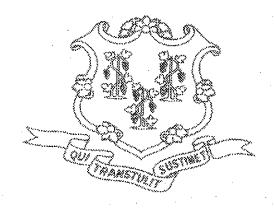
State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as I	icensed)	· · · · · · · · · · · · · · · · · · ·					
Trinity Hill Care Cent	,						
		in Code)					<u> </u>
`	ress (No. & Street, City, State, Zip Code) Hillside Avenue, Hartford, CT 06016						
Type of Facility	ilariiora, ex o	0010				··········	
Chronic and C	onvalescent only (CCNH)		Rest Home with Supervision only (RHNS)	_		Other	
Report for Year Begin 10/1/2017	nning		Report for Year 9/30/2018	Ending		***************************************	
			•				
License Numbers:		CCNH 2222-C	RHNS		Other AIDS	N	Medicare Provider 07-5268
		······	L				
Medicaid Provider No	umbers:	CC 9555	CNH	RI	INS		ICF-IID 49553
For Department Use	e Only		1.				
Sequence Number Assigned	Signed and Notarized	Date Received	Sequence N Assigne		Signed a	nd Notarized	Date Received
•							

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2018	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, 2017 and ending September 30, 2018, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) George Kingston			Printed Name (Owner) Chris Wright	2/13/14
Subscribed and Sworn	State of	Date	Signed (Notary Public)	goods Comme Expires
to before me: Bunda Walsh	CT	2/13/19	Brenda Walsh	BRENDA WALSH Notary Public-Connecticut My Commission Expires
Address of Notary Public	,	7. / . /	d and a second	February 29, 2020
341 REDWILL	St 11	malasto	c AT ALAUD	aktiin saakkiin mak tiin makkiin ni 1952 kuu millituur niin muuringa quagtii ka makkiin mi Calima dallama saata

(Notary Seal)

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2018	1	37

Administrator's/Owner's Certification

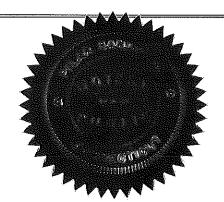
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Signed (Administrator)	/	Date	Signed (Owner)	Date
A. W. Kal	<i>∕</i>	2-04-19		
Printed Name (Administrator)			Printed Name (Owner)	
George Kingston			Chris Wright	
Subscribed and Sworn	State of	Date	Signed (Notary Public)	Comm. Expires
to before me: GEORGE KINGSTON,	CONNECTICUT	2-04-19	Color Soudoul	8 ,31 ,2019
Address of Notary Public	~ 3			1



PILAR SANDOVAL NOTARY PUBLIC MY COMMISSION EXPIRES AUG. 31, 20 I 9

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State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent	***	Page 1A	of 37
Name of Facility		Period Cov	ered:	From	То
Trinity Hill Care Center, LLC				10/1/2017	9/30/2018
Address of Facility 151 Hillside Avenue, Hartford, CT 06016					
Report Prepared By		Phone Nun	nber	Date	
iCare Management, LLC		860-570-2	140	2/15/2019	
Item		Total	CCNH	RHNS	Other
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	ar Ended	Page		of
=======================================			-951-1060	-	9/30/2018		2		37
Name of Facility (as shown on license)			Address (No	o. & S	treet, City, Sta	te, Zip)			
Trinity Hill Care Center, LLC			151 Hillside	Ave	nue, Hartford,	CT 0601			
	CNH		RHNS		Other		Medicare P	rovic	ler No.
License Numbers: 2222-	·C			AID	S		07-5268		
Type of Facility (Check appropriate box(es))									
Chronic and Convalescent Nursing Home only (CCNH)			t Home with lervision only		- 1/1	Other			
Type of Ownership (Check appropriate box)									
O Proprietorship O LLC O Partne	rship	0	Profit Corp.		Non-Profit Cor		Government	0	Trust
If this facility opened or closed during report year	provide	:		Date	Opened	Date Clo	sed		
Has there been any change in ownership									
or operation during this report year?		0	Yes	0	No	If "Yes,"	explain fully	7.	
Administrator								.'	
Name of Administrator					Nursing Ho				
George Kingston					Administrat	1	1327		
					License 1	10::			
Other Operators/Owners who are assistant admini	istrators	(full	or part time)	of thi		т !			
Name					License 1	NO.:			
			w						

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General Information and Questionnaire Partners/Members

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C	Report for Y 9/30/2018	ear Ended	Page of 3 37
Legal Name of Part Trinity Hill Care Center, LLC	tnership/LLC	Business 151 Hillside Av Hartford, CT 0	enue,		or Town(s) in egistered
Name of Partners/Members	Business A	ddress		Title	% Owned
V. Robert Salazar	2500 18th Street, Suite CO 80211	200, Denver,	Member		31.3
David Sebbag	245 South Benton Stre 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

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	9/30/2018		3A 37
If this facility is owned or operated as a corpo	ration, provide the	following informatio	n:	
Legal Name of Corporation	PMP-W	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				

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page of
Trinity Hill Care Center, LLC	2222-C	9/30/2018	3B 37
If this facility is owned or operated as an individua	ıl proprietorship, p	provide the following informa	ition:
	ner(s) of Facility		
	· •		
10 to			
		and the second of the second o	
			· •···
water and the state of the stat			
A. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.			
			·
			4

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Related Parties*

Name of Facility Trinity Care Center, LL		License No. 2222-C	ပ္ခု	Report for Year Ended 9/3/2018		Page 4	of 37
				The state of the s			America
		Also Provides Goods/Services to Non-	ovides		Indicate Where		Actual Cost to the
Name of Related Individual or Company	Business Address	Related Parties	Parties	Description of Goods/Services Provided	in Annual Report Page # / Line #	Cost Reported	Related Party
Bidwell Care Center,	333 Bidwell St. Manchester,	 	╟	Sharad Employees		(13,460)	13.460
Chelsea Place Care	25 Lorraine St. Hartford, CT			Shared Employees		(14.147)	14.147
Chestnut Point Care	2			United Services	10		
Chestnut Point Care	171 Main St. East Windsor,			Charad Franchises		(35 403)	35 403
Farmington Care	20 Scott Swamp Rd.			Bank Fees	16 M	*	
Farmington Care	20 Scott Swamp Rd. Farmington, CT 06032			Shared Employees	1	(13,771)	13,771
Kettle Brook Care	96 Prospect Hill Rd. East Windsor, CT 06088			Laundry Services	19 3		1
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088			Shared Employees		(3,085)	3,085
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450			Shared Employees	2	941	(941)
Trinity Hill Care	151 Hillside Ave. Hartford, CT 06106			Shared Employees	,	ı	,
Westside Care Center 1.1 C	5 G			Shared Employees	,	(5,247)	5,247
Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002			Shared Employees	,	(8,145)	8,145
Secure Care Center	60 West Street, Rocky Hill, CT 06067			Shared Employees	1	11,175	(11,175)
Touchpoints at Homecare L.LC	1838 Silas Deane Hwy, Rocky Hill, CT 06067			Shared Employees			•
Touchpoints therapy	171 Main St. East Windsor, CT. 06088			OT/PT/ST	13 5,8,10	226,524	(226,524)
Bidwell Realty, LLC	1-0			Building Lease & Rent	22,22,27 10,9,14		'
iCare Management,	341 Bidwell St. Manchester, CT 06040			Postage & Legal	16, 15 ME	7,509	(7,509)
iCare Health	341 Bidwell St. Manchester, CT 06040			Shared EEs not part of mgmt agmt	-	163,452	(163,452)
,				Management Services, Direct	20 5j	162,152	(162,152)
**	1			Management Services, Indirect	20	22,228	(22,228)
-			1	Management Services, Administrative	16 M12	414,771	(414,771)
**				Add - 1717	-		1
***************************************				The state of the s	1		1 1
1	* *			and the second s	1		
Tamandahara Canada	1				1		
All 9 Care Centers,				Share Common 401k, Pension and Insurance plans, courier, legal and various other services	grance plans, courier, 1	egal and various or	ther services
* TI 14:4:4-11	3	_					

^{*} Use additional sheets if necessary.

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

General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No		Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C		9/30/2018	5	37
If the facility is licensed as CDH and/or RCH or	provides A	IDS or TBI	services with special Medicaid	rates, costs	3
must be allocated to CCNH and RHNS as follow					
Item			Method of Allocation		
Dietary			meals served to residents		
Laundry			pounds processed	<u> </u>	
Housekeeping			square feet serviced		
		}	hours of routine care provided	-	
Nursing		1 * *	lassification, i.e., Director (or C		
		-	Nurses, Licensed Practical Nur	ses, Aides	and
		Attendants		1	
Direct Resident Care Consultants			hours of resident care provided	by EACH	
			(See listing page 13)		
Maintenance and operation of plant		Square feet			w
Property costs (depreciation)		Square feet			
Employee health and welfare		Gross salar			
Management services			e cost center involved		
All other General Administrative expenses		I	rect and Allocated Costs	1 1 1	
The preparer of this report must answer the following	owing questi	ons applica			
1. In the preparation of this Report, were all	⊙ Yes	O No	If "No," explain fully why such	h allocation	ı was
costs allocated as required?	- 103		not made.		
	- IVII				
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 cent	ers?
(e.g., Assisted Living, Home Health, Outpati	ent Services	, Adult Day	Care Services, etc.)		
	• Yes	O No	If "No," explain fully why such not made.	h allocatioi	ı 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

should not be included in these amounts.

Name of Facility			License No.	Report for Year Ended	ear Ended		Page of
Trinity Hill Care Center, LLC			2222-C	9/30/2018	TO THE PARTY OF TH		6 37
	Related * to	d * to					
	Owners,	iers,					
	Operators,	ators,				Annual	
	Officers	cers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Claimed
Accelerated Care Plus Corp.	0	0	Omnistim Electrotherapy and Omnisound Theraneutic Ultrasound Equipment	05/18/10	 yr with automatic 	10,305	10,305
MS-100,	0	0	Time Clocks and Payroll Punch Equip	06/01/10	60 months & automatic	8,953	8,953
GE Capital C/O Wells Fargo, P.O.Box 41564, Philadelpha PA 19191	0	0	Copier	03/05/14		9,298	9,298
Neopost USA Inc, 25880 Network Place, Chicago, IL	0	0	Postage Rental	04/16/13	Month to month	714	714
	0	0					
	0	0					
	0	0					
	0	0					
- called the state of the state	0	0					
	0	0					
Is a Mileage I on Book Maintained for All Leased Vehicles?	- Nessed We	hicles	O Yes		o No	Total ***	29,271

Is a Mileage Log Book Maintained for All Leased Vehicles?

