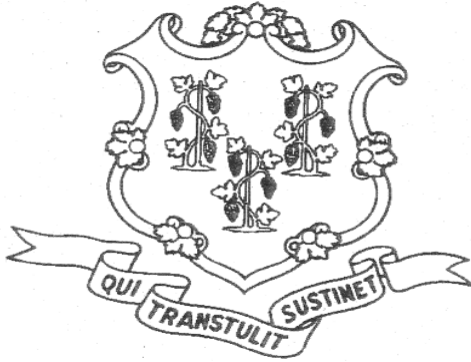


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2022

Name of Facility (as licensed) Trinity Hill Care Center, LLC	
Address (No. & Street, City, State, Zip Code) 151 Hillside Avenue, Hartford, CT 06016	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> NurseFac-Aids	
Report for Year Beginning 10/1/2021	Report for Year Ending 9/30/2022

License Numbers:	CCNH 2222-C	RHNS	NurseFac-Aids AIDS	Medicare Provider 07-5268
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Medicaid Provider Numbers:	CCNH 9555	RHNS	ICF-IID 49553
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For Department Use Only

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

General Information

Name of Facility (as licensed) Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2022	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Trinity Hill Care Center, LLC [facility name], for the cost report period beginning October 1, 2021 and ending September 30, 2022, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Trinity Hill Care Center, LLC		Period Covered:	From 10/1/2021	To 9/30/2022
Address of Facility 151 Hillside Avenue, Hartford, CT 06016				
Report Prepared By iCare Management, LLC		Phone Number 860-570-2140	Date 2/15/2023	
Item	Total	CCNH	RHNS	NurseFac- Aids
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire

Type of Facility - Organization Structure

	Phone No. of Facility 860-951-1060	Report for Year Ended 9/30/2022	Page 2	of 37
Name of Facility (as shown on license) Trinity Hill Care Center, LLC		Address (No. & Street, City, State, Zip) 151 Hillside Avenue, Hartford, CT 06016		
License Numbers:	CCNH 2222-C	RHNS	NurseFac-Aids AIDS	Medicare Provider No. 07-5268
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> NurseFac-Aids				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Yong Crandall		Nursing Home Administrator's License No.:	002046	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

**General Information and Questionnaire
 Partners/Members**

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2022	Page 3	of 37
Legal Name of Partnership/LLC Trinity Hill Care Center, LLC		Business Address 151 Hillside Avenue, Hartford, CT 06016		State(s) and/or Town(s) in Which Registered CT	
Name of Partners/Members	Business Address	Title		% Owned	
V. Robert Salazar	2500 18th Street, Suite 200, Denver, CO 80211	Member		31.3	
David Sebbag	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		21.4	
Ari Krausz	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		21.3	
Solomon Melamed	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		1	
Christopher Wright	341 Bidwell Street, Manchester, Ct 06040	Member		5	
Premier First Investors	245 S. Benton Street, Lakewood, CO 80226	Member		10	
Global World Investors	245 S. Benton Street, Lakewood, CO 80226	Member		10	

General Information and Questionnaire Corporate Owners

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2022	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated	

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each

Names of Stockholders Owning at Least 10% of Shares	Business Address	Title	No. Shares Held by Each

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2022	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

1. In the preparation of this Report, were all costs allocated as required? Yes No If "No," explain fully why such allocation was not made.

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

Yes No If "No," explain fully why such allocation was not made.

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 Trinity Hill Care Center, LLC			License No. 2222-C		Report for Year Ended 9/30/2022		Page of 6 37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909	<input type="radio"/>	<input checked="" type="radio"/>	Time Clocks and Payroll Punch Equip	06/01/10	60 months & automatic			
GE Capital C/O Wells Fargo, P.O.Box 41564, Philadelphai, PA 19101	<input type="radio"/>	<input checked="" type="radio"/>	Copier	03/05/14	48 months & automatic			
Neopost USA Inc, 25880 Network Place, Chicago, IL 60673	<input type="radio"/>	<input checked="" type="radio"/>	Postage Rental	04/16/13	Month to month			
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes	<input checked="" type="radio"/> No
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.

