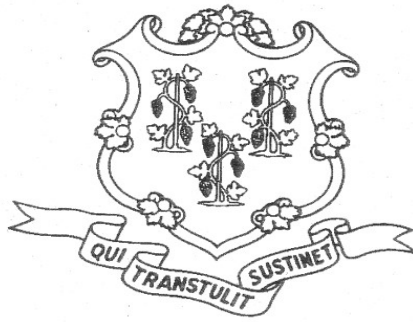


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2024

Name of Facility (as licensed) Trinity Hill Care Center, LLC	
Address (No. & Street, City, State, Zip Code) 151 Hillside Avenue, Hartford, CT 06016	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input checked="" type="checkbox"/> NurseFac-Aids	
Report for Year Beginning 10/1/2023	Report for Year Ending 9/30/2024

License Numbers:	CCNH / RHNS 2222-C	(Specify)	NurseFac-Aids AIDS	Medicare Provider 07-5268
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Medicaid Provider Numbers:	CCNH / RHNS 9555	(Specify)	NurseFac-Aids 49553
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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2024	1	37

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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, 2023 and ending September 30, 2024, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) George Kingston			Printed Name (Owner) Chris Wright		
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 10/1/2023	To 9/30/2024
Address of Facility 151 Hillside Avenue, Hartford, CT 06016				
Report Prepared By iCare Management, LLC		Phone Number 860-570-2140	Date 2/15/2025	
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 9/30/2024	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 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 George Kingston				
		Nursing Home Administrator's License No.:	2169	
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 9/30/2024	Page 3 of 37
Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered	
Trinity Hill Care Center, LLC	151 Hillside Avenue, Hartford, CT 06016	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

Owner(s) of Facility

**General Information and Questionnaire
Related Parties***

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C		Report for Year Ended 9/30/2024		Page 4	of 37	
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input checked="" type="radio"/> Yes <input type="radio"/> 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 page 4		<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.
** 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 9/30/2024	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

Other Lines of Business

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2024	Page 6	of 37
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Square footage of entire facility.	51,572
------------------------------------	--------

Outpatient Therapy

Does the Facility provide outpatient therapy services?	No
--	----

If yes, please complete the following:

	Square footage of therapy space.
--	----------------------------------

Meals on Wheels

Does the facility provide Meals on Wheels?	No
--	----

If yes, please complete the following:

	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
--	----

If yes, please complete the following:

	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	9/30/2024	7	37

Child Day Care

Does the Facility provide Child Day Care?

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?

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 9/30/2024			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	134	104		30	134	104		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	124	100		24	124	100		24				
B. As of midnight of THIS report period	129	107		22					129	107		22
3. Total Number of Days Care Provided During Period												
A. Medicare	785	656		129	562	462		100	223	194		29
B. Medicaid (Conn.)	44,188	35,239		8,949	33,025	26,145		6,880	11,163	9,094		2,069
C. Medicaid (other states)												
D. Private Pay	4	4			4	4						
E. State SSI for RCH												
F. Other (Specify) Insurance												
G. Total Care Days During Period (3A thru F)	44,977	35,899		9,078	33,591	26,611		6,980	11,386	9,288		2,098
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)	44,977	35,899		9,078	33,591	26,611		6,980	11,386	9,288		2,098

Schedule of Resident Statistics (Cont'd)

Name of Facility Trinity Hill Care Center, LLC				License No. 2222-C		Report for Year Ended 9/30/2024				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)	(1)	(2)	(3)	
	X												
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	5	102				22							
Per Diem Rate													
a. One bed rm.	543.00	#####				351.13							
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				1,681	1,342			339					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments				2,529	2,019			510					
2. Restorative Treatments				3,168	2,529			639					
C. Other				3,640	2,905			735					
D. Total Physical Therapy Treatments				11,018	8,794			2,224					
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B				284	227			57					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments				351	280			71					
2. Restorative Treatments				134	107			27					
C. Other				420	335			85					
D. Total Speech Therapy Treatments				1,189	949			240					
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B				1,177	939			238					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments				865	690			175					
2. Restorative Treatments				1,897	1,514			383					
C. Other				1,718	1,371			347					
D. Total Occupational Therapy Treatments				5,657	4,515			1,142					

