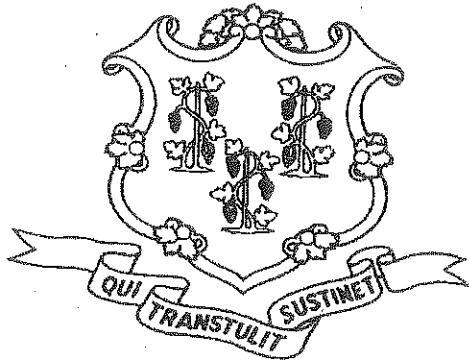


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed) Trinity Hill Care Center, LLC	
Address (No. & Street, City, State, Zip Code) 151 Hillside Avenue, Hartford, CT 06016	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)
	<input checked="" type="checkbox"/> NurseFac-Aids
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

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

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

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General Information

Name of Facility (as licensed) Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2017	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Trinity Hill Care Center, LLC [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Trinity Hill Care Center, LLC		Period Covered:	From 10/1/2016	To 9/30/2017
Address of Facility 151 Hillside Avenue, Hartford, CT 06016				
Report Prepared By iCare Management, LLC		Phone Number 860-570-2140	Date 2/15/2016	
Item	Total	CCNH	RHNS	NurseFac- Aids
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-951-1060		Report for Year Ended 9/30/2017	Page 2	of 37
Name of Facility (as shown on license) Trinity Hill Care Center, LLC		Address (No. & Street, City, State, Zip) 151 Hillside Avenue, Hartford, CT 06016		
License Numbers:	CCNH 2222-C	RHNS	NurseFac-Aids AIDS	Medicare Provider No. 07-5268
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> NurseFac-Aids				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator George Kingston		Nursing Home Administrator's License No.:	1327	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire
Partners/Members

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2017	Page 3	of 37
Legal Name of Partnership/LLC Trinity Hill Care Center, LLC		Business Address 151 Hillside Avenue, Hartford, CT 06016		State(s) and/or Town(s) in Which Registered CT	
Name of Partners/Members	Business Address	Title		% Owned	
V. Robert Salazar	2500 18th Street, Suite 200, Denver, CO 80211	Member		31.3	
David Sebbag	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		21.4	
Ari Krausz	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		21.3	
Solomon Melamed	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		1	
Christopher Wright	341 Bidwell Street, Manchester, Ct 06040	Member		5	
Premier First Investors	245 S. Benton Street, Lakewood, CO 80226	Member		10	
Global World Investors	245 S. Benton Street, Lakewood, CO 80226	Member		10	

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Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of		
Trinity Care Center, LLC	2222-C	9/3/2017	4	37		
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No			
Bidwell Care Center, LLC	333 Bidwell St. Manchester, CT 06040			-	(20,688)	20,688
Chelsea Place Care Center, LLC	25 Lorraine St. Hartford, CT 06105			-	(21,704)	21,704
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088			19		-
Chestnut Point Care Center, LLC	171 Main St. East Windsor, CT 06088			-	(55,669)	55,669
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032			16 M	-	-
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032			-	(12,764)	12,764
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088			19		-
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088			-	(15,621)	15,621
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450			-	(2,860)	2,860
Trinity Hill Care Center, LLC	151 Hillside Ave. Hartford, CT 06106			-	-	-
Westside Care Center, LLC	349 Bidwell St. Manchester, CT 06040			-	(13,496)	13,496
Wintonbury Care Center, LLC	140 Park Ave. Bloomfield, CT 06002			-	(12,894)	12,894
Secure Care Center LLC	60 West Street, Rocky Hill, CT 06087			-	(2,142)	2,142
Touchpoints at Homecare LLC	1838 Silas Deane Hwy, Rocky Hill, CT 06067			-	-	-
Touchpoints therapy	171 Main St. East Windsor, CT 06088			13	205,862	(205,862)
Bidwell Realty, LLC	341 Bidwell St. Manchester, CT 06040			22,22,27	1,327,947	(1,327,947)
iCare Management, LLC	341 Bidwell St. Manchester, CT 06040			16, 15	8,101	(8,101)
iCare Health Management, LLC	341 Bidwell St. Manchester, CT 06040			-	135,704	(135,704)
-	-			20	162,850	(162,850)
-	-			20	22,052	(22,052)
-	-			16	429,404	(429,404)
-	-			-	-	-
-	-			-	-	-
-	-			-	-	-
-	-			-	-	-
-	-			-	-	-
All 9 Care Centers, mgmt co, reaty cos				-	-	-
Share Common 401k, Pension and Insurance plans, courier, legal and various other services						

* Use additional sheets if necessary.

