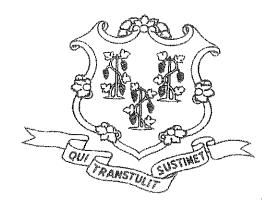
### **State of Connecticut**



### **Annual Report of Long-Term Care Facility**

Cost Year 2015

Name of Facility (as l	icensed)						
Trinity Hill Care Cen	ter, LLC						
Address (No. & Stree	t, City, State, Z	ip Code)	,				
151 Hillside Avenue,	Hartford, CT	06016					
Type of Facility							
Chronic and C	onvalescent		Rest Home with	Nursing			
✓ Nursing Home	only		Supervision on	У	☑ Nu	ırseFac-Aids	S
(CCNH)			(RHNS)				
Report for Year Begi	nning		Report for Year	Ending			
10/1/2014			9/30/2015				
License Numbers:		CCNH 2222-C	RHNS	Nι	ırseFac-Aids AIDS	Me	dicare Provider 07-5268
Medicaid Provider N	umbers:	CC	CNH	RI	INS	IC.	F-IID
ivicalcula i lovidel iv	unio ero.	9555	)		1115		49553
For Department Use	e Only						
Sequence Number	Signed and	Date	Sequence N	umber	Signed and	Notanizad	Data Bassiyad
Assigned	Notarized	Received	Assign	ed	Signed and	inotarized	Date Received

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### **General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2015	1	37

### Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Trinity Hill Care Center, LLC [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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.

			2 /		]
Signed (Administrator)	<i>(</i>	Date	Signed (Owner)	- Date	ĺ
A W.K	14	2/10/16	Thus X Ma	ught a/10/16	
Printed Name (Administrator)		, , , , ,	Printed Name (Owner)		
George Kingston			Chris Wright		
				BRENDA WALSH	
Subscribed and Sworn	State of	Date	Signed (Notary Public)	Notar Commission Expires	U
to before me:		1.14	(A)	η η February 29, 2020	
George Kingston	$\frac{1}{2}$	2/10/16	Drenda Wa		48,007-00
Address of Notary Public		•			
341 Ridge (1)	Stropf	Manch	vestor CIC	160 Un	

(Notary Seal)

### State of Connecticut

### **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page	of
		T= =		1A	37
Name of Facility		Period Cov	ered:	From	То
Trinity Hill Care Center, LLC				10/1/2014	9/30/2015
Address of Facility					
151 Hillside Avenue, Hartford, CT 06016					
Report Prepared By		Phone Nun	nber	Date	
Denise MacKinnon	enise MacKinnon   860-570-2140 ext 15				
Item		Total	CCNH	RHNS	NurseFac- Aids
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

### General Information and Questionnaire Type of Facility - Organization Structure

		Pho	ne No. of Fac	cility	Report for Ye	ar Ended	Page	of
		860	-951-1060		9/30/2015		2	37
Name of Facility (as shown on license)			Address (No	o. & S	Street, City, Sta	ite, Zip)		
Trinity Hill Care Center, LLC			151 Hillside	Ave	nue, Hartford,	CT 0601	6	
	CCNH		RHNS	]	NurseFac-Aids		Medicare F	Provider No.
License Numbers:	2222-C			AID	S		07-5268	
Type of Facility (Check appropriate box(e	(s))							
☐ Chronic and Convalescent Nursing Home only (CCNH)			t Home with bervision only		- 1/1	NurseFac	c-Aids	
Type of Ownership (Check appropriate bo	ox)							
O Proprietorship <b>O</b> LLC O	Partnership	0	Profit Corp.	0	Non-Profit Co	ъ. О	Government	O Trust
If this facility opened or closed during rep	ort year provid	e:		Date	e Opened	Date Clo	sed	
Has there been any change in ownership				L		1		
or operation during this report year?		0	Yes	⊙	No	If "Yes,"	explain full	у.
Administrator								
Name of Administrator			***		Nursing He	ome		
George Kingston					Administra	or's	1327	
					License 1	No.:		
Other Operators/Owners who are assistan	t administrators	(ful	l or part time)	) of tl		•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Name					License 1	No.:		
								, , , , , , , , , , , , , , , , , , , ,

### **General Information and Questionnaire Partners/Members**

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2015		Page of 3 37
Legal Name of Partnership/LLC Trinity Hill Care Center, LLC		Business 151 Hillside Av Hartford, CT 0	venue,		or Town(s) in Registered
Name of Partners/Members	Business Ad	ddress		Title	% Owned
V. Robert Salazar	2500 18th Street, Suite CO 80211	200, Denver,	Member		31.3
David Sebbag	245 South Benton Stre Lakewood, CO 80226	et, Suite 100,	Member		21.4
Ari Krausz	245 South Benton Street, Suite 100, Lakewood, CO 80226		Member		21.3
Solomon Melamed	245 South Benton Street, Suite 100, Lakewood, CO 80226		Member		I
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, I 80226	Lakewood, CO	Member		10

### Annual Report of Long-Term Care Facility

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### General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year En	ded	Page of
Trinity Hill Care Center, LLC	2222-C	9/30/2015		3A 37
If this facility is owned or operated as a corp	oration, provide th	e following informa	tion:	
Legal Name of Corporation		ss Address	State(s) in Whi	ch Incorporated
_				
Name of Directors, Officers	Busines	ss Address	Title	No. Shares Held by Each
				·
Names of Stockholders Owning at Least 10% of Shares				

### General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page of
Trinity Hill Care Center, LLC	2222-C	9/30/2015	3B 37
If this facility is owned or operated as an individua	l proprietorship, p	rovide the following informat	ion:
Owi	ner(s) of Facility		1
		· · · · · · · · · · · · · · · · · · ·	
	<del> </del>		
	· · · · · · · · · · · · · · · · · · ·		
1			
	<del></del>		

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# General Information and Questionnaire Related Parties\*

Name of Facility Trinity Hill Care Center, LLC	LLC	License No	e No. 2222-C	R 9	Report for Year Ended 9/30/2015		Page 4	of 37
Are any individuals receimarriage, ability to contr	Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?	acility re	lated thr		Yes © No	If "Yes," provide the Name/Address and complete the information on Page 11 of the report.	e Name/Ad	dress and ge 11 of the report.
Are any individuals or control including the rental of properties association to any of the	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?	s or serv to this f , contro	ices, acility, l, or busi	ness	• Yes O No	If "Yes," provide the following information:	e following	information:
Name of Related	Business	Good	Also Provides Goods/Services to Non-Related Parties	les es to	Description of Goods/Services	Indicate Where Costs are Included in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	No	**%	Provided	Page # / Line #	Reported	Related Party
See Attached		0	0					The state of the s
		0	0					
		0	0					
The state of the s		0	0					
		0	0					
	- Principal Control of	0	0					
		0	0					
		0	0					
		0	0					
	٠.							

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Provide the percentage amount of revenue received from non-related parties.

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### Related Parties\*

Name of Related Address Individual or Company Address Bitwell Care Center, LLC Chelsea Place Care 25 Lorraine St. Manchester, CT Center, LLC Chestrut Point Care 171 Main St. East Windsor, CT Center, LLC Center, LLC Chestrut Point Care 60508 Chestrut Point Care 60508 Center, LLC Consus Farmington Care Center, 20 Scott Swamp Rd. Farmingto LLC CT 06032 CENTER Brook Care Center, CT 06032 Kettle Brook Care Center, CT 06038 Meriden Care Center, CT 06038 Meriden Care Center, CT 06038 Meriden Care Center, LLC 33 Roy St. Meriden, CT (Silver Springs) Trinity Hill Care Center, CT 06108 Westside Care Center, LLC 349 Bidwell St. Manchester, CT 06040 Wintonbury Care Center, LLC 06040 Wintonbury Care Center, LLC 06040	Business Address Address 333 Bidwell St. Manchester, CT 66040 25 Lorraine St. Hartford, CT 06105 171 Main St. East Windsor, CT	Also Provides	/ides		T. dinner When		
ed LLC LLC mter, mter, enter, erter, r, LLC for, er, LLC mter,	usiness ddress Manchester, CT Hartford, CT ast Windsor, CT	Also Prov	/ides		To discote Without		
ed LLC LLC mter, mter, enter, erter, c, LLC fr, LLC er, LLC	usiness ddress Manchester, CT Hartford, CT ast Windsor, CT	Goods/Services to Non-	Non-		Costs are Included		Actual Cost to the
LLC LLC mter, mter, enter, enter, erter, erter, erter, mter,	ddress Manchester, CT Hartford, CT ast Windsor, CT	Related Parties	arties	Description of Goods/Services	in Annual Report	Cost	Related
nter, mter, enter, enter, er, LLC er, LLC er, LLC	Manchester, CT Hartford, CT ast Windsor, CT	Yes No	**%	Provided	Page # / Line #	Reported	Party
nter, nter, enter, enter, r, LLC fr, LLC er, LLC	Hartford, CT ast Windsor, CT			Shared Employees		(11,025)	11,025
int Care int Care Care Center, Care Center, Care Center, Care Center, Care Center, are Center, are Center, Care Center, Care Center, Care Center, Care Center,	ast Windsor, CT			Shared Employees		(15,980)	15,980
				Laundry Services	19 3		,
	171 Main St. East Windsor, CT			Chared Employees		(75.853)	75.853
	20 Scott Swamp Rd. Farmington, CT 06032			Pank Fees	16 M		(961)
	20 Scott Swamp Rd. Farmington, CT 06032			Shared Employees		(4,742)	4_742
	II Rd. East Windsor,			Laundry Services	19 3		1
()	Il Rd. East Windsor,			Shared Employees		(36,815)	36,815
27	Meriden, CT			Shared Employees		(28,701)	28,701
27	e. Hartford, CT			Shared Employees		•	•
	349 Bidwell St. Manchester, CT 06040			Shared Employees		(8,676)	8,676
	Bloomfield, CT			Shared Employees		(5,221)	5,221
ure Care Center LLC	t, Rocky Hill, CT			Shared Employees		(5,417)	5,417
Tonchnoints therapy 06088	st Windsor, CT			OT/PT/ST	13 5,8,10	370,528	(370,528)
341 Bidwell Realty, LLC 06040	Manchester, CT			Building Lease & Rent	22,22,27 10,9,14	1,563,332	(1,563,332)
1.0	Manchester, CT			Postage & Legal	16,15 M,E	30,942	(30,942)
ıt,	Manchester, CT			Shared EEs not part of memt aemt		111,891	(111,891)
				Management Services, Direct	20 5j		(137,681)
				Management Services, Indirect	20 5j	48,915	(48,915)
				Management Services, Administrative	16 M12	284,522	(284,522
							_
- Committee of the Comm	the best of the second						
All 9 Care Centers, mgmt co,				saditras redita sucitory base losel returns such assumed has assumed 4100, assumes seeds	ne less parties and such	ione other centine	

<sup>\*</sup> Use additional sheets if necessary.

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

### **General Information and Questionnaire Basis for Allocation of Costs**

Name of Facility	License No.		Report for Year Ended	Page of		
Trinity Hill Care Center, LLC	2222-C		9/30/2015	5 37		
If the facility is licensed as CDH and/or RCH o	r provides Al	IDS or TB	services with special Medica	id rates, costs		
must be allocated to CCNH and RHNS as follo-	ws:		-			
Item			Method of Allocation			
Dietary	1	Number of	meals served to residents			
Laundry	1	Number of	pounds processed			
Housekeeping	1	Number of	square feet serviced			
	1	Number of	hours of routine care provide	d by EACH		
Nursing	ε	employee c	lassification, i.e., Director (or	Charge Nurse),		
-	I	Registered	Nurses, Licensed Practical Nu	urses, Aides and		
	· · · · · · · · · · · · · · · · · · ·	Attendants				
Direct Resident Care Consultants	1	Number of	hours of resident care provide	ed by EACH		
	S	specialist (	See listing page 13)	•		
Maintenance and operation of plant	5	Square feet				
Property costs (depreciation)	5	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  O Yes O No  If "No," explain fully why such allocation was						
costs allocated as required? Yes O No not made.						
	not made.					
2. Explain the allocation of related company ex	xpenses and a	ttach copy	of appropriate supporting dat	ta.		
3. Did the Facility appropriately allocate and so	elf-disallow o	direct and i	ndirect costs to non-nursing h	ome cost centers?		
(e.g., Assisted Living, Home Health, Outpat						
			If "No," explain fully why su	ch allocation was		
	• Yes	O No	not made.	ch anocation was		
			not mage,			

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## General Information and Questionnaire Leases (Excluding Real Property)

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

should not be included in these amounts.							
Name of Facility			License No.	Report for Year Ended	ear Ended		Page of
Trinity Hill Care Center, LLC			2222-C	9/30/2015			6 37
	Related * to	d * to					
	Owners,	iers,					
	Operators,	ators,				Annual	
	Officers	cers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	$N_0$	Description of Items Leased	Lease**	Lease	of Lease	Claimed
Accelerated Care Plus Corp. 4850 Joule Street, Suite A-1 Reno, NV	0	0	Omnistim Electrotherapy and Omnisound Therapeutic Ultrasound Equipment	05/18/10	automatic annual	12,134	12,134
ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909	0	•	Time Clocks and Payroll Punch Equip	06/01/10	60 Months	10,764	10,764
GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphai, PA 19101	0	0	Copier	03/05/14	48 months	12,823	13,870
Neopost USA Inc, 25880 Network Place, Chicago, IL 60673	0	0	Postage Rental	04/16/13	Month to month	577	577
GE Capital C/O Ricoh USA, P.O.Box 41564, Philadelphai, PA 19101	0	0	Copier	08/29/15	48 months	9	9
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
							_

Is a Mileage Log Book Maintained for All Leased Vehicles?