Annual Report of Long-Term Care Facility

CSP-10 Rev. 3/2023

Report of Expenditures - Salaries & Wages

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2024	Page 10	of 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)	149,306		1,398				37,756		699
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	85,770		1,402				21,689		701
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	1,073,574		28,301				271,481		14,151
5. Dietary Service									
a. Head Dietitian	41,147		1,053				10,405		304
b. Food Service Supervisor	50,573		1,625				12,789		469
c. Dietary Workers	469,391		18,939				118,698		5,463
6. Housekeeping Service									
a. Head Housekeeper									
b. Other Housekeeping Workers	259,018		13,263				129,509		6,631
7. Repairs & Maintenance Services									
a. Engineer or Chief of Maintenance	2,417		64				1,209		32
b. Other Maintenance Workers	27,589		1,462				13,794		731
8. Laundry Service									
a. Supervisor									
b. Other Laundry Workers	61,561		3,173				30,781		1,586
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	294,686		3,019				74,519		1,510
b. RN									
1. Direct Care	444,334		9,172				178,000		3,579
2. Administrative**	534,968		7,757				135,281		3,879
c. LPN									
1. Direct Care	1,307,080		41,197				180,868		5,400
2. Administrative**	229,607		3,435				58,062		
d. Aides and Attendants	1,682,833		73,319				503,364		23,320
e. Physical Therapists									
f. Speech Therapists									
g. Occupational Therapists									
h. Recreation Workers	165,299		6,176				41,800		1,782
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	638,390		17,426				161,434		5,027
n. Marketing									
o. Other (Specify) See Attached Schedule	345,298		13,532				140,296		6,057
A-13. Total Salary Expenditures	7,862,842		245,713				2,121,735		81,320

* 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 Fees (Page 13)

Service	CCNH / RHNS			(Specify)			Nurse/Fac-Aids		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ (123,496)		(2,743)				\$ (31,229)		(694)
ADMISSIONS C/S LABOR	\$ (514,728)		(17,617)				\$ (130,162)		(5,082)
CENTRAL SUPPLY CONTRACT SERVICE	\$ (11,477)		(634)				\$ (2,902)		(160)
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ (965,225)		(14,947)				\$ (244,082)		(7,473)
RESPIRATORY THERAPY CONTRACT SERVICES	\$ 1,722		13				\$ 435		3
Total	\$ (1,613,204)	\$ -	(35,927)	\$ -	\$ -	-	\$ (407,941)	\$ -	(13,406)

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

Name of Facility Trinity Hill Care Center, LLC				License No. 2222-C		Report for Year Ended 9/30/2024			Page 11	of 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		9/30/2024			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	106,953		37,356	Administrator		2,097	same as empl			
George Kingston	42,352		400	Administrator			same as empl			
				Administrator			same as empl			
Section IV - Assistant Administrators										
Papa Kojo Affainie	85,770		21,689			2,103				

*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			9/30/2024			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	20,831		238				5,268		60
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	172,461		3,304						
b. Other									
6. Social Worker	5,980		79				1,512		23
7. Recreation Worker	4,075		15 Hours +C				1,030		
8. Physicians									
a. Medical Director (entire facility)	36,000		249				64,992		529
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	10,911		14				2,759		4
9. Speech Therapist									
a. Resident Care	39,699		761						
b. Other									
10. Occupational Therapist									
a. Resident Care	121,771		2,333						
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	113,907		1,372						
2. Administrative***	(717,402)		(13,648)				(181,414)		
b. LPN									
1. Direct Care	72,388		1,551				18,305		
2. Administrative***									
c. Aides	74,298		2,859				18,788		
d. Other									
12. Other (Specify)									
See Attached Schedule	(1,613,204)		(35,927)				(407,941)		(13,406)
B-13 Total Fees Paid in Lieu of Salaries	(1,658,285)		(36,816)				(476,700)		(12,790)