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

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2017	Page 5	of 37
If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:				
Item	Method of Allocation			
Dietary	Number of meals served to residents			
Laundry	Number of pounds processed			
Housekeeping	Number of square feet serviced			
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants			
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (See listing page 13)			
Maintenance and operation of plant	Square feet			
Property costs (depreciation)	Square feet			
Employee health and welfare	Gross salaries			
Management services	Appropriate cost center involved			
All other General Administrative expenses	Total of Direct and Allocated Costs			
The preparer of this report must answer the following questions applicable to the cost information provided.				
1. In the preparation of this Report, were all costs allocated as required? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.				
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)				
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				

General Information and Questionnaire
Accounting Basis

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2017	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain.				
Independent Accounting Firm				
Name of Accounting Firm 1 O'Connor, Davies LLP 2 3 4		Address (No. & Street, City, State, Zip Code) 100 Great Meadow Road, Ste 401, Wethersfield, CT 06109		
Services Provided by This Firm (<i>describe fully</i>)				
1	Taxes, financial statements, accounting support	\$	4,303	
2		\$		
3		\$		
4		\$		
			Charge for Services Provided	
			\$	4,303
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No 15D				
Legal Services Information				
Name of Legal Firm or Independent Attorney 1 iCare Health Management, LLC 2 Starble and Harris 3 Durant Nichols / Robinson & Cole, LLP 4 Various others (American Arbitration , Various Arbitration, Murtha Cullina, Jackson Lewis)) 5 Starble and Harris, iCare Health Management LLC			Telephone Number 860-570-2140 860-678-7775 860-275-8200 860-678-7775 & 860-570-2140	
Address (<i>No. & Street, City, State, Zip Code</i>) 1 341 Bidwell Street, Manchester CT 2 32 Main Street, Avon, CT 3 280 Trumbull St, Hartford, CT 4 5 32 Main Street, Avon, CT & 341 Bidwell Street, Manchester CT				
Services Provided by This Firm (<i>describe fully</i>)				
1	Lease and contract issues, general legal advice, Labor Law	\$	7,422	
2	Lease and contract issues, general legal advice, union funds advice	\$	526	
3	Employment law, arbitrations, contract negotiations	\$	3,866	
4	Employment Arbitrations, healthcare law	\$	6,804	
5	Conservatorships & Collections	\$		
			Charge for Services Provided	
			\$	18,617
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No 15E				

Schedule of Resident Statistics

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C		Report for Year Ended 9/30/2017						Page 8	of 37
			Period 10/1 Thru 6/30		Period 7/1 Thru 9/30		Total	RHNS	NurseFac-Aids	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total NurseFac-Aids	Total	CCNH				RHNS
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	143	114	29	143	114	29	169	139	30	
B. As of midnight of THIS report period	166	139	27	169	139	30	166	139	27	
3. Total Number of Days Care Provided During Period										
A. Medicare	1,849	1,849		1,377	1,377		472	472		
B. Medicaid (Conn.)	49,010	38,688	10,322	36,683	28,936	7,747	12,327	9,752	2,575	
C. Medicaid (other states)										
D. Private Pay	120	120		120	120					
E. State SSI for RCH										
F. Other (Specify) Insurance	31	31		31	31					
G. Total Care Days During Period (3A thru F)	51,010	40,688	10,322	38,211	30,464	7,747	12,799	10,224	2,575	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds										
A. Medicaid Bed Reserve Days										
B. Other Bed Reserve Days										
5. Total Resident Days (3C + 4A + 4B)	51,010	40,688	10,322	38,211	30,464	7,747	12,799	10,224	2,575	

Schedule of Resident Statistics (Cont'd)