General Information and Questionnaire
Accounting Basis

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2022	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

Is the accounting basis for this period the same as for the previous period? Yes No If "No," explain.

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

1 Taxes, financial statements, accounting support	\$ 10,312
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 10,312

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No 15D

Legal Services Information

Name of Legal Firm or Independent Attorney 1 iCare Health Management, LLC 2 Robinson & Cole, LLP 3 Various others (American Arbitration , Various Arbitration, Murtha Cullina) 4 5 iCare Health Management LLC	Telephone Number 860-570-2140 860-275-8200 860-678-7775 & 860-570-2140
---	---

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

1 341 Bidwell Street, Manchester CT
2 280 Trumbull St, Hartford, CT
3
4
5 341 Bidwell Street, Manchester CT

Services Provided by This Firm (*describe fully*)

1 Lease and contract issues, general legal advice, Labor Law	\$ 439
2 General legal advice, union funds advice, employment law	\$
3 Employment Arbitrations, healthcare law & Conservatorships	\$ 1,289
4	\$
5 Collections	\$ (0)
	Charge for Services Provided
	\$ 1,728

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No 15E

Schedule of Resident Statistics

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C		Report for Year Ended 9/30/2022				Page 8	of 37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total NurseFac-Aids	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	NurseFac-Aids	Total	CCNH	RHNS	NurseFac-Aids	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	144	114		30	144	114		30					
B. On last day of THIS report period	144	114		30					144	114			30
2. Number of Residents													
A. As of midnight of PREVIOUS report period	115	92		23	115	92		23					
B. As of midnight of THIS report period	120	96		24					120	96			24
3. Total Number of Days Care Provided During Period													
A. Medicare	695	695			588	588			107	107			
B. Medicaid (Conn.)	42,178	33,813		8,365	31,516	25,225		6,291	10,662	8,588			2,074
C. Medicaid (other states)													
D. Private Pay	9	9			9	9							
E. State SSI for RCH													
F. Other (Specify) Insurance	14	14			13	13			1	1			
G. Total Care Days During Period (3A thru F)	42,896	34,531		8,365	32,126	25,835		6,291	10,770	8,696			2,074
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)	42,896	34,531		8,365	32,126	25,835		6,291	10,770	8,696			2,074

Schedule of Resident Statistics (Cont'd)

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C			Report for Year Ended 9/30/2022			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	NurseFac-Aids	Lost			Gained			CCNH	RHNS	NurseFac-Aids	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	NurseFac-Aids			
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH		CCNH	RHNS	CCNH	RHNS	NurseFac-Aids	R.C.H.	ICF-MR				
No. of Residents	3		93				24						
Per Diem Rate													
a. One bed rm.	492.00		340.00				355.00						
b. Two bed rms.													
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	NurseFac-Aids		
A. Medicare - Part B								774	623		151		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								380	306		74		
2. Restorative Treatments								1,502	1,209		293		
C. Other								1,051	846		205		
D. Total Physical Therapy Treatments								3,707	2,984		723		
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								211	170		41		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								227	183		44		
2. Restorative Treatments								130	105		25		
C. Other								233	188		45		
D. Total Speech Therapy Treatments								801	645		156		
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								981	790		191		
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								358	288		70		
2. Restorative Treatments								2,023	1,629		394		
C. Other								1,102	887		215		
D. Total Occupational Therapy Treatments								4,464	3,593		871		

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Trinity Hill Care Center, LLC	2222-C	9/30/2022	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	NurseFac-Aids	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	134,018	1,385			32,465	693
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	557,710	19,320			278,855	9,660
5. Dietary Service						
a. Head Dietitian	1,450	38			351	10
b. Food Service Supervisor	87,301	1,726			21,148	454
c. Dietary Workers	420,579	18,322			101,884	4,822
6. Housekeeping Service						
a. Head Housekeeper	45				22	
b. Other Housekeeping Workers	297,264	16,313			148,632	8,157
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	25,396	1,444			12,698	722
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	67,463	3,675			33,731	1,837
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	124,481	1,984			62,240	992
b. RN						
1. Direct Care	345,107	5,407			185,879	3,814
2. Administrative**	280,036	6,033			140,018	3,016
c. LPN						
1. Direct Care	1,266,411	34,299			230,136	7,386
2. Administrative**	9,282	259				
d. Aides and Attendants	1,403,346	67,033			437,713	24,217
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	165,020	6,615			40,270	1,741
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	384,911	11,610			93,243	3,055
n. Marketing						
o. Other (Specify) See Attached Schedule	180,002	8,575			90,109	4,442
<i>A-13. Total Salary Expenditures</i>	5,749,821	204,037			1,909,396	75,017