^{*} Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

^{**} Attach copies of newly acquired leases.

^{***} Amount should agree to Page 22, Line 6e.

General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2018		7	37
	period covered by this report	were maintained on the following basis:		······································	
_	•	C			1
O Accrual O Cash O	Modified Cash				
Is the accounting basis for this					
1 ····	Yes	If "No," explain.			
previous period?	No				
					İ
T. J					
Independent Accounting Firm Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)			
1 O'Connor, Davies LLP		100 Great Meadow Road, Ste 401, Wether)6109	
2		100 Grout Mode, See 101, 11 mar			
3					
4					
Services Provided by This Firm (de	escribe fully)				
			\$	9,749	
1 Taxes, financial statements, accounting	g support		\$		
2			\$		
<u>3</u>			<u> </u>		
4				orania and Dec	wided
			Charge for So)VIGCG
			\$	9,749	
1	liture Portion of This Report? If Y	es, Specify Expense Classification and Line No.			
O Yes O No Legal Services Information	[13D]				
Name of Legal Firm or Independen	at Attorney		Telephone N	ıımber	
l iCare Health Management, LL	· · · · · · · · · · · · · · · · · · ·		860-570-214		
2 Starble and Harris	,0		860-678-777		
3 Durant Nichols / Robinson &	Cole, LLP		860-275-820	Ю	
		n, Murtha Cullina, Jackson Lewis))	•		
5 Starble and Harris, iCare Heal			860-678 <i>-777</i>	5 & 860-5	570-2140
Address (No. & Street, City, State,				•	
1 341 Bidwell Street, Manchest	er CT				
2 32 Main Street, Avon, CT					
3 280 Trumbull St, Hartford, C.	Γ				
4					
5 32 Main Street, Avon, CT &		ster CT			
Services Provided by This Firm (d	escribe fully)				
1 Lease and contract issues, general leg	al advice, Labor Law		\$	6,694	
2 Lease and contract issues, general leg	al advice, union funds advice		\$	188	
3 Employment law, arbitrations, contra	net negotiations		\$	92	
4 Employment Arbitrations, healthcare	law		\$	2,802	
5 Conservatorships & Collections			\$		
			Charge for S	ervices Pr	ovided
			\$	9,777	
Are These Charges Reflected in the Expen	diture Portion of This Report? If Y	es, Specify Expense Classification and Line No.			
	15E				
O Yes O No					

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

Schedule of Resident Statistics

Name of Facility			License No.	Zo.			Report for	Report for Year Ended	ğ		Page	Jo
Trinity Hill Care Center, LLC			22	2222-C			9/30/2018				8	37
					ş-4-	eriod 10/	Period 10/1 Thru 6/30	01		Period 7/1	Period 7/1 Thru 9/30	0
	Total All	Total CCNH	Total RHNS							1	Ç.	S
	Levels	Level	Level	Total Other	Iotal	CCNH	KHNS	Other	lotal	E CCINE	KHNS	Ciner
	;			ć	4	-		75	77.	7.		, ,
A. On last day of PKE VIOUS report period	144	114		30	Ŧ	114		AC .	† † † † † † † † † † † † † † † † † † †	177		2
B. On last day of THIS report period	144	114		30	144	114	WASHINGTON TO THE PARTY OF THE	30	144	114		30
2. Number of Residents												
 As of midnight of PREVIOUS report period 	140	113		27	140	113		27	143	113		30
B. As of midnight of THIS report period	138	110		28	143	113		30	138	110		28
3. Total Number of Days Care Provided During Period												
A. Medicare	1,512	1,512			1,093	1,093		- Augustus and a second	419	419		
B. Medicaid (Conn.)	49,408	38,891		10,517	36,968	29,117		7,851	12,440	9,774		2,666
C. Medicaid (other states)												
D. Private Pay	61	61			61	61						
E. State SSI for RCH												
F. Other (Specify) Insurance	39	39			18	18		NAME OF THE PARTY	21	21		
G. Total Care Days During Period (3A thru F)	51,020	40,503		10,517	38,140	30,289		7,851	12,880	10,214		2,666
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)	51,020	40,503		10,517	38,140	30,289		7,851	12,880	10,214		2,666

Schedule of Resident Statistics (Cont'd)

Name of Faci Trinity Hill C	•	tor IIC	,		ise No. 222-C				-	for Year 9/30/201			Page	of 37
тишцу гип С	are Cen	ter, LLC			222-0			i		91301201	. 0		<u> </u>	31
4. Were the	ere any o	changes	in the certified b	ed ca	pacity du	ring t	he repo	rt yea	r?	0	Yes	•	No	
If "YES"	, provid	e the fol	llowing informat	ion:										
		Place of	f Change		Ch	ange	in Bed	S		Ca	pacity Afte	r Change		
Date of	CCNH	RHNS	Other		Lost		(Jaine	i					
CI)														
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Other	Reason fo	r Change
	ļ													
	L	l												
5. If there v	vas any	change	in certified bed	capaci	ty during	the r	eport ve	ear (as	report	ed in iten	a 4 above)	provide the nun	aber of	
	•	_	90 days followir	_	-		1 ,	•	1		ĺ	•		
				-O										
			Change in Re	esider	at Dave					CC	CNH	RHNS	Oti	ner
1st chan	ge		Change in re	osidoi	n Days					<u>_</u>	21411	14145		
2nd char														
3rd char					······································									
4th chan														
6. Number	of Resid	lents an	d Rates on Septe	mber			ar							
			Medicare		Medi	caid				Se	elf-Pay		Other Stat	e Assisted
	Item		CCNH	C	CNH	RI	HNS	CC	CNH	RI	INS	Other	R.C.H.	ICF-MR
No. of R		3	2	90000000000	108	1201000220000	200000000000000000000000000000000000000	2000000000		**************	******************	28	***************************************	***************************************
Per Dier														
a. One b			469.00	<u> </u>	281.00			 				286.00		
				ļ										
c. Three		e :		1								•		
beg :	IIIS.			<u> </u>		L		1						
7. Total Ni	ımber ot	f Physica	al Therapy Treat	ments	;					TO	TAL	CCNH	RHNS	Other
		are - Par									637	506		131
B.	Medica	aid (Exc	lusive of Part B))										
			e Treatments								1,373	730		643
		torative	Treatments								1,747	1,747		
	Other		1								3,387	2,329		1,058
			Therapy Treat							100000000000000000000000000000000000000	7,144	5,312		1,833
			Therapy Treatn	ients							1.47	117		30
A.	Medica	are - Par	lusive of Part B)								147	117		30
D.			e Treatments	,						***************************************	46	20		26
			Treatments								81	81		
C.	Other		<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>								228	164		64
D.	Total S	Speech :	Therapy Treatm	ents							502	382		120
			ational Therapy	Treatr	nents									
		are - Par									282	224	200000000000000000000000000000000000000	58
В.			lusive of Part B))										_
			e Treatments							ļ	1,125	617		509
0	2. Res	iorative	Treatments								1,342 2,700	1,342 1,867		833
		Occuna	tional Therapy I	Freat	nents						5,449	4,050	<u> </u>	1,400
U.		-conput	ionai inciupy		10051613					1	J, 11 7	1 7,000	<u> </u>	1,700