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C			Report for Year Ended 9/30/2017			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH (1)	RHNS (2)	NurseFac-Aids (3)	Lost			Gained			CCNH	RHNS	NurseFac-Aids	
				(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days										CCNH	RHNS	NurseFac-Aids	
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH		CCNH	RHNS	CCNH	RHNS	NurseFac-Aids	R.C.H.	ICF-MR				
No. of Residents	6		107				27						
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	539.00		286.00				308.00						
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments							TOTAL	CCNH	RHNS	NurseFac-Aids			
A. Medicare - Part B							1,290	1,029		261			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments							3,215	2,564		651			
C. Other							1,869	1,491		378			
D. Total Physical Therapy Treatments							6,374	5,084		1,290			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B							141	112		29			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments							247	197		50			
C. Other							251	200		51			
D. Total Speech Therapy Treatments							639	510		129			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B							263	210		53			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments							1,034	825		209			
C. Other							711	567		144			
D. Total Occupational Therapy Treatments							2,008	1,602		406			

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Trinity Hill Care Center, LLC	2222-C	9/30/2017	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	NurseFac-Aids	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	128,102	1,390			32,498	695
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	195,272	7,777			49,538	3,889
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor	69,573	1,651			17,650	435
c. Dietary Workers	413,021	20,597			104,778	5,420
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	216,194	13,003			108,097	6,501
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	34,488	1,348			17,244	674
b. Other Maintenance Workers	23,104	1,523			11,552	762
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	91,815	5,349			23,292	1,408
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	149,922	2,851			74,961	1,425
b. RN						
1. Direct Care	352,364	7,752			218,781	5,638
2. Administrative**	239,541	6,179			60,768	1,626
c. LPN						
1. Direct Care	1,054,167	35,109			239,348	9,279
2. Administrative**						
d. Aides and Attendants	1,508,788	88,307			558,293	33,611
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	61,040	4,715			62,657	1,546
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	81,513	3,750			82,732	3,073
n. Marketing						
o. Other (Specify)						
See Attached Schedule	100,028	4,392			25,376	1,534
A-13. Total Salary Expenditures	4,718,931	205,694			1,687,564	77,515

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
 ** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
 *** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		NurseFac-Aids	
	\$	Hours	\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$ 32,928	1,650			\$ 8,353	434
MEDICAL RECORDS SALARIES	\$ 17,131	1,144			\$ 4,346	301
CENTRAL SUPPLY SALARIES	\$ 49,970	1,598			\$ 12,677	799
RESPIRATORY THERAPY SALARIES	\$ -	-			\$ -	-
Total	\$ 100,028	4,392	\$ -	-	\$ 25,376	1,534

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		NurseFac-Aids	
	\$	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$ 5,929	1			\$ 1,504	0
ADMISSIONS C/S LABOR	\$ 36,481	684			\$ 9,255	180
CENTRAL SUPPLY CONTRACT SERVICE	\$ (36,959)	(1,178)			\$ (9,376)	(299)
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$ 71,240	2,401			\$ 18,073	632
RESPIRATORY THERAPY CONTRACT SERVICES	\$ -	-			\$ -	-
PHYSICAL THERAPY C/S MEDICIAD	\$ 51,687	850			\$ 13,112	
SPEECH THERAPY C/S Medicaid	\$ 10,362	177			\$ 2,629	
OCCUPATIONAL THERAPY C/S MEDICIAD	\$ 15,420	284			\$ 3,912	
Total	\$ 154,161	3,219	\$ -	-	\$ 39,109	513

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

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2017				Page 11	of 37		
		Salary Paid		Line Where Claimed on Page 10	Total Hours Worked				
Name	CCNH	RHNS	Nurse/Fac- Aids			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Name and Address of All Other Employment**
Section I - Operators/Owners									
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).									

* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.
 ** Include all employment worked during the cost year.

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

Name of Facility (as licensed) Trinity Hill Care Center, LLC		License No. 2222-C		Report for Year Ended 9/30/2017		Page 12	of 37		
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS							
Section III - Administrators***									
George Kingston	128,102		32,498	same as employees less union funds	Administrator	2,086	A2		
				same as employees less union funds	Administrator		A2		
				same as employees less union funds	Administrator		A2		
Section IV - Assistant Administrators									