Defer to Dage 1 for definition of related If "Vec " transaction charld be renotted a

Total \*\*\*

O No

O Yes

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

\*\* Attach copies of newly acquired leases.

\*\*\* Amount should agree to Page 22, Line 6e.

### General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended	!	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2015		7	37
The records of this facility for the p	period covered by this rep	port were maintained on the following basis:			
	Modified Cash				
Is the accounting basis for this					
	Yes	lf "No," explain.			
previous period? O	No				
Independent Accounting Firm		Address (No. 9: Street City State 7in Cod	1	******	
Name of Accounting Firm		Address (No. & Street, City, State, Zip Cod		0.0100	
1 O'Connor, Davies LLP		100 Great Meadow Road, Ste 401, We	thersheid, Ci	06109	
2					
3					
Services Provided by This Firm (de	escribe fully )				
l Taxes, financial statements, accounti	ng support		\$	3,712	
2	<u></u>		\$	· · · · · · · · · · · · · · · · · · ·	
3			\$		
4			s		
	<del></del>		Charge for	Services P	rovided
	•				Ovided
Ass Thous Charges Reflected in the Espan	ditura Partian of This Panart'	? If Yes, Specify Expense Classification and Line No.	\$	3,712	
• Yes • No	15D	in res, obecity expense classification and line ivo.			
Legal Services Information	1100				
Name of Legal Firm or Independer	nt Attorney		Telephone	Number	
l iCare Health Management, LL			860-570-21		
2 Starble and Harris			860-678-77		
3 Durant Nichols / Robinson &	Cole, LLP		860-275-82		
		ation, Murtha Cullina,Robinson))			
5 Starble and Harris, iCare Heal					
Address (No. & Street, City, State,	• •				
1 341 Bidwell Street, Mancheste	er CT				
2 32 Main Street, Avon, CT					
3 280 Trumbull St, Hartford, CT		:			
4	au bit ilia i a	t com			
5 32 Main Street, Avon, CT & 3		chester CT			
Services Provided by This Firm (do	escribe juity )				
1 Lease and contract issues, general le			<u> </u>	29,739	
Lease and contract issues, general leg	A.L. T. C.		<u>\$</u>	11,653	
3 Employment law, arbitrations, contra			<u> </u>	21,144	
4 Employment Arbitrations, healthcare	: law		\$	7,904	
5 Collections			<u> </u>	418	
			Charge for	Services P	rovided
			\$	70,859	
Are These Charges Reflected in the Exper		? If Yes, Specify Expense Classification and Line No.			
⊙ Yes O No	15E				

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## Schedule of Resident Statistics

Name of Facility Trinity Hill Care Center 1.1.C			License No.	e No.		:	Report fo 9/30/2015	Report for Year Ended 9/30/2015	þ		Page 8	of 37
						]						
						Period 10/	Period 10/1 Thru 6/30	30		Репод 7/	Period 7/1 Thru 9/30	0
	Total All	Total CCNH	Total RHNS	Total NurseFac-				NurseFac-				NurseFac-
	Levels	Level	Level	Aids	Total	CCNH	RHNS	Aids	Total	CCNH	RHNS	Aids
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	144	114		30	144	114		30	144	114		30
B. On last day of THIS report period	144	114		30	144	114		30	144	114		30
2. Number of Residents												
A. As of midnight of PREVIOUS report period	141	112		29	141	112		29	142	116		26
B. As of midnight of THIS report period	139	110		29	142	116		26	139	110		29.
3. Total Number of Days Care Provided During Period												
A. Medicare	1,038	787		251	692	109		16	346	186		160
B. Medicaid (Conn.)	49,771	39,288		10,483	37,283	29,305		7,978	12,488	9,983		2,505
C. Medicaid (other states)												
D. Private Pay					:							
E. State SSI for RCH												
F. Other (Specify) INSURANCE	71	71			89	89			3	3		
G. Total Care Days During Period (3A thru F)	50,880	40,146		10,734	38,043	29,974		8,069	12,837	10,172		2,665
Total Number of Days Not Included in Figures in 3G 4. for Which Revenue Was Received for Reserved												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days		1										
5. Total Resident Days (3G + 4A + 4B)	50,880	40,146		10,734	38,043	29,974		8,069	12,837	10,172		2,665

Schedule of Resident Statistics (Cont'd)

Name of Faci	•	+ou 116			nse No. 222-C				Report	for Year			Page	of
Trinity Hill C	are Cen	ter, LLC			222-C					9/30/201	(3		9	37
	•	_	in the certified b		ipacity du	iring 1	the repo	ort yea	ar?	0	Yes	0	No	
H . AFS			llowing informa	non;	- Cl		in Bed			Ca		- Class		
D. C			f Change NurseFac-Aids			lange			1	Ca	pacity Aft	er Change		
Date of	CCNH	KHNS	NurseFac-Aids		Lost	, <del></del>	'	Gaine	d		}	NurseFac-		
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	Aids	Danson fo	or Change
	(1)	(4)	(3)	(1)	(2)	(3)		(4)	(3)	CCIVII	KIINS	Aids	Keason i	or Change
•													· · · · · · · · · · · · · · · · · · ·	
			- 1 1 11 11 11 11 11											
						·								
5 Ifthono	uon onu	ahanaa	in certified bed	00000	itu durina	r tha i	ranaut i	100 × (0		tad in ita	m 4 abaya	\ provide the go	mbay of	
	-	_	90 days followir	-		3 1110 1	героп у	cai (a	is repor	ied iii iie	m 4 above	) provide the na	moer or	
KESIDI	ENIDA	13 101	90 days followii	ig the	change,					1		<del></del>		<u>.</u>
			Chanas in D	مما ما مم	t Davis						CNILL	DINIO	MurgaE	ac-Aids
1st chan	no.		Change in Ro	estaer	R Days					- C	CNH	RHNS	Nuiser	ac-Aius
2nd char										<b></b>				
3rd chan														
4th chan					,									
		dents an	d Rates on Septe	embei			ar							
			Medicare		Medi	caid				S	elf-Pay		Other Sta	le Assisted
												1		
												NurseFac-		
*******	Item		CCNH	C	CNH	R.	HNS	C	CNH	R	HNS	Aids	R.C.H.	ICF-MR
No. of R		·	3		107							29		
Per Dier a. One l														
b, Two			562,00		279,00			ļ				312,00		
c. Three			302,00		217,00							312,00		
bed i		C				İ								
000	111101		L					1		<del>                                     </del>				
														NurseFae-
7. Total Ni	ımber o	f Physic	al Therapy Treat	ment	s					TC	TAL	CCNH	RHNS	Aids
Α.	Medica	are - Par	1 B								875	689		186
В.			lusive of Part B)	1										
			e Treatments								1.500			
	2. Res	torative	Treatments							-	4,786 1,503	3,771 1,184		1,015
		Physical	Therapy Treate	nents							7,164	5,645		319 1,519
			n Therapy Treatn								7,10	3,615		1,517
	. Medica										103	81		22
			lusive of Part B)	)							and the second			
			e Treatments											
		torative	Treatments								301	237		64
	Other								··	ļ	165	130		35_
			Therapy Treatm								569	448		120,64
	amber o Medica		ational Therapy	ı reat	ments						1 27'	+ 000		22.
			t B clusive of Part B	١							1,371	1,080		291
J.			re Treatments	,										
			Treatments							<del> </del>	5,268	4,151		1,117
C.	Other										1,269	1,000		269
D.	Total (	Оссира	ional Therapy T	reatr	nents		-				7,908	6,231		1,677

### **Annual Report of Long-Term Care Facility**

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility Report of Ex	License No.	Durant	Report for Year		D	
Trinity Hill Care Center, LLC	2222-C		1	Ended	Page	of
A CONTRACTOR OF THE CONTRACTOR			9/30/2015		10	37
Are time records maintained by all individuals receiving co	mpensation?	•	Yes	0	No	
			Total Cost a	nd Hours	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
					NurseFac-	
Item	CCNH	Hours	RHNS	Hours	Aids	Hours
A. Salaries and Wages*     1. Operators/Owners (Complete also Sec. 1)	0.000					
of Schedule A1)						
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)	97,460	1,390		<u> </u>	48,730	695
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
4. Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	144,189	6,968			72,095	3,484
5. Dietary Service		1.0				
a. Head Dietitian	(0.696	1 475			15.070	200
b. Food Service Supervisor c. Dietary Workers	60,686 425,293				15,970 111,919	388 5,464
6. Housekeeping Service	425,293	20,701			111,717	3,404
a. Head Housekeeper						
b. Other Housekeeping Workers	224,806	13,080			112,403	6,540
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	32,001				16,001	677
b. Other Maintenance Workers	23,605	1,536			11,803	768
8. Laundry Service						
a. Supervisor b. Other Laundry Workers	104,199	5,698			27,421	1,500
Barber and Beautician Services	104,155	5,076			27,721	1,500
10. Protective Services		······································				
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	163,300	2,835			81,650	1,418
b. RN	270 241	0.014			262 771	( (3/
1. Direct Carc 2. Administrative**	379,341 195,015				262,771 97,508	6,630 1,605
e. LPN	193,013	0,101			97,308	1,002
1. Direct Care	1,009,467	33,763			202,502	6,601
2. Administrative**						
d. Aides and Attendants	1,551,307	90,807			505,933	27,724
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists h. Recreation Workers	72,064	5,080			50 113	2 /1 /
i. Physicians	72,004	3,080			58,113	3,414
1. Medical Director						
2. Utilization Review		<u> </u>				
3. Resident Care***			Ī			
4. Other (Specify)						
i Dontista		-				<u> </u>
j. Dentists k. Pharmacists						
I. Podiatrists						
m. Social Workers/Case Management	66,254	2,894			75,437	2,719
n. Marketing					/ /	1
o. Other (Specify)		6 (3) (6)				
See Attached Schedule	100,357				35,968	
A-13. Total Salary Expenditures	4,649,345	208,248		İ	1,736,222	71,240

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

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

### Schedule of Other Salaries and Wages (Page 10)

	CC	NH	RE	INS	NurseFac	-Aids
Position	\$	Hours	<b>.</b>	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$ 5,766	250			\$ 1,517	66
MEDICAL RECORDS SALARIES	\$ 54,235	2,843			\$ 14,272	748
CENTRAL SUPPLY SALARIES	\$ 40,356	2,397			\$ 20,178	799
A CONTRACTOR OF THE PROPERTY O						· · · · · · · · · · · · · · · · · · ·
	<u> </u>			-		<u> </u>
			· · · · · · · · · · · · · · · · · · ·			
			· · · · · · · · · · · · · · · · · · ·			
		1 + 3 + 3 + 3 + 3 + 3				
	ļ		3 2 3 3			
	<u> </u>		1 14 1			
					1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	
				51 5.0		
Total	\$ 100,357	5,490	\$ -	-	\$ 35,968	1,613

### Schedule of Other Fees (Page 13)

		cc	NII	R	HNS	NurseFa	c-Aids
Service		\$	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$	(16,014)	(790)			\$ (4,309)	(212)
ADMISSIONS C/S LABOR	\$	22,557	649			\$ 6,069	171
CENTRAL SUPPLY CONTRACT SERVICE	\$	(33,828)	(951)			\$ (8,902)	(256)
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$	67,380	1,876			\$ 17,732	494
RESPIRATORY THERAPY CONTRACT SERVICES	\$	1,469	33			\$ 395	9
		~					
·							
	-						
			•				
							· · · · · · · · · · · · · · · · · · ·
Total	\$	41,564	817	\$ -	-	\$ 10,985	205