* 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 9/30/2024	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"/>			
		<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 Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2024					Page 15	of 37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac- Aids	Adjustment	
1. Administrative and General								
a. Employee Health & Welfare Benefits								
1. Workmen's Compensation	\$ 164,289	129,377				34,912		
2. Disability Insurance	\$							
3. Unemployment Insurance	\$							
4. Social Security (F.I.C.A.)	\$ 816,218	642,771				173,447		
5. Health Insurance	\$ 1,414,753	1,114,117				300,637		
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 581,195	457,690				123,505		
8. Uniform Allowance	\$							
9. Other (<i>Specify</i>) See Attached Schedule	\$ 49,979	39,358				10,621		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$							
c. Bad Debts*	\$ 820,102	820,102						
d. Accounting and Auditing	\$ 9,592	7,656				1,936		
e. Legal (<i>Services should be fully described on Page 15b</i>)	\$ (1,411)	(1,126)				(285)		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$							
g. Office Supplies	\$ 13,164	10,507				2,657		
h. Telephone and Cellular Phones								
1. Telephone & Pagers	\$ 29,202	23,308				5,894		
2. Cellular Phones	\$ 11,700	9,338				2,361		
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	\$ 928,822	741,352				187,470		
Subtotal	\$ 4,837,604	3,994,449				843,155		

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

(Carry Subtotals forward to next page)

Schedule of Other Employee Benefits

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
UNION TRAINING	\$ 39,358				\$ 10,621	
Total	\$ 39,358	\$ -	\$ -	\$ -	\$ 10,621	\$ -

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 9/30/2024	Page 15b	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 If "No," explain.
☐ No

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	\$ 9,592
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$ 9,592

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 2 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	\$
2 General legal advice, union funds advice, employment law	\$
3 Employment Arbitrations, healthcare law & Conservatorships	\$ (1,411)
4	\$
5 Collections	\$
	Charge for Services Provided
	\$ (1,411)

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	9/30/2024					16	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment	
Subtotals Brought Forward:	4,837,604	3,994,449				843,155		
l. Travel and Entertainment								
1. Resident Travel and Entertainment \$								
2. Holiday Parties for Staff \$	1,340	1,070				270		
3. Gifts to Staff and Residents \$	89	71				18		
4. Employee Travel \$	17,603	14,050				3,553		
5. Education Expenses Related to Seminars and Conventions \$	2,935	2,342				592		
6. Automobile Expense (<i>not purchase or depreciation</i>) \$								
7. Other (<i>Specify</i>) \$	1,254	1,001				253		
See Attached Schedule								
m. Other Administrative and General Expenses								
1. Advertising Help Wanted (<i>all such expenses</i>) \$	25,080	20,018				5,062		
2. Advertising Telephone Directory (<i>all such expenses</i>)*** \$								
3. Advertising Other (<i>Specify</i>)*** \$	22,477	17,940				4,537		
See Attached Schedule								
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 \$	3,870	3,089				781		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) \$	9,164	7,315				1,850		
See Attached Schedule								
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$								
9. Subscriptions \$	574	458				116		
10. Contributions*** \$	650	519				131		
See Attached Schedule								
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>) \$	195,839	156,312				39,527		
12. Administrative Management Services** \$	474,605	378,812				95,793		
13. Other (<i>Specify</i>) \$	49,875	39,809				10,066		
See Attached Schedule								
C-14 Total Administrative & General Expenditures \$	5,642,957	4,637,253				1,005,704		

* 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	\$ 1,001				\$ 253	
Total Other Travel and Entertainment	\$ 1,001	\$ -	\$ -	\$ -	\$ 253	\$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
COMMUNICATIONS SPECIAL EVENTS	\$ 17,940				\$ 4,537	
Total Other Advertising	\$ 17,940	\$ -	\$ -	\$ -	\$ 4,537	\$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
ALTCFM						
CAHCF Dues	\$ 7,315				\$ 1,850	
OTHER DUES						
Total Dues	\$ 7,315	\$ -	\$ -	\$ -	\$ 1,850	\$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment
CONTRIBUTIONS	\$ 519				\$ 131	
Total Contributions	\$ 519	\$ -	\$ -	\$ -	\$ 131	\$ -