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Trinity Hill Care Center, LLC	2222-C	9/30/2017	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	NurseFac-Aids	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	9,743	161			2,472	41
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	62,155	831				340
b. Other						
6. Social Worker	8,833	(146)			2,241	(38)
7. Recreation Worker	4,957	35+Cable			1,257	35+Cable
8. Physicians						
a. Medical Director (entire facility)	37,808	864			74,584	227
b. Utilization Review (Title 18 and 19 only) monthly meeting	160	4			40	1
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify) Physician Care Contract Services	17,377	58			4,408	15
9. Speech Therapist						
a. Resident Care	23,249	294				95
b. Other						
10. Occupational Therapist						
a. Resident Care	21,878	266				111
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	7,131					
2. Administrative***	(99,930)	(1,447)				(381)
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides	(2,498)	(68)				
d. Other						
12. Other (Specify) See Attached Schedule	154,161	3,219			39,109	513
B-13 Total Fees Paid in Lieu of Salaries	245,025	4,035			124,111	925

* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.
 ** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.
 *** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

Name of Facility		License No.		Report for Year Ended	Page	of
Trinity Hill Care Center, LLC		2222-C		9/30/2017	14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Omicare	Pharmacy Consulting	<input type="radio"/>	<input checked="" type="radio"/>			
Tocuhpoints Therapy	Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Healthdrive Physician Services	Audiology, Dental and Podiatry	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Tress	HIV Med Dr	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Johnson Fielding III	Asst Med Dir	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Lindenberg Leslie	Med Dir	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
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		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2017		15	37
Item	Total	CCNH	RHNS	NurseFac-Aids	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 384,637	306,805			77,832
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 545,595	435,193			110,403
5. Health Insurance	\$ 1,089,333	868,904			220,429
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 376,771	300,530			76,240
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 46,107	36,777			9,330
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 322,284	322,284			
d. Accounting and Auditing	\$ 4,303	3,432			871
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 18,617	14,850			3,767
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 17,749	14,158			3,592
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 12,617	10,064			2,553
2. Cellular Phones	\$ 2,593	2,068			525
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$ 2,525	2,014			511
3. Resident Day User Fee	\$ 1,072,609	855,564			217,045
Subtotal	\$ 3,895,741	3,172,643			723,098

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

(Carry Subtotals forward to next page)

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

Trinity Hill Care Center, LLC
9/30/2017

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	NurseFac- Aids
UNION TRAINING	\$ 36,777		\$ 9,330
Total	\$ 36,777	\$ -	\$ 9,330

Schedule of Other Taxes

Description	CCNH	RHNS	NurseFac- Aids
INTERNET EXPENSES	\$ 2,014		\$ 511
Total	\$ 2,014	\$ -	\$ 511

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

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2017	16	37
Item	Total	CCNH	RHNS	NurseFac-Aids
Subtotals Brought Forward:	3,895,741	3,172,643		723,098
l. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$ 1,440	1,149		291
3. Gifts to Staff and Residents	\$ 251	200		51
4. Employee Travel	\$ 3,339	2,663		676
5. Education Expenses Related to Seminars and Conventions	\$ 6,807	5,429		1,377
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$ 5,820	4,643		1,178
7. Other (<i>Specify</i>) See Attached Schedule	\$ 489	390		99
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 5,389	4,299		1,090
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 11,754	9,375		2,378
4. Fund-Raising***	\$			
5. Medical Records	\$			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 904	721		183
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 9,777	7,799		1,978
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$			
9. Subscriptions	\$			
10. Contributions*** See Attached Schedule	\$ 250	199		51
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 116,119	92,622		23,497
12. Administrative Management Services**	\$ 429,404	342,513		86,891
13. Other (<i>Specify</i>) See Attached Schedule	\$ 22,312	17,797		4,515
C-14 Total Administrative & General Expenditures	\$ 4,509,795	3,662,442		847,353

* Do not include Subscriptions, which should go in item 9.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	NurseFac-Aids
MEALS	\$ 390		\$ 99
Total Other Travel and Entertainment	\$ 390	\$ -	\$ 99

Schedule of Other Advertising

Description	CCNH	RHNS	NurseFac-Aids
COMMUNICATIONS SPECIAL EVENTS	\$ 9,375		\$ 2,378
Total Other Advertising	\$ 9,375	\$ -	\$ 2,378

Schedule of Dues

Description	CCNH	RHNS	NurseFac-Aids
ALTCFM			
CAHCF Dues	\$ 7,671		\$ 1,946
OTHER DUES	\$ 128		\$ 32
Total Dues	\$ 7,799	\$ -	\$ 1,978