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	of 37 Hours
Are time records maintained by all individuals receiving compensation? Total Cost and Hours	Hours 695
Item CCNH Hours RHNS Hours Other	695
Item	695
A. Salaries and Wages* 1. Operators/Owners (Complete also Sec. I of Schedule A1) 2. Administrator(s) (Complete also Sec. III of Schedule A1) 3. Assistant Administrator (Complete also Sec. IV of Schedule A1) 4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) 5. Dietary Service a. Head Dietitian b. Food Service Supervisor 70,501 1,651 18,306 c. Dietary Workers 418,939 21,255 108,782 6. Housekeeping Service a. Head Housekeeper	695
A. Salaries and Wages* 1. Operators/Owners (Complete also Sec. I of Schedule A1) 2. Administrator(s) (Complete also Sec. III of Schedule A1) 3. Assistant Administrator (Complete also Sec. IV of Schedule A1) 4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) 5. Dietary Service a. Head Dietitian b. Food Service Supervisor 70,501 c. Dietary Workers 418,939 21,255 108,782 6. Housekeeping Service a. Head Housekeeper	695
A. Salaries and Wages* 1. Operators/Owners (Complete also Sec. I of Schedule A1) 2. Administrator(s) (Complete also Sec. III of Schedule A1) 3. Assistant Administrator (Complete also Sec. IV of Schedule A1) 4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) 5. Dietary Service a. Head Dietitian b. Food Service Supervisor 70,501 c. Dietary Workers 418,939 21,255 108,782 6. Housekeeping Service a. Head Housekeeper	695
1. Operators/Owners (Complete also Sec, I of Schedule A1) 35,231 2. Administrator(s) (Complete also Sec, III of Schedule A1) 135,681 1,390 35,231 3. Assistant Administrator (Complete also Sec, IV of Schedule A1) 4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) 158,186 7,776 79,093 5. Dietary Service a. Head Dietitian 5. Food Service Supervisor 70,501 1,651 18,306 c. Dietary Workers 418,939 21,255 108,782 6. Housekeeping Service a. Head Housekeeper 418,939 21,255 108,782	
of Schedule A1) 2. Administrator(s) (Complete also Sec. III of Schedule A1) 135,681 1,390 35,231 3. Assistant Administrator (Complete also Sec. IV of Schedule A1) 0 Schedule A1) 0 Schedule A1) 4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) 158,186 7,776 79,093 5. Dietary Service a. Head Dietitian 1,651 18,306 b. Food Service Supervisor 70,501 1,651 18,306 c. Dietary Workers 418,939 21,255 108,782 6. Housekeeping Service a. Head Housekeeper 418,939 21,255 108,782	
2. Administrator(s) (Complete also Sec. III of Schedule A1) 135,681 1,390 35,231 3. Assistant Administrator (Complete also Sec. IV of Schedule A1) 0 Schedule A1) 0 Schedule A1) 4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) 158,186 7,776 79,093 5. Dietary Service a. Head Dietitian 1,651 18,306 b. Food Service Supervisor 70,501 1,651 18,306 c. Dietary Workers 418,939 21,255 108,782 6. Housekeeping Service 418,939 21,255 108,782	
of Schedule A1) 135,681 1,390 35,231 3. Assistant Administrator (Complete also Sec. IV of Schedule A1) 0 Schedule A1) 0 Schedule A1) 4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) 158,186 7,776 79,093 5. Dietary Service a. Head Dietitian 5 Food Service Supervisor 70,501 1,651 18,306 c. Dietary Workers 418,939 21,255 108,782 6. Housekeeping Service a. Head Housekeeper 418,939 21,255 108,782	
3. Assistant Administrator (Complete also Sec. IV of Schedule A1) 4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) 5. Dietary Service a. Head Dietitian b. Food Service Supervisor 70,501 c. Dietary Workers 418,939 21,255 108,782 6. Housekeeping Service a. Head Housekeeper	
of Schedule A1) 4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) 158,186 7,776 79,093 5. Dietary Service	3,888
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) 158,186 7,776 79,093 5. Dietary Service a. Head Dietitian b. Food Service Supervisor 70,501 1,651 18,306 c. Dietary Workers 418,939 21,255 108,782 6. Housekeeping Service a. Head Housekeeper	3,888
Operator, clerks, receptionists, etc.) 158,186 7,776 79,093	3,888
a. Head Dietitian 18,306 b. Food Service Supervisor 70,501 1,651 18,306 c. Dietary Workers 418,939 21,255 108,782 6. Housekeeping Service 20,255 20,255 20,255 20,255 a. Head Housekeeper 20,255	
b. Food Service Supervisor 70,501 1,651 18,306 c. Dietary Workers 418,939 21,255 108,782 6. Housekeeping Service a. Head Housekeeper 418,939 21,255 2	1
c. Dietary Workers 418,939 21,255 108,782 6. Housekeeping Service a. Head Housekeeper	
6. Housekeeping Service a. Head Housekeeper	435
a. Head Housekeeper	5,593
	A1000100000000000000000000000000000000
b. Other Housekeeping Workers 212,773 12,717 106,386	6,358
7. Repairs & Maintenance Services	
a. Engineer or Chief of Maintenance 34,762 1,342 17,381	671
b. Other Maintenance Workers 23,226 1,560 11,613	780
8. Laundry Service	
a. Supervisor 5. Other Laundry Workers 78,185 4,588 39,092	2,294
9. Barber and Beautician Services	2,27
10. Protective Services	
11. Accounting Services	
a. Head Accountant	
b. Other Accountants	
12. Professional Care of Residents	
a. Directors and Assistant Director of Nurses 116,092 2,060 58,046	1,030
b. RN 1. Direct Care 381,504 8,063 228,905	5,763
1. Direct Care 381,504 8,063 228,905 2. Administrative** 190,990 4,752 95,495	2,376
c. LPN	
1. Direct Care 1,057,750 35,745 247,672	9,413
2. Administrative**	
d. Aides and Attendants 1,533,100 90,655 413,650	24,856
e. Physical Therapists f. Speech Therapists	
g. Occupational Therapists	
h. Recreation Workers 76,437 5,317 65,700	1,823
i. Physicians	
1. Medical Director	
2. Utilization Review	
3. Resident Care***	
4. Other (Specify)	
j. Dentists	
k. Pharmacists	
1. Podiatrists	
m. Social Workers/Case Management 74,612 3,353 79,276	2,968
n. Marketing	
o. Other (Specify)	1.65
See Attached Schedule 84,455 4,745 21,929 A-13. Total Salary Expenditures 4,647,193 206,967 1,626,559	1,650 70,599

^{*} 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)

		CCI	NH	RĐ	INS	Othe	er
Position		\$	Hours	\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$	33,079	1,692			\$ 8,589	445
MEDICAL RECORDS SALARIES	\$	19,972	1,333			\$ 5,186	351
CENTRAL SUPPLY SALARIES	\$	31,404	1,720			\$ 8,154	860
RESPIRATORY THERAPY SALARIES	\$					S -	•
		0.000					
	3.3						
	201000 000000 201000 00000						
			- 2 19 27 17 17 18 18 18 18 18 18 18 18				
Total	8	84,455	4,745	s -	÷	\$ 21,929	1,656

Schedule of Other Fees (Page 13)

		CC	NH	R	HNS	Oth	er
Service		\$	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$	4,835	6			\$ 1,255	2
ADMISSIONS C/S LABOR	\$	36,379	802			\$ 9,446	211
CENTRAL SUPPLY CONTRACT SERVICE	\$	(25,596)	(1,522)			\$ (6,646)	(395)
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$	73,680	2,430			\$ 36,840	1,215
RESPIRATORY THERAPY CONTRACT SERVICES	\$	773	17			\$ 201	4
PHYSICAL THERAPY C/S MEDICIAD	\$	49,540	819			\$ 12,864	
SPEECH THERAPY C/S Medicaid	\$	4,987	82			\$ 1,295	
OCCUPATIONAL THERAPY C/S MEDICIAD	\$	39,986	661			\$ 10,383	
	500						
	337 3.5000						
	0000						
	10.26						
	230 1 2 25						
Total	8	184,583	3,296	\$ -		\$ 65,637	1,037

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*

									f	,
Name of Facility				License No.		Report for	Report for Year Ended		Page	oĮ
Trinity Hill Care Center, LLC				2222-C		9/30/2018			11	37
		Salary Paid	-							
Name	CCNH	RHNS	Other	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Section I - Operators/Owners								The state of the s		

Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
*****		,								

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

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

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

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

Assistant Administrators and Other Related Parties*

1 T 1 T 1 T 1 T				Y isomes Me		Donort for Voor Daded	or Dudod	,	Dage	J.
Iname of Facility (as neclised)				LICCIISC INO.		i ioi modavi	our manner		7 10 10 10 10 10 10 10 10 10 10 10 10 10	70
Trinity Hill Care Center, LLC				2222-C		9/30/2018			12	37
		Salary Paid								
				Fringe Benefits and/or Other Payments	Full Description of	Total Hours	Line Where	Name and Address of All	Total Hours	Compensation
Name	CCNH	RHINS	Other	(describe fully)	Services Rendered	Worked		Other Employment**	Worked	Received
Section III - Administrators***										
				same as employees less	•					
George Kingston	135,681		35,231	35,231 union funds	Administrator	2,086 A2	A.2			
				same as employees less						
				union funds	Administrator		A2			
				same as						
				employees less	Administrator		47			
Section IV - Assistant Administrators										
				The state of the s						
		31								

*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	License No.		Report for Y		Page	of
Trinity Hill Care Center, LLC	2222	2-C	9/30/2018		13	37
			Total Cost a	and Hours		
Item	CCNH	Hours	RHNS	Hours	Other	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	45			•	22	
2. Dentist						
3. Pharmacist	16,363	271	:		4,249	70
4. Podiatrist		100000000000000000000000000000000000000				
5. Physical Therapy						
a. Resident Care	51,479	695				312
b. Other		- 1-				
6. Social Worker	15,888	267			4,126	70
7. Recreation Worker	3,919	35+Cable		************************	1,960	35+Cable
8. Physicians						
a. Medical Director (entire facility)	39,296	959		***************************************	75,196	252
b. Utilization Review						
(Title 18 and 19 only) monthly meeting		4			£	1
c. Resident Care**						
d. Administrative Services facility						
Infection Control Committee (Quarterly meetings)					<u> </u>	
2 Pharmaceutical Committee		- 11 - 12 - 111				· · · · · · · · · · · · · · · · · · ·
(Quarterly meetings)					·	
3. Staff Development Committee						
(Once annually)						
e. Other (Specify)					4004	2.
Physician Care Contract Services	18,618	78			4,834	21
9. Speech Therapist	1665	211				(1
a. Resident Care	16,650	214				61
b. Other						
10. Occupational Therapist	27.440	501				240
a. Resident Care	37,440	501				240
b. Other						
11. Nurses and aides and attendants						
a. RN	0.100					
1. Direct Care	8,123	(650)				(1/72)
2. Administrative***	(40,158)	(658))			(173)
b. LPN						
1. Direct Care					:	
2. Administrative***	((124)	(1.60)				
c. Aides	(6,134)	(160))			
d. Other						
12. Other (Specify) See Attached Schedule	104 603	2.207			65,637	1,037
	184,583	3,296	<u> </u>		156,023	1,891
# Do not include in this section management consultants or services which	346,113	5,467		<u> </u>	1	1,071

^{*} 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	License No.		Report for Y	ear Ended	Page	of
Trinity Hill Care Center, LLC	2222-C		9/30/2018		14	37
Name & Address of Individual	Full Explanation of Service		to Owners, rs, Officers	Expla	nation of F	Relationship
Omnicare/ Pharm Scripts	Pharmacy Consulting	0	0			
Tocuhpoints Therapy	Therapy	0	0	Common Own	ership	
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver Springs, Westside Care Centers, iCare Health and iCAre Management, SecureCare Options, Home	Shared Employees	· O	0	Common Own	ership	
Care Healthdrive Physician Services	Audiology, Dental and Podiatry	0	•			
Dr Tress	HIV Med Dr	0	•			
Dr Johnson Fielding III	Asst Med Dir	0	•			
Dr Lindenberg Leslie	Med Dir	0	•			
		0	•			
		0	•			
**************************************	VANDA	0	•			
	•	0	0			
		0	0			
		0	0			
		0	0			
	1	0	0			
		0	0			
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0	0			
		0	0			
	A A A A A A A A A A A A A A A A A A A	0	0			
		0	0			
		0	0			
		0	0			