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-11 Rev. 10/2005

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

Assistant Administrators and Other Related Parties\*

Name of Facility			Toologa	License No	Assistant Aunthinstrators and Outer Avertaged 1 anno	Report for	Report for Year Ended		Page	Jo
ואמוויר טו ז מכזוונץ				TOTAL TAGE		in index	-		D S	}
Trinity Hill Care Center, LLC				2222-C		9/30/2015			11	37
		Salary Paid	jd							
	{	\$ \$ \$	NurseFac-	Fringe Benefits and/or Other Payments	Full Description of	Total Hours	Line Where Claimed on	Name and Address of All	Total Hours	Compensation
Name	CCNH	KHINS	Aids	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Keceived
Section I - Operators/Owners					The second secon					
								and an address of the second s		
						· · · · ·				
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
* N. All answers from a long to a considered and and a few management of the additional absence if manning	L. 000001000	المدرامين لمدر	.11 : C	a is massified than	to the state of th	7		- Po-App		

<sup>\*</sup> No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

<sup>\*\*</sup> Include all employment worked during the cost year.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

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

Assistant Administrators and Other Related Parties\*

Name of Facility (as licensed)		7	The state of the s	I icense No	License No Report for Year Ended	Report for Year Ended	ear Ended		Page	Jo
Traine of a defined (do modified)						· · · · · · · · · · · · · · · · · · ·			, ,	
Trinity Hill Care Center, LLC				2222-C		9/30/2015	and the second		12	37
		Salary Paid	q							
				Fringe Benefits and/or Other		Total	Line Where		Total	
,		ģ.	NurseFac-	Payments	Full Description of	Hours	Claimed on	Name and Address of All	Hours	Compensation
Name	CCNH	KHNS	Aids	(describe fully)	Services Kendered	Worked	Page 10	Other Employment**	worked	Kecelved
Section III - Administrators***										
				same as						
George Kingston	97,460	,	48,730	empioyees less 48,730 union funds	Administrator	2,086 A2	A2			
				same as						
1				employees less union funds	Administrator		A2			
				same as						
				employees less						
				union funds	Administrator		A2			
Section IV - Assistant										
Auministrators				***************************************						
						:				
									·	
*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.	be consider	red unless f	ull informatic	on is provided. Us	e additional sheets if rec	uired.				

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

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

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

### Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

**B.** Report of Expenditures - Professional Fees

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Trinity Hill Care Center, LLC	2222	2 <b>-</b> C	9/30/2015		13	37
		<u></u>	Total Cost	and Hours	T	
ltem	CCNH	Hours	RHNS	Hours	NurseFac- Aids	Hours
*B. Direct care consultants paid on a fee	2.5000					
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1 Dietitian	3,598	80		ļ.	947	21
2. Dentist						-
3. Pharmacist	5,777	168			1,520	45
4. Podiatrist						
5. Physical Therapy	122.020					
a. Resident Care	132,920	1,462		1	35,763	393
b. Other	17.050	20.1		ļ	1 * < 0	
6. Social Worker	15,838	284 35+Cable		<u> </u>	4,168	75
7. Recreation Worker	5,011	35+Cable			1,319	35+Cable
8. Physicians	25 (25	050			74267	507
a. Medical Director (entire facility) b. Utilization Review	35,625	253			74,367	596
	1.000				262	
(Title 18 and 19 only) monthly meeting c. Resident Care**	1,000				263	
d. Administrative Services facility						
1 Infection Control Committee						
(Quarterly meetings)						
<ol> <li>Pharmaceutical Committee</li> </ol>						
(Quarterly meetings) 3 Staff Development Committee						
(Once annually)						
e. Other (Specify)						
Physician Care Contract Services	17,262	177			4,543	47
9. Speech Therapist			-		,,,	
a. Resident Care	24,488	295			6,589	79
b. Other					,	
10. Occupational Therapist						
a. Resident Care	132,146	1,607			35,555	432
b. Other						
11. Nurses and aides and attendants						
a. RN	100	100				
1. Direct Care	724				a pagasa a sa  . Opening the second se	
2. Administrative***	(97,220)	(1,985)			(25,584)	(522
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides	(1,151)	(80)				
d. Other						
12. Other (Specify)						
See Attached Schedule	41,564	817			10,985	205
B-13 Total Fees Paid in Lieu of Salaries	317,583	3,077			150,434	1,370

<sup>\*</sup> 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.

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

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

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

Name of Facility	License No.		Report for	Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	D-1-4-14	9/30/2015		14	37
Name & Address of Individual	Full Explanation of Service	Operato	* to Owners, ors, Officers		nation of Re	lationship
		Yes	No			
Omnicare	Pharmacy Consulting	0	•			
Tocuhpoints Therapy	Therapy	•	0	Common Own	ership	
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	•	0	Common Own	ership	
Healthdrive Physician Services	Audiology, Dental and Podiatry	0	0			-
Dr Tress	HIV Med Dr	0	•		,	er Art Base Phys
Dr Johnson Fielding III	Asst Med Dir	0 ,	•			
Dr Lindenberg Leslie	· Med Dir	0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		Ö	0			-
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0,			
		0	0			
		0	0			
		0	0			

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

### C. Expenditures Other Than Salaries - Administrative and General

Name of Facility License No.	 Report for Y	ear Ended	Page	of
Trinity Hill Care Center, LLC 2222-C	9/30/2015		15	37
				NurseFac-
Item	 Total	CCNH	RHNS	Aids
1. Administrative and General				
a. Employee Health & Welfare Benefits	200		30000	
1. Workmen's Compensation	\$ 232,793	169,497		63,296
2. Disability Insurance	\$			
3. Unemployment Insurance	\$			
4. Social Security (F.I.C.A.)	\$ 612,421	445,905		166,516
5. Health Insurance	\$ 1,082,627	788,263		294,364
6. Life Insurance (employees only)			0.000000000	terms cover on the
(not-owners and not-operators)	\$ 			
7. Pensions (Non-Discriminatory)	\$ 356,602	259,643		96,959
(not-owners and not-operators)	 100 100 100 100 100			
8. Uniform Allowance	\$			
9. Other (Specify)	\$ 46,563	33,903		12,660
See Attached Schedule				
b. Personal Retirement Plans, Pensions, and	\$			
Profit Sharing Plans for Owners and				
Operators (Discriminatory)*			2 d 3 d 3 d 3 d 3 d 3 d 3 d 3 d 3 d 3 d	
c. Bad Debts*	\$ 55,535	43,760		11,774
d. Accounting and Auditing	\$ 3,712	2,938		773
e. Legal (Services should be fully described on Page 7)	\$ 70,859	56,097		14,762
f. Insurance on Lives of Owners and	\$			
Operators (Specify)*				Marin Inc.
g. Office Supplies	\$ 13,208	10,457		2,752
h. Telephone and Cellular Phones			4.5	
1. Telephone & Pagers	\$ 	24,542		6,459
2. Cellular Phones	\$ 3,156	2,499		658
i, Appraisal (Specify purpose and	\$			
attach copy )*				400000
				Michigan Carlos
j. Corporation Business Taxes (franchise tax)	\$ 252	200		53
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$			
2. Other (Specify)	\$ AMARA IRIMANANANAN INI			
See Attached Schedule				5.653443333
3. Resident Day User Fee	\$ 	838,593		225,629
Subtotal	\$ 3,572,950	2,676,296	I	896,654

<sup>\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

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

Trinity Hill Care Center, LLC 9/30/2015

Attachment Page 15

### Schedule of Other Employee Benefits

Description	(	CCNH	RHNS		rseFac- Aids
UNION TRAINING	\$	33,903		\$	12,660
		* ***			
				<u></u>	
			·		
			- 1		
				2.1	
	·	:	· · · · · · · · · · · · · · · · · · ·		
			****		
			——————————————————————————————————————		
· · · · · · · · · · · · · · · · · · ·					
Total	\$	33,903	-	\$	12,660

### **Schedule of Other Taxes**

Description	CC	CNH	RHN	IS	NurseF: Aids	
Total	\$	_	. \$	-	\$	-

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

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Trinity Hill Care Center, LLC	2222-C		9/30/2015		16	37
						NurseFac-
Item			Total	CCNH	RHNS	Aids
	ils Brought Forwa	rd:	3,572,950	2,676,296		896,654
1. Travel and Entertainment						
Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$				
3. Gifts to Staff and Residents		\$				
4. Employee Travel		\$	6,629	5,248		1,381
5. Education Expenses Related to Seminars a	nd Conventions	\$	5,061	3,988		1,073
6. Automobile Expense (not purchase or dep	reciation)	\$	1,875	1,485		391
7. Other (Specify)		\$	669	530		139
See Attached Schedule						
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expense	es )	\$	5,631	4,458		1,173
2. Advertising Telephone Directory (all such	expenses )***	\$		•		
3. Advertising Other (Specify)***		\$	6,616	5,238		1,378
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 servi	ce)***					
7. Postage		\$	1,220	966		254
* 8. Dues and Membership Fees to Professiona	1	\$	9,777	7,740		2,037
Associations (Specify)						
See Attached Schedule						6.000
8a. Dues to Chamber of Commerce & Other Non-A	Allowable Org.***	\$				
9. Subscriptions		\$	373	295		78
10. Contributions***		\$	538	426		112
See Attached Schedule						
11. Services Provided by Contract (Specify and	d Complete	\$	117,996	92,979		25,017
Schedule C-2, Page 21 for each firm or inc	lividual)					
12. Administrative Management Services**		\$	284,523	224,200	The second secon	60,322
13. Other (Specify)		\$	25,887	20,472		5,415
See Attached Schedule						
C-14 Total Administrative & General Expenditures	1	\$	4,039,745	3,044,320		995,425

<sup>\*</sup> Do not include Subscriptions, which should go in item 9.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

### Schedule of Other Travel and Entertainment

Description	 CCNH		RIINS	seFac- cids
Description MEALS	 \$ 5	30		\$ 139
Total Other Travel and Entertainment	\$ 5	30 \$		\$ 139

### Schedule of Other Advertising

Description	 CONH		RHNS	 rseFac- Aids
COMMUNICATIONS SPECIAL EVENTS	\$ 5,238	ļ.		\$ 1,378
Total Other Advertising	\$ 5,238	S		\$ 1,378

### Schedule of Dues

Description	CCNH	RHNS	NurseFac- Aids
Dues			
CAHCF Dues	\$ 7,740,03		\$ 2,036,85
OTHER DUES			
	1	,	
	1000000		
	1.1.11		
	111 1111		
	170000000000000000000000000000000000000		1 1 1
	2000 100		
Total Dues	\$ 7,740	\$ -	\$ 2,037

### Schedule of Contributions

Description	(	COH	RH		sel ac- cids
CHARITABLE CONTRIBUTIONS	\$	426		\$	112
	<del>-</del>			_	
Total Contributions	. \$	426	\$	 \$	112

### Schedule of Other Administrative and General

Description	CCNH	RHNS	NurseFne- Aids		
			1		
SOCIAL SERVICE SUPPLIES	\$ 948		\$	249	
SOC SVC MINOR EQUIPMENT	\$ -		\$	-	
ADMINISTRATIVE MINOR EQUIPMENT	\$ 4,136		\$	1,088	
EMPLOYEE RELATIONS	\$ 5,130		\$	1,350	
EMPLOYEE RELATIONS-OTHER	\$ 25		\$	7	
PERMITS & LICENSES	\$ 2,106		\$	554	
VOLUNTEER EXPENSE	\$		\$	-	
BANK FEES	\$ 6,389		\$	1,681	
CMS REVISIT USER FEES	\$ -		\$	•	
PENALTES	\$ 1,488		\$	392	
LATE FEES	\$ 354		\$	93	
Rounding	\$ (105)		\$ .	. 0	
			-		
Total Other Administrative and General	\$ 20,472	\$	\$	5,415	

### Schedule C-1 - Management Services\*

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2015	Page of 17   37
Name & Address of Individual or Company Supplying Service iCare Management, LLC/iCare Health Management, LLC	Cost of Management Service 284,523	Full Description of Mgmt. Service Provided  Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Indicate Where Costs are Included in Annual Report Page #/Line # Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	137,681	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	48,915	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j
-			

<sup>\*</sup> 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)