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	\$ 5,208				\$ 1,317	
EMPLOYEE RELATIONS	\$ 1,305				\$ 330	
EMPLOYEE RELATIONS-OTHER	\$ 392				\$ 99	
PERMITS & LICENSES	\$ 3,000				\$ 759	
BANK FEES	\$ 6,222				\$ 1,573	
PENALTIES	\$ 13,295				\$ 3,362	
LATE FEES	\$ 582				\$ 147	
INTERNET EXPENSES	\$ 9,802				\$ 2,479	
Rounding	\$ 3					
Total Other Administrative and General	\$ 39,809	\$ -	\$ -	\$ -	\$ 10,066	\$ -

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2024	Page 17	of 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	474,605	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12	
iCare Management, LLC/iCare Health Management, LLC	191,323	MANAGEMENT FEES- DIRECT CARE	Pg 20 G38	
iCare Management, LLC/iCare Health Management, LLC	43,528	MANAGEMENT FEES- INDIRECT CARE	Pg 20 G39	

*** 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 9/30/2024				Page 18	of 37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 368,054	293,768				74,287		
2. Non-Food Supplies	\$ 46,868	37,409				9,460		
3. Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 16,857	13,454				3,402		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ (16,497)	(13,168)				(3,330)		
c. Other (Specify) _____ DIETARY MINOR EQUIPMENT	\$ 2,939	2,346				593		
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 418,221	333,809				84,412		
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 Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2024				Page 19	of 37
Item		Total	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)		\$ 356	237				119	
LAUNDRY MINOR EQUIPMENT								
3D. Total Laundry Expenditures (3a + b + c)		\$ 54,011	36,008				18,004	
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	9/30/2024				20	37
Item			Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac-Aids
4.	Housekeeping	Sq. Ft. Serviced by Personnel						
a.	In-House Care							
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt.	\$ 25,872	17,248				8,624
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)		\$ 66,390	44,260				22,130
5.	Resident Care (Supplies)**							
a.	Prescription Drugs***							
1.	Own Pharmacy		\$					
2.	Purchased from PHARMACY		\$ 120,154	120,154				
b.	Medicine Cabinet Drugs		\$ 9,508	7,589				1,919
c.	Medical and Therapeutic Supplies		\$ 98,720	78,795				19,925
d.	Ambulance/Limousine***		\$ 1,808	1,205				603
e.	Oxygen							
1.	For Emergency Use		\$ 2,957	2,957				
2.	Other***		\$					
f.	X-rays and Related Radiological Procedures***		\$ 822	822				
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$					
h.	Laboratory***		\$ 18,663	18,663				
i.	Recreation		\$					
j.	Direct Management Services*		\$ 191,323	152,707				38,616
k.	Indirect Management Services*		\$ 43,528	34,742				8,785
l.	Cable TV		\$					
m.	Other (Specify)**** See Attached Schedule		\$ 78,725	66,647				12,078
n.	Physical Therapy Expense		\$					
o.	Speech Therapy Expense		\$					
5P.	Total Resident Care Expenditures (5a - 5o)		\$ 566,208	484,281				81,927

