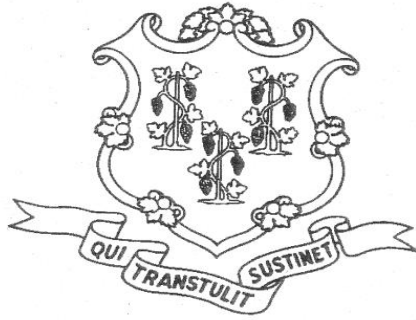


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2023

Name of Facility (as licensed) Trinity Hill Care Center, LLC	
Address (No. & Street, City, State, Zip Code) 151 Hillside Avenue, Hartford, CT 06016	
Type of Facility Chronic and Convalescent <input type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input checked="" type="checkbox"/> (Specify) <input checked="" type="checkbox"/> NurseFac-Aids	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 2222-C	(Specify)	NurseFac-Aids AIDS	Medicare Provider 07-5268
------------------	-----------------------	-----------	-----------------------	------------------------------

Medicaid Provider Numbers:	CCNH / RHNS 9555	(Specify)	NurseFac-Aids 49553	
----------------------------	---------------------	-----------	------------------------	--

General Information

Name of Facility (as licensed) Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2023	Page 1	of 37
---	-----------------------	------------------------------------	-----------	----------

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, 2022 and ending September 30, 2023, 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)

Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Other Lines of Business	6
General Information and Questionnaire - Other Lines of Business (Continued)	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

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 10/1/2022	To 9/30/2023
Address of Facility 151 Hillside Avenue, Hartford, CT 06016				
Report Prepared By iCare Management, LLC		Phone Number 860-570-2140	Date 2/15/2024	
Item	Total	CCNH / RHNS	(Specify)	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 9/30/2023	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 / RHNS 2222-C	(Specify)	NurseFac-Aids AIDS	Medicare Provider No. 07-5268	
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input checked="" type="checkbox"/> (Specify) <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 9/30/2023	Page 3	of 37
Legal Name of Partnership/LLC Trinity Hill Care Center, LLC		Business Address 151 Hillside Avenue, Hartford, CT 06016		State(s) and/or Town(s) in Which Registered CT	
Name of Partners/Members	Business Address	Title		% Owned	
V. Robert Salazar	2500 18th Street, Suite 200, Denver, CO 80211	Member		31.3	
David Sebbag	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		21.4	
Ari Krausz	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		21.3	
Solomon Melamed	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		1	
Christopher Wright	341 Bidwell Street, Manchester, Ct 06040	Member		5	
Premier First Investors	245 S. Benton Street, Lakewood, CO 80226	Member		10	
Global World Investors	245 S. Benton Street, Lakewood, CO 80226	Member		10	

**General Information and Questionnaire
 Related Parties***

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2023	Page 4	of 37
---	-----------------------	------------------------------------	-----------	----------

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

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

* Use additional sheets if necessary.

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

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 9/30/2023	Page 5	of 37
---	-----------------------	------------------------------------	-----------	----------

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
Other Lines of Business

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility. 0				
Outpatient Therapy				
Does the Facility provide outpatient therapy services?		No		
<i>If yes, please complete the following:</i>				
	Square footage of therapy space.			
Meals on Wheels				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
	Square footage of kitchen			
	Number of meals served per week			
No	Are meals included in meals served on page 18 of the Annual Report?			
No	Are direct costs included in the Annual Report?			
<i>If yes, please state where costs are reported.</i>				
No	Are drivers for the program included in the facility's payroll?			
<i>If yes, please complete the following:</i>				
		Amount Reported		
		Annual Report page and line		
Please state the salary amounts of specific cooks and/or dietary aides				
Please state where the cooks and/or dietary aides are reported in the Annual Report				
Apartments, Independent Living, Assisted Living				
Does the facility have apartments, independent living, and/or assisted living?		No		
<i>If yes, please complete the following:</i>				
	Square footage of apartments			
	Square footage of independent living			
	Square footage of assisted living			
Please identify the services provided:				

General Information and Questionnaire
Other Lines of Business (Continued)

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Cent	2222-C	9/30/2023	7	37

Child Day Care

Does the Facility provide Child Day Care? No

If yes, please complete the following:

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

Adult Day Care

Does the Facility provide Adult Day Care? No

If yes, please complete the following:

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

Schedule of Resident Statistics

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C		Report for Year Ended 9/30/2023				Page 8		of 37	
	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total NurseFac-Aids	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	NurseFac-Aids	Total	CCNH / RHNS	(Specify)	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	134	104		30					134	104		30
2. Number of Residents												
A. As of midnight of PREVIOUS report period	120	96		24	120	96		24				
B. As of midnight of THIS report period	124	100		24					124	100		24
3. Total Number of Days Care Provided During Period												
A. Medicare	1,138	1,138			853	853			285	285		
B. Medicaid (Conn.)	42,619	34,518		8,101	31,718	25,786		5,932	10,901	8,732		2,169
C. Medicaid (other states)												
D. Private Pay												
E. State SSI for RCH												
F. Other (Specify) Insurance												
G. Total Care Days During Period (3A thru F)	43,757	35,656		8,101	32,571	26,639		5,932	11,186	9,017		2,169
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)	43,757	35,656		8,101	32,571	26,639		5,932	11,186	9,017		2,169

Schedule of Resident Statistics (Cont'd)

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C			Report for Year Ended 9/30/2023			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	(Specify)	NurseFac-Aids	Lost			Gained			CCNH / RHNS	(Specify)	NurseFac-Aids	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	(Specify)	(Specify)		
5/1/2023	X			(10)									
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	(Specify)	NurseFac-Aids		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	NurseFac-Aids	R.C.H.	ICF-MR					
No. of Residents	2	98				24							
Per Diem Rate													
a. One bed rm.	554.00	#####				351.00							
b. Two bed rms.													
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments					TOTAL	CCNH / RHNS	(Specify)	Outpatient	NurseFac-Aids				
A. Medicare - Part B					249	203			46				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments					581	473			108				
2. Restorative Treatments					1,990	1,622			368				
C. Other					1,496	1,219			277				
D. Total Physical Therapy Treatments					4,316	3,517			799				
8. Total Number of Speech Therapy Treatments					TOTAL	CCNH / RHNS	(Specify)	Outpatient	NurseFac-Aids				
A. Medicare - Part B					202	165			37				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments					154	125			29				
2. Restorative Treatments					151	123			28				
C. Other					175	143			32				
D. Total Speech Therapy Treatments					682	556			126				
9. Total Number of Occupational Therapy Treatments					TOTAL	CCNH / RHNS	(Specify)	Outpatient	NurseFac-Aids				
A. Medicare - Part B					1,017	829			188				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments					701	571			130				
2. Restorative Treatments					2,683	2,186			497				
C. Other					1,672	1,362			310				
D. Total Occupational Therapy Treatments					6,073	4,949			1,124				

Annual Report of Long-Term Care Facility

CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility		License No.		Report for Year Ended			Page		of	
Trinity Hill Care Center, LLC		2222-C		9/30/2023			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 / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	NurseFac-Aids	Adjustment	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)	139,393		1,377				31,670		689	
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	12,411		235				2,820		117	
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	835,544		27,682				417,772		13,841	
5. Dietary Service										
a. Head Dietitian	41,178		1,031				9,356		297	
b. Food Service Supervisor	51,559		1,619				11,714		467	
c. Dietary Workers	460,440		18,258				104,611		5,267	
6. Housekeeping Service										
a. Head Housekeeper										
b. Other Housekeeping Workers	307,006		15,379				153,503		7,690	
7. Repairs & Maintenance Services										
a. Engineer or Chief of Maintenance										
b. Other Maintenance Workers	26,126		1,413				13,063		707	
8. Laundry Service										
a. Supervisor										
b. Other Laundry Workers	55,772		2,891				27,886		1,445	
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	184,157		2,803				92,079		1,401	
b. RN										
1. Direct Care	442,994		6,816				191,646		4,085	
2. Administrative**	303,994		6,378				151,997		3,189	
c. LPN										
1. Direct Care	1,399,066		36,393				236,099		8,039	
2. Administrative**	91,063		2,180							
d. Aides and Attendants	1,586,022		66,789				440,432		22,229	
e. Physical Therapists										
f. Speech Therapists										
g. Occupational Therapists										
h. Recreation Workers	197,526		7,511				44,878		2,167	
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	638,050		17,236				144,964		4,972	
n. Marketing										
o. Other (Specify) See Attached Schedule	217,977		9,330				94,818		4,345	
<i>A-13. Total Salary Expenditures</i>	<i>6,990,280</i>		<i>225,321</i>				<i>2,169,308</i>		<i>80,947</i>	

* 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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH / RHNS			(Specify)			NurseFac-Aids		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
UNIT SECRETARIES SALARIES	\$ 48,019		1,627				\$ 10,910		469
MEDICAL RECORDS SALARIES	\$ 15,758		319				\$ 3,580		92
CENTRAL SUPPLY SALARIES	\$ 33,848		1,323				\$ 7,690		661
RESPIRATORY THERAPY SALARIES	\$ -		-				\$ -		-
PLANT SECURITY SALARIES	\$ 120,352		6,060				\$ 27,344		1,377
MEDICAL RECORDS SALARIES SPCL	\$ -		-				\$ 45,294		1,745
Total	\$ 217,977	\$ -	9,330	\$ -	\$ -	-	\$ 94,818	\$ -	4,345