Schedule of Contributions

Description	CCNH	RHNS	NurseFac-Aids
CONTRIBUTIONS	\$ 199		\$ 51
Total Contributions	\$ 199	\$ -	\$ 51

Schedule of Other Administrative and General

Description	CCNH	RHNS	NurseFac-Aids
SOCIAL SERVICE SUPPLIES	\$ -		\$ -
SOC SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 1,057		\$ 268
EMPLOYEE RELATIONS	\$ 7,106		\$ 1,803
EMPLOYEE RELATIONS-OTHER	\$ 32		\$ 8
PERMITS & LICENSES	\$ 1,994		\$ 506
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 6,997		\$ 1,775
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ -		\$ -
LATE FEES	\$ 610		\$ 155
Rounding	\$ 1		\$ -
	\$ 0		
Total Other Administrative and General	\$ 17,797	\$ -	\$ 4,515

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Trinity Hill Care Center, LLC	2222-C	9/30/2017	17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
iCare Management, LLC/iCare Health Management, LLC	429,404	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	162,850	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	22,052	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2017	18	37
Item	Total	CCNH	RHNS	NurseFac-Aids
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 281,518	224,552		56,966
2. Non-Food Supplies	\$ 33,675	26,861		6,814
3. Other (<i>Specify</i>) _____ DIETARY SUPPLEMENTS	\$ 20,346	16,229		4,117
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	\$ 182	145		37
c. Management Services**	\$			
d. Other (<i>Specify</i>) _____ DIETARY MINOR EQUIPMENT	\$ 5,479	4,370		1,109
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 341,199	272,157		69,043
2F. Dietary Questionnaire	Total	CCNH	RHNS	NurseFac-Aids
G. Resident Meals: Total no. of meals served per day:*	504	419		85
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

** 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)**

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2017	Page 19	of 37
Item		Total	CCNH	RHNS	NurseFac-Aids
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	358	286	73
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.			
		Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.			
		Amt. \$			
4. Repair and/or purchase of linens.***		Lbs.			
		Amt. \$			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	52,584	41,944	10,641
c. Management Services**		\$			
d. Other (Specify) LAUNDRY MINOR EQUIPMENT		\$	727	580	147
3E. Total Laundry Expenditures (3a + b + c + d)		\$	53,670	42,810	10,860
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			

* 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.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC		2222-C	9/30/2017		20	37
Item			Total	CCNH	RHNS	NurseFac-Aids
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt.	\$ 25,894	17,263		8,631
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt.	\$ 39,708	26,472		13,236
c.	Management Services*		\$			
d.	Other (<i>Specify</i>) HOUSEKEEPING MINOR EQUIPMENT		\$			
4E.	Total Housekeeping Expenditures (4a + b + c + d)		\$ 65,602	43,734		21,867
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy		\$			
2.	Purchased from OMNICARE PHARMACY		\$ 101,923	101,923		
b.	Medicine Cabinet Drugs		\$ 11,785	9,400		2,385
c.	Medical and Therapeutic Supplies		\$ 70,770	56,449		14,320
d.	Ambulance/Limousine***		\$ 36	24		12
e.	Oxygen					
1.	For Emergency Use		\$ 2,317	2,317		
2.	Other***		\$			
f.	X-rays and Related Radiological Procedures***		\$ 1,104	1,104		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$			
h.	Laboratory***		\$ 3,262	3,262		
i.	Recreation		\$			
j.	Other (Specify)**** See Attached Schedule		\$ 337,898	257,786		80,112
5K.	Total Resident Care Expenditures (5a - 5j)		\$ 529,094	432,265		96,829

* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
 ** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.
 *** Facility should self-disallow the expense on Page 29 of the Cost Report.
 **** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	NurseFac-Aids
NURSING ADMIN SUPPLIES	\$ 52		\$ 13
NURSING MINOR EQUIP	\$ 6,999		\$ 1,775
MEDICAL RECORDS SUPPLIES	\$ (92)		\$ (23)
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATIONS - DIRECT	\$ 129,897		\$ 32,953
NON-COVERED PPS DR. VISITS	\$ 134		\$ 34
RESIDENT CARE SUPPLIES	\$ -		\$ -
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 7,288		\$ 1,849
PERSONAL CARE SUPPLIES	\$ 5,545		\$ 1,407
INCONTINENCY SUPPLIES	\$ 20,639		\$ 5,236
VACCINE RESIDENTS	\$ 120		\$ -
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	\$ -		\$ -
SPEECH THERAPY SUPPLIES	\$ -		\$ -
SPEECH THERAPY EQUIPMENT RENT	\$ -		\$ -
SPEECH THERAPY MINOR EQUIPMENT	\$ -		\$ -
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 18,854		\$ 9,427
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 1,726		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ -		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ -		\$ -
IV THERAPY SUPPLIES	\$ 40,060		\$ 20,030
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 2,730		\$ 1,365
ACTIVITIES SUPPLIES	\$ 3,350		\$ 850
ACTIVITIES MINOR EQUIPMENT	\$ 2,895		\$ 734
MANAGEMENT ALLOCATION - INDIRECT	\$ 17,590		\$ 4,462
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ -		\$ -
STRIKE COSTS NON REIMBURSABLE	\$ -		\$ -
Total Other Resident Care	\$ 257,786	\$ -	\$ 80,112

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

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2017	Total Cost/Page Ref.***			Page of 21 37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Full Explanation of Service Provided*	CCNH	RHNS	NurseFac-Aids	Pg	Line
		Yes	No						
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input type="radio"/>	Housekeeping Services	39,708			20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input type="radio"/>	Laundry Services	52,584			19	3b
Eagle Elevator		<input type="radio"/>	<input type="radio"/>	Elevator Contract	6,279			22	6F
Bioserve, Inc.		<input type="radio"/>	<input type="radio"/>	Medical Waste	4,094			22	6F
The Brickman Group/ Stevan Infante		<input type="radio"/>	<input type="radio"/>	Snow Removal/Landscaping	13,176			22	6F
All Waste Inc		<input type="radio"/>	<input type="radio"/>	Trash removal	35,681			22	6F
American HealthTech		<input type="radio"/>	<input type="radio"/>	Software Maintenance Contract	10,683			16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	<input type="radio"/>	<input type="radio"/>	Payroll Services	49,084			16	M11
National Datacare Corp		<input type="radio"/>	<input type="radio"/>	Resident Trust Software	2,989			16	M11
Prime Care Technology services		<input type="radio"/>	<input type="radio"/>	Computer Consulting Services	25,336			16	M11
Priority Express		<input type="radio"/>	<input type="radio"/>	Courier Services	4,964			16	M11
Point Right Inc		<input type="radio"/>	<input type="radio"/>	Nursing Software	4,680			16	M11
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						

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

** Refer to Page 4 for definition of related.

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

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

Name of Facility	License No.	Report for Year Ended			Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2017			22	37
Item	Total	CCNH	RHNS	NurseFac-Aids		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 47,613	31,742			15,871	
b. Heat	\$ 52,339	34,893			17,446	
c. Light & Power	\$ 77,392	51,595			25,797	
d. Water	\$ 55,180	36,786			18,393	
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 27,191	21,689			5,502	
f. Other (<i>itemize</i>)	\$ 172,061	114,707			57,354	
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 431,775	291,411			140,364	
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 23,564	18,796			4,768	
c. Non-Movable Equipment	\$ 459	366			93	
d. Movable Equipment	\$ 43,707	34,863			8,844	
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 67,730	54,025			13,705	
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 47,704	38,051			9,653	
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 47,704	38,051			9,653	
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,243,464	991,846			251,618	
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 278,763	222,355			56,408	
c. Personal property taxes	\$ 29,234	23,318			5,916	
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,666,895	1,329,595			337,300	

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	NurseFac-Aids
PLANT SUPPLIES	\$ 5,762		\$ 2,881
PLANT CONTRACT SERVICE LABOR	\$ -		\$ -
ELEVATOR CONTRACT SERVICE	\$ 4,186		\$ 2,093
FIRE/SPRINKLER CONTRACT SERVICE	\$ 6,295		\$ 3,147
LANDSCAPING CONTRACT SERVICE	\$ 4,507		\$ 2,254
SNOW REMOVAL CONTRACT SERVICE	\$ 4,277		\$ 2,138
TRASH REMOVAL CONTRACT SERVICE	\$ 23,787		\$ 11,894
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ 55,970		\$ 27,985
PLANT CONTRACT SERVICE OTHER	\$ 2,220		\$ 1,110
PLANT MINOR EQUIPMENT	\$ 5,289		\$ 2,644
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ 2,415		\$ 1,208
RENT OTHER	\$ -		\$ -
Total Other Repairs and Maintenance	\$ 114,707	\$ -	\$ 57,354