^{*} 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 N			Report for Ye	ear Ended	Page	of
Trinity Hill Care Center, LLC	2222-C		9/30/2018		15	37
Item			Total	CCNH	RHNS	Other
1. Administrative and General						
a. Employee Health & Welfare Benefits						
Workmen's Compensation		\$	28,278	22,449		5,829
2. Disability Insurance		\$				
Unemployment Insurance		\$				
4. Social Security (F.I.C.A.)		\$	548,767	435,647		113,120
5. Health Insurance		\$	1,076,421	854,533		221,888
6. Life Insurance (employees only)						
(not-owners and not-operators)		\$				
7. Pensions (Non-Discriminatory)		\$	375,701	298,256		77,445
(not-owners and not-operators)						
8. Uniform Allowance		\$				
9. Other (Specify)		\$	46,392	36,829		9,563
See Attached Schedule						
b. Personal Retirement Plans, Pensions, and		\$				
Profit Sharing Plans for Owners and						
Operators (Discriminatory)*						
•						
c. Bad Debts*		\$	(113,855)	(113,855)		
d. Accounting and Auditing		\$	9,749	7,740		2,010
e. Legal (Services should be fully described of	on Page 7)	\$	9,777	7,761		2,015
f. Insurance on Lives of Owners and		\$				
Operators (Specify)*						
g. Office Supplies		\$	18,961	12,641		6,320
h. Telephone and Cellular Phones						
1. Telephone & Pagers		\$	13,424	10,657		2,767
2. Cellular Phones		\$	1,667	1,324		344
i. Appraisal (Specify purpose and		\$				
attach copy)*						
j. Corporation Business Taxes (franchise tax	:)	\$				
k. Other Taxes (Not related to property - See						
1. Income*	<i>,</i>	\$	000.00000000000000000000000000000000000		22224000000000000000000000000000000000	***************************************
2. Other (Specify)		\$				
See Attached Schedule		•				
3. Resident Day User Fee		\$	1,072,440	851,373		221,067
Subtotal		\$		2,425,355		662,369

^{*} 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 9/30/2018

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	Other		
UNION TRAINING	\$ 36,829		\$ 9,563		
Total	\$ 36,829	\$ -	\$ 9,563		

Schedule of Other Taxes

Description	CCNH	RHNS	Other
INTERNET EXPENSES	\$ -		\$ -
Total	\$ -	\$ -	\$ -

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

Name of Facility License No.			Report for Y	ear Ended	Page	of
Trinity Hill Care Center, LLC	2222-C		9/30/2018		16	37
Item			Total	CCNH	RHNS	Other
Subtota	s Brought Forward	d:	3,087,724	2,425,355		662,369
1. Travel and Entertainment						
Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$	47	37		10
3. Gifts to Staff and Residents		\$	127	101		26
4. Employee Travel		\$	6,333	5,028		1,305
5. Education Expenses Related to Seminars and	Conventions	\$	2,604	2,067		537
6. Automobile Expense (not purchase or depre		\$	4,289	3,405		884
7. Other (Specify)		\$	840	667		173
See Attached Schedule						
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expenses)	\$	5,510	4,374		1,136
2. Advertising Telephone Directory (all such ex	cpenses)***	\$				
3. Advertising Other (Specify)***		\$	13,960	11,083		2,878
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service is		\$		010000000000000000000000000000000000000	******************************	************************
directly and not by contract or fee for service)***					
7. Postage		\$	821	652		169
* 8. Dues and Membership Fees to Professional		\$	10,127	8,039		2,088
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-	Allowable Org.***	\$				
9. Subscriptions		\$				
10. Contributions***		\$	1,529	1,214		315
See Attached Schedule						
11. Services Provided by Contract (Specify and	•	\$	132,489	88,326		44,163
Schedule C-2, Page 21 for each firm or ind	ividual)					0.00
12. Administrative Management Services**	· · · · · · · · · · · · · · · · · · ·	\$		329,272		85,499
13. Other (Specify)		\$	16,459	13,067		3,393
See Attached Schedule						00
C-14 Total Administrative & General Expenditures		\$	3,697,631	2,892,687		804,944

^{*} 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	Other
MEALS	\$ 667		\$ 173
Total Other Trayel and Entertainment	\$ 667	\$	\$ 173

Schedule of Other Advertising

Description	CCNH	RHNS	Other
COMMUNICATIONS SPECIAL EVENTS	\$ 11,083		\$ 2,878
			9.225.35.030
Total Other Advertising	\$ 11,083	\$	\$ 2,878

Schedule of Ducs

Description	CCNH	RHNS	Other
ALTERM			Production Contraction
CAHCF Dues	\$ 7,912		\$ 2,055
OTHER DUES	\$ 127		\$ 33
			\$1,1070,1930,000
	321 version (2013)		100000000000000000000000000000000000000
Total Dues	\$ 8,039	\$	\$ 2,088

Schedule of Contributions

Description	CCNH	RHNS	Other
CONTRIBUTIONS	\$ 1,214		\$ 315
Total Contributions	\$ 1,214	\$	\$ 315

Schedule of Other Administrative and General

Description	CCNH	RHNS	Other
SOCIAL SERVICE SUPPLIES	\$		\$
SOC SVC MINOR EQUIPMENT	\$		\$
ADMINISTRATIVE MINOR EQUIPMENT	\$ 1,389		\$ 361
EMPLOYEE RELATIONS	\$ 1,630		\$ 423
EMPLOYEE RELATIONS-OTHER	\$ 37		\$ 10
PERMITS & LICENSES	\$ 1,437		\$ 373
VOLUNTEER EXPENSE	\$		\$ -
BANK PEES	\$ 6,307		\$ 1,638
CMS REVISIT USER FEES	\$		\$
PENALTIES	\$		\$
LATE FEES	\$ 382		\$ 99
INTERNET EXPENSES	\$ 1,883		\$ 489
Rounding	\$		\$
	\$ 0		
	Ş. 1. S. 1. S. 1. S.		
	forest see		
Total Other Administrative and General	\$ 13,067	\$ -	\$ 3,393

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Trinity Hill Care Center, LLC	2222-C	9/30/2018	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	414,771	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	162,152	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	22,228	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)

NI	CT2 - 112			u rage s)	Report for Y	Toon Endod	Page	of
	ne of Facility ity Hill Care Center, LLC		Licens	2222-C	9/30/2018		18	37
1110	ity Hii Care Center, LLC				3/30/2010		10	
	Item			Total	CCNH	RHNS	C	Other
2.	Dietary							
	a. In-House Preparation & Service							
	1. Raw Food		9	291,751	231,611			60,140
	2. Non-Food Supplies		9		30,723			7,978
	3. Other (Specify)		9	16,018	12,716			3,302
	DIETARY SUPPLEMENTS							
	b. Purchased Services (by contract other		9	67	53			14
	than through Management Services)							
	(Complete Schedule C-2 att. Page 21)							
	c. Other (Specify)		9	5,748	4,563			1,185
	DIETARY MINOR EQUIPMENT							
2D.	Total Dietary Expenditures $(2a+b+c+d)$		\$	352,285	279,666			72,618
2F.	Dietary Questionnaire	1		Total	CCNH	RHNS	(Other
G.	Resident Meals: Total no. of meals served per			419	419			
H.	Is cost of employee meals included in 2E?	0	Yes	<u> </u>	No			
I.	Did you receive revenue from employees?	0	Yes	•	No	If yes, specify amt.		
J.	Where is the revenue received reported in the	Cost	Repor	t? (Page/Line I	tem)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	0	Yes	•	No	If yes, specify cost.		
L.	Is any revenue collected from these people?	0	Yes	•	No	If yes, specify amt.		
M.	Where is the revenue received reported in the	Cost	Repor	t? (Page/Line I	tem)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?		Yes		No	If yes, specify cost.		
O.	Is any revenue collected from employees?	0	Yes	0	No	If yes, specify amt.		
P.	Where is the revenue received reported in the	Cost	Repor	t? (Page/Line I	tem)			
							······································	

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

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

Name of Facility		License		Report for Y	ear Ended	Page of
Trin	ity Hill Care Center, LLC	2	222-C	9/30/2018		19 37
	Item		Total	CCNH	RHNS	Other
3.	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies,	Lbs.	275	183		92
	gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	2/3	183		92
	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. \$			1.11.41.41	
	4. Repair and/or purchase of linens.***	Lbs.				
	b. Purchased Services (by contract other	Amt. \$	53,121	35,414		17,707
	than through Management Services) (Complete Schedule C-2 att. Page 21)			ŕ		
	c. Other (Specify) LAUNDRY MINOR EQUIPMENT	\$				149
3D.	Total Laundry Expenditures (3a+b+c)	\$	53,843	35,896		17,948
3F. G.	Laundry Questionnaire Is cost of employee laundry included in 3E?) Yes	•	No	If yes, specify cost.	Andrew Miller (1994) William Co.
H.	Did you receive revenue from employees?) Yes	•	No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cos	t Report?		(Page/Line	Item)	
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?) Yes	•	No	If yes, specify cost.	
K.	*) Yes	•	No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cos			(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.