Schedule of Other Fees (Page 13)

Service	CCNH / RHNS			(Specify)			NurseFac-Aids		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ (9,321)		Storage				\$ (2,118)		Storage
ADMISSIONS C/S LABOR	\$ (517,299)		(9,040)				\$ (117,530)		(2,608)
CENTRAL SUPPLY CONTRACT SERVICE	\$ (13,957)		(764)				\$ (3,171)		(174)
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ (634,133)		(15,233)				\$ (317,066)		(7,616)
RESPIRATORY THERAPY CONTRACT SERVICES	\$ 1,484		-				\$ 337		-
PHYSICAL THERAPY C/S MEDICIAD	\$ -		-				\$ -		-
SPEECH THERAPY C/S Medicaid	\$ -		-				\$ -		-
OCCUPATIONAL THERAPY C/S MEDICIAD	\$ -	-	-				\$ -		-
Total	\$ (1,173,226)	\$ -	(25,037)	\$ -	\$ -	-	\$ (439,548)	\$ -	(10,398)

**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	9/30/2023			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	(Specify)	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		9/30/2023			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	(Specify)	NurseFac-Aids							
Section III - Administrators***										
Yong Crandall	139,393		31,670	Administrator		2,066	same as empl			
				Administrator			same as empl			
				Administrator			same as empl			
Section IV - Assistant Administrators										
	12,411		2,820			352				

*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	9/30/2023					13	37	
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	NurseFac-Aids	Adjustment	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	21,467		175				4,877		40
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	70,356		1,348						
b. Other									
6. Social Worker	4,823		52				1,096		15
7. Recreation Worker	2,497		6 Hours + Ca				1,248		
8. Physicians									
a. Medical Director (entire facility)	36,000		240				64,992		477
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	11,465		14				2,605		4
9. Speech Therapist									
a. Resident Care	23,142		443						
b. Other									
10. Occupational Therapist									
a. Resident Care	111,543		2,137						
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	176,983		1,896						
2. Administrative***	(517,198)		(8,985)						
b. LPN									
1. Direct Care	205,472		2,824						
2. Administrative***									
c. Aides	53,614		1,615						
d. Other									
12. Other (Specify)									
See Attached Schedule	(1,173,226)		(25,037)				(439,548)		(10,398)
B-13 Total Fees Paid in Lieu of Salaries	(973,063)		(23,279)				(364,729)		(9,862)

* 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 in the Adjustment column.

*** 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 9/30/2023		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 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"/>				
		<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	9/30/2023					15	37
Item	Total Including Adjustment	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment	
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 172,253	131,975				40,278		
2. Disability Insurance	\$							
3. Unemployment Insurance	\$							
4. Social Security (F.I.C.A.)	\$ 747,831	572,965				174,866		
5. Health Insurance	\$ 1,189,000	910,975				278,025		
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 527,198	403,923				123,275		
8. Uniform Allowance	\$							
9. Other (<i>Specify</i>) See Attached Schedule	\$ 48,707	37,318				11,389		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$							
c. Bad Debts*	\$ 343,696	343,696						
d. Accounting and Auditing	\$ 39,072	31,838				7,234		
e. Legal (<i>Services should be fully described on Page 15b</i>)	\$ 2,151	1,753				398		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$							
g. Office Supplies	\$ 8,898	5,932				2,966		
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$ 28,259	23,027				5,232		
2. Cellular Phones	\$ 11,393	9,284				2,109		
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	\$ 895,851	729,997				165,854		
Subtotal	\$ 4,014,310	3,202,682				811,628		

* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac- Aids	Adjustment
UNION TRAINING	\$ 37,318				\$ 11,389	
Total	\$ 37,318	\$ -	\$ -	\$ -	\$ 11,389	\$ -

Schedule of Other Taxes

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac- Aids	Adjustment
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

General Information and Questionnaire Accounting Basis

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2023	Page 15b	of 37
---	-----------------------	------------------------------------	-------------	----------

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 Plante & Moran, PLLC 2 3 4	Address (No. & Street, City, State, Zip Code) PO Box 307 3000 Town Center, Suite 100 Southfield, MI 48075
--	--

Services Provided by This Firm (*describe fully*)

1 Taxes, financial statements, accounting support	\$ 39,072
2	\$
3	\$
4	\$
Charge for Services Provided	
\$ 39,072	

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 Senior Care Valuation LLC 2 Murtha Cullinal LLP 3 Various others (American Arbitration , Various Arbitration) 4 5	Telephone Number
---	------------------