Depreciation Schedule

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C		Report for Year Ended 9/30/2017				Page 23	of 37
Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
									Is a mileage logbook maintained?
Yes	No	Month	Year						
A. Land Improvements									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
A-4. Subtotal									
B. Building and Building Improvements									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
B-4. Subtotal									
C. Non-Movable Equipment									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Movable Equipment									
1. Motor Vehicles (Specify name, model and year of each vehicle)									
a. Van Repair: Hillside Automotive Cefx									
b.									
c.									
d.									
2. Movable Equipment									
a. Acquired prior to this report period									
b. Disposals (attach schedule)									
c. Acquired during this report period (attach schedule)									
D-3. Subtotal									
E. Total Depreciation									
								43,707	
								67,750	

Trinity Hill Care Center, LLC
9/30/2017

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
1/13/2017	Privacy Curtains: Direct Supply	\$ 2,532	60	\$ 338
1/12/2017	Bed & Wheelchair for overweight resident: Direct Supply	\$ 2,913	60	\$ 388
2/1/2017	Bed: Medline	\$ 10,954	60	\$ 1,278
2/18/2017	Bladder Scanner: Medline	\$ 6,381	84	\$ 532
2/15/2017	Portable Shelving: Direct Supply	\$ 3,722	120	\$ 217
12/12/2016	Avalo Emargency Care: Direct Supply	\$ 3,971	120	\$ 298
9/29/2017	Defibrillator: Direct Supply	\$ 2,545	60	\$ -
9/30/2016	Laptops & Desktop: Prime Care	\$ 3,132	36	\$ 1,044
8/31/2017	EMR Systme Project Phase 1: Multiple Vendors	\$ 14,142	60	\$ 236
7/31/2017	EMR Systme Project Phase 1: Primecare Tech	\$ 7,707	36	\$ 428
Total additions for Movable Equipment		\$ 57,999		\$ 4,759 *
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
1/18/2017	Upgrade Walk In Cooler: Proline	\$ 6,120	180	\$ 272
3/14/2017	Generator Repair: Advanced Power Services	\$ 2,739	60	\$ 274
8/19/2016	Wiring: Precision Electrical & S&S Wired	\$ 3,196	240	\$ 120
Total additions for Leaschold Improvement		\$ 12,054		\$ 666 *
Deletions:				
Total deletions for Leaschold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C		Report for Year Ended 9/30/2017		Page 24	of 37	
	Date of Acquisition Month Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations			Basis for Computing Amortization**
A. Organization Expense							
1.							
2.							
3.							
A-4. Subtotal							
B. Mortgage Expense							
1.							
2.							
3.							
B-4. Subtotal							
C. Leasehold Improvements and Other							
1. Acquired prior to this report period			684,802	398,499		47,039	
2. Disposals (attach schedule)							
3. Acquired during this report period (attach schedule)			12,054			666	
C-4. Subtotal							
D. Total Amortization							47,704
							47,704

* Straight-line method must be used.
 ** Specify which of the following bases were used:
 A. Minimum of 5 years or 60 months.
 B. Life of mortgage; OR
 C. Remaining Life of Lease; OR
 D. Actual Life if owned by Related Party.

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

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2017	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased	04/01/99				
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase	04/01/99				
4. Date of Initial Licensure	04/01/99				
5. Total Licensed Bed Capacity	144				
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)		HUD fixed			
b. Date Mortgage Obtained		05/30/13			
c. Interest Rate for the Cost Year		335.00%			
d. Term of Mortgage (number of years)		24			
e. Amount of Principal Borrowed		4,208,200			
f. Principal balance outstanding as of 9/30/2017					
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)		Sale of Real Estate			
h. Date of Refinancing		08/09/17			
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	
Summit Trinity Hill SNF, LLC	151 Hillside Ave, Hartford, CT	08/09/17	15 year with 2	\$1,368,000 yr 1	