<b>3</b> 7	CP:!!!			N-	D 4 C 37	ID 11	In	
	ne of Facility		License		Report for Y		Page	of
ı rın	ity Hill Care Center, LLC		<u> </u>	2222-C	9/30/2015		18	37
	Item			Total	CCNH	RHNS	Nurse	Fac-Aids
2.	Dietary			0.00	100			
	a. In-House Preparation & Service				100			
	1. Raw Food		\$	292,023	194,682			97,341
	2. Non-Food Supplies		\$	41,411	32,632			8,780
	3. Other (Specify)		. \$	24,639	16,426			8,213
	DIETARY SUPPLEMENTS							
	b. Purchased Services (by contract other		\$	(1,132)	(892)			(240
	than through Management Services)							
	(Complete Schedule C-2 att. Page 21)							
	c. Management Services**		\$					
	d. Other (Specify)		\$	5,751	4,532			1,219
	DIETARY MINOR EQUIPMENT							
2E.	Total Dietary Expenditures $(2a + b + c + d)$		\$	362,694	247,380			115,313
2F.	Dietary Questionnaire			Total	CCNH	RHNS	Nurse	Fac-Aids
G.	Resident Meals: Total no. of meals served pe	r day	y:*	504	416			88
Н,	Is cost of employee meals included in 2E?		Yes	0	No			
I.	Did you receive revenue from employees?	0	Yes	•	No	If yes, specify amt.		
J.	Where is the revenue received reported in the	Cos	st Repoi	rt? (Page/Line	ltem)			
	Is cost of meals provided to persons other					16		
K.	than employees or residents (i.e., Board	0	Yes	•	No	If yes, specify		
	Members, Guests) included in 2E?					cost.		
L.	Is any revenue collected from these people?	0	Yes	•	No	If yes, specify amt.	•	
M.	Where is the revenue received reported in the	Co:	st Repoi	rt? (Page/Line	ltem)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	0	Yes	•	No	If yes, specify cost.		
O.	Is any revenue collected from employees?	0	Yes	•	No	If yes, specify amt.		· · · ·
P.	Where is the revenue received reported in the	Co	st Repo	rt? (Page/Line	Item)	•		

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

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

	lame of Facility rinity Hill Care Center, LLC		se No. 2222-C	F	Report for Y 9/30/2015	ear Ended	Page 19	of   37
1 1 111	Try Triff Care Center, BBC				713012013			31
	Item		Total		CCNH	RHNS	Nurse	Fac-Aids
3.	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies,	Lbs						
	gowns and other resident care items washed, ironed, and/or processed.***	Amt.	\$ 90	09	716			193
	<ol><li>Employee items including uniforms, gowns, etc. washed, ironed and/or</li></ol>	Lbs						
	processed.***	Amt.	\$					
	3. Personal clothing of residents	Lbs		_				
	washed, ironed, and/or processed.***	Amt.	\$	_				
	4. Repair and/or purchase of linens.***	Lbs	,	4				<b></b>
		Amt.			41.640			
	b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$ 52,72	26	41,547			11,178
	c. Management Services**		\$					
	d. Other ( <i>Specify</i> )  LAUNDRY SUPPLIES		\$	57	45			12
3E.	Total Laundry Expenditures (3a+b+c+d)		\$ 53,69	92	42,308			11,383
3F. G.	Laundry Questionnaire  Is cost of employee laundry included in 3E?	) Yes	(	• 1	 No	If yes, specify cost.		
Н.	Did you receive revenue from employees?	Yes	0	1 <b>e</b>	No	If yes, specify amt.		
i.	Where is the revenue received reported in the Cos	st Repo	rt?		(Page/Line	ltem)		
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	) Yes	(	1 C	No	If yes, specify cost.		
K.	Did you receive revenue from these people?	) Yes	(	1 C	No	If yes, specify amt.		
L.	Where is the revenue received reported in the Co.	st Repo	rt?		(Page/Line	Item)		

<sup>\*</sup> Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4. All allocations should add to total recorded in 3E.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> 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)

Nam	e of Facility	License No.	Rep	ort for Year E	Inded	Page	of
Trin	ity Hill Care Center, LLC	2222-C		9/30/2015		20	37
	ltem			Total	CCNH	RHNS	NurseFac- Aids
4.	Housekeeping	Sq. Ft. Serviced					
	a. In-House Care	by Personnel					
	1. Supplies - Cleaning (Mops,	Amt.	\$	18,069	14,238		3,831
	pails, brooms, etc.)				,		
	b. Purchased Services (by contract other	Sq. Ft. Serviced					
	than through Management Services)	by Personnel					
	(Complete Schedule C-2 att.	Amt.	\$	40,075	31,578		8,496
	Page 21)						
	c. Management Services*	•	\$				
	d. Other (Specify)		\$				
	HOUSEKEEPING MINIR EQUIP						
4E.	Total Housekeeping Expenditures (4a +	\$	58,144	45,816		12,327	
5.					1000		
	a. Prescription Drugs***				17 (A) (A)		
	1. Own Pharmacy		\$				
	2. Purchased from		\$	47,704	45,644		2,059
	OMNICARE PHARMACY						
	b. Medicine Cabinet Drugs		\$	13,804	10,877		2,927
	c. Medical and Therapeutic Supplies		\$	66,303	52,246		14,057
	d. Ambulance/Limousine***		\$	25,070	19,755		5,315
	e. Oxygen						
	<ol> <li>For Emergency Use</li> </ol>		\$	1,812	1,428		384
	2. Other***		\$				
	f. X-rays and Related Radiological		\$	484	382		103
	Procedures***					The second second	
	g. Dental (Not dentists who should be inc	luded under	\$		Produkt CONTENSORONI debugast produkt virus as as as as	ed and de White fold and a feet a feet and a feet a	
	salaries or fees)						
	h. Laboratory***		\$	2,825	2,226		599
	i. Recreation		\$				
	j. Other (Specify)****		\$	290,830	229,201	en international and	61,629
	See Attached Schedule						
5K.	Total Resident Care Expenditures (5a - 5	5j)	\$	448,832	361,759		87,073

<sup>\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*</sup> Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 29 of the Cost Report.

<sup>\*\*\*\*</sup> ICFMR's should provide a detailed schedule of all Day Program Costs.

### Schedule of Other Resident Care

Description		CCNH	RHNS		rseFac- Aids
NURSING ADMIN SUPPLIES	\$	270		\$	73
NURSING MINOR EQUIP	\$	5,696		\$	1,533
MEDICAL RECORDS SUPPLIES	\$	(933)	1.	\$	(251
MEDICAL RECORDS MINOR EQUIPMENT	\$	<u></u>		\$	_
MANAGEMENT ALLOCATIONS - DIRECT	\$	108,491		\$	29,190
NON-COVERED PPS DR. VISITS	\$	-		\$	
RESIDENT CARE SUPPLIES	\$	278		\$	75
CENTRAL SUPPLY MINOR EQUIPMENT	\$	6,629		\$	1,744
PERSONAL CARE SUPPLIES	\$	6,024		\$	1,621
INCONTINENCY SUPPLIES	\$	27,098		\$	7,291
VACCINE RESIDENTS	\$	564		\$	152
PATIENT SPECIAL NEEDS	\$	_		\$	-
PHYSICAL THERAPY SUPPLIES	\$	-		\$	-
PHYSICAL THERAPY EQUIPMENT RENT	\$	_		\$	-
PHYSICAL THERAPY MINOR EQUIPMENT	\$	_		\$	-
OCCUPATIONAL THERAPY SUPPLIES	\$	-		\$	-
OCCUPATIONAL THERAPY EQUIP RENTAL	\$	-		\$	_
OCCUPATIONAL THERAPY MINOR EQUIP	\$	1 - 1		\$	-
SPEECH THERAPY SUPPLIES	\$	-	est and the second	\$	-
SPEECH THERAPY EQUIPMENT RENT	\$			\$	_
SPEECH THERAPY MINOR EQUIPMENT	\$		:	\$	
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$	18,477		\$	4,971
EQUIPMENT RENTAL: AIDS UNIT	\$	-		\$	-
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$	29		\$	8
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$	_		\$	-
HI LOW BED RENTAL & MATTRESSES	\$	357		\$	96
IV THERAPY SUPPLIES	\$	10,102		\$	2,718
IV THERAPY CONTRACT SERVICE	\$	<u>.</u>		\$	_
MEDICAL WASTE CONTRACT SERVICE	\$	4,119		\$	1,108
ACTIVITIES SUPPLIES	\$	2,579		\$	694
ACTIVITIES MINOR EQUIPMENT	\$	878		\$	236
MANAGEMENT ALLOCATION - INDIRECT	\$	38,544		\$	10,371
ADMISSIONS SUPPLIES	\$	-		\$	
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$			\$	
	T			1	
	1			1	
Total Other Resident Care	\$	229,201	\$ -	\$	61,629

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

Related ** to Owners, Operators, Officers   Charles	Name of Facility Trinity Hill Care Center 11.C				License No.	Report for Year Ended 9/30/2015	Ŧ			Page 21	of 37
Related #** to Owners.   Related #** to Owners.   Paylamation of majorations, Officers   Paylamation of majorations, Officers   Paylamation of majorations			ere de la composition de la co		And Andrews	The state of the s					
Individual or			Related ** t	o Owners,				(	; ;		
Individual or   Address   Yes   No   Relationship   Service Provided*   CCNH   RIINS   Aids   Pg			Operators,	Officers				Total Cost	/Page Ret. ***		
Scriptor   Scriptor	Name of Individual or	~	***************************************	<u>,</u>	Explanation of	Full Explanation of	III	PITNIC	NurseFac-		.:
Group         Beneslen, PA 19020         O         VENDOR         Housekeeping Services         39,708         20           Group/Unitex         3220 Tillman Drive, services         O         VENDOR         Laundry Services         52,584         19           Services         Beraslem, PA 19020         O         VENDOR         Elevator Contract         6,126         22           Broup/Stevan         O         O         VENDOR         Medical Waste         5,227         22           Broup/Stevan         O         O         VENDOR         Renvoal/Landscaping         17,032         22           Britch         O         O         VENDOR         Trash renoval         35,537         22           Britch         O         O         VENDOR         Contract         10,504         16           Processing         Lous Box 9001006,         O         VENDOR         Resident Treat Software         2,516         16           Processing         Lous Box 9001006,         O         VENDOR         Resident Treat Software         2,516         16           Incomplexity services         O         O         VENDOR         Counter Services         5,388         16           Incomplexity services         O	Company	Address 3220 Tillman Drive,	ß	ON	Netalionship	Sel vice i lovined	CCIVII	CATTA	CHILL		2
Group/Unitex         3220 Tillman Drive, services         O         VENDOR         Laundry Services         52.584         19           services         Bentsalem, PA 19020         O         VENDOR         Elevator Contract         6,126         22           3roup/ Stevan         O         O         VENDOR         Medical Waste         5,227         22           3roup/ Stevan         O         O         VENDOR         Trach removal         35,537         22           Arrich         D         O         VENDOR         Trach removal         35,537         22           Arrich         D         O         VENDOR         Trach removal         35,537         22           Arrich         D         O         VENDOR         Trach removal         35,537         16           Arrich         D         O         VENDOR         Removal/Landscaping         10,504         16           Arrich         D         O         VENDOR         Resident Trust Software         2,516         16           Arrich         D         O         VENDOR         Competers         3,538         16           Arrich         D         O         VENDOR         Arrich         16         16	Health Services Group	Bensalem, PA 19020	0	0	VENDOR	Housekeeping Services	39,708				4b
Services   Computer Contract   Contract	Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	0	0	VENDOR	Laundry Services	52,584			19	36
Broup/ Stevan         O         O VENDOR         Medical Waste         5,227         22           Broup/ Stevan         O         O VENDOR         Trash removal/Landscaping         17,032         22           Infech         O         O VENDOR         Trash removal         35,537         22           Infech         P.O. Box 9001006,         O         O VENDOR         Contract         10,504         16           Infech         P.O. Box 9001006,         O         O VENDOR         Resident Trust Software         2,516         16           Infoessing         Infoessing         O         O VENDOR         Resident Trust Software         2,516         16           Infoessing         O         O         VENDOR         Counter Services         5,388         16           Infoessing         O         O         VENDOR         Counter Services         5,388         16           Infoessing         O         O         VENDOR         Counter Services         5,388         16           Infoessing         O         O         VENDOR         Nursing Software         4,680         16	Eagle Elevator		0	0	VENDOR	Elevator Contract	6,126			22	6F
Group/ Stevan         Snow         Snow         Removal/Landscaping         17,032         22           Allech         O         VENDOR         Trash removal         35,537         22           Allech         D. Box 9001006,         O         VENDOR         Contract         10,504         16           I Processing         Louisville, KY 40290         O         VENDOR         Resident Trust Software         2,516         16           In Computer Computer Consulting         O         VENDOR         Computer Consulting         16           In Computer Consulting         O         VENDOR         Courier Services         5,388         16           In Computer Consulting         O         VENDOR         VENDOR         Nursing Software         4,680         16           In Contract Services         O         VENDOR         VENDOR         VENDOR         16         16	Bioserve, Inc.		0	0	VENDOR	Medical Waste	5,227			22	6F
hTech         Contract         VENDOR         Trash removal         35,537         22           hTech         P.O. Box 9001006, arconsing         O         VENDOR         Contract         Inj504         Inf6           re Corp         P.O. Box 9001006, arconsiling         O         VENDOR         Resident Trust Software Consulting         2,516         Inf6           re Corp         O         VENDOR         Resident Trust Software Consulting         20,470         Inf6           strongley services         O         VENDOR         Counter Services         5,388         Inf6           strongley services         O         VENDOR         Nursing Software         4,680         Inf6           strongley services         O         VENDOR         Nursing Software         4,680         Inf6	The Brickman Group/ Stevan Infante		0	0	VENDOR	Snow Removal/Landscaping	17,032			22	6F
F.O. Box 9001006,   O   O   VENDOR   Contract   IO,504     16,504     16,504     16,504     16,504     16,504     16,504       16,504       16,504	All Waste Inc		0	0	VENDOR	Trash removal	35,537			22	6F
P.O. Box 9001006, Louisville, KY 40290         O         VENDOR         Resident Trust Software         51,737         16           re Corp         Louisville, KY 40290         O         VENDOR         Resident Trust Software         2,516         16           hologuy services         O         VENDOR         Computer Consulting Services         20,470         16           indoguy services         O         VENDOR         Nursing Software         4,680         16           indoguy services         O         O         VENDOR         Nursing Software         4,680         16           indoguy services         O         O         VENDOR         Nursing Software         4,680         16	American HealthTech		0	0	VENDOR	Software Maintenance Contract	10,504			16	ME
ne Corp         O         VENDOR         Resident Trust Software         2,516         16           hnologuy services         O         VENDOR         Services         20,470         16           s         O         VENDOR         Courier Services         5,388         16           O         O         VENDOR         Nursing Software         4,680         16           O         O         VENDOR         VENDOR         16           O         O         VENDOR         16	Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	0	0	VENDOR	Payroll Services	51,737			16	MII
hnologuy services         O         O         VENDOR         Computer Consulting Services         20,470         16           s         O         VENDOR         Courier Services         5,388         16           O         O         VENDOR         Nursing Software         4,680         16           O         O         VENDOR         VENDOR         16           O         O         VENDOR         16	National Datacare Corp		0	0	VENDOR	Resident Trust Software	2,516			16	MI
G         O         VENDOR         Courier Services         5,388         16           O         O         VENDOR         Aursing Software         4,680         16           O         O         VENDOR         16           O         O         VENDOR         16	Prime Care Technologuy services		0	0	VENDOR	Computer Consulting Services	20,470			16	M E
O         O         VENDOR         Nursing Software         4,680         16           O         O         VENDOR         O <t< td=""><td>Priotiry Express</td><td></td><td>0</td><td>0</td><td>VENDOR</td><td>Courier Services</td><td>5,388</td><td></td><td></td><td></td><td>MII</td></t<>	Priotiry Express		0	0	VENDOR	Courier Services	5,388				MII
0 0	Point Right Inc		0	0	VENDOR	Nursing Software	4,680				Ξ
0			0	0	VENDOR						
			0	0	VENDOR						