Address (*No. & Street, City, State, Zip Code*)
 1
 2
 3
 4
 5

Services Provided by This Firm (*describe fully*)

1 Lease and contract issues, general legal advice, Labor Law	\$ 1,000
2 General legal advice, union funds advice, employment law	\$ 173
3 Employment Arbitrations, healthcare law & Conservatorships	\$ 978
4	\$
5 Collections	\$ (0)
Charge for Services Provided	
\$ 2,151	

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

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	9/30/2023					16	37
Item	Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment	
Subtotals Brought Forward:	4,014,310	3,202,682				811,628		
l. Travel and Entertainment								
1. Resident Travel and Entertainment	\$							
2. Holiday Parties for Staff	\$ 1,752	1,428				324		
3. Gifts to Staff and Residents	\$ 452	369				84		
4. Employee Travel	\$ 25,057	20,418				4,639		
5. Education Expenses Related to Seminars and Conventions	\$ 2,363	1,926				438		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$							
7. Other (<i>Specify</i>) See Attached Schedule	\$ 1,109	904				205		
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 24,196	19,716				4,480		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$							
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 12,303	10,025				2,278		
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	\$ 3,974	3,238				736		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 9,777	7,967				1,810		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$							
9. Subscriptions	\$ 1,013	826				188		
10. Contributions*** See Attached Schedule	\$ 200	163				37		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 147,946	98,631				49,315		
12. Administrative Management Services**	\$ 463,757	377,899				85,858		
13. Other (<i>Specify</i>) See Attached Schedule	\$ 24,943	20,326				4,617		
C-14 Total Administrative & General Expenditures	\$ 4,733,153	3,766,517				966,636		

* 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 in the Adjustment column.

Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
MEALS	\$ 904				\$ 205	
Total Other Travel and Entertainment	\$ 904	\$ -	\$ -	\$ -	\$ 205	\$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
COMMUNICATIONS SPECIAL EVENTS	\$ 10,025				\$ 2,278	
Total Other Advertising	\$ 10,025	\$ -	\$ -	\$ -	\$ 2,278	\$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
ALTCFM						
CAHCF Dues	\$ 7,967				\$ 1,810	
OTHER DUES						
Total Dues	\$ 7,967	\$ -	\$ -	\$ -	\$ 1,810	\$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
CONTRIBUTIONS	\$ 163				\$ 37	
Total Contributions	\$ 163	\$ -	\$ -	\$ -	\$ 37	\$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
SOCIAL SERVICE SUPPLIES	\$ -				\$ -	
SOC SVC MINOR EQUIPMENT	\$ -				\$ -	
ADMINISTRATIVE MINOR EQUIPMENT	\$ 3,061				\$ 695	
EMPLOYEE RELATIONS	\$ (803)				\$ (182)	
EMPLOYEE RELATIONS-OTHER	\$ 288				\$ 65	
PERMITS & LICENSES	\$ 3,049				\$ 693	
VOLUNTEER EXPENSE	\$ -				\$ -	
BANK FEES	\$ 5,036				\$ 1,144	
CMS REVISIT USER FEES	\$ -				\$ -	
PENALTIES	\$ -				\$ -	
LATE FEES	\$ (67)				\$ (15)	
INTERNET EXPENSES	\$ 9,759				\$ 2,217	
Rounding	\$ 3					
Total Other Administrative and General	\$ 20,326	\$ -	\$ -	\$ -	\$ 4,617	\$ -