* 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	\$ 40				\$ 10	
NURSING MINOR EQUIP	\$ 2,106				\$ 532	
MEDICAL RECORDS SUPPLIES	\$ (652)				\$ (165)	
NON-COVERED PPS DR. VISITS	\$ 281				\$ 71	
RESIDENT CARE SUPPLIES	\$ -				\$ -	
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 13,580				\$ 3,434	
PERSONAL CARE SUPPLIES	\$ -				\$ -	
INCONTINENCY SUPPLIES	\$ -				\$ -	
VACCINE RESIDENTS	\$ 1,031				\$ -	
PATIENT SPECIAL NEEDS	\$ 133				\$ -	
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 24,208				\$ -	
EQUIPMENT RENTAL: AIDS UNIT	\$ -				\$ -	
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 108				\$ -	
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ 9,421				\$ -	
HI LOW BED RENTAL & MATTRESSES	\$ -				\$ -	
IV THERAPY SUPPLIES	\$ 13,183				\$ 6,592	
IV THERAPY CONTRACT SERVICE	\$ -				\$ -	
MEDICAL WASTE CONTRACT SERVICE	\$ 1,519				\$ 760	
ACTIVITIES SUPPLIES	\$ 1,375				\$ 688	
ACTIVITIES MINOR EQUIPMENT	\$ 313				\$ 157	
ADMISSIONS SUPPLIES	\$ -				\$ -	
Total Other Resident Care	\$ 66,647	\$ -	\$ -	\$ -	\$ 12,078	\$ -

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 9/30/2024				Page 21	of 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	6,458			22	6F
Brightview Landscapes LLC		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Landscaping	7,185			22	6F
Peter Marcue		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Snow Removal	21,538			22	6F
All Waste Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Trash removal	35,830			22	6F
Facility Complainece		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Plant Contract Services	108,406			22	6F
American HealthTech/ Pointclickcare	P.O. Box 9001006, Louisville, KY 40290	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Software Maintenance Contract	26,836			16	M11
Automatic Data Processing		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Payroll Services	55,906			16	M11
National Datacare Corp		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Resident Trust Software	3,437			16	M11
Prime Care Technology services		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Computer Consulting Services	67,787			16	M11
Priotiry Express		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Courier Services	3,454			16	M11
Point Right Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Nursing Software	5,501			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 Trinity Hill Care Center, LLC		License No. 2222-C		Report for Year Ended 9/30/2024			Page 22	of 37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	NurseFac- Aids	Adjustment
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$	59,046	39,364				19,682	
b. Heat	\$	51,956	34,637				17,319	
c. Light & Power	\$	98,611	65,741				32,870	
d. Water	\$	83,572	55,715				27,857	
e. Equipment Lease (<i>Provide detail on page 22b</i>)	\$	20,391	16,275				4,116	
f. Other (<i>itemize</i>)	\$	239,510	159,673				79,837	
See Attached Schedule								
6g. Total Maint. & Operating Expense (6a - 6f)		\$ 553,086	371,405				181,681	
7. Depreciation (<i>complete schedule page 23*</i>)								
a. Land Improvements	\$							
b. Building & Building Improvements	\$	19,221	15,342				3,880	
c. Non-Movable Equipment	\$							
d. Movable Equipment	\$	39,014	31,140				7,874	
*7e. Total Depreciation Costs (7a + b + c + d)		\$ 58,235	46,481				11,754	
8. Amortization (<i>Complete att. Schedule Page 24*</i>)								
a. Organization Expense	\$							
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$	52,932	42,248				10,684	
d. Other (<i>Specify</i>)	\$							
*8e. Total Amortization Costs (8a + b + c + d)		\$ 52,932	42,248				10,684	
9. Rental payments on leased real property less real estate taxes included in item 10b		\$ 1,226,369	978,843				247,526	
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	\$	29,929	19,953				9,976	
11. Total Property Expenses (7e + 8e + 9 + 10)		\$ 1,722,772	1,324,397				398,376	

* 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	\$ 11,883				\$ 5,941	
PLANT CONTRACT SERVICE LABOR	\$ 11,718				\$ 5,859	
ELEVATOR CONTRACT SERVICE	\$ 4,305				\$ 2,153	
FIRE/SPRINKLER CONTRACT SERVICE	\$ 5,862				\$ 2,931	
LANDSCAPING CONTRACT SERVICE	\$ 4,790				\$ 2,395	
SNOW REMOVAL CONTRACT SERVICE	\$ 14,359				\$ 7,179	
TRASH REMOVAL CONTRACT SERVICE	\$ 23,886				\$ 11,943	
PLANT (POOL) CONTRACT SERVICES OTHER	\$ 72,271				\$ 36,135	
SECURITY CONTRACT SERVICE	\$ -				\$ -	
PLANT CONTRACT SERVICE OTHER	\$ 2,789				\$ 1,394	
PLANT MINOR EQUIPMENT	\$ 4,903				\$ 2,452	
RENT EQUIPMENT	\$ 2,908				\$ 1,454	
Total Other Repairs and Maintenance	\$ 159,673	\$ -	\$ -	\$ -	\$ 79,837	\$ -