* 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)

Position	CCNH		RHNS		NurseFac-Aids	
	\$	Hours	\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$ 44,565	1,679			\$ 10,796	442
MEDICAL RECORDS SALARIES	\$ -	-			\$ -	-
CENTRAL SUPPLY SALARIES	\$ 29,644	1,371			\$ 7,181	686
RESPIRATORY THERAPY SALARIES	\$ -	-			\$ -	-
PLANT SECURITY SALARIES	\$ 105,793	5,524			\$ 25,628	1,338
MEDICAL RECORDS SALARIES SPCL	\$ -	-			\$ 46,504	1,976
Total	\$ 180,002	8,575	\$ -	-	\$ 90,109	4,442

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		NurseFac-Aids	
	\$	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ 6,081	Storage			\$ 1,473	Storage
ADMISSIONS C/S LABOR	\$ (238,841)	(3,002)			\$ (57,858)	(790)
CENTRAL SUPPLY CONTRACT SERVICE	\$ (13,601)	(890)			\$ (3,295)	(216)
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ (276,392)	(4,766)			\$ (138,196)	(2,383)
RESPIRATORY THERAPY CONTRACT SERVICES	\$ -	-			\$ -	-
PHYSICAL THERAPY C/S MEDICIAD	\$ -	-			\$ -	-
SPEECH THERAPY C/S Medicaid	\$ -	-			\$ -	-
OCCUPATIONAL THERAPY C/S MEDICIAD	\$ -	-			\$ -	-
Total	\$ (522,753)	(8,659)	\$ -	-	\$ (197,876)	(3,389)

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Trinity Hill Care Center, LLC				2222-C	9/30/2022			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	NurseFac-Aids							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Trinity Hill Care Center, LLC				2222-C	9/30/2022			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	NurseFac-Aids							
Section III - Administrators***										
Yong Crandall	134,018		32,465	same as employees less union funds	Administrator	2,078	A2			
				same as employees less union funds	Administrator		A2			
				same as employees less union funds	Administrator		A2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Trinity Hill Care Center, LLC	2222-C	9/30/2022	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	NurseFac-Aids	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	20,245	161			4,904	39
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	57,979	1,111				
b. Other						
6. Social Worker	3,953	41			958	11
7. Recreation Worker	2,108	4 Hours +Ca			1,054	4 Hours +Ca
8. Physicians						
a. Medical Director (entire facility)	48,000	256			64,992	495
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify) Physician Care Contract Services	11,785	11			2,855	3
9. Speech Therapist						
a. Resident Care	25,633	491				
b. Other						
10. Occupational Therapist						
a. Resident Care	85,659	1,641				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	472,798	3,583				
2. Administrative***	(283,651)	(4,044)				
b. LPN						
1. Direct Care	122,608	1,741				
2. Administrative***						
c. Aides	161,736	3,955				
d. Other						
12. Other (Specify) See Attached Schedule	(522,753)	(8,659)			(197,876)	(3,389)
B-13 Total Fees Paid in Lieu of Salaries	206,099	287			(123,113)	(2,841)