Schedule C-1 - Management Services*

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2023	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
iCare Management, LLC/iCare Health Management, LLC	463,757	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	148,961	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	36,908	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		License No.	Report for Year Ended				Page	of
Trinity Hill Care Center, LLC		2222-C	9/30/2023				18	37
Item	Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 379,950	309,607				70,342		
2. Non-Food Supplies	\$ 46,681	38,038				8,642		
3. Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 11,071	9,021				2,050		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ (33,900)	(27,624)				(6,276)		
c. Other (Specify) _____ DIETARY MINOR EQUIPMENT	\$ 3,827	3,119				709		
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 407,628	332,162				75,467		
2E. Dietary Questionnaire		Total	CCNH / RHNS	(Specify)		NurseFac-Aids		
F. Resident Meals:	Total no. of meals served per day:*							
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	9/30/2023				19	37
Item		Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
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)		\$	353	235			118	
LAUNDRY MINOR EQUIPMENT								
3D. Total Laundry Expenditures (3a + b + c)		\$	54,009	36,006			18,003	
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	9/30/2023				20	37	
Item			Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
4.	Housekeeping	Sq. Ft. Serviced by Personnel							
a.	In-House Care								
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt.	\$ 24,846	16,564				8,282	
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)		\$ 65,364	43,576				21,788	
5.	Resident Care (Supplies)**								
a.	Prescription Drugs***								
	1. Own Pharmacy		\$						
	2. Purchased from PHARMACY		\$ 136,423	136,423					
b.	Medicine Cabinet Drugs		\$ 6,414	5,226				1,187	
c.	Medical and Therapeutic Supplies		\$ 98,415	80,195				18,220	
d.	Ambulance/Limousine***		\$ 626	418				209	
e.	Oxygen								
	1. For Emergency Use		\$ 1,384	1,384					
	2. Other***		\$						
f.	X-rays and Related Radiological Procedures***		\$ 693	693					
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$						
h.	Laboratory***		\$ 23,747	23,747					
i.	Recreation		\$						
j.	Direct Management Services*		\$ 148,961	121,383				27,578	
k.	Indirect Management Services*		\$ 36,908	30,075				6,833	
l.	Cable TV		\$						
m.	Other (Specify)**** See Attached Schedule		\$ 82,856	60,631				22,226	
n.	Physical Therapy Expense		\$						
o.	Speech Therapy Expense		\$						
5P.	Total Resident Care Expenditures (5a - 5o)		\$ 536,428	460,175				76,253	

* 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 in the Adjustment column.
 **** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-	
					Aids	Adjustment
NURSING ADMIN SUPPLIES	\$ 167				\$ 38	
NURSING MINOR EQUIP	\$ 1,977				\$ 449	
MEDICAL RECORDS SUPPLIES	\$ (690)				\$ (157)	
MEDICAL RECORDS MINOR EQUIPMENT	\$ -				\$ -	
NON-COVERED PPS DR. VISITS	\$ 27				\$ 6	
RESIDENT CARE SUPPLIES	\$ -				\$ -	
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 12,823				\$ 2,913	
PERSONAL CARE SUPPLIES	\$ -				\$ -	
INCONTINENCY SUPPLIES	\$ -				\$ -	
VACCINE RESIDENTS	\$ 4,041				\$ -	
PATIENT SPECIAL NEEDS	\$ 290				\$ -	
PHYSICAL THERAPY SUPPLIES	\$ -				\$ -	
PHYSICAL THERAPY EQUIPMENT RENT	\$ -				\$ -	
PHYSICAL THERAPY MINOR EQUIPMENT	\$ -				\$ -	
OCCUPATIONAL THERAPY SUPPLIES	\$ -				\$ -	
OCCUPATIONAL THERAPY EQUIP RENTAL	\$ -				\$ -	
OCCUPATIONAL THERAPY MINOR EQUIP	\$ -				\$ -	
SPEECH THERAPY SUPPLIES	\$ -				\$ -	
SPEECH THERAPY EQUIPMENT RENT	\$ -				\$ -	
SPEECH THERAPY MINOR EQUIPMENT	\$ -				\$ -	
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 18,364				\$ 9,182	
EQUIPMENT RENTAL: AIDS UNIT	\$ -				\$ -	
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 240				\$ -	
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ 3,805				\$ -	
HI LOW BED RENTAL & MATTRESSES	\$ -				\$ -	
IV THERAPY SUPPLIES	\$ 16,236				\$ 8,118	
IV THERAPY CONTRACT SERVICE	\$ -				\$ -	
MEDICAL WASTE CONTRACT SERVICE	\$ 1,506				\$ 753	
ACTIVITIES SUPPLIES	\$ 1,612				\$ 806	
ACTIVITIES MINOR EQUIPMENT	\$ 234				\$ 117	
ADMISSIONS SUPPLIES	\$ -				\$ -	
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS						
STRIKE COSTS NON REIMBURSABLE	\$ -				\$ -	
COVID NON REIMBURSABLE	\$ -				\$ -	
Total Other Resident Care	\$ 60,631	\$ -	\$ -	\$ -	\$ 22,226	\$ -