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

<sup>\*\*</sup> Refer to Page 4 for definition of related.

<sup>\*\*\*</sup> 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

1	ense No.	Report for Y	ear Ended		Page of
Trinity Hill Care Center, LLC	2222-C	9/30/2015			22   37
Item		Total	CCNH	RHNS	NurseFac-Aids
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$	32,633	25,714		6,919
b. Heat	\$	75,624	50,416		25,208
c. Light & Power	\$	81,762	54,508		27,254
d. Water	\$	55,793	37,195		18,598
e. Equipment Lease (Provide detail on page	(6) \$	37,351	24,901		12,450
f. Other (itemize)	\$	182,016	121,755		60,261
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$	465,179	314,489		150,689
7. Depreciation (complete schedule page 23*)					
a. Land Improvements	\$				
b. Building & Building Improvements	\$	17,437	17,437		
c. Non-Movable Equipment	\$	459	306		153
d. Movable Equipment	\$	49,736	39,374		10,362
*7e. Total Depreciation Costs $(7a + b + c + d)$	\$	67,632	57,117		10,515
8. Amortization (Complete att. Schedule Page 2	24*)			1-111111	
a. Organization Expense	\$	]			
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$	49,531	33,021		16,510
d. Other (Specify)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$	49,531	33,021		16,510
9. Rental payments on leased real property less					
real estate taxes included in item 10b	\$	1,223,303	815,535		407,768
10. Property Taxes					
a. Real estate taxes paid by owner	-\$				
b. Real estate taxes paid by lessor	\$	278,724	185,816		92,908
c. Personal property taxes	\$	26,267	20,795		5,472
11. Total Property Expenses $(7e + 8e + 9 + 10)$	\$	1,645,456	1,112,284		533,173

<sup>\*</sup> 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	Nurs	eFac-Aids
PLANT SUPPLIES	\$	8,004		\$	4,002
PLANT CONTRACT SERVICE LABOR	\$			\$	_
ELEVATOR CONTRACT SERVICE	\$	6,193		\$	3,097
FIRE/SPRINKLER CONTRACT SERVICE	\$	4,956		\$	2,478
LANDSCAPING CONTRACT SERVICE	\$	6,037		\$	3,019
SNOW REMOVAL CONTRACT SERVICE	\$	5,317		\$	2,659
TRASH REMOVAL CONTRACT SERVICE	\$	23,691		\$	11,846
HVAC CONTRACT SERVICE	\$			\$	-
SECURITY CONTRACT SERVICE	\$			\$	-
PLANT CONTRACT SERVICE OTHER	\$	59,548		\$	29,774
PLANT MINOR EQUIPMENT	\$	5,406		\$	2,703
RENT AUTO	\$	_		: \$	_
RENT EQUIPMENT	\$	2,603		\$	685
RENT OTHER	\$	. <b>-</b>		\$	-
	-				
		i vija			
		( * ** s			
Total Other Repairs and Maintenance	\$	121,755	\$ -	\$	60,261

State of Connecticut Annual Report of Long-Term Care Facility CSP-23 Rev. 10/2006 Depreciation Schedule

Truny Hill Care Censes, LLC			ייייייייייייייייייייייייייייייייייייייי	Dept continue					4	
Historical   Lass   Depreciation to   Department to   Department to   Department to   Department to   Department to   Department to   Department to   Department to   Department to   Department to   Department to   Department to   Department to   Department to   Department to   Department to   Depa	Name of Facility Trinity Hill Care Center 11 C		License No.	<i>)</i> -0		Keport for Year I 9/30/2015	ended		Page 23	to 37
Historical   Property Item   Property Item   Historical   Land Improvements   Property Item   Exclusive of Salvage   Cost to be a Property Item   Exclusive of Salvage   Cost to be a Property of the Property Item   Proper	Trinity filli Care Center, LLC		7777	۲-۲		9/30/2013			C7	37
Property Item			Historical			Accumulated				
Property Hem   Prop			Cost	Iress	1	Depreciation to	Method of	,		
Land Improvements	d.		Exclusive of	Salvage	Cost to Be	Beginning of		Useful 1 ifa	Depreciation	Totale
Language principal princ			Land	v anuc	Depreciated	1 car s Operations	_	LIIC	101 Lills Lead	LOGAS
1. Acquired plants this report period (attach schedule)   3. Acquired during this report period (attach schedule)   3. Acquired during this report period (attach schedule)   3. Acquired during this report period (attach schedule)   4. Acquired during this report period (attach schedule)   3. Acquired during this report period (attach schedule)   4. Acquired during this report period (attach schedule)   5. Acquired during this report period (attach schedule)   6. Acquired during this report period (attach schedule)   8. Acquired during this report period (attach schedule)   9. Disposals (attach schedule)   1. Acquired during this report period (attach schedule)   1. Acquired during this report period (attach schedule)   1. Acquired during this report period (attach schedule)   2. Disposals (attach schedule)   3. Acquired during this report period (attach schedule)   4. Acquired attach schedule)   5. Acquired attach schedule)   6. Acquired attach schedule)   8. Acquired attach schedule)   8. Acquired attach schedule)   9. Acquired attach schedule)   9. Acquired attach schedule)   9. Acquired attach schedule)   9. Acquired attach schedule)   1. Acquired attach schedule)   2. Acquired attach schedule)   3. Acquired attach schedule)   3. Acquired attach schedule)   4. Acquired attach schedule)   5. Acquired attach schedule)   6. Acquired attach schedule)   8. Acquired attach schedule)   9. Acquired attach	Ľ									
2. Disposals (utach schedule)  2. Acquired during this report period (utach schedule)  2. Lisposals (utach schedule)  3. Acquired during this report period (utach schedule)  3. Acquired during this report period (utach schedule)  3. Acquired during this report period (utach schedule)  3. Acquired during this report period (utach schedule)  3. Acquired during this report period (utach schedule)  3. Acquired during this report period (utach schedule)  3. Acquired during this report period (utach schedule)  3. Acquired during this report period (utach schedule)  3. Acquired during this report period (utach schedule)  4. Acquired during this report period (utach schedule)  4. Acquired during this report period (utach schedule)  5. Acquired during this report period (utach schedule)  6. Cost of this schedule)  6. Cost of this schedule)  6. Cost of this schedule)  7. Motor Verbinels (Specify utame, model and any schedule)  8. Acquired furing this report period  9. Acquired furing this report period  10. Acquired furing this report period  11. Acquired furing this report period  12. Disposals (utach schedule)  3. Acquired furing this report period  4. Value Cost to Be schedule)  5. Acquired furing this report period  6. Acquired furing this report period  2. Acquired furing this report period  3. Acquired furing this report period  4. Acquired furing this report period  5. Acquired furing this report period  6. Acquired furing this report period  6. Acquired furing this report period  7. Acquired furing this report period  8. Acquired furing this report period  9. Acquired furing this report period  10. Acquired furing this report period  10. Acquired furing this report period  10. Acquired furing this report period  11. Acquired furing this report period  12. Acquired furing this report period  13. Acquired furing this report period  14. Acquired furing this report period  15. Acquired furing this report period  16. Acquired furing this report period  16. Acquired furing this report period  16. Acquired furing this	<ol> <li>Acquired prior to this report period</li> </ol>									
Subtracted during this report period (attach schedule)	2. Disposals (attach schedule)									
Substance		th schedule)								
Puliding and Building Inprovements   17,437	A-4. Subtotal									
1. Acquired prior to this report period attack schedule    2. Disposals (intext schedule)   17,437   17,437   17,437   17,437   17,437   17,437   17,437   17,437   17,437   17,437   17,437   17,437   17,437   17,437   17,437   17,438										
2. Disposals (attack schedule) 2. A Captured during this report period (attach schedule) 3. A captured during this report period (attach schedule) 3. A captured during this report period (attach schedule) 3. A captured during this report period (attach schedule) 3. A captured during this report period (attach schedule) 3. A captured during this report period (attach schedule) 3. A captured during this report period (attach schedule) 3. A captured during this report period (attach schedule) 3. A captured during this report period (attach schedule) 3. A captured during this report period (attach schedule) 4. A captured during this report period (attach schedule) 4. A captured during this report period (attach schedule) 5. A captured during this report period (attach schedule) 5. A captured during this report period (attach schedule) 6. Sabased 6. Sabased 6. Sabased 6. Sabased 7. 990 7.	1. Acquired prior to this report period		359,317		359,317				17,437	
3. Acquired during this report period (attach schedule)	2. Disposals (attach schedule)									
Non-Morable Equipment		th schedule)	(14,100)		(14,100)					
Non-Movable Equipment	B-4. Subtotal									17,437
1. Acquired prior to this report period (attach schedule)   2. Disposals (attach schedule)   3. Acquired during this report period (attach schedule)   3. Acquired during this report period (attach schedule)   3. Acquired during this report period (attach schedule)   3. Acquired during this report period (attach schedule)   3. Acquired during this report period (attach schedule)   4.014	l							200		
2. Disposals (attach schedule)  3. Acquired during this report period (attach schedule)  Subtoral  Is a mileage    Post	1. Acquired prior to this report period		7,990		7,990	4,014			459	
Subtoral   Acquired during this report period (attach schedule)   Acquired during this report period (attach schedule)   Acquired during this report period (attach schedule)   Acquired during this report period   Acquired during this report period   Acquired beginning of a Acquired beginning of a Cost to Be										
Subtotal   Is a mileage   Is a mil		ch schedule)								
15 a mileage   10 gbook   Description to   Depreciation to   Depreciation to   Depreciation to   Depreciation to   Depreciation   Depreciation   Life   For This Year   Towarble Equipment	Sul									459
Movable Equipment         Yes         No         Mount         Year         Land         Value         Depreciation to be preciation         Depreciation to this report period (attach schedule)         Depreciation         Depreciation to this report period (attach schedule)         Depreciation		Is a mileage logbook	Historical			Accumulated				
No. No. No. No. No. No. No. No. No. No.	ш	maintained?	Cost			Depreciation to	Method of		•	
Movable Equipment         Movable Equipment         6,889         6,889         2,105           a. Van Repair Hillside Automotive Ce         6,889         6,889         2,105           b. C. Aduired Equipment         2. Movable Equipment         4.2,806           b. Disposals (attach schedule)         3355,907         355,907         42,806           b. Disposals (attach schedule)         55,569         4,825           Subtotal         Total Depreciation         4,825			 Exclusive of Land		Cost to Be Depreciated	Beginning of Year's Operations		Useful Life	Depreciation for This Year	Totals
1. Motor Vehicles (Specify name, model and year of each vehicle)       6,889       6,889       2,105         a. Van Repair: Hillside Automotive Ce       6,889       6,889       2,105         b. D. Movable Equipment       355,907       355,907       190,461       42,806         b. Disposals (attach schedule)       c. Acquired during this report period (attach schedule)       55,569       4,825         Subtotal       Total Depreciation       4,825	Movable Equipment									
and year of each vehicle) a. Van Repair: Hillside Automotive Ce b. c. d. 2. Movable Equipment a. Acquired prior to this report period (attach schedule) c. Acquired during this report period (attach schedule) c. Acquired schedule) c. Acquired schedule) c. Acquired schedule) c. Acquired schedule) c. Acquired schedule) c. Acquired schedule) c. Acquired schedule) c. Acquired schedule) c. Acquired schedule) c. Acquired schedule) c. Acquired schedule) c. Acquired schedule) for a schedule sc	I. Motor Vehicles (Specify name, model									
a. Van Repair. Hillside Automotive Ce       6,889       6,889       2,105         b. C. Acquired prior to this report period (attach schedule)       355,907       355,907       190,461       4,825         c. Acquired during this report period (attach schedule)       55,569       4,825         Subtotal       Total Depreciation       4,825       190,461       190,461       190,461	and year of each vehicle)									
b. C. Movable Equipment  a. Acquired prior to this report period  b. Disposals (attach schedule)  c. Acquired during this report period	a. Van Repair: Hillside Automotive Ce		 6,889		688.9				2,105	
c.       d.         2. Movable Equipment       355,907       355,907       190,461       42,806         a. Acquired prior to this report period       b. Disposals (attach schedule)       55,569       4,825         c. Acquired during this report period (attach schedule)       55,569       4,825         Subtotal       Total Depreciation	p.									
d.       Disposals (attach schedule)       355,907       355,907       190,461       42,806         b. Disposals (attach schedule)       c. Acquired during this report period (attach schedule)       55,569       4,825         Subtotal       Total Depreciation       Total Depreciation	C.									
2. Movable Equipment       355,907       355,907       190,461       42,806         a. Acquired prior to this report period       b. Disposals (attach schedule)       55,569       4,825         c. Acquired during this report period (attach schedule)       55,569       4,825         Subtotal       Total Depreciation										
a. Acquired prior to this report period       355,907       355,907       190,461       42,806         b. Disposals (attach schedule)       c. Acquired during this report period (attach schedule)       55,569       4,825         Subtotal       Total Depreciation										
b. Disposals (attach schedule) c. Acquired during this report period			355,907		355,907	190,461			42,806	
c. Acquired during this report period (attach schedule) Subtotal  Total Depreciation	b. Disposals (attach schedule)			3 4 5 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3						
(attach schedule)         55,569         4,825           Subtotal         Total Depreciation	c. Acquired during this report period									
Subtotal  Total Depreciation	(attach schedule)		55,569						4,825	
Total Depreciation	D-3. Subtotal									49,736
										67,632