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

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

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

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

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C		Report for Year Ended 9/30/2022	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Tocuhpoints Therapy	Therapy for residents, also Therapy for Workers comp for staff	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Pharm Scripts	Pharmacy Contract	<input type="radio"/>	<input checked="" type="radio"/>			
Guardian Consulting Srv	Pharmacy Consulting	<input type="radio"/>	<input checked="" type="radio"/>			
Healthdrive Physician Services	Audiology, Dental and Podiatry	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Johnson Fielding III	Med Dir	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Villanueva Elmo	Med Dir	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Tress	HIV Med Dr	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2022		15	37
Item	Total	CCNH	RHNS	NurseFac-Aids	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 40,810	30,787			10,022
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 631,461	476,386			155,075
5. Health Insurance	\$ 1,059,279	799,140			260,139
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 412,176	310,953			101,223
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 47,133	35,558			11,575
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 113,134	113,134			
d. Accounting and Auditing	\$ 10,312	8,301			2,011
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 1,728	1,391			337
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 13,563	9,042			4,521
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 36,489	29,374			7,116
2. Cellular Phones	\$ 6,069	4,885			1,183
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 885,648	712,941			172,707
Subtotal	\$ 3,257,802	2,531,893			725,909

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	NurseFac-Aids
UNION TRAINING	\$ 35,558		\$ 11,575
Total	\$ 35,558	\$ -	\$ 11,575

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2022		16	37
Item	Total	CCNH	RHNS	NurseFac-Aids	
Subtotals Brought Forward:	3,257,802	2,531,893		725,909	
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	10,928	8,797	2,131	
5. Education Expenses Related to Seminars and Conventions	\$	1,093	880	213	
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$	386	310	75	
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	18,851	15,175	3,676	
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	13,870	11,165	2,705	
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	2,421	1,949	472	
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	9,777	7,870	1,907	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	709	571	138	
10. Contributions*** See Attached Schedule	\$	250	201	49	
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	130,457	86,971	43,486	
12. Administrative Management Services**	\$	431,081	347,018	84,064	
13. Other (<i>Specify</i>) See Attached Schedule	\$	8,641	6,957	1,684	
C-14 Total Administrative & General Expenditures	\$	3,886,266	3,019,757	866,508	

* 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	\$ 310		\$ 75
Total Other Travel and Entertainment	\$ 310	\$ -	\$ 75

Schedule of Other Advertising

Description	CCNH	RHNS	NurseFac-Aids
COMMUNICATIONS SPECIAL EVENTS	\$ 11,165		\$ 2,705
Total Other Advertising	\$ 11,165	\$ -	\$ 2,705

Schedule of Dues

Description	CCNH	RHNS	NurseFac-Aids
ALTCFM			
CAHCF Dues	\$ 7,870		\$ 1,907
OTHER DUES			
Total Dues	\$ 7,870	\$ -	\$ 1,907

Schedule of Contributions

Description	CCNH	RHNS	NurseFac-Aids
CONTRIBUTIONS	\$ 201		\$ 49
Total Contributions	\$ 201	\$ -	\$ 49

Schedule of Other Administrative and General

Description	CCNH	RHNS	NurseFac-Aids
SOCIAL SERVICE SUPPLIES	\$ -		\$ -
SOC SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 4,638		\$ 1,123
EMPLOYEE RELATIONS	\$ 2,514		\$ 609
EMPLOYEE RELATIONS-OTHER	\$ 259		\$ 63
PERMITS & LICENSES	\$ 1,703		\$ 412
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 4,311		\$ 1,044
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ (9,554)		\$ (2,315)
LATE FEES	\$ 733		\$ 178
INTERNET EXPENSES	\$ 2,351		\$ 569
Rounding	\$ 3		
Total Other Administrative and General	\$ 6,957	\$ -	\$ 1,684

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Trinity Hill Care Center, LLC	2222-C	9/30/2022	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	431,081	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	168,496	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	40,503	MANAGEMENT FEES- INDIRECT CARE	Pg 20 k