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 9/30/2023				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	(Specify)	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	7,011			22	6F
Brightview Landscapes LLC		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Landscaping	7,035			22	6F
Peter Marcue		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Snow Removal	14,306			22	6F
All Waste Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Trash removal	34,553			22	6F
Facility Complainece		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Plant Contract Services	101,237			22	6F
American HealthTech	P.O. Box 9001006, Louisville, KY 40290	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Software Maintenance Contract	23,033			16	M11
Automatic Data Processing		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Payroll Services	50,792			16	M11
National Datacare Corp		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Resident Trust Software	3,216			16	M11
Prime Care Technology services		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Computer Consulting Services	43,610			16	M11
Priotiry Express		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Courier Services	3,232			16	M11
Point Right Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Nursing Software	5,149			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	9/30/2023				22	37
Item	Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
6. Maintenance & Operation of Plant							
a. Repairs & Maintenance	\$ 29,862	19,908				9,954	
b. Heat	\$ 69,339	46,226				23,113	
c. Light & Power	\$ 88,936	59,290				29,645	
d. Water	\$ 81,915	54,610				27,305	
e. Equipment Lease (<i>Provide detail on page 22b</i>)	\$ 22,145	18,045				4,100	
f. Other (<i>itemize</i>)	\$ 235,868	157,246				78,623	
See Attached Schedule							
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 528,066	355,326				172,740	
7. Depreciation (<i>complete schedule page 23*</i>)							
a. Land Improvements	\$						
b. Building & Building Improvements	\$ 19,523	15,908				3,614	
c. Non-Movable Equipment	\$ 306	249				57	
d. Movable Equipment	\$ 43,632	35,554				8,078	
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 63,460	51,711				11,749	
8. Amortization (<i>Complete att. Schedule Page 24*</i>)							
a. Organization Expense	\$						
b. Mortgage Expense	\$						
c. Leasehold Improvements	\$ 59,339	48,353				10,986	
d. Other (<i>Specify</i>)	\$						
*8e. Total Amortization Costs (8a + b + c + d)	\$ 59,339	48,353				10,986	
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 2,127,147	1,733,335				393,812	
10. Property Taxes							
a. Real estate taxes paid by owner	\$						
b. Real estate taxes paid by lessor	\$ 355,307	236,872				118,436	
c. Personal property taxes	\$ 28,689	19,126				9,563	
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 2,633,941	2,089,397				544,545	

* 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	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
PLANT SUPPLIES	\$ 8,364				\$ 4,182	
PLANT CONTRACT SERVICE LABOR	\$ 16,558				\$ 8,279	
ELEVATOR CONTRACT SERVICE	\$ 4,674				\$ 2,337	
FIRE/SPRINKLER CONTRACT SERVICE	\$ 5,086				\$ 2,543	
LANDSCAPING CONTRACT SERVICE	\$ 4,690				\$ 2,345	
SNOW REMOVAL CONTRACT SERVICE	\$ 9,537				\$ 4,769	
TRASH REMOVAL CONTRACT SERVICE	\$ 23,036				\$ 11,518	
PLANT (POOL) CONTRACT SERVICES OTHER	\$ 67,491				\$ 33,746	
SECURITY CONTRACT SERVICE	\$ -				\$ -	
PLANT CONTRACT SERVICE OTHER	\$ 7,402				\$ 3,701	
PLANT MINOR EQUIPMENT	\$ 7,001				\$ 3,501	
RENT AUTO	\$ -				\$ -	
RENT EQUIPMENT	\$ 3,408				\$ 1,704	
RENT OTHER	\$ -				\$ -	
Total Other Repairs and Maintenance	\$ 157,246	\$ -	\$ -	\$ -	\$ 78,623	\$ -

General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility			License No.	Report for Year Ended			Page	of
Trinity Hill Care Center, LLC			2222-C	9/30/2023			22b	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	automatic renewals	9,178		9,178
GE Capital C/O Wells Fargo, P.O.Box 41564, Philadelphai, PA 19101	<input type="radio"/>	<input checked="" type="radio"/>	Copier	03/05/14	automatic renewals	11,921		11,921
Neopost USA Inc, 25880 Network Place, Chicago, IL 60673	<input type="radio"/>	<input checked="" type="radio"/>	Postage Rental	04/16/13	Month to month	1,046		1,046
	<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"/>						
							Total ***	22,145

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes No

* 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.

Depreciation Schedule

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C		Report for Year Ended 9/30/2023			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	173,977			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	7,685			306				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal										306			
		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						706,620		706,620	588,932			41,047	
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative						18,218						1,487	
d. Standard Resident						16,067						411	
e. Specialized Resident						8,637						687	
Total Acquired during this report period						42,922						2,585	
D-3. Subtotal													43,632
E. Total Depreciation													63,460

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

Amortization Schedule*

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C		Report for Year Ended 9/30/2023			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				1,111,945	694,384			59,339	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				12,142					
C-4. Subtotal									59,339
D. Total Amortization									59,339

* 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 9/30/2023	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> 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		134		
6. Square Footage		51,572		
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd 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	1,445,287