### Schedule of Land Improvements Acquired during this report period

Description of Item	Cost	Useful Life	Depreciation
			·
		4.1.1	a jugaran
			1.5
		<del></del>	
vements	\$ -		\$ -
		***************************************	
/ements	\$ -		\$ -
	vements	vements \$	Description of Item  Cost Life  verments  \$ -

<sup>\*</sup>Ties to Page 23, Line A3

### Schedule of Building Improvements Acquired during this report period

				Useful	
Acquisition Date	Description of Item		Cost	Life	Depreciation
Additions:					1
9/1/2015 elevator mod	dernization credit	5	(14,100)		
				***************************************	
Total additions for Building Im	provements		ß (14,100)		\$ -
Deletions:					
	·				
Total deletions for Building Im	provements	9	B -		\$

<sup>\*</sup>Ties to Page 23, Line B3

### Schedule of Non-Movable Equipment Acquired during this report period

				Useful	
Acquisition Date	Description of Item		Cost	Life	Depreciation
Additions:					1
	10-11-2011				<del> </del>
<del></del>	W-1,				
Fotal additions for Non-Movabl	e Equipment		-		\$ -
Deletions:					
	- Abr				
		-			<del>                                     </del>
					<u> </u>
Fotal deletions for Non-Movabl	e Equipment	9	-		. \$ -

<sup>\*</sup>Ties to Page 23, Line C3

<sup>\*\*</sup>Ties to Page 23, Line A2

<sup>\*\*</sup>Ties to Page 23, Line B2

<sup>\*\*</sup>Ties to Page 23, Line C2

			Useful		
Acquisition Date	Description of Item	 Cost	Life	Depre	ciation
Additions:					
9/24/2014	Steam Table Supply: Direct Supply	\$ 4,779	60	\$	876
12/4/2014	New Dishwasher: Proline	\$ 25,158	120	\$	1,887
12/19/2014	Television: Kingston George	\$ 3,233	60	\$	485
3/17/2015	High - Low Lock Bed	\$ 11,911	60	\$	1,191
2/27/2015	Dishwasher: Precision electrical	\$ 3,700	120	\$	216
6/9/2015	Dryer: Daniels Equipment	\$ 6,788	120	\$	170
					·
4.411-					
		 			·
Total additions for	r Movable Equipment	 55,569	W. C	\$	4,825
Deletions:					Ava.
			· · · · · · · · · · · · · · · · · · ·		
				<u> </u>	
Total deletions for	Movable Equipment	 		\$	

<sup>\*</sup>Ties to Page 23, Line D2c

Schedule of Leasehold Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
1/29/2015	Electrical Wiring: Precision Electreical	\$ 7,232	240	\$ 241
2/16/2015	Replaced Heat Exchenger: Link Mechanicals Srv	\$ 4,967	120	\$ 290
8/9/2015	New Phone System: S&S Wired System	\$ 10,651	120	\$ 89
6/10/2015	Fence: Hartford Fence	\$ 34,667	180	\$ 193
4/23/2015	Upgrade Water Boiler: Link Michnical Srv	\$ 3,846	120	\$ 160
10/1/2013	Survey for Elevator phase 1: Newmont Elevator	\$ 5,850	120	\$ 1,170
10/1/2013	Elevator Door: Eagle Elevator	\$ 6,767	240	\$ 677
10/1/2013	Elvator Pits: Eagele Elevator	\$ 8,038	240	\$ 804
Total additions for	r Leasehold Improvement	\$ 82,018		\$ 3,623
Deletions:				
			- :	
Total deletions for	Leasehold Improvement	\$ -		\$ -

<sup>\*</sup>Ties to Page 24, Line C3

<sup>\*\*</sup>Ties to Page 23, Line D2b

<sup>\*\*</sup>Ties to Page 24, Line C2

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

# Amortization Schedule\*

Trinity Hill Care Center, LLC	Name of Facility		License No.		Report for Year Ended	r Ended		Page	Jo
Date of Accumulated Accumulated Accumulated Accumulated Amortization   Acquisition   Length of Amortization   Acquisition   Length of Amortization   Amort	Trinity Hill Care Center, LLC		2222		9/30/2015			24	37
Page of Amort. to Date of Amort. to Date of Amort. to Date of Amort. and Date of Amort.					Accumulated				
Pagintize   Paginting   Pagi		Date of			Amort. to				
Organization Expense         Month Year Amortization Month Year Amortization Expense         Length of Cost to Be Amortization Amorti		Acquisition			Beginning of	Basis for			
Item         Month Year         Amortization         Amortization         Amortization         Amortization**         % for This Year         Tr         1.         2.         3.         Subtotal         Amortization**         % for This Year         Tris         <			Length of	Cost to Be	Year's	Computing	Rate	Amortization	
Organization Expense         Organization Expense         Percentage	Item			Amortized	Operations	Amortization**		or This Year	Totals
2.2. 3. Subtotal  Mortgage Expense 1.	A. Organization Expense								
Subtotal   Mortgage Expense	1.								
3. Subtotal  Mortgage Expense  1.	÷.								
Subtotal       Mortgage Expense       Advitage Expense         1.       2.         2.       3.         3.       3.         2.       3.         3.       3.         3.       45,908         45,908       45,908         2.       205,615         2.       205,615         2.       205,615         3.       Acquired prior to this report period         4.       3.         3.       Acquired during this report period         4.       45,908         3.       Acquired during this report period         4.       45,908         4.       45,908         3.       Acquired during this report period         4.       45,908         4.       45,908         4.       45,908         4.       45,908         4.       45,908         4.       45,908         4.       45,908         4.       45,908         4.       45,908         4.       45,908         4.       45,908         4.       45,908         4.       45,908	3.								
Mortgage Expense         Mortgage Expense         Mortgage Expense         Accounted prior to this report period (attach schedule)         Accounted prior to this	A-4. Subtotal								
1.         2.         3.         Subtotal       556,615       297,990       45,908         2.       45,908       45,908         2.       Disposals (attach schedule)       3. Acquired during this report period (attach schedule)       82,018       3,623         Subtotal       Subtotal       3,623       3									
2.       3.       3.       4. <td< td=""><td>ij</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>	ij								
3.       Subtotal       Casehold Improvements and Other       Control	2.								
SubtotalLeasehold Improvements and Other556,615297,99045,9081. Acquired prior to this report period2. Disposals (attach schedule)3,6233,6232. Disposals (attach schedule)82,0183,623SubtotalSubtotal3,6233,623	3.								
Leasehold Improvements and Other556,615297,99045,9081. Acquired prior to this report period2. Disposals (attach schedule)3.6233.6233. Acquired during this report period (attach schedule)82,0183,62345,9083,6235. Acquired during this report period (attach schedule)82,0183,6236. Subtotal7otal Amortization82,01882,018									
sired prior to this report period556,615297,99045,908osals (attach schedule)11sired during this report period82,0183,623ch schedule)3,623		-							
osals (attach schedule) sired during this report period charged by schedule) ch schedule) nortization	1. Acquired prior to this report perior	-   p		556,615	297,990			45,908	
irred during this report period character char	2. Disposals (attach schedule)								
ch schedule)         82,018         3,623           nortization         3,623	3. Acquired during this report period								
nortization	(attach schedule)			82,018				3,623	
	C-4. Subtotal								49,531
	D. Total Amortization								49,531

\* 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; ORC. Remaining Life of Lease; ORD. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year En	ided		Page of
Trinity Hill Care Center, LLC	2222-C	9/30/2015			25   37
11. Property Questionnaire					
Part A	<del></del>				
Is the property either owned by the	ne Facility		_		If "Yes," complete Part B.
or leased from a Related Party?*	, 0	Yes	O	No	If "No," complete Part C.
*If any owner or operator of this fa					•
business association to any person	or organization from whon	n buildings are leased, th	en it is considered		
a related party transaction.  Description		Total			
1. Date Land Purchased		04/01/99			
Date Structure Completed		0 1/ 01/ 22			
3. If <b>NOT</b> Original Owner, Date	e of Purchase	04/01/99	9.8 (3.9)	USB CONTRACTOR	
4. Date of Initial Licensure		04/01/99		Parameter St.	
<ol><li>Total Licensed Bed Capacity</li></ol>		144			
6. Square Footage			States and		
7. Acquisition Cost					
a. Land			ne brokenski	on what has republic	
b. Building		1-4 3 44	10.100	2 1 3 4	
Part B - Owner and Related Pa  1. Financing	rties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
a. Type of Financing (e.g., f	ived variable)	HUD fixed			
b. Date Mortgage Obtained	ixed, variable)	05/30/13			
c. Interest Rate for the Cost	Year	335.00%	<b>_</b>		
d. Term of Mortgage (numb	er of years)	24			
e. Amount of Principal Borr		4,208,200			
f. Principal balance outstand		3,943,842			
Complete if Mortgage was					
During Current Cost Ye					
g. Type of Financing (e.g., f	ixed, variable)				
h. Date of Refinancing i. New Interest Rate					
j. Term of Mortgage (numb	er of years)				Western Communication of the C
k. Amount of Principal Borr					
l. Principal Outstanding on					
Part C - Arms-Length Leas	es for Real Property	Improvements Onl	y		
Name and Address of Lesso	r Pro	perty Leased	Date of Lease	Term of Lease	Annual Amount of Lease
-					

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

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

Name of Facility	License No.		Report for Ye	ar Ended		Page of
Trinity Hill Care Center, LLC	2222-C		9/30/2015			26   37
ltem			Total	CCNH	RHNS	NurseFac-Aids
12. Interest						
A. Building, Land Improve	ment & Non-Movabl	e				:
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	on			10116	10.45	
1. Original Loan Amou	nt	\$				
2. Loan Origination Da	e					
3. Interest Rate %	·					
4. Term				no no ligita		
5. CHEFA Interest Exp	ense			The second secon	The Court of the C	
12 B7. Total Building Interest Exp		\$				
	<u>`</u>			v Subtotala :	C 1.	

