			\$		42.0	
	5,	Investments Related to Resid	lent Care (itemize)	40.44-	\$		43,0	UU
		Patient Trust Funds		40,445	-			
ļ		Long Term Deposit - prin		2,555				
	6.				\$			
		Name and Address	Amount	Loan Date	-	5 (10 5 (10)		
						100		
<u> </u>					Ψ.			
	7.	Other Assets (itemize)			3			
				4.4	-			
					_			
							40.0	
		otal Investments and Other A)	\$		43,0	
D-9	. To	otal All Assets (Lines A9 + B)	10 + C8 + D8)		\$	Western	3,294,6	128

^{*} 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 Fac			License No.	Report for Year E	Inded	Page	of
Trinity Hill (Care (Center, LLC	2222-C	9/30/2016		33	37
			Account			An	nount
Liabilities							
A.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable			[\$		265,789
	2.	Notes Payable (itemize)			\$		D/30 2037 277
		Working Capital Line of C	Credit	AA AA AA AA AA AA AA AA AA AA AA AA AA			
							and the second second
	3.	Loans Payable for Equipm			\$		
		Name of Lender	Purpose	Amount	Date Due		
							Barrier Barrier
		•					
							10-24 P
		4 1D 11/77 7 1		(Ct1-11 days1)	\$	1	299,443
	4.	Accrued Payroll (Exclusiv			\$		299,443
ļ	5.	Accrued Payroll (Owners	······································	only)	\$		
	6.	Accrued Payroll Taxes Pa					
	7.	Medicare Final Settlemen			\$		
	8.	Medicare Current Financi			\$		
	9.	Mortgage Payable (Curre			\$		710.
		. Interest Payable (Exclusiv	e of Owner and/or R	Related Parties)	\$		
		. Accrued Income Taxes*			\$		
	12	. Other Current Liabilities ((itemize)		\$)	865,336
		Related Party Payables		3,392			
		Accrued Expenses		,712			
		Accrued Resident User Fees		,390			
		Accrued Workers Comp Expense		3,842			1.400.500
A-13	3. Ta	otal Current Liabilities (Li	nes A1 thru 12)		9	<u> </u>	1,430,568

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

G. Balance Sheet (cont'd)

Name of Facility License No. Report for Year Ended		Ended	Page		of	
Trinity Hill Care Center, LLC	2222-C	9/30/2016		34		37
4	Account			An	nount	
		Total Broug	ht Forward:		1,43	0,568
Liabilities (cont'd)						
B. Long-Term Liabilities						
1. Loans Payable-Equipment			\$			
Name of Lender	Purpose	Amount	Date Due			
				* * * * * * * * * * * * * * * * * * * *		
2. Mortgages Payable			\$			
3. Loans from Owners or Rel	ated Parties (itemize	2)	\$			
Name and Address of Lender	Amount	Loan D	ate			
				4.7		
4. Other Long-Term Liabiliti	es (itemize)		\$		4	0,445
Patient Trust Funds		40,445		7 7		
		- America				
	/* (The state of the state of				10	0.445
B-5. Total Long-Term Liabilities			\$			0,445
C. Total All Liabilities (Lines A-	-12 + R-2)		\$		1,47	1,012

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

	ne of Facility	License No.	1 4	Year Ended	Page	of
Trin	ity Hill Care Center, LLC	2222-C	9/30/2016		35	37
Α.	Reserves	Account			A	mount
A.						
	1. Reserve for value of leased	and			\$	
	2. Reserve for depreciation val	ue of leased buildin	gs and appurte	enances		
	to be amortized				\$	
	3. Reserve for depreciation val	ue of leased person	al property (E	quity)	\$	
	4. Reserve for leasehold real p	roperties on which f	air rental valu	e is based	\$	
	5. Reserve for funds set aside	as donor restricted			\$	
	6. Total Reserves				\$	
В.	Net Worth					
	1. Owner's Capital				\$	1,000
	2. Capital Stock				\$	
	3. Paid-in Surplus				\$	
	4. Treasury Stock				\$	
	5. Cumulated Earnings				\$	1,093,826
	6. Gain or Loss for Period	10/1/20	15 thru	9/30/2016	\$	728,790
	7. Total Net Worth				\$	1,823,615
C.	Total Reserves and Net Worth				\$	1,823,615
D.	Total Liabilities, Reserves, and	l Net Worth			\$	3,294,628

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year	Ended	Page	of	
Trinity Hill Care Center, LL	C 2222-C	9/30/2016	· · · · · · · · · · · · · · · · · · ·	36	37	
Account					Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2015						
3. Total Revenue (From Statement of Revenue Page 30)					15,114,691	
C. Total Expenditures (From Statement of Expenditures Page 27)					14,385,901	
D. Net Income or Deficit					728,790 728,790	
	Balance					
	Additions 1. Additional Capital Contributed (itemize)					
2. Other (itemize)						
F-3. Total Additions	Total Additions					
G. Deductions	Deductions					
1. Drawings of Owne	1. Drawings of Owners/Operators/Partners (Specify)					
Name and Addre	ss (No., City, State, Zip)	Title	Amount			
2. Other Withdrawin	gs (Specify)			\$	**************************************	
	Purpose Amount		ount			
2. Total Dahutiana						
3. Total Deductions H. Balance at End of Period 09/30/16				\$	728,790	
H. Balance at End of Period 09/30/16					120,190	

I. Preparer's/Reviewer's Certification

Name of Facility		License No.	Report for Year Ended	Page of				
Trinity Hill Care Center, LLC		2222-C	9/30/2016	37 37				
Check appropriate category								
Ø	Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	☑ NurseFac-Aids					
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.								
Signat	ure of Preparer se Management LLC	Title	Date Signed 2 14	117				
Printed Name of Preparer								
iCare	Management, LLC							
Addres Address			Phone Number	Phone Number				
341 Bidwell Street, Manchester, CT 06040			860-570-2140					

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