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	9/30/2023				26	37
Item		Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
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		9/30/2023				27	37	
Item				Total Including Adjustments	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
Subtotals Brought Forward:										
12. C. Movable Equipment										
1. Automotive Equipment				\$						
A. Item		Rate	Amount							
Lender										
Address of Lender										
2. Other (Specify)				\$						
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 (Specify) INTEREST				\$	51	41			9	
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	51	41			9	
14. Insurance										
a. Insurance on Property (buildings only)				\$	9,077	6,051			3,026	
b. Insurance on Automobiles				\$						
c. Insurance other than Property (as specified above)										
1. Umbrella (Blanket Coverage)				\$	99,445	66,297			33,148	
2. Fire and Extended Coverage				\$						
3. Other (Specify) Other insurance, crime				\$	13,460	8,974			4,487	
14d. Total Insurance Expenditures (14a + b + c)				\$	121,983	81,322			40,661	
15. Total All Expenditures (A-13 thru C-14)				\$	16,902,418	13,181,737			3,720,680	

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2023		30	37
Item	Total	CCNH / RHNS	(Specify)	NurseFac-Aids	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 14,826,102	11,955,944		2,870,159	
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>)	\$ 919,769	919,769			
b. Medicare Room and Board Contractual Allowance **	\$				
4. a. Private-Pay Residents and Other	\$				
b. Private-Pay Room and Board Contractual Allowance **	\$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 92,803	92,803			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (92,803)	(92,803)			
c. Prescription Drugs - Non-Medicare	\$ 61,534	40,236		21,297	
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (61,534)	(40,236)		(21,297)	
2. a. Medical Supplies - Medicare	\$ 539	539			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (539)	(539)			
c. Medical Supplies - Non-Medicare	\$ 8,157	4,424		3,733	
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (8,157)	(4,424)		(3,733)	
3. a. Physical Therapy - Medicare	\$ 38,098	38,098			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (33,831)	(33,831)			
c. Physical Therapy - Non-Medicare	\$ 92,235	75,568		16,667	
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (92,235)	(75,568)		(16,667)	
4. a. Speech Therapy - Medicare	\$ 1,890	1,890			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (1,915)	(1,915)			
c. Speech Therapy - Non-Medicare	\$ 27,899	19,263		8,635	
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (27,899)	(19,263)		(8,635)	
5. a. Occupational Therapy - Medicare	\$ 52,380	52,380			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (38,166)	(38,166)			
c. Occupational Therapy - Non-Medicare	\$ 134,902	105,448		29,453	
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (134,902)	(105,448)		(29,453)	
6. a. Other (<i>Specify</i>) - Medicare	\$ (394,808)	(394,808)			
b. Other (<i>Specify</i>) - Non-Medicare	\$ 84,724	84,724			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 15,454,244	12,584,085		2,870,159	
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>)	\$ 60,003	60,003			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 29,284	29,284			
V. Total Other Revenue (I thru 8)	\$ 89,286	89,286			
VI. Total All Revenue (III +V)	\$ 15,543,530	12,673,371		2,870,159	