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

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

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2022	Page 18	of 37
Item		Total	CCNH	RHNS	NurseFac-Aids
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 313,788	252,597		61,191
2.	Non-Food Supplies	\$ 35,233	28,362		6,871
3.	Other (<i>Specify</i>) _____ DIETARY SUPPLEMENTS	\$ 6,835	5,502		1,333
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	\$ (22,213)	(17,881)		(4,332)
c.	Other (<i>Specify</i>) _____ DIETARY MINOR EQUIPMENT	\$ 2,817	2,268		549
2D. Total Dietary Expenditures (2a + b + c + d)		\$ 336,460	270,848		65,612
2E. Dietary Questionnaire		Total	CCNH	RHNS	NurseFac-Aids
F.	Resident Meals: Total no. of meals served per day:*	353	353		
G.	Is cost of employee meals included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K.	Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
N.	Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility		License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC		2222-C	9/30/2022	19	37
Item		Total	CCNH	RHNS	NurseFac-Aids
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	53,656	35,771		17,885
c. Other (Specify) LAUNDRY MINOR EQUIPMENT	\$	688	459		229
3D. Total Laundry Expenditures (3a + b + c)	\$	54,344	36,229		18,115
3E. Laundry Questionnaire					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3D.

*** Pounds of Laundry only required for multi-level facilities.

**C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care
 Basis for Allocation of Costs (See Note on Page 5)**

Name of Facility		License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC		2222-C	9/30/2022		20	37
Item			Total	CCNH	RHNS	NurseFac-Aids
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
	a. In-House Care					
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	26,779	17,853		8,926
	b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$	40,518	27,012		13,506
	C. Other (<i>Specify</i>)		\$			
	HOUSEKEEPING MINOR EQUIPMENT					
4D.	Total Housekeeping Expenditures (4a + b + c)		\$ 67,297	44,865		22,432
5.	Resident Care (Supplies)**					
	a. Prescription Drugs***					
	1. Own Pharmacy		\$			
	2. Purchased from PHARMACY		\$ 49,330	49,330		
	b. Medicine Cabinet Drugs		\$ 3,804	3,062		742
	c. Medical and Therapeutic Supplies		\$ 104,711	84,292		20,419
	d. Ambulance/Limousine***		\$ 80	54		27
	e. Oxygen					
	1. For Emergency Use		\$ 1,395	1,395		
	2. Other***		\$			
	f. X-rays and Related Radiological Procedures***		\$ 449	449		
	g. Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$			
	h. Laboratory***		\$ 15,898	15,898		
	i. Recreation		\$			
	j. Direct Management Services*		\$ 168,496	135,638		32,858
	k. Indirect Management Services*		\$ 40,503	32,605		7,898
	l. Other (Specify)**** See Attached Schedule		\$ 74,853	55,391		19,461
5M.	Total Resident Care Expenditures (5a - 5j)		\$ 459,518	378,112		81,405

* 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	\$ 82		\$ 20
NURSING MINOR EQUIP	\$ 3,549		\$ 860
MEDICAL RECORDS SUPPLIES	\$ (421)		\$ (102)
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
NON-COVERED PPS DR. VISITS	\$ 47		\$ 11
RESIDENT CARE SUPPLIES	\$ 10		\$ 3
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 10,201		\$ 2,471
PERSONAL CARE SUPPLIES	\$ 370		\$ 90
INCONTINENCY SUPPLIES	\$ -		\$ -
VACCINE RESIDENTS	\$ 5,672		\$ -
PATIENT SPECIAL NEEDS	\$ 77		\$ -
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	\$ 16,294		\$ 8,147
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 28		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ 3,558		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ -		\$ -
IV THERAPY SUPPLIES	\$ 11,479		\$ 5,739
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 1,366		\$ 683
ACTIVITIES SUPPLIES	\$ 2,670		\$ 1,335
ACTIVITIES MINOR EQUIPMENT	\$ 409		\$ 205
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS			
STRIKE COSTS NON REIMBURSABLE	\$ -		\$ -
COVID NON REIMBURSABLE	\$ -		\$ -
Total Other Resident Care	\$ 55,391	\$ -	\$ 19,461