(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 Y 9/30/2015	ear Ended		Page of 27   37
Iter	m		Total	CCNH	RHNS	NurseFac-Aids
	Subtotals Bro	ought Forward:				
12. C. Movable Equipment						
Automotive Equipment		\$				
A. Item	Rate	Amount				
		1				
Lender						
Address of Lender						
Address of Defider						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
			0.650.040			
Address of Lender						
	D -4 -	A				
B. Item	Rate	Amount				
Lender						
Lenger						
Address of Lender						
12. C. 3. Total Movable Equip	ment Interest					
Expense (C1 + 2)		\$				
12. D. Other Interest Expense (	Specify)	\$	416	329		87
INTEREST				0.000		
12 Trade I All Trades and Even seemed [	1007 + 1002 + 10	D) •	416	220		0.7
13. <i>Total All Interest Expense</i> (1) 14. Insurance	$12B/ \pm 12C3 \pm 12$	D) \$	416	329	4.8 B	87
a. Insurance on Property (b	uildings only)	\$	6,650	4,433		2,217
b. Insurance on Automobile		<del>_</del> \$		2,462		648
c. Insurance other than Pro						3.10
1. Umbrella (Blanket Co		<u> </u>	54,654	43,268		11,386
2. Fire and Extended Co	verage	\$				
3. Other (Specify)		\$	2,791	2,210		582
14d Total Insurance Emenditus	os (14a ± h ± a)	<u> </u>	67.206	50 272		14.020
<ul><li>14d. Total Insurance Expenditur</li><li>15. Total All Expenditures (A-1.</li></ul>		\$		52,373		14,832 3,806,958
15. Total All Experimenes [A-1.	J 11114 C-17)	Ψ	13,774,743	10,107,707		2,000,730

## D. Adjustments to Statement of Expenditures

	e of Fa	-	· · · · · · · · · · · · · · · · · · ·	Lie	cense No.	Report for Ye	ar Ended	Page	of
Trini	ty Hill	Care	Center, LLC		2222-C	9/30/2015		28	37
					Total				
	Page	1			Amount of				
No.			Item Description		Decrease	CCNH	RHNS	NurseF	ac-Aids
Page	10 - S	Salarie	es and Wages		V-10-2-1-1	1.0			
1.			Outpatient Service Costs	\$					
2.			Salaries not related to Resident Care	\$	<del></del>				
3.			Occupational Therapy	\$					
4.			Other - See attached Schedule	\$					
Page	13 - F	rofes	sional Fees						
5.			Resident Care Physicians **	\$					
6.			Occupational Therapy	\$					
7.			Other - See attached Schedule	\$	132,061	104,062			27,999
Page	s 15 &	: 16 -	Administrative and General						
8.			Discriminatory Benefits	\$					
9.			Bad Debts	\$	55,535	43,760			11,774
10.			Accounting & Legal	\$					
11.			Telephone	\$					
12.			Cellular Telephone	\$					
13.			Life insurance premiums on the life				15005593		
			of Owners, Partners, Operators	\$					
14.			Gifts, flowers and coffee shops	\$					
15.			Education expenditures to colleges or				E-10-10-10-10-10-10-10-10-10-10-10-10-10-		
			universities for tuition and related costs						
			for owners and employees	\$					
16.			Travel for purposes of attending						
			conferences or seminars outside the						
			continental U.S. Other out-of-state						
			travel in excess of one representative	\$					
17.	<u> </u>		Automobile Expense (e.g. personal use)	\$					
18.			Unallowable Advertising *	\$		5,238			1,378
19.			Income Tax / Corporate Business Tax	\$		5,250			1,576
20.			Fund Raising / Contributions	\$			<u> </u>		
21.	<u> </u>		Unallowable Management Fees	\$	+				
22,	<del> </del>		Barber and Beauty	\$	<u> </u>			<del>                                     </del>	<del></del>
23.	<del> </del>		Other - See attached Schedule	\$		14,724		<del> </del>	3,979
		Diotar	y Expenditures	Ψ	10,702	14,724			3,717
24.		161111	Meals to employees, guests and others				C. FUEL BUILDING	1400	100 OF 15 10
24,			who are not residents	\$					
Dana	10 1		lry Expenditures	φ					
25.		Juunu	Laundry services to employees, guests						
۷٥,			and others who are not residents	¢					
Danie	20	Jane		\$					
		10use	keeping Expenditures						
26.			Housekeeping services to employees, guests	ተ					
			and others who are not residents	\$	<del> </del>	1.00 = 0.1			4
			Subtotal (Items 1 - 26)	\$	212,914	167,784			45,130

<sup>\*</sup> All except "Help Wanted".

<sup>(</sup>Carry Subtotal forward to next page)

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

#### Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description			 CC	NH	RH	INS	NurseFa	c-Aid
en				 	 					
		*****								
			<u> </u>	1						
			*							
otal Othe	r Salaries	Adjustment			\$		\$	-	\$	-

#### Schedule of Fees Adjustments

Page Ref	Line Ref	Description		CCNH	RHNS	Nurs	seFac-Aids
16		Management fee over cost	\$	104,062		\$	27,999
					***************************************		
			*	· .			
Total Othe	r Fees Adj	ustments	\$	104,062	\$ -	\$	27,999

#### Schedule of Other A&G Adjustments

Page Ref	Line Ref Description	CCNH	RHNS	NurseFac-Aids
16a	PENALTIES	\$ 1,488		\$ 392
16a	LATE FEES	\$ 354		\$ 93
16a	PRIOR PERIOD EXPENSES	***************************************		
	rounding	-104.56		
	Provider User Fee for Medicare days	12,986.17		3,494.01
Total Othe	r A&G Adjustments	\$ 14,724 \$	-	\$ 3,979

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

			D. Adjustments to Statement						
	e of Fa	-		Lic	ense No.	Report for Y	'ear Ended	Page	of
Trini	ty Hill	Care	Center, LLC	<u></u>	2222-C	9/30/2015		29	37
					Total				
Item	Page	Line			Amount of				
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	Nursel	Fac-Aids
			Subtotals Brought Forward	\$	212,914	167,784			45,130
Page	20 - I	Reside	nt Care Supplies***						
27.			Prescription Drugs	\$					
28.			Ambulance/Limousine	\$	25,070	19,755			5,315
29.			X-rays, etc	\$	484	382			103
30.			Laboratory	\$	2,825	2,226			599
31.			Medical Supplies	\$					
32.			Oxygen (non emergency)	\$					
33.			Occupational Therapy	\$					
34.			Other - See Attached Schedule	\$					
Page	22 - A	Mainte	enance and Property		14 3 3 G 1 F				
35.			Excess Movable Equipment Depreciation						10 (6 16
			See Attached Schedule	\$					1000
36.			Depreciation on Unallowable						
			Motor Vehicles	\$					Hallow or the control of the control
37.			Unallowable Property and Real						
			Estate Taxes	\$					
38.			Rental of Building Space or Rooms	\$					
39.			Other - See Attached Schedule	\$					
Page	27 - 1	nsura							•
40.			Mortgage Insurance	\$					
41.			Property Insurance	\$					
	r - Mi	scella		<u> </u>					Acres (San
42.			Research or Experimental Activities	\$	and the state of t				
43.			Radio and Television Revenue	\$					
44.			Vending Machine Revenue	\$					
45.			Purchase Discounts and Allowances	\$					
46.			Duplications of functions or services	\$		1,			
47.			Expenditures made for the protection,		11				
, , ,			enhancement or promotion of the				earthur seine e	4-1	
			providers interest	\$					
48.			Interest Income on Accounts Rec	\$					
49.			Other (include personnel and other	*					
			costs unrelated to resident care) - See					0.0	
			Attached Schedule	\$					100000000000000000000000000000000000000
Not	For Pr	ofit P	roviders Only	4					
50.		J; 1. 1	Building/Non Movable Eq. Depreciation						
50.			Unallowable Building Interest -						
			See Attached Schedule	\$			=		
5.1	Total	Apro	unt of Decreuse (Items 1 - 50)	<del>-\$</del>	241,293	190,147			51 1/16
٦١.	1 ()tal	/1/n0	uni of Decreuse (Hems 1 - 30)	Φ	241,293	170,14/	<u> </u>	L	51,146

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

#### Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
20	5J	NON-COVERED PPS DR. VISITS	_		<u>-</u>
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	_ "		
13	B9A	ST- Resident Care (for outpatent therapy - see schedule)	-		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	-		
			:		
		·			
		·			
		·			
Total Othe	r Ancillary	Costs	\$	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
Total Exce	ss Movable	E Equipment Depreciation	\$	\$ -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
		·			
				1.5	
Total Othe	r Property	Adjustments	\$ -	\$	\$

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
20	4A1	Houskeeping Supplies (for Outpatient Therapy - see schedule)	-		
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)	<u>-</u>		·
22	6B	Heat (for outpatient Therapy see schedule)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
22	6C	Light and Power (for outpatient therapy see schedule)		71 + 2 N.E. N.T. 14 V	
22	6D	water (for outpatient therapy see schedule)			111111111111111111111111111111111111111
22	6A	Repair&Maint (for outpatient therapy see schedule)			
		·			
Total Othe	r Adjustm	ents	\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description		CCNH	RHNS	NurseFac-Aids
				gradient was de state of the st	3 - 3	1 1 1
			AN MALL PANALLY		iges of the	7
						· ·
						1.
		:				
-						
				·		
Total Una	llowable Bi	uilding Interest	_	\$	\$ -	\$ -

### Annual Report of Long-Term Care Facility

CSP-30 Rev.10/2005

## F. Statement of Revenue

Name of Facility  Trinity Hill Care Center, LLC  License No. 2222-C		Report for Y 9/30/2015	ear Ended		Page of 30   37
Item		Total	CCNH	RHNS	NurseFac-Aids
I. Resident Room, Board & Routine Care Revenue		Total	CCIVII	Kiliya	Nuiser ac-Aids
1. a. Medicaid Residents (CT only)	\$	14,222,076	10,947,711		3,274,366
b. Medicaid Room and Board Contractual Allowance **	\$		10,547,711		3,274,300
2. a. Medicaid (All other states)	<del>-</del> \$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (all inclusive)	<u> </u>		471,458		124,068
b. Medicare Room and Board Contractual Allowance **	\$		1,1,100		121,000
4. a. Private-Pay Residents and Other	\$		30,043		
b. Private-Pay Room and Board Contractual Allowance **	\$	<del> </del>			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$	43,250	43,250		
b. Prescription Drugs - Medicare Contractual Allowance **	\$		(43,250)		
c. Prescription Drugs - Non-Medicare	\$		24,236		1,786
d. Prescription Drugs - Non-Medicare Contractual Allowance **	<del>-</del> \$		(24,236)		(1,786)
A. Medical Supplies - Medicare	\$	<del> </del>	134		(1,760)
b. Medical Supplies - Medicare Contractual Allowance **	\$	<del></del>	(134)		
c. Medical Supplies - Non-Medicare	\$		5,338		694
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$	+	(5,338)		(694)
3. a. Physical Therapy - Medicare	\$		72,290		(0)4)
b. Physical Therapy - Medicare Contractual Allowance **	<u>\$</u>		(47,361)		
c. Physical Therapy - Non-Medicare	\$	<b>—</b>	144,245		21,590
d. Physical Therapy - Non-Medicare Contractual Allowance **	<u> </u>		(144,245)		(21,590)
4. a. Speech Therapy - Medicare	<u> </u>		24,151		(21,000)
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$	+	19,205		11,496
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$		(19,205)		(11,496)
5. a. Occupational Therapy - Medicare	\$	1	82,134		(11,130)
b. Occupational Therapy - Medicare Contractual Allowance **	\$	<del> </del>	1		
c. Occupational Therapy - Non-Medicare	\$	1	165,557		15,501
d. Occupational Therapy - Non-Medicare Contractual Allowance **		<del></del>			(15,501)
6. a. Other (Specify) - Medicare	\$	1	(**** /- *** /		
b. Other (Specify) - Non-Medicare	\$		8,937		
III. Total Resident Revenue (Section I. thru Section II.)	\$	<del></del>	11,396,021		3,398,434
IV. Other Revenue*		,,,,,			2.000
Meals sold to guests, employees & others	\$				Jane 1
Rental of rooms to non-residents	<u> </u>				
3. Telephone	<u> </u>	1			
Rental of Television and Cable Services	\$	-			
5. Interest Income (Specify)	\$	1			
6. Private Duty Nurses' Fees	<u> </u>	1		<u> </u>	
7. Barber, Coffee, Beauty and Gift shops	<u> </u>				
8. Other (Specify)	<u> </u>				
V. Total Other Revenue (1 thru 8)	<u> </u>	<del> </del>			
VI. Total All Revenue (III +V)	<u> </u>		11,396,021		3,398,434

<sup>\*</sup> Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

<sup>\*\*</sup> Facility should report all contractual allowances and/or payer discounts.