* 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	(Specify)	NurseFac-Aids
	Lab Medicare	\$ 5,570		
	Lab Medicare CA	\$ (5,570)		
	Oxygen Medicare	\$ -		
	Oxygen Medicare CA	\$ -		
	Equipment rental	\$ -		
	Equipment rental CA	\$ -		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds Medicare	\$ -		
	Therapy Beds Medicare CA	\$ -		
	Radiology Medicare	\$ 567		
	Radiology Medicare CA	\$ (567)		
	IV Therapy	\$ 12,606		
	IV Therapy CA	\$ (12,606)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose testing	\$ -		
	Glucose testing CA	\$ -		
	Outpatient therapy Medicare	\$ -		
	MEDICAID COVID REVENUE	\$ -		
	CRF MEDICAID REVENUE	\$ -		
	MEDICAID WAGE & ENHANCEMENT RESERVE	\$ (394,808)		
Total Other Resident Revenue - Medicare		\$ (394,808)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH / RHNS	(Specify)	NurseFac-Aids
	Lab	21,800		
	Lab CA	(21,800)		
	Oxygen	\$ -		\$ -
	Oxygen CA	\$ -		\$ -
	Equipment rental	\$ -		
	Equipment rental CA	\$ -		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds	\$ -		
	Therapy Beds CA	\$ -		
	Radiology	\$ -		
	Radiology CA	\$ -		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose Testing	\$ -		
	Glucose Testing CA	\$ -		
	IV therapy	\$ 5,767		\$ 105
	IV therapy CA	\$ (5,767)		\$ (105)
	Flu shot revenue	\$ 1,324		
	Outpatient therapy	\$ -		
	prior period revenue	\$ (28,174)		
	Optum B	\$ 156,990		
	Optum B CA	\$ (45,415)		
	C/A VBP	\$ -		
	rounding	\$ (1)		
Total Other Resident Revenue		\$ 84,724	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH / RHNS	(Specify)	NurseFac-Aids
	INTEREST INCOME		\$ 60,003		
Total Interest Income			\$ 60,003	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH / RHNS	(Specify)	NurseFac-Aids
	MEALS	\$ -		
	TELEVISION INCOME	\$ -		
	OTHER INCOME: DMHAS OPERATING REVENUE	\$ -		
	OTHER INCOME: DMHAS ORGANIZATIONAL REV	\$ -		
	OTHER INCOME: DEFERRED REVENUE	\$ 13,044		
	MEDICARE COVID STIMULUS REVENUE	\$ -		
	CONCESSIONS / VENDING INCOME	\$ -		
	RESIDENT LATE FEE REVENUE	\$ -		
	RESIDENT ATTORNEY FEE REVENUE	\$ -		
	TELEPHONE INCOME	\$ -		
	OTHER INCOME	\$ -		
	OPTUM DIVIDENDS REVENUE	\$ 16,240		
	OPTUM OUTLIERS	\$ -		
	HHS GENERAL FUND REVENUE	\$ -		
	HHS INFECTION CONTROL REVENUE	\$ -		
	CARES ACT REVENUE	\$ -		
	EMPLOYEE TESTING REVENUE	\$ -		
	COVID ECHO TRAINING REVENUE	\$ -		
Total Other Revenue		\$ 29,284	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2023	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	1,521,956
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	3,997,854
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	15,878
5. Prepaid Expenses			\$	232,328
a. Prepaid Insurance	133,239			
b. Prepaid Property Taxes	95,916			
c. Prepaid Expenses Other	3,173			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(1,230,155)
Due From (to) Related Parties	510,110			
Other Owners reserves	(1,740,265)			
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	4,537,861
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost 394,955		\$	201,456
	Accum. Depreciation 193,500	Net		
4. Leasehold Improvements	*Historical Cost 1,124,086		\$	370,363
	Accum. Depreciation 753,723	Net		
5. Non-Movable Equipment	*Historical Cost 7,990		\$	(1)
	Accum. Depreciation 7,991	Net		
6. Movable Equipment	*Historical Cost 749,542		\$	116,978
	Accum. Depreciation 632,564	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
Construction in Progress				
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	688,796

* 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	
Total Prepaid Expenses			\$ -

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

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	
Total Other Other Fixed Assets (Itemize)			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

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	
Total Other Current Liabilities (Itemize)			\$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2023	32	37
Account			Amount	
Total Brought Forward:			\$	5,226,658
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			\$	848,657
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	43,542
	Patient Trust Funds	32,387		
	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>)			\$	11,824,978
	RIGHT TO USE ASSET	13,879,767		
	ACCUM RIGHT TO USE ASSET	(2,054,789)		
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	12,717,177
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	17,943,834

* 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 9/30/2023	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	251,606
2. Notes Payable (<i>itemize</i>)				\$	

See Schedule					
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	470,897
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	13,947,187
Related Party Payables		13,716,773			
Accrued Expenses		144,180			
Accrued Resident User Fees		0			
Accrued Workers Comp Expense		86,234	See Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	14,669,690

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2023		Page 34	of 37
Account				Amount	
Total Brought Forward:				14,669,690	
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		32,387			
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 32,387	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 14,702,076	

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	9/30/2023	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			\$	4,599,646
6. Gain or Loss for Period			\$	(1,358,888)
	10/1/2022	thru	9/30/2023	
7. Total Net Worth			\$	3,241,758
C. Total Reserves and Net Worth			\$	3,241,758
D. Total Liabilities, Reserves, and Net Worth			\$	17,943,834

H. Changes in Total Net Worth

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2023	Page 36	of 37	
Account			Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$ 15,543,530		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$ 16,902,418		
D. Net Income or Deficit			\$ (1,358,888)		
E. Balance			\$ (1,358,888)		
F. Additions					
1. Additional Capital Contributed (<i>itemize</i>)					
2. Other (<i>itemize</i>)					
F-3. Total Additions			\$		
G. Deductions					
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)					
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount		
2. Other Withdrawings (<i>Specify</i>)			\$		
Purpose		Amount			
3. Total Deductions			\$		
H. Balance at End of Period			\$ (1,358,888)		
			09/30/23		

I. Preparer's/Reviewer's Certification

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
<input type="checkbox"/> Chronic and Convalescent Nursing <input type="checkbox"/> Home (CCNH) & RHNS <input type="checkbox"/> Combined	<input checked="" type="checkbox"/> (Specify)	<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				