^{***} 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)

Nan	ne of Facility	License No.	Rep	ort for Year E	nded	Page	of
Trin	ity Hill Care Center, LLC	2222-C		9/30/2018		20	37
	Item	T		Total	CCNH	RHNS	Other
4.	Housekeeping	Sq. Ft. Serviced					
	a. In-House Care	by Personnel					
	1. Supplies - Cleaning (Mops,	Amt.	\$	27,802	18,535		9,267
<u> </u>	pails, brooms, etc.)						
	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att.	Amt,	\$	40,113	26,742		13,371
	Page 21)						
	C. Other (Specify)		\$				
	HOUSEKEEPING MINOR EQUI	PMENT					
4D.	Total Housekeeping Expenditures (4a +	b+c)	\$	67,916	45,277		22,639
5.	Resident Care (Supplies)**						
	a. Prescription Drugs***						
	1. Own Pharmacy		\$		000340040040040040444444444444444444444	10000000000000000000000000000000000000	
	2. Purchased from		\$	89,099	89,099		
	OMNICARE PHARMACY						
	b. Medicine Cabinet Drugs		\$	4,839	3,842		997
	c. Medical and Therapeutic Supplies		\$	88,216	70,032		18,184
	d. Ambulance/Limousine***		\$				
	e. Oxygen						
	1. For Emergency Use		\$	1,121	1,121	***************************************	<u> </u>
	2. Other***		\$				
	f. X-rays and Related Radiological		\$	1,259	1,259		
	Procedures***						
	g. Dental (Not dentists who should be inc.	luded under	\$				
	salaries or fees)		•				
	h. Laboratory***		\$	5,397	5,397		
 	i. Recreation		\$	- , *	- ,		
	i. Direct Management Services*		\$				
	k. Indirect Management Services*		\$				
\vdash	Other (Specify)****		<u> </u>		238,497		76,553
	See Attached Schedule		4	215,000			
5M	Total Resident Care Expenditures (5a - 5	i)	\$	504,981	409,245		95,735
V 1 V 1.	Tour House Care Dispermentes (Ja - 5	<i>'</i> J <i>)</i>	Ψ	1 201,701	1 37,213		1 ,,,,,,,,

^{*} 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	(Other
NURSING ADMIN SUPPLIES	\$	223		\$	58
NURSING MINOR EQUIP	\$	5,837		\$	1,516
MEDICAL RECORDS SUPPLIES	\$	(1,174)		\$	(305)
MEDICAL RECORDS MINOR EQUIPMENT	\$			\$	42.00
MANAGEMENT ALLOCATIONS - DIRECT	\$	128,727		\$	33,425
NON-COVERED PPS DR. VISITS	\$	456		S	118
RESIDENT CARE SUPPLIES	\$			\$	
CENTRAL SUPPLY MINOR EQUIPMENT	\$	11,048		\$	2,869
PERSONAL CARE SUPPLIES	\$	1,940		\$	504
INCONTINENCY SUPPLIES	\$	5,120		\$	1,329
VACCINE RESIDENTS	\$	1,214	110, 100	\$	
PATIENT SPECIAL NEEDS	\$	138		\$	
PHYSICAL THERAPY SUPPLIES	\$			\$	
PHYSICAL THERAPY EQUIPMENT RENT	\$			\$	
PHYSICAL THERAPY MINOR EQUIPMENT	\$			\$	
OCCUPATIONAL THERAPY SUPPLIES	-8	2		\$	
OCCUPATIONAL THERAPY EQUIP RENTAL	\$			\$	H. S.
OCCUPATIONAL THERAPY MINOR EQUIP	\$			\$	-
SPEECH THERAPY SUPPLIES	\$			\$	5 (2) (3) (3) (3) 5 (3) (3)
SPEECH THERAPY EQUIPMENT RENT	\$			\$	
SPEECH THERAPY MINOR EQUIPMENT	\$			\$	7
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$	20,627		\$	10,314
EQUIPMENT RENTAL: AIDS UNIT	\$			\$	- -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$	2,263		\$	- ·
PEN THERAPY FOOD NOT BILLABLE TO PART B	s	144		\$	7
HI LOW BED RENTAL & MATTRESSES	\$			\$	¥
IV THERAPY SUPPLIES	\$	26,198		\$	13,099
IV THERAPY CONTRACT SERVICE	\$	e e		\$	2
MEDICAL WASTE CONTRACT SERVICE	\$	1,291		\$	645
ACTIVITIES SUPPLIES	\$	4,960		\$	2,480
ACTIVITIES MINOR EQUIPMENT	\$	4,235		\$	2,118
MANAGEMENT ALLOCATION - INDIRECT	\$	17,646		\$	4,582
ADMISSIONS SUPPLIES	\$	- 6. 6 .		\$	
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$	7,604		\$	3,802
STRIKE COSTS NON REIMBURSABLE	\$			\$	
				. C. C. C.	
Total Other Resident Care	\$	238,497	\$ -	\$	76,553

State of Connecticut
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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 9/30/2018				Page 21	of 37
		Related ** to Owners, Operators, Officers	o Owners, Officers		•		Total Cost/	Total Cost/Page Ref.***	y.	
Name of Individual or Company	Address	Yes	No.	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHINS	Other	P	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	0	•	VENDOR	Housekeeping Services	40,113			- 0	49
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	0	0	VENDOR	Laundry Services	53,121			19	36
Eagle Elevator		0	•	VENDOR	Elevator Contract	6,126			22	6F
Bioserve, Inc.		0	•	VENDOR	Medical Waste	1,936			22	6F
Brightview Landscapes LLC/Stevan Infante		0	•	VENDOR	Snow Removal/Landscaping	13,590			22	6F
All Waste Inc		0	•	VENDOR	Trash removal	36,404			22	6F
American HealthTech		0	•	VENDOR	Software Maintenance Contract	11,335			16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	0	0	VENDOR	Payroll Services	48,945			16	MII
National Datacare Corp		0	•	VENDOR	Resident Trust Software	3,100			16	M11
Prime Care Technologuy services		0	0	VENDOR	Computer Consulting Services	30,519			16	MII
Priotiry Express		0	0	VENDOR	Courier Services	3,235			16	Mii
Point Right Inc		0	•	VENDOR	Nursing Software	4,680			16	M11
Aron Security Inc		0	0	VENDOR	Security Contract Services	85,696			22 6F	6F
		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 Y	ear Ended		Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2018			22	37
Item		Total	CCNH	RHNS	0	ther
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	37,536	25,024			12,512
b. Heat	\$	50,480	33,654			16,827
c. Light & Power	\$	80,339	53,560			26,780
d. Water	\$	60,126	40,084			20,042
e. Equipment Lease (Provide detail on p	page 6) \$	29,271	23,237			6,034
f. Other (itemize)	\$	188,352	125,568			62,784
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a	- 6f) \$	446,104	301,126			144,978
7. Depreciation (complete schedule page 23	*)					
a. Land Improvements	\$					
b. Building & Building Improvements	\$	23,564	18,707			4,857
c. Non-Movable Equipment	\$	459	364			95
d. Movable Equipment	\$	52,459	41,645			10,814
*7e. Total Depreciation Costs (7a+b+c+c	1) \$	76,481	60,716			15,765
8. Amortization (Complete att. Schedule Pa	ge 24*)					
a. Organization Expense	\$					
b. Mortgage Expense	\$				ļ	
c. Leasehold Improvements	\$	40,424	32,091			8,333
d. Other (Specify)	\$					
*8e. Total Amortization Costs (8a+b+c+c	d) \$	40,424	32,091			8,333
9. Rental payments on leased real property l	ess					
real estate taxes included in item 10b	\$	1,329,175	1,055,186			273,989
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	278,887	185,925			92,962
c. Personal property taxes	\$	31,014	20,676			10,338
11. Total Property Expenses (7e + 8e + 9 +	10) \$	1,755,981	1,354,593		<u> </u>	401,388

^{*} 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	Other
PLANT SUPPLIES	\$ 3,729		\$ 1,865
PLANT CONTRACT SERVICE LABOR	\$ 6,496		\$ 3,248
ELEVATOR CONTRACT SERVICE	\$ 4,084		\$ 2,042
FIRE/SPRINKLER CONTRACT SERVICE	\$ 5,169		\$ 2,585
LANDSCAPING CONTRACT SERVICE	\$ 4,438		\$ 2,219
SNOW REMOVAL CONTRACT SERVICE	\$ 4,610		\$ 2,305
TRASH REMOVAL CONTRACT SERVICE	\$ 24,269		\$ 12,135
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ 57,130		\$ 28,565
PLANT CONTRACT SERVICE OTHER	\$ 6,838		\$ 3,419
PLANT MINOR EQUIPMENT	\$ 6,350		\$ 3,175
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ 2,453		\$ 1,226
RENT OTHER	\$ -		\$ -
Total Other Repairs and Maintenance	\$ 125,568	\$ -	\$ 62,784

State of Connecticut

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Depreciation Schedule

			Poprocioni ponomio						
Name of Facility		License No.).		Report for Year Ended	habed		Page	of
Trinity Hill Care Center, LLC		2	2222-C	AMARITA TOTAL	9/30/2018			23	37
		Historical Cost	1 Less		Accumulated Depreciation to	Method of			
ş		Exclusive of		Cost to Be	Beginning of	Computing	Useful	Depreciation	7.64.1
Property Item		Land	value	Depreciated	rears Operations	Depreciation	Lile	ior inis rear	LOGAIS
A. Land Improvements								*****	
 Acquired prior to this report period 									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	hedule)								
A-4. Subtotal									
B. Building and Building Improvements									
1. Acquired prior to this report period		394,955	55	394,955	61,626	AUX BARRA		23,564	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	hedule)								
B-4. Subtotal									23,564
C. Non-Movable Equipment									
1. Acquired prior to this report period		7,990	06	7,990	5,391			459	
2. Disposals (attach schedule)	Amiden de marcon de la companya de l								
3. Acquired during this report period (attach schedule)	hedule)								
C-4. Subtotal	AMALIANCE CONTRACTOR C								459
Is a lo	Is a mileage Date of	Historical	I		Accumulated				
main	19 A		Less		Depreciation to	Method of			
Vec	Month	Exclusive of	of Salvage	Cost to Be	Beginning of Year's Operations	Computing Depreciation	Useful Life	Depreciation for This Year	Totals
D. Movable Equipment	THEOREM CAN	-		i i	I				
1. Motor Vehicles (Specify name, model								•	
and year of each vehicle)									
a. Van Repair: Hillside Automotive Celx		9,580	80	13,085	7,595			1,186	
b. Van Repair. Hillside Automotive Cel	8 20	2018 3,505	05						
C.									
d.									
2. Movable Equipment									
a. Acquired prior to this report period		494,456	56	494,456	320,176			43,716	
b. Disposals (attach schedule)									
c. Acquired during this report period									
(attach schedule)		84,988	88					7,557	
D-3. Subtotal								1	52,459
F. Total Denreciation									76.481

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
otal additions for	Land Improvements	\$ -		\$ -
Deletions:				
			53 (434); 5 (95) (25);	
		io in recession		
			200000000000000000000000000000000000000	
otal deletions for I	Land Improvements	\$ -		\$ -

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
Cotal additions for	Building Improvements	\$ -		s -
Deletions:				
93. (S. 68. a) (6. a)		(1)		
Total deletions for	Building Improvements	\$ -		\$ -

^{*}Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

A	Described to a CTA con	654	Useful	D
Acquisition Date Additions:	Description of Item	Cost	Life	Depreciation
ANGUIDIE.		104.086165.104.096		
			101101111111111111111111111111111111111	
Total additions for	Non-Movable Equipment	\$ -		\$ -
Deletions:				
		11.166.001.00.000		
Total deletions for l	Non-Movable Equipment	\$ -	201200000000000000000000000000000000000	\$ -