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 9/30/2024		Page 22b		of 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	9,174	9,174			
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	10,171	10,171			
Pitney Bowes P.O. Box 856460	<input type="radio"/>	<input checked="" type="radio"/>	Postage Machine		automatic annual	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"/>								
	<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 ***		
								20,391		

* 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.

Name of Facility Trinity Hill Care Center, LLC					License No. 2222-C			Report for Year Ended 9/30/2024			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	193,500			19,221		
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
B-4. Subtotal												19,221	
C. Non-Movable Equipment													
1. Acquired prior to this report period					7,990		7,990	7,991					
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal													
	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													
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative													
d. Standard Resident													
e. Specialized Resident													
Total Acquired during this report period													
D-3. Subtotal													
E. Total Depreciation													

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
Additions:					
4/11/2024	Supplies from Farmington: Farmington CC	Standard Resident	\$ 1,574	60	\$ 131
3/13/2024	New Steamtable: HPC FoodServ	Standard Resident	\$ 3,369	180	\$ 112
6/25/2024	Replace Washer: Daniels Equipment	Standard Resident	\$ 5,308	120	\$ 133
12/29/2023	Laptops: PrimeCare	Administrative	\$ 4,320	36	\$ 1,080
2/13/2024	Laptops: PrimeCare	Administrative	\$ 4,458	36	\$ 867
4/8/2024	Laptops: PrimeCare	Administrative	\$ 6,785	36	\$ 942
6/27/2024	Laptops: PrimeCare	Administrative	\$ 12,327	36	\$ 1,027
7/16/2024	Laptops: PrimeCare	Administrative	\$ 2,545	36	\$ 141
8/23/2024	Tablets: Apple Inc	Administrative	\$ 7,117	60	\$ 119
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
		PICK A CATEGORY			
Total additions for Movable Equipment			\$ 47,803		\$ 4,553 *
Deletions:					
Total deletions for Movable Equipment			\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
4/18/2023	Nurse Call System Equipment: S&S Wired	\$ 2,672	120	\$ 379
3/5/2024	Painting Project: Sherwin Williams & Facilities Comp	\$ 21,243	60	\$ 2,124
3/16/2024	Repair Elevator: Excel Elevator & Escalator	\$ 12,856	120	\$ 643
3/18/2024	Roof Repairs: Roofed Right America	\$ 5,052	120	\$ 253
5/3/2024	Plumbing Repaires: Facilities Compliance Services	\$ 3,833	240	\$ 64
6/20/2024	Upgrade Fire Control Penal: S&S Wired STM	\$ 7,250	120	\$ 181
8/27/2024	Fence Replacement: Target 10 Construction	\$ 17,516	180	\$ 97
8/7/2024	Replace Flooring: Target 10 Construction	\$ 2,659	120	\$ 22
9/25/2024	Repaire AC: Saucier Mechanical	\$ 6,680	180	-
Total additions for Leasehold Improvement		\$ 79,760		\$ 3,763 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, 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 9/30/2024			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				1,124,086	753,723			49,169	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				79,760				3,763	
C-4. Subtotal									52,932
D. Total Amortization									52,932

* 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 9/30/2024	Page 25	of 37
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11. Property Questionnaire