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

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C		Report for Year Ended 9/30/2022			Page of 21 37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	NurseFac-Aids	Pg	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Housekeeping Services	40,518			20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Laundry Services	53,656			19	3b
Eagle Elevator		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Elevator Contract	6,435			22	6F
Brightview Landscapes LLC		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Landscaping	6,936			22	6F
Peter Marcue		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Snow Removal	12,677			22	6F
All Waste Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Trash removal	32,214			22	6F
Facility Complainece		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Plant Contract Services	156,955			22	6F
American HealthTech	P.O. Box 9001006, Louisville, KY 40290	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Software Maintenance Contract	18,870			16	M11
Automatic Data Processing		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Payroll Services	49,038			16	M11
National Datacare Corp		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Resident Trust Software	3,908			16	M11
Prime Care Technology services		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Computer Consulting Services	37,382			16	M11
Priotiry Express		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Courier Services	2,837			16	M11
Point Right Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Nursing Software	5,011			16	M11
		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR						

* List all contracted services over \$10,000. Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended			Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2022			22	37
Item	Total	CCNH	RHNS	NurseFac-Aids		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 53,775	35,850			17,925	
b. Heat	\$ 43,470	28,980			14,490	
c. Light & Power	\$ 74,201	49,467			24,734	
d. Water	\$ 64,422	42,948			21,474	
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 19,951	16,061			3,891	
f. Other (<i>itemize</i>)	\$ 280,856	187,238			93,619	
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 536,675	360,543			176,132	
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 19,523	15,716			3,807	
c. Non-Movable Equipment	\$ 459	369			89	
d. Movable Equipment	\$ 53,043	42,700			10,344	
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 73,025	58,785			14,240	
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 55,496	44,674			10,822	
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 55,496	44,674			10,822	
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,408,591	1,133,907			274,684	
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 297,992	198,661			99,331	
c. Personal property taxes	\$ 31,541	21,027			10,514	
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,866,644	1,457,053			409,591	

* 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	\$ 6,741		\$ 3,371
PLANT CONTRACT SERVICE LABOR	\$ 14,252		\$ 7,126
ELEVATOR CONTRACT SERVICE	\$ 4,290		\$ 2,145
FIRE/SPRINKLER CONTRACT SERVICE	\$ 3,970		\$ 1,985
LANDSCAPING CONTRACT SERVICE	\$ 4,624		\$ 2,312
SNOW REMOVAL CONTRACT SERVICE	\$ 8,451		\$ 4,226
TRASH REMOVAL CONTRACT SERVICE	\$ 21,476		\$ 10,738
PLANT (POOL) CONTRACT SERVICES OTHER	\$ 104,637		\$ 52,318
SECURITY CONTRACT SERVICE	\$ -		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 8,614		\$ 4,307
PLANT MINOR EQUIPMENT	\$ 6,594		\$ 3,297
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ 3,589		\$ 1,794
RENT OTHER	\$ -		\$ -
Total Other Repairs and Maintenance	\$ 187,238	\$ -	\$ 93,619

Depreciation Schedule

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C			Report for Year Ended 9/30/2022			Page 23	of 37			
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
A. Land Improvements													
1. Acquired prior to this report period													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
B. Building and Building Improvements													
1. Acquired prior to this report period			394,955		394,955	154,454			19,523				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal										19,523			
C. Non-Movable Equipment													
1. Acquired prior to this report period			7,990		7,990	7,226			459				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal										459			
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year								
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period						666,540		666,540	535,889			50,885	
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative						14,768						449	
d. Standard Resident						25,312						1,709	
e. Specialized Resident													
Total Acquired during this report period						40,080						2,158	
D-3. Subtotal												52,595	
E. Total Depreciation												72,576	

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Building Improvements		\$ -		\$ - *
Deletions:				
Total deletions for Building Improvements		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Non-Movable Equipment		\$ -		\$ - *
Deletions:				
Total deletions for Non-Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Annual Report of Long-Term Care Facility

CSP-24 Rev. 10/2006

Amortization Schedule*

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C		Report for Year Ended 9/30/2022			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
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				949,979	638,888			51,082	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				161,966				4,414	
C-4. Subtotal									55,496
D. Total Amortization									55,496

* Straight-line method must be used.

** Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

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

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2022	Page 25	of 37
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11. Property Questionnaire

Part A

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

Yes No

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	04/01/99
3. If NOT Original Owner, Date of Purchase	04/01/99
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	144
6. Square Footage	51,572
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties

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

1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
Summit Trinity Hill SNF, LLC	151 Hillside Ave, Hartford, CT	08/09/17	15 year with 2	1,420,430

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC		2222-C	9/30/2022		26	37
Item			Total	CCNH	RHNS	NurseFac-Aids
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2022	27	37
Item	Total	CCNH	RHNS	NurseFac-Aids
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment	\$			
A. Item	Rate	Amount		
Lender				
Address of Lender				
2. Other (<i>Specify</i>)	\$			
A. Item	Rate	Amount		
Lender				
Address of Lender				
B. Item	Rate	Amount		
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)	\$			
12. D. Other Interest Expense (<i>Specify</i>) INTEREST	\$	754	607	147
13. Total All Interest Expense (12B7 + 12C3 + 12D)	\$	754	607	147
14. Insurance				
a. Insurance on Property (buildings only)	\$	8,394	5,596	2,798
b. Insurance on Automobiles	\$	(1,000)	(667)	(333)
c. Insurance other than Property (as specified above)				
1. Umbrella (<i>Blanket Coverage</i>)	\$	105,982	70,655	35,327
2. Fire and Extended Coverage	\$			
3. Other (<i>Specify</i>) Other insurance, crime	\$	14,448	9,632	4,816
14d. Total Insurance Expenditures (14a + b + c)	\$	127,825	85,216	42,608
15. Total All Expenditures (A-13 thru C-14)	\$	15,077,985	11,609,152	3,468,833

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC				2222-C	9/30/2022	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	C	Bad Debts	\$ 113,134	113,134		
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$ 13,870	11,165		2,705
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ (10,959)	(8,822)		(2,137)
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 116,046	115,478		568

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
16a		PENALTIES	\$ (9,554)		\$ (2,315)
16a		LATE FEES	\$ 733		\$ 178
16a		PRIOR PERIOD EXPENSES			
		rounding			
Total Other A&G Adjustments			\$ (8,822)	\$ -	\$ (2,137)

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

Name of Facility				License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC				2222-C	9/30/2022	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
Subtotals Brought Forward				\$ 116,046	115,478		568
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.	20	5d	Ambulance/Limousine	\$ 80	54		27
29.	20	5f	X-rays, etc	\$ 449	449		
30.	20	5h	Laboratory	\$ 15,898	15,898		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 58	47		11
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 132,531	131,925		606

*** 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	NurseFac-Aids
20	5J	Non Covered PPS Visits	46.77		11.33
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	-		
13	B9A	ST- Resident Care (for outpatient therapy - see schedule)	-		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	-		
Total Other Ancillary Costs			\$ 47	\$ -	\$ 11

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

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

Schedule of Other - Miscellaneous Administrative Adjustments

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

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2022			30	37
Item	Total	CCNH	RHNS	NurseFac-Aids		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 14,534,070	11,404,141		3,129,929		
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 546,709	432,812		113,898		
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 8,550	8,550				
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 28,930	28,930				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (28,830)	(28,830)				
c. Prescription Drugs - Non-Medicare	\$ 35,734	30,834		4,900		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (35,734)	(30,834)		(4,900)		
2. a. Medical Supplies - Medicare	\$ 757	757				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (757)	(757)				
c. Medical Supplies - Non-Medicare	\$ 5,718	2,383		3,335		
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (5,718)	(2,383)		(3,335)		
3. a. Physical Therapy - Medicare	\$ 37,050	37,050				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (25,302)	(25,302)				
c. Physical Therapy - Non-Medicare	\$ 67,805	59,374		8,432		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (67,805)	(59,374)		(8,432)		
4. a. Speech Therapy - Medicare	\$ 1,710	1,710				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (833)	(833)				
c. Speech Therapy - Non-Medicare	\$ 33,926	26,117		7,808		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (33,926)	(26,117)		(7,808)		
5. a. Occupational Therapy - Medicare	\$ 44,214	44,214				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (29,436)	(29,436)				
c. Occupational Therapy - Non-Medicare	\$ 92,359	77,531		14,828		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (89,913)	(75,085)		(14,828)		
6. a. Other (<i>Specify</i>) - Medicare	\$ 54,020	54,020				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 153,025	153,025				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 15,326,324	12,082,497		3,243,827		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 53,630	53,630				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 88,195	88,195				
V. Total Other Revenue (1 thru 8)	\$ 141,825	141,825				
VI. Total All Revenue (III +V)	\$ 15,468,148	12,224,322		3,243,827		

* 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.