^{*}Ties to Page 23, Line C3

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

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

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

Useful

Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
10/4/2017	Bariatric Floor Lift; Direct Supply	\$ 3,058	120	\$ 280
11/1/2017	Beds & Mattress: Medline	\$ 15,269	60	\$ 2,545
12/21/2017	Beds & Mattress: Medline	\$ 16,728	60	\$ 2,509
1/22/2018	Convection Oven: HPC Foodservice	\$ 3,865	120	\$ 258
6/28/2018	Beds & Mattress; Medline	\$ 14,885	60	\$ 744
8/10/2018	Privacy Curtains: Direct Supply	\$ 6,224	60	\$ 104
9/1/2018	Mattress - Medline	\$ 2,614	60	÷
6/22/2018	Dining RM Project(Chairs): Direct Supply	\$ 22,345	60	\$ 1,117
Total additions for	r Movable Equipment	\$ 84,988		\$ 7,557
Deletions:				
50 800 000 00 6 100				
Total deletions for	Movable Equipment	\$ -		\$ -

^{*}Ties to Page 23, Line D2c

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
12/15/2017	Replace Nurse Call System: S&S Wired	\$ 27,757	120	\$ 2,082
12/20/2017	Door Locksets: Accurate Comm. Door	\$ 11,894	60	\$ 1,784
2/2/2018	Metal Doors: Accurate Comm. Door	\$ 7,849	240	\$ 229
2/14/2018	Celling Panel: H.D. Supply	\$ 3,031	120	\$ 177
1/21/2018	Wiring: Precision Electrical	\$ 2,945	240	\$ 98
7/31/2018	FM Wanderguard Systme: S&S Wired System	\$ 8,231	60	\$ 274
6/22/2018	Dining Room Project; Multiple Vendors	\$ 58,069	180	\$ 968
CANS ATT QUINDESS				
Total additions fo	r Leaschold Improvement	\$ 119,776		\$ 5,612
Deletions:				
Total deletions for	Leasehold Improvement	\$		\$ -

^{*}Ties to Page 24, Line C3

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

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

State of Connecticut

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Amortization Schedule*

Name of Facility		License No.		Report for Year Ended	r Ended		Page	jo
Trinity Hill Care Center, LLC		2222-C		9/30/2018			24	37
				Accumulated				
	Date of			Amort. to				*****
	Acquisition			Beginning of	Basis for			
		Length of	Cost to Be	Year's	Computing	Rate	Amortization	
Item	Month Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A. Organization Expense								
1.								
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	1		696,856	446,204			34,812	
2. Disposals (attach schedule)								
3. Acquired during this report period								
(attach schedule)			119,776				5,612	
C-4. Subtotal							•	40,424
D. Total Amortization								40,424
* Ctroinst line mothed minet be need								

* 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

1	ense No.	Report for Year En	ded		Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2018			25	37
11. Property Questionnaire						
Part A						
Is the property either owned by the Fac	cility) Yes	•		If "Yes," complete	
or leased from a Related Party?*		, 1 cs	O	140	If "No," complete	e Part C.
*If any owner or operator of this facility is						
business association to any person or orga related party transaction.	nization from whom	buildings are leased, then i	t is considered a			
Description		Total				
Date Land Purchased		04/01/99				
Date Structure Completed	W-V					
3. If NOT Original Owner, Date of I	Purchase	04/01/99				
Date of Initial Licensure		04/01/99				
5. Total Licensed Bed Capacity		144				
6. Square Footage						
7. Acquisition Cost						
a. Land b. Building						
		1 at Martino co	2nd Mortgage	2rd Mortaga	4th Mortg	1000
Part B - Owner and Related Parties 1. Financing		1st Mortgage	Ziid Mortgage	31th Mortgage	411 1010112	gage
a. Type of Financing (e.g., fixed,	variable)					
b. Date Mortgage Obtained	Tarracio					
c. Interest Rate for the Cost Year						
d. Term of Mortgage (number of	years)					
e. Amount of Principal Borrowed						
f. Principal balance outstanding						*************************
Complete if Mortgage was Refi	nanced					
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	veare)					
k. Amount of Principal Borrowed						
Principal Outstanding on Note						
Part C - Arms-Length Leases fo		Improvements Onl	y			
Name and Address of Lessor		operty Leased	Date of Lease		Annual Amoun	t of Lease
Summit Trinity Hill SNF, LLC	151 Hills	ide Ave, Hartford,	08/09/17	15 year with 2	\$1,368,000 yr 1	
	СТ					

i .	ŀ		Ī	l	.1	

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

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

Name of Facility	icense No.		Report for Yea	r Ended		Page	of
Trinity Hill Care Center, LLC	2222-C		9/30/2018			26	37
Item			Total	CCNH	RHNS	0	ther
12. Interest							
A. Building, Land Improveme	nt & Non-Movable		1				
Equipment 1. First Mortgage		\$	I				
Name of Lender		Rate]				
Twine of Bondon		rate					
Address of Lender							
2. Second Mortgage Name of Lender		\$ Rate					
Name of Lenger		Rate					
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender			-				
Than the state of							
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender							
Address of Lender							
B. CHEFA Loan Information			-				
Original Loan Amount		\$					
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expen	se					-possosososos	
12 B7. Total Building Interest Expen		\$				1	
12 Di. 10th Durang Interest Exper	55 (III 1II · D3)	Ψ		v Subtotals	formand to r	L oxt nag	.)

(Carry Subtotals forward to next page)

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

Name of Facility	License No.			Ţ	Report for Ye	ear Ended		Page	of
Trinity Hill Care Center, LLC	2222-0	3		ŧ	9/30/2018	· · · · · · · · · · · · · · · · · · ·		27	37
				T					
. It	em				Total	CCNH	RHNS	Otl	her
		ls Brot	ight Forward	<u>:</u>				······································	
12. C. Movable Equipment				\top					
1. Automotive Equipme	ent		9	\$					
A. Item		Rate	Amount						
				_					
Lender									
				_					
Address of Lender									
				_					
2. Other (Specify)		<u> </u>		\$					
A. Item		Rate	Amount						
Lender	1			-					
Lender									
Address of Lender				-					
Tradices of London									
B. Item		Rate	Amount	-					
2, 1,011	1		1 11110						
Lender									
Address of Lender									
12. C. 3. Total Movable Equip	pment Interest								
Expense (C1 + 2)				\$					
12. D. Other Interest Expense	(Specify)		;	\$	4,670	3,707		****************	963
INTEREST									
	(1000) 1000	. 105		.		2.505			0.64
13. Total All Interest Expense	(12B7 + 12C3)	+ 12D) 1	\$	4,670	3,707			963
14. Insurance	T!13!:1N		,	٦	(020	5 400			1,410
a. Insurance on Property (b. Insurance on Automobil				<u>\$ </u> \$	6,838 4,220	5,428 3,350		<u> </u>	870
c. Insurance other than Pro		ified at		Ψ.	4,220	3,330		<u> </u>	670
1. Umbrella (Blanket C		mou at		\$	48,456	32,304			16,152
2. Fire and Extended C				\$.0,100	2,231		†	,
3. Other (Specify)				\$	3,973	3,154			819
Other insurance, cris	me								
14d. Total Insurance Expenditu	ires (14a + b +	c)		\$	63,487	44,236			19,250
15. Total All Expenditures (A-	13 thru C-14)			\$	13,722,784	10,359,740		3	,363,045

D. Adjustments to Statement of Expenditures

	e of Fa			Lie	cense No.	Report for Ye	ar Ended	Page		of
Trini	ty Hill	Care	Center, LLC		2222-C	9/30/2018		28		37
					Total					
Item	Page	Line			Amount of					
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	(Other	
Page	10 - S	alari	es and Wages							
1.			Outpatient Service Costs	\$						
2.			Salaries not related to Resident Care	\$						
3,			Occupational Therapy	\$						
4.			Other - See attached Schedule	\$						
Page	13 - I	Profes	sional Fees							
5.			Resident Care Physicians **	\$						
6.			Occupational Therapy	\$						
7.			Other - See attached Schedule	\$						
Page	s 15 &	2 16 -	Administrative and General							
8,			Discriminatory Benefits	\$						
9.			Bad Debts	\$		(113,855)				
10.			Accounting	\$						
10a.			Legal	\$						
11.			Telephone	\$	<u> </u>					
12.			Cellular Telephone	\$						
13.			Life insurance premiums on the life							
•			of Owners, Partners, Operators	\$	poccessoros	***************************************		***********	200000000000000000000000000000000000000	copositipos:
14.			Gifts, flowers and coffee shops	\$					- "	
15.	-		Education expenditures to colleges or							
			universities for tuition and related costs							
			for owners and employees	\$			***************************************	P	00000000000	3000000000
16.			Travel for purposes of attending							
, 0,			conferences or seminars outside the							
			continental U.S. Other out-of-state							
		1	travel in excess of one representative	\$				*************	200000000000000000000000000000000000000	400040000
17.			Automobile Expense (e.g. personal use)	\$						
18.			Unallowable Advertising *	_ \$		11,083			2	,878
19.			Income Tax / Corporate Business Tax	 \$						· · · · · · · · · · · · · · · · · · ·
20.			Fund Raising / Contributions	\$						
21.			Unallowable Management Fees	\$				 		
22.	 	 	Barber and Beauty	\$				1		
23.			Other - See attached Schedule	- \$		26,399		1		5,855
	18 ~ 1	Dietar	y Expenditures		33,===					
24.	1	1	Meals to employees, guests and others							
۷۱,			who are not residents	\$				880000000000000000000000000000000000000	\$\$\$\$\$\$\$\$\$\$\$\$\$	(000000000)
Paga	19	Laund	lry Expenditures	ų,						
25.	1/-/	Juant	Laundry services to employees, guests							
43.			and others who are not residents	\$				100000000000000000000000000000000000000	300000000000000000000000000000000000000	*************
Done	20	House	ekeeping Expenditures	4	<u> </u>	1				
	- 20 - 1	Louse	Housekeeping services to employees, guests		 	1	 			
26.			and others who are not residents	\$,			**************************************		
	<u></u>	<u> </u>	Subtotal (Items 1 - 26			(76,373)			. (7,732
			Subtotal (nems 1 - 20	<i>)</i> 3	<u> </u>	arry Subtotal	····	<u></u>		,,,,,,,