Part A

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

☒ Yes ☐ No

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

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

Description	Total				
1. Date Land Purchased	04/01/99				
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase	04/01/99				
4. Date of Initial Licensure	04/01/99				
5. Total Licensed Bed Capacity	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	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Interest-Only Loan			
b. Date Mortgage Obtained	05/01/24			
c. Interest Rate for the Cost Year	750.00%			
d. Term of Mortgage (number of years)	24			
e. Amount of Principal Borrowed	8,075,575			
f. Principal balance outstanding as of	8,075,575			
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2024				Page 26	of 37
Item		Total	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 Trinity Hill Care Center, LLC			License No. 2222-C		Report for Year Ended 9/30/2024			Page 27	of 37		
Item					Total	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					\$	628	501			127	
13. Total All Interest Expense (12B7 + 12C3 + 12D)					\$	628	501			127	
14. Insurance											
a. Insurance on Property (buildings only)					\$	10,303	6,869			3,434	
b. Insurance on Automobiles					\$						
c. Insurance other than Property (as specified above)											
1. Umbrella (Blanket Coverage)					\$	100,860	67,240			33,620	
2. Fire and Extended Coverage					\$						
3. Other (Specify) Other insurance, crime					\$	13,112	8,741			4,371	
14d. Total Insurance Expenditures (14a + b + c)					\$	124,275	82,850			41,425	
15. Total All Expenditures (A-13 thru C-14)					\$	16,998,140	13,519,321			3,478,820	

F. Statement of Revenue

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C		Report for Year Ended 9/30/2024		Page 30	of 37
Item		Total	CCNH / RHNS	(Specify)	NurseFac-Aids		
I. Resident Room, Board & Routine Care Revenue							
1. a. Medicaid Residents (<i>CT only</i>)	\$	15,097,907	11,927,067		3,170,841		
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>)	\$	709,201	709,201				
b. Medicare Room and Board Contractual Allowance **	\$						
4. a. Private-Pay Residents and Other	\$	1,953	1,953				
b. Private-Pay Room and Board Contractual Allowance **	\$						
II. Other Resident Revenue							
1. a. Prescription Drugs - Medicare	\$	49,820	49,820				
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(48,520)	(48,520)				
c. Prescription Drugs - Non-Medicare	\$	89,807	63,950		25,857		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(89,807)	(63,950)		(25,857)		
2. a. Medical Supplies - Medicare	\$	1,338	1,338				
b. Medical Supplies - Medicare Contractual Allowance **	\$	(1,338)	(1,338)				
c. Medical Supplies - Non-Medicare	\$	10,643	8,468		2,175		
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$	(10,643)	(8,468)		(2,175)		
3. a. Physical Therapy - Medicare	\$	56,293	56,293				
b. Physical Therapy - Medicare Contractual Allowance **	\$	(36,256)	(36,256)				
c. Physical Therapy - Non-Medicare	\$	212,954	195,026		17,928		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$	(212,954)	(195,026)		(17,928)		
4. a. Speech Therapy - Medicare	\$	10,137	10,137				
b. Speech Therapy - Medicare Contractual Allowance **	\$	(6,057)	(6,057)				
c. Speech Therapy - Non-Medicare	\$	40,045	36,529		3,516		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	(40,045)	(36,529)		(3,516)		
5. a. Occupational Therapy - Medicare	\$	38,092	38,092				
b. Occupational Therapy - Medicare Contractual Allowance **	\$	(29,328)	(29,328)				
c. Occupational Therapy - Non-Medicare	\$	115,801	115,529		272		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(115,801)	(115,529)		(272)		
6. a. Other (<i>Specify</i>) - Medicare	\$	(247,919)	(247,919)				
b. Other (<i>Specify</i>) - Non-Medicare	\$	167,703	167,703				
III. Total Resident Revenue (Section I. thru Section II.)		\$ 15,763,025	12,592,185		3,170,841		
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>)	\$	32,995	32,995				
6. Private Duty Nurses' Fees	\$						
7. Barber, Coffee, Beauty and Gift shops	\$						
8. Other (<i>Specify</i>)	\$	276,981	276,981				
V. Total Other Revenue (1 thru 8)		\$ 309,976	309,976				
VI. Total All Revenue (III +V)		\$ 16,073,001	12,902,161		3,170,841		