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2022	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	2,830,842
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	3,295,061
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	32,187
5. Prepaid Expenses			\$	259,139
a. Prepaid Insurance	160,259			
b. Prepaid Property Taxes	95,960			
c. Prepaid Expenses Other	2,920			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(787,902)
Due From (to) Related Parties	330,029			
Other Owners reserves	(1,117,931)			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	5,629,327
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		
	Net			
3. Buildings	*Historical Cost	394,955	\$	220,978
	Accum. Depreciation	173,977		
	Net			
4. Leasehold Improvements	*Historical Cost	1,111,945	\$	417,561
	Accum. Depreciation	694,384		
	Net			
5. Non-Movable Equipment	*Historical Cost	7,990	\$	305
	Accum. Depreciation	7,685		
	Net			
6. Movable Equipment	*Historical Cost	706,620	\$	117,688
	Accum. Depreciation	588,932		
	Net			
7. Motor Vehicles	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		
	Net			
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	1,527
Construction in Progress	1,527			
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	758,059

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref Line Ref Description

Page Ref	Line Ref	Description	
Total Prepaid Expenses			\$ -

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

Page Ref Line Ref Description

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			\$ -

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

Page Ref Line Ref Description

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref Line Ref Description

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

Page Ref Line Ref Description

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			\$ -

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

Page Ref Line Ref Description

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			\$ -

G. Balance Sheet (cont'd)

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2022	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 6,387,386	
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			\$	
	*Historical Cost _____	Accum. Depreciation _____	Net	
3. Buildings			\$	
	*Historical Cost _____	Accum. Depreciation _____	Net	
4. Non-Movable Equipment			\$	
	*Historical Cost _____	Accum. Depreciation _____	Net	
5. Movable Equipment			\$	
	*Historical Cost _____	Accum. Depreciation _____	Net	
6. Motor Vehicles			\$	
	*Historical Cost _____	Accum. Depreciation _____	Net	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$ 827,224	
3. Organization Expense			\$	
	*Historical Cost _____	Accum. Depreciation _____	Net	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$ 50,753	
	Patient Trust Funds	39,598		
	Long Term Deposit - primecare	11,155		
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 877,978	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 7,265,364	

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

G. Balance Sheet (cont'd)

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2022	Page 34	of 37
Account			Amount	
Total Brought Forward:			2,548,668	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)				
				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$
Patient Trust Funds		39,598	39,598	
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 39,598
C. Total All Liabilities (Lines A-13 + B-5)				\$ 2,588,267

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

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2022	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	1,000
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	4,285,934
6. Gain or Loss for Period			\$	390,163
	10/1/2021	thru	9/30/2022	
7. Total Net Worth			\$	4,677,097
C. Total Reserves and Net Worth			\$	4,677,097
D. Total Liabilities, Reserves, and Net Worth			\$	7,265,364

H. Changes in Total Net Worth

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2022	Page 36	of 37	
Account			Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2021			\$		
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$ 15,468,148		
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$ 15,077,985		
D. Net Income or Deficit			\$ 390,163		
E. Balance			\$ 390,163		
F. Additions					
1. Additional Capital Contributed <i>(itemize)</i>					
2. Other <i>(itemize)</i>					
F-3. Total Additions			\$		
G. Deductions					
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>					
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount		
2. Other Withdrawings <i>(Specify)</i>			\$		
Purpose		Amount			
3. Total Deductions			\$		
H. <i>Balance at End of Period</i>			\$ 390,163		
09/30/22					

I. Preparer's/Reviewer's Certification

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2022	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> NurseFac-Aids		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
iCare Management, LLC				
Address Address		Phone Number		
341 Bidwell Street, Manchester, CT 06040		860-570-2140		
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number		
Kartik Patel		860-570-2140		
Contact Email Address				
kpatel@icarehn.com				