^{*} 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

		Description	CCNH	RHNS	Other
	0.0000.0000				
otal Other	Salaries A	Adjustment	\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
	200000000000000000000000000000000000000				
2.5 (6.8)					
Total Othe	r Fees Adj	ustments	\$ -	\$ -	s -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
16a		PENALTIES	\$ -		\$ -
16a		LATE FEES	\$ 382		\$ 99
16a		PRIOR PERIOD EXPENSES			
		rounding	\$ 1		
		Provider User Fee for Medicare days	\$ 26,016		\$ 6,755
Total Othe	r A&G Ac	ljustments	\$ 26,399	\$ -	\$ 6,855

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

λI _α :	of Fa		D. Adjustments to Stateme		or Expend ense No.	Report for Y		Page	of
		•		LIC	2222-C	9/30/2018	cai Enucu	29	37
rinit	y Hill	Care	Center, LLC			9/30/2018		29	37
Ψ.	~	т '			Total				
•	Page		Y. 75		Amount of	COMIT	DING	,	\th a
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	•	Other 0.702
	20 5		Subtotals Brought Forward	- \$	(66,641)	(76,373)			9,732
	20 - K		nt Care Supplies***						
27.			Prescription Drugs	\$					
28.			Ambulance/Limousine	\$					
29.			X-rays, etc	\$	1,259	1,259		ļ	
30.			Laboratory	\$	5,397	5,397			
31.		:	Medical Supplies	\$					
32.			Oxygen (non emergency)	\$					
33.			Occupational Therapy	\$					
34.			Other - See Attached Schedule	\$	575	456			118
Page	22 - N	<i>Iainta</i>	enance and Property		5 45 5 46 19 45				
35.			Excess Movable Equipment Depreciation					100 100 100	
			See Attached Schedule	\$					
36.			Depreciation on Unallowable						
			Motor Vehicles	\$	The second desired the delication of the second	and the second s	and the County Server of the S		
37.			Unallowable Property and Real						
			Estate Taxes	\$			Commence of the second		Carlotter a Carlotte (Backer) person in process
38.			Rental of Building Space or Rooms	\$					
39.			Other - See Attached Schedule	\$					
Page	27 - I	nsura	ince						
40.			Mortgage Insurance	\$					
41.			Property Insurance	\$					
Othe	r - Mis	scella	neous						
42.			Other - Indirect	\$					
43.			Interest Income on Account Rec.	\$					
44.			Other - Miscellaneous Administrative	\$					
45.			Management Fees Direct	\$					
46.			Management Fees Indirect	\$					
47.			Other - Direct	\$					
	For Pr	ofit P	Providers Only						
48.	<i>5. 11</i>	- J - F - A	Building/Non Movable Eq. Depreciation				Control of the	44.000	
10,			Unallowable Building Interest -						
			See Attached Schedule	\$					
10	Total	Amo	unt of Decrease (Items 1 - 48)	\$		(69,261)			9,851

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	Other
20	5J		456.27		118.48
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)			
	rici eco Serves				
100.00	0.00				
Total Othe	r Ancillar	y Costs	\$ 456	\$ -	\$ 118

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	Other
40 Selection					
3 100 00 00					
Total Exce	ss Movabl	e Equipment Depreciation	\$ -	s -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	Other
2000 1000 1000 1000 1000 1000 1000 1000	staat saar garaanga. Garaatsa maasa gaa				
	00, 00,000, 000				
Total Othe	r Propert	y Adjustments	\$ -	\$ -	S -

Page Ref	Line Ref	Description	CCNH	RHNS	Other
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)	\$ -		
2.78.788.78					
Total Othe	r Adjustm	ents	\$ +	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	Other
7 900 200 000	.1674.05				
1000000					
	0.0000000000000000000000000000000000000				
	100				
Total Unal	Iowable Bi	allding Interest	\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility License No.	CII	Report for Y	ear Ended		Page	of
Trinity Hill Care Center, LLC 2222-C		9/30/2018	ear Enged		30	1 37
		3,00,2010				1 5,
Item		Total	CCNH	RHNS	0	ther
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$	14,133,925	10,990,493			3,143,432
b. Medicaid Room and Board Contractual Allowance **	\$	17,100,720	10,770,475		·	7,140,402
2. a. Medicaid (All other states)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (all inclusive)	\$	732,558	579,942			152,616
b. Medicare Room and Board Contractual Allowance **	\$	152,550	217,712			102,010
4. a. Private-Pay Residents and Other	\$	(19,883)	(19,883)			
b. Private-Pay Room and Board Contractual Allowance **	\$	(15,000)	(12,000)			
II. Other Resident Revenue	Ψ;					
1. a. Prescription Drugs - Medicare	\$	58,985	58,985			
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(58,985)	(58,985)			
c. Prescription Drugs - Non-Medicare	\$	20,638	18,305			2,333
d. Prescription Drugs - Non-Medicare Contractual Allowance **	- \$	(20,638)	(18,305)			(2,333)
2. a. Medical Supplies - Medicare	<u>ф</u> \$	1,708	1,708			(2,333)
b. Medical Supplies - Medicare Contractual Allowance **	 \$	(1,708)				
c. Medical Supplies - Non-Medicare	\$		(1,708)			2 /11
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$	13,815 (13,815)	10,404 (10,404)			3,411
3. a. Physical Therapy - Medicare	\$					(3,411)
b. Physical Therapy - Medicare Contractual Allowance **	\$	91,565 (69,991)	91,565 (69,991)	<u> </u>		
c. Physical Therapy - Non-Medicare c. Physical Therapy - Non-Medicare	<u></u> \$					10.066
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$	120,650	100,784 (100,784)			19,866
4. a. Speech Therapy - Medicare 4. a. Speech Therapy - Medicare	<u></u> \$	(120,650)	31,560			(19,866)
b. Speech Therapy - Medicare Contractual Allowance **	<u> </u>	31,560				
c. Speech Therapy - Non-Medicare	<u>э</u> \$	(18,482)	(18,482)			1.420
d. Speech Therapy - Non-Medicare Contractual Allowance **	_ \$	13,223 (13,223)	11,784			1,439 (1,439)
5. a. Occupational Therapy - Medicare	<u>\$</u>	` `	(11,784)			(1,439)
b. Occupational Therapy - Medicare Contractual Allowance **	<u>\$</u>	74,152 (64,384)	74,152			
c. Occupational Therapy - Non-Medicare c. Occupational Therapy - Non-Medicare	<u>\$</u>		(64,384) 86,401			14,524
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(101,911)	(87,387)	<u></u>		(14,524)
6. a. Other (Specify) - Medicare	\$		(61,367)			(14,324)
b. Other (Specify) - Non-Medicare	\$	8,517	8,517		<u> </u>	
III. Total Resident Revenue (Section I. thru Section II.)	\$		11,602,503			3,296,049
IV. Other Revenue*	Ψ	14,898,332	11,002,303			3,290,049
	ď					
Meals sold to guests, employees & others Destal of constants and provide the second	\$					
2. Rental of rooms to non-residents	\$					
Telephone Rental of Television and Cable Services	\$			<u> </u>		
Kental of Television and Cable Services Interest Income (Specify)	\$ \$				 	
6. Private Duty Nurses' Fees	<u> </u>				-	
	<u> </u>				 	
7. Barber, Coffee, Beauty and Gift shops 8. Other (Specify)	<u>3</u> \$	401	601			
	<u>\$</u>	601			-	
V. Total Other Revenue (1 thru 8)		601	601	1	-	
VI. Total All Revenue (III+V)	\$	14,899,153	11,603,104			3,296,049

^{*} 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	Other
	Lab Medicare	S -		
	Lab Medicare CA	\$	aren errenia er	A DE BARRETARA
W. 988	Oxygen Medicare	\$ 48		0.000,000
	Oxygen Medicare CA	\$ (48)		
	Equipment rental	\$,		电子记录程序
 Introduce 	Equipment rental CA	\$		
nji siliyin	Pen Therapy	\$	in see sont his	utrace trace
virigen.	Pen Therapy CA	\$	sidesiasu:	ukty-Byan
	Therapy Beds Medicare	\$		
	Therapy Beds Medicare CA	\$		
11.000	Radiology Medicare	\$ 1,317		MAD THE STREET
7.30	Radiology Medicare CA	\$ (1,317)		
	IV Therapy	\$ 20,101		
	IV Therapy CA	\$ (20,101)	60,000,000	100000
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose testing	\$		E
940498	Glucose testing CA	\$		31/301/2011
	Outpatient therapy Medicare	\$		\$1.00 to \$1.
		Alexander of		
Total Other	er Resident Revenue - Medicare	3	\$.	5

Schedule of Other Non-Medicare Resident Revenue

Related Exp

nge Ref	Description	CONH	RHNS	Other
13,7780	Lab	Resident States	17387258818883318	ación de com
	Lab.CA	000000000		V-5-000
14.74	Oxygen	\$ 270		\$]2
	Oxygen CA	\$ (270)		\$ (12
	Equipment rental	S		
2000	Equipment rental CIA	\$	<u>zaden kaŭ</u>	
Problem Proble	Pen Therapy	\$		
	Pen Therapy CA	\$		
	Therapy Beds	\$	Jephin Message	
	Therapy Beds CA	\$.		FEET 4, D. C.
	Radiology	\$		John Stra
, S S.	Radiology CA	\$		J. S. 1601.
vi Vizi	Medical Transportation	\$		
$\{X_i\}_{i=1}^{N}$	Medical Transportation CA	\$		
(1949S)	Glucose Testing	\$		reigiroergi,
	Gluçose Testing CA	S	200000	
	IV therapy.	\$ 40,867		\$ 5,037
	IV therapy CA	\$ (40,867)		\$ (5,037
	Fix shot revenue	\$	PROBLEMS	
	Outpatient therapy	\$	and and and	40.000000000000000000000000000000000000
	prior period revenue	\$ 8,675		
13.00				
	rounding	\$ (158)	i di la discissione de	000-0000-000
43000				18,30,000
otal Oth	er Resident Revenue	\$ 8,517	\$	\$