* 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	9/30/2024		31	37
Account					Amount	
Assets						
A. Current Assets						
1. Cash (on hand and in banks)					\$	736,045
2. Resident Accounts Receivable (Less Allowance for Bad Debts)					\$	3,626,656
3. Other Accounts Receivable (Excluding Owners or Related Parties)					\$	
4 Inventories					\$	15,554
5. Prepaid Expenses					\$	250,205
a. Prepaid Insurance 145,880						
b. Prepaid Property Taxes 98,365						
c. Prepaid Expenses Other 5,960						
d. See Schedule						
6. Interest Receivable					\$	
7. Medicare Final Settlement Receivable					\$	
8. Other Current Assets (itemize)					\$	(713,508)
Due From (to) Related Parties 983,723						
Other Owners reserves (1,697,231)						
See Schedule						
A-9. Total Current Assets (Lines A1 thru 8)					\$	3,914,952
B. Fixed Assets						
1. Land					\$	
2. Land Improvements *Historical Cost _____					\$	
Accum. Depreciation _____ Net						
3. Buildings *Historical Cost 394,955					\$	182,235
Accum. Depreciation 212,721 Net						
4. Leasehold Improvements *Historical Cost 1,203,846					\$	397,192
Accum. Depreciation 806,654 Net						
5. Non-Movable Equipment *Historical Cost 7,990					\$	(1)
Accum. Depreciation 7,991 Net						
6. Movable Equipment *Historical Cost 797,345					\$	125,767
Accum. Depreciation 671,578 Net						
7. Motor Vehicles *Historical Cost _____					\$	
Accum. Depreciation _____ Net						
8. Minor Equipment-Not Depreciable					\$	
9. Other Fixed Assets (itemize)					\$	2,320
Construction in Progress 2,320						
See Schedule						
B-10. Total Fixed Assets (Lines B1 thru 9)					\$	707,513

* 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 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 Long-Term Liabilities (Itemize)			\$ -

G. Balance Sheet (cont'd)

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2024	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ 4,622,465	
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			\$ 905,600	
2. Escrow Deposits			\$	
3. Organization Expense *Historical Cost _____ Accum. Depreciation _____ Net			\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$ 36,958	
Patient Trust Funds		25,803		
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>)			\$ 10,612,982	
RIGHT TO USE ASSET		13,879,767		
ACCUM RIGHT TO USE ASSET		(3,266,785)		
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ 11,555,540	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 16,178,005	

* 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 9/30/2024	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	332,154
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>)				\$	447,500
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>)				\$	13,093,855
Related Party Payables		12,571,111			
Accrued Expenses		236,323			
Accrued Resident User Fees		234,352			
Accrued Workers Comp Expense		52,070	See Schedule		
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	13,873,510

* 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 9/30/2024		Page 34	of 37	
Account					Amount		
Total Brought Forward:					13,873,510		
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>)					\$ 25,803		
Patient Trust Funds			25,803				
See Schedule							
B-5. Total Long-Term Liabilities (Lines B1 thru 4)					\$ 25,803		
C. Total All Liabilities (Lines A-13 + B-5)					\$ 13,899,313		

G. Balance Sheet (cont'd)

Reserves and Net Worth

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2024	Page 35	of 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			\$	3,202,830
6. Gain or Loss for Period			\$	(925,139)
7. Total Net Worth			\$	2,278,691
C. Total Reserves and Net Worth			\$	2,278,691
D. Total Liabilities, Reserves, and Net Worth			\$	16,178,004

H. Changes in Total Net Worth

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2024	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2023			\$	
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$ 16,073,001	
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$ 16,998,140	
D. Net Income or Deficit			\$ (925,139)	
E. Balance			\$ (925,139)	
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		09/30/24	\$ (925,139)	

I. Preparer's/Reviewer's Certification

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2024	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input type="checkbox"/> Home (CCNH) & RHNS <input type="checkbox"/> Combined	<input 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 in the Adjustments columns. 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				