#### Schedule of Other Resident Revenue - Medicare

#### Related Exp

Page Ref	Description	C	CNH	RHNS	NurseFac-Aids
	Lab Medicare	\$	2,827		
	Lab Medicare CA	\$	(2,827)		
	Oxygen Medicare	\$	6		
	Oxygen Medicare CA	\$	(6)		
	Equipment rental	\$	-		
	Equipment rental CA	\$	-		
	Pen Therapy .	\$			
	Pen Therapy CA	\$	-		
	Therapy Bods Medicare	\$	-		
	Therapy Bods Medicare CA	\$	-		
	Radiology Medicare	\$	79		
	Radiology Medicare CA	\$	(79)		
	IV Therapy	\$	13,930		
	IV Therapy CA	\$	(13,930)		
	Medical Transportation	\$	-		
	Medical Transportation CA	\$	-		
	Glucose testing	\$	-		
	Glucose testing CA	S			
	Outpatient therapy Medicare	\$			
Total Oth	er Resident Revenue - Medicare	\$		s -	\$ -

#### Schedule of Other Non-Medicare Resident Revenue

#### Related Exp

ge Ref Description	CCNB	RHNS	Nurs	eFac-Aid
Lab				
Lab CA				
Oxygen	\$ 1,452		5	246
Oxygen CA	\$ (1,452	)	S	(246)
Equipment rental	\$ -			
Equipment rental CA	\$ -			
Pen Therapy	\$ -			
Pen Therapy CA	\$ -			
Therapy Beds	\$ -			
Therapy Bods CA	\$ -			
Radiology	\$ -			
Radiology CA	<b>\$</b> -			
Medical Transportation	s -			
Medical Transportation CA	\$ -			
Glucose Testing	s -			
Glacose Testing CA	. \$ -	1		
IV therapy	\$ 15,661		\$	2,009
IV therapy CA	\$ (15,661	)	s	(2,009
Flu shot revenue	\$ 58			
Outpatient therapy	\$ -			
PRIOR YEAR ADJ - ANCILLARY & OTHER	\$ 8,879			
rounding	s -			
ital Other Resident Revenue	\$ 8,937	\$ -	\$	-

#### Interest Income

#### Account

Page Ref	Account		Balance	CCNH	RHN5	NurseFac-Aids
	INTEREST INCOME			s -		
		· .				
					l	
Total Inte	rest Income			s -	\$ -	s -

#### Schedule of Other Revenue

Page Ref	Description	CCN	H	RHNS	Nursefac-Aids
	MEALS	s			
	TELEVISION INCOME	\$		]	
	CONCESSIONS / VENDING INCOME	\$	-		
	RESIDENT LATE FEE REVENUE	\$	-		
	RESIDENT ATTORNEY FEE REVENUE	\$	-		
	TELEPHONE INCOME	\$	-		
	OTHER INCOME	\$	-		
***	OPTUM DIVIDENDS REVENUE	\$	-		
Total Oth	er Reyenue	\$		\$ -	\$ -

## G. Balance Sheet

Name of Facility	License No.	Report for Year	r Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2015		31	37
	Account			Am	ount
Assets					
A. Current Assets					
<ol> <li>Cash (on hand and ir</li> </ol>			\$		1,527,162
	eceivable (Less Allowan	<del> </del>	\$		2,260,631
	ivable (Excluding Owne	rs or Related Parties)	\$		23,335
4 Inventories			\$		32,187
<ol><li>Prepaid Expenses</li></ol>			\$		303,842
<ul> <li>a. Prepaid Insurance</li> </ul>		290,786			
b. Prepaid Property	Taxes	6,609	<u> </u>		
c. Prepaid Expenses	Other	6,447			
d.					
6. Interest Receivable			\$		
7. Medicare Final Settle	ement Receivable		\$		
8. Other Current Assets	(itemize)		\$		(940,043)
Due From (to) Relate		129,480			
Other Owners reserve	S	(1,069,522	2)		
<u>, ,</u>					
A-9. Total Current Assets (L	ines A1 thru 8)		\$		3,207,114
B. Fixed Assets	, , , , , , , , , , , , , , , , , , ,				
1. Land			\$		
2. Land Improvements	*Historical Cos	st	\$		
2. Band Improvence	Accum, Depres		- <sub>Net</sub>		
3. Buildings	*Historical Cos				327,780
J. Dananigo	Accum. Depres		<b></b>   '		327,700
4. Leasehold Improvem					291,112
4. Eduschold Improven	Accum. Depres		`		271,112
5. Non-Movable Equip					3,517
5. Non-Movable Equip.	Accum. Depres		Net	•	5,517
6. Movable Equipment	*Historical Cos				173,384
6. Movable Equipment	Accum. Depre		<del></del>		173,304
7. Motor Vehicles	*Historical Co				1 701
7. Motor venicles			<b>—</b> 1		4,784
8. Minor Equipment-No	Accum, Depre	ciation 2,103	Net \$		
8. Winor Equipment-No	of Depreciable		Φ		
9. Other Fixed Assets (	•		\$		
Construction in Pr	ogress				
B-10. Total Fixed Assets (	Linas D1 thm; (1)		ф.		000 555
B-10. Total Fixed Assets (	Lines of und 3)		\$		800,577

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

# G. Balance Sheet (cont'd)

1		Facility	License No.	Report for Year Ended		Page	of
Trini	ty F	Iill Care Center, LLC	2222-C	9/30/2015		32	37
			Account			Am	ount
				Total Brought Forward	d: \$		4,007,691
C.		asehold or like property recor-	ded for Equity Purpose	es.			
		Land	******		\$		
	2.	Land Improvements	*Historical Cost				
			Accum. Depreciation	n Net	\$		
	3.	Buildings	*Historical Cost	· · · · · · · · · · · · · · · · · · ·			
			Accum. Depreciation	n Net	\$		
	4.	Non-Movable Equipment	*Historical Cost				
			Accum. Depreciation	n Net	\$		
	5.	Movable Equipment	*Historical Cost				
			Accum. Depreciation	n Net	\$		
	6.	Motor Vehicles	*Historical Cost				
			Accum. Depreciation	n Net	\$		
	7.	Minor Equipment-Not Depre	eciable		\$		
C-8	To	tal Leasehold or Like Proper	ties (C1 thru 7)		\$		
D.	lnv	estment and Other Assets					
	1.	Deferred Deposits			\$		
	2.	Escrow Deposits			\$		
	3.	Organization Expense	*Historical Cost		,		
}		,	Accum. Depreciation	on Net	\$		
	4.	Goodwill (Purchased Only)			\$		
		Investments Related to Resid	dent Care (itemize)		\$		43,000
		Patient Trust Funds	,	40,445			
		Long Term Deposit - prin	necare	2,555			
	6.	Loans to Owners or Related			\$		
-		Name and Address	Amount	Loan Date			
	7	Other Assets (itemize)	<b>!</b>		\$		
							6 S F S A B
D-8	Ta	tal Investments and Other A	esets (Lines D1 thru 7	)	\$		43,000
		tal All Assets (Lines A9 + B)		<u>/</u>	\$		4,050,691

<sup>\*</sup> 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			License No.	Report for Year	Ended	Page	of
Trinity Hill (	Care (	Center, LLC	2222-C	9/30/2015		33	37
			Account	I		An	nount
Liabilities							
Α.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable			\$		292,270
	2.	Notes Payable (itemize)			[\$		952,197
		Working Capital Line of C	Credit	952,197	7		
							40.65
		Loans Davoble for Equipme	ant (Command martin	· \ (!t ===? - \)	4		
	3,	Loans Payable for Equipm Name of Lender	<del> </del>	<del> </del>	Sata Dua		
		Name of Lender	Purpose	Amount	Date Due		
						100	
	4.	Accrued Payroll (Exclusive	e of Owners and/or .	Stockholders only)	\$	)	296,557
	5.	Accrued Payroll (Owners	and/or Stockholders	only)	\$		
	6.	Accrued Payroll Taxes Pay	yable		\$	,	
	7.	Medicare Final Settlement	Payable		\$	•	
	8.	Medicare Current Financia			\$		
	9.	Mortgage Payable (Currer			\$		
		Interest Payable (Exclusive	e of Owner and/or R	elated Parties)	\$		
		Accrued Income Taxes*			\$		
	12.	Other Current Liabilities (	itemize )	ı	\$	h Andrews	934,642
		Related Party Payables	370,	347			
		Accrued Expenses	130,				
		Accrued Resident User Fees	262,	561		1	
	m	Accrued Workers Comp Expense	171,	497			
A-13	. 10	tal Current Liabilities (Lin	es A1 thru 12)				2,475,666

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

# G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year	Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2015		34	37
	Account			An	nount
		Total Broug	ht Forward:		2,475,666
Liabilities (cont'd)					
B. Long-Term Liabilities					
<ol> <li>Loans Payable-Equipment</li> </ol>	(itemize)		\$		
Name of Lender	Purpose	Amount	Date Due		AGE CONT
				34.5	
					kravično i se se
2. Mortgages Payable			\$		
3. Loans from Owners or Rel	ated Parties (itemize	2)	\$		
Name and Address of Lender	Amount	Loan D	ate		
•					
_					
·			5		
4. Other Long-Term Liabiliti	es (itamiza)		\$		40 445
Patient Trust Funds	cs (nemize)	40,445	19		40,445
Fattent Trust Funds		40,443			
D. 5 Total Long Taym Linkilities (	Lines Di theu 4				40.445
B-5. Total Long-Term Liabilities ( C. Total All Liabilities (Lines A-			\$.		40,445
C. Total All Liabilities (Lines A-	TO CD-OJ		\$		2,516,111

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

1	ne of Facility	License No.	Report for Y	ear Ended	Page	of
Trin	ity Hill Care Center, LLC	2222-C	9/30/2015		35	37
A.	Reserves	Account			Aı	nount
Α.	Reserve for value of leased	land			· ·	
					\$	
	2. Reserve for depreciation va	ilue of leased build	ings and appurte	nances		
	to be amortized				\$	
	3. Reserve for depreciation va	llue of leased perso	nal property (Eq	uity)	\$	
	4. Reserve for leasehold real j	properties on which	fair rental value	is based	\$	
	5. Reserve for funds set aside	as donor restricted			\$	
	6. Total Reserves				\$	
В.	Net Worth					
	1. Owner's Capital				\$	1,000
	2. Capital Stock				\$	
	3. Paid-in Surplus				\$	
	4. Treasury Stock				\$	
	5. Cumulated Earnings				\$	734,070
	6. Gain or Loss for Period	10/1/20	014 thru	9/30/2015	\$	799,509
	7. Total Net Worth				\$	1,534,579
C.	Total Reserves and Net Worth				\$	1,534,579
D.	Total Liabilities, Reserves, and	d Net Worth			\$	4,050,691

# H. Changes in Total Net Worth

Name of Facility		License No. Report for Year Ended		Ended	Page	of	
Trinity Hill Care Center, LLC		2222-C	9/30/2015		36	37	
Account						Amount	
A. Balance at End of I	\$						
B. Total Revenue (Fre	\$	14,794,454					
C. Total Expenditures	\$	13,994,945					
D. Net Income or Def	\$	799,509					
E. Balance	\$	799,509					
F. Additions  1. Additional Cap  2. Other (itemize)							
F-3. Total Additions							
G. Deductions							
1. Drawings of Owners/Operators/Partners (Specify)							
Name and Ad	dress (No., City,	State, Zip)	Title	Amount			
	<i>(C. 16)</i>				\$		
2. Other Withdrawings (Specify)							
Purpose		Amount					
3. Total Deductio	, , , , , , , , , , , , , , , , , , ,				\$		
						700 500	
H. Balance at End of Period 09/30/15						799,509	

## I. Preparer's/Reviewer's Certification

Name of Facility		License No	License No.		Report for Year Ended Page		of				
Trinity Hill Care Center, LLC			2222-C	9/30/2015	37	37					
Check appropriate category											
Ø	Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)			☑ NurseFac-Aids						
Preparer/Reviewer Certification											
I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.											
Signature of Preparer		Title			Date Signed						
M.		W 3	vp Finance		2-11-16						
Printe	d Name of Preparer	•									
D	M. Who										
Denise MacKinnon					Phone Number						
Addres Address					Fnone Number						
341 Bidwell Street, Manchester, CT 06040					860-570-2140 ext 15						