Interest Income

Account

Page Ref Account	Balance	CCNH	RHNS	Other
INTEREST INCOME		S		
	4000000000			V 55 78 9438
	3 14 20 X X 17 2		iganika Pelis	A78 9854623.
Total Interest Income		\$	5 -	\$
		1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	Other
	MEALS	\$ -	Pakakana.	
	TRLEVISION INCOME	S		
r telephonesis Telephonesis	CONCESSIONS / VENDING INCOME	\$		et et attillelete
18.87,286	RESIDENT LATE FEE REVENUE	\$		
- CHANGE 9	RESIDENT ATTORNEY FEE REVENUE	s -		10.910,71972.0
Y (4)34.	TELEPHONE INCOME	\$		
	OTHER INCOME	\$ 601	At A Milleria	
	OPTUM DIVIDENDS REVENUE	\$		
(C) (C)				300000000000000000000000000000000000000
				116, 136, 27
			March March	
1.00				
Total Offic	er Revenue	\$ 601	\$	\$ -

G. Balance Sheet

Name o	of Facility	License No.	Report for Year Ended	Page	of
Trinity 1	Hill Care Center, LLC	2222-C	9/30/2018	31	37
		Account		A	mount
Assets					
A. C	urrent Assets				
1.	Cash (on hand and in banks)			\$	197,541
2.	Resident Accounts Receivable	e (Less Allowance for	r Bad Debts)	\$	2,679,841
3.	Other Accounts Receivable (E	Excluding Owners or	Related Parties)	\$	
4	Inventories			\$	32,187
5.	Prepaid Expenses			\$	618,072
	a. Prepaid Insurance		539,324		
	b. Prepaid Property Taxes		77,257		
	c. Prepaid Expenses Other		1,492		
	d. See Schedule				
6,	Interest Receivable			\$	
7.	Medicare Final Settlement Re	ceivable		\$	
8.	Other Current Assets (itemize)		\$	(224,841)
	Due From (to) Related Parties	······································	278,944	_	
	Other Owners reserves		(503,785)	\dashv	
	See Schedule	,		\dashv	
A-9. T	otal Current Assets (Lines A1 t	hru 8)		\$	3,302,801
B. Fi	ixed Assets				
1.	. Land			\$	
2.	. Land Improvements	*Historical Cost		\$	
	-	Accum, Depreciation	on Net		
3.	. Buildings	*Historical Cost	394,955	\$	309,766
	-	Accum. Depreciation	on 85,190 Net		
4.	Leasehold Improvements	*Historical Cost	816,632	\$	330,004
	•	Accum. Depreciation	on 486,628 Net		
5.	. Non-Movable Equipment	*Historical Cost	7,990	\$	2,141
		Accum, Depreciation	on 5,849 Net		
6.	. Movable Equipment	*Historical Cost	579,444	\$	207,995
		Accum. Depreciation	on 371,449 Net		
7.	. Motor Vehicles	*Historical Cost	13,085	\$	4,305
		Accum. Depreciation	on 8,780 Net		
8.	. Minor Equipment-Not Depre			\$	**************************************
9	Other Fixed Assets (itemize)			\$	20,092
	Construction in Progress		20,092		
	See Schedule	and the state of t			
B-10.	Total Fixed Assets (Lines B)	thru 9)		\$	874,303

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

G. Balance Sheet (cont'd)

Nam	Name of Facility License No. Report for Year Ended		Report for Year Ended		Page	of	
Trini	ty H	lill Care Center, LLC	2222-C	222-C 9/30/2018		32	37
			Account			Amo	ount
				Total Brought Forward:	\$		4,177,103
C.	Le	asehold or like property record	ed 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 Depre	ciable		\$		
C-8	To	tal Leasehold or Like Properi	ties (C1 thru 7)		\$		
D.	Inv	estment and Other Assets					
	1.	Deferred Deposits			\$		
	2.	Escrow Deposits			\$		538,592
	3.	Organization Expense	*Historical Cost				
<u></u>			Accum. Depreciation	Net	\$		
	4.	Goodwill (Purchased Only)			\$		
	5.	Investments Related to Resid	ent Care (itemize)		\$	400000000000000000000000000000000000000	35,571
		Patient Trust Funds		33,016			
<u> </u>		Long Term Deposit - prim		2,555			
	6.	Loans to Owners or Related			\$		
		Name and Address	Amount	Loan Date			
	7.	Other Assets (itemize)			\$		
					-		
					-		
		See Schedule	/Y * T 4 .1 -1				574160
		tal Investments and Other As			\$		574,163
D-9.	10	tal All Assets (Lines A9 + B1	U + C8 + D8)		\$		4,751,266

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

G. Balance Sheet (cont'd)

Name of Faci	ame of Facility License No. Report for Year Ended		Page	of			
Trinity Hill C	are (Center, LLC	2222-C	9/30/2018		33	37
			Account			Am	ount
Liabilities							
A.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable			9		301,975
	2.	Notes Payable (itemize)			<u> </u>	}	
		Working Capital Line of C	redit				
		0 01 11					
		See Schedule	. / (7	\		h	
ļ	3.	Loans Payable for Equipm		Amount	Date Due	Þ	
<u> </u>		Name of Lender	Purpose	Amount	Date Due		
	4.	Accrued Payroll (Exclusive	e of Owners and/or S	Stockholders only)		\$	190,087
	5.	Accrued Payroll (Owners a	und/or Stockholders	only)		\$	
	6.	Accrued Payroll Taxes Pay	able			\$	
	7.	Medicare Final Settlement	Payable			\$	
	8.	Medicare Current Financin	g Payable			\$	
	9.	Mortgage Payable (Curren	t Portion)			\$	
	10	. Interest Payable (Exclusive	e of Owner and/or Re	elated Parties)		\$	
	11	. Accrued Income Taxes*				\$	
	12	. Other Current Liabilities (itemize)		4	\$	1,701,956
		Related Party Payables	1,216,	967			
		Accrued Expenses	39,	534			
		Accrued Resident User Fees	260,	310			
		Accrued Workers Comp Expense		145 See Schedule			
A-13.	To	tal Current Liabilities (Lir	es A1 thru 12)			\$	2,194,018

^{*} 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.			Page	of	
Trinity Hill Care Center, LLC	2222-C	9/30/2018		34	37	
	Account			An	nount	
		Total Brougl	nt Forward:		2,194,018	}
Liabilities (cont'd)						
B. Long-Term Liabilities						
1. Loans Payable-Equipment	····		\$			8888
Name of Lender	Purpose	Amount	Date Due			

2. Mortgages Payable			\$			
Loans from Owners or Rel	ated Parties (itemize)	\$		********************************	10001
Name and Address of Lender	Amount	Loan D	ate			
		1				
						8
						<u>~</u>
4. Other Long-Term Liabilitie	es (itemize)	22.02.1	\$		33,010	ე ‱
Patient Trust Funds		33,016				
Coo Cahadala						
See Schedule B-5. Total Long-Term Liabilities (I inac R1 thru A)		\$		33,01	∰ 6
C. Total All Liabilities (Lines A-			\$		2,227,03	
C, I DEMETER LINGUISTICS (LINGS A.	10 . 10 0)		ψ		m, m m 1 , U J .	_

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

	ne of Facility	License No.	Report for Yea	r Ended	Page	of
Trii	ity Hill Care Center, LLC	2222-C	9/30/2018		35	37
 A.	A. Reserves					Amount
Δ.	Reserve for value of leased	lond			¢.	
					\$	
	2. Reserve for depreciation va	lue of leased building	gs and appurtenar	nces		
	to be amortized				\$	
	3. Reserve for depreciation va	lue of leased person	al property (<i>Equit</i>	v)	\$	
	4. Reserve for leasehold real p	properties on which t	fair rental value is	based	\$	
	5. Reserve for funds set aside	as donor restricted			\$	
	6. Total Reserves				\$	
B.	Net Worth					
	Owner's Capital				\$	1,000
	2. Capital Stock				\$	
	3. Paid-in Surplus	t			\$	
	4. Treasury Stock				\$	
	5. Cumulated Earnings				\$	1,346,864
	6. Gain or Loss for Period	10/1/20	17 thru	9/30/2018	\$	1,176,369
	7. Total Net Worth				\$	2,524,233
C.	Total Reserves and Net Worth	t			\$	2,524,233
D.	Total Liabilities, Reserves, an	d Net Worth			\$	4,751,268

H. Changes in Total Net Worth

Name of Facility		License No. Report for Year Ended		Ended	Page	of			
Trinity Hill Care Center, LLC		2222-C 9/30/2018			36	37			
Account						Amount			
<u>A.</u>	Balance at End of Prior Period as s		<u>\$</u> \$						
B. Total Revenue (From Statement of Revenue Page 30)						14,899,153			
⊢	C. Total Expenditures (From Statement of Expenditures Page 27)					13,722,784			
D. Net Income or Deficit					<u>\$</u> \$	1,176,369			
<u>E.</u>	Balance					1,176,369			
	Additions 1. Additional Capital Contributed (itemize) 2. Other (itemize)								
F-3.	Total Additions		\$						
G.	Deductions Deductions								
U.	1. Drawings of Owners/Operators/Partners (Specify)								
<u> </u>	Name and Address (No., City		Title	Amount	\$				
		, ~~~, &,		A AAAAV WAAAL	4				
2. Other Withdrawings (Specify)						\$			
	Purpose		Amount						
3. Total Deductions					\$ \$				
H.	H. Balance at End of Period 09/30/18					1,176,369			

I. Preparer's/Reviewer's Certification

Name of Facility		License No.	License No.		Page	of					
Trinity	Hill Care Center, LLC	enter, LLC 2222-C		9/30/2018	37	37					
Check appropriate category											
Ø	Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	Ø	☑ Other							
Preparer/Reviewer Certification											
I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.											
Signature of Preparer		Title	Title		Date Signed						
Printed Name of Preparer											
iCare Management, LLC Addres Address Phone Number											
, , , , , ,	(1.ddi 00)										
	dwell Street, Manchester, CT 06040		860-570-2140								
Annua	I Report Contact		Phone Number								
Annual Report Contact Email Address											