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC		2222-C	9/30/2017		26	37
Item			Total	CCNH	RHNS	NurseFac-Aids
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Trinity Hill Care Center, LLC		2222-C		9/30/2017		27	37
Item				Total	CCNH	RHNS	NurseFac-Aids
Subtotals Brought Forward:							
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify)				\$	936	747	189
INTEREST							
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	936	747	189
14. Insurance							
a. Insurance on Property (buildings only)				\$	6,802	5,425	1,376
b. Insurance on Automobiles				\$	3,733	2,977	755
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$	46,526	37,112	9,415
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$	3,863	3,081	782
Other insurance, crime							
14d. Total Insurance Expenditures (14a + b + c)				\$	60,924	48,596	12,328
15. Total All Expenditures (A-13 thru C-14)				\$	14,435,521	11,087,713	3,347,808

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Trinity Hill Care Center, LLC			2222-C	9/30/2017	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$ 322,284	322,284		
10.			Accounting & Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.			Unallowable Advertising *	\$ 11,754	9,375		2,378
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 39,757	31,712		8,045
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 373,794	363,371		10,423

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
16a		PENALTIES	\$ -		\$ -
16a		LATE FEES	\$ 610		\$ 155
16a		PRIOR PERIOD EXPENSES			
		rounding	\$ 1		
		Provider User Fee for Medicare days	\$ 31,102		\$ 7,890
Total Other A&G Adjustments			\$ 31,712	\$ -	\$ 8,045

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

Name of Facility				License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC				2222-C	9/30/2017	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
Subtotals Brought Forward				\$ 373,794	363,371		10,423
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$			
28.			Ambulance/Limousine	\$ 36	24		12
29.			X-rays, etc	\$ 1,104	1,104		
30.			Laboratory	\$ 3,262	3,262		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 168	134		34
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$			
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51. Total Amount of Decrease (Items 1 - 50)				\$ 378,364	367,895		10,469

*** 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.

Trinity Hill Care Center, LLC
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
20	5J		133.62		33.90
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	-		
13	B9A	ST- Resident Care (for outpatient therapy - see schedule)	-		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	-		
Total Other Ancillary Costs			\$ 134	\$ -	\$ 34

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2017			30	37
Item	Total	CCNH	RHNS	NurseFac-Aids		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 14,223,208	11,064,367		3,158,841		
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 989,189	783,108		206,081		
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 69,996	69,996				
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 87,534	87,534				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (87,534)	(87,534)				
c. Prescription Drugs - Non-Medicare	\$ 21,804	16,527		5,277		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (21,804)	(16,527)		(5,277)		
2. a. Medical Supplies - Medicare	\$ 1,884	1,884				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (1,884)	(1,884)				
c. Medical Supplies - Non-Medicare	\$ 12,955	11,207		1,748		
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (12,955)	(11,207)		(1,748)		
3. a. Physical Therapy - Medicare	\$ 102,011	102,011				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (62,021)	(62,021)				
c. Physical Therapy - Non-Medicare	\$ 109,214	101,035		8,179		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (109,214)	(101,035)		(8,179)		
4. a. Speech Therapy - Medicare	\$ 37,055	37,055				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (24,962)	(24,962)				
c. Speech Therapy - Non-Medicare	\$ 24,472	23,148		1,324		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (24,472)	(23,148)		(1,324)		
5. a. Occupational Therapy - Medicare	\$ 32,575	32,575				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (24,899)	(24,899)				
c. Occupational Therapy - Non-Medicare	\$ 37,327	36,029		1,298		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (37,157)	(35,859)		(1,298)		
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$ 28,676	28,676				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 15,371,000	12,006,077		3,364,922		
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 12	12				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 1	1				
V. Total Other Revenue (1 thru 8)	\$ 13	13				
VI. Total All Revenue (III+V)	\$ 15,371,012	12,006,090		3,364,922		

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	NurseFac-Aids
	Lab Medicare	\$ 208		
	Lab Medicare CA	\$ (208)		
	Oxygen Medicare	\$ 18		
	Oxygen Medicare CA	\$ (18)		
	Equipment rental	\$ -		
	Equipment rental CA	\$ -		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds Medicare	\$ -		
	Therapy Beds Medicare CA	\$ -		
	Radiology Medicare	\$ 2,358		
	Radiology Medicare CA	\$ (2,358)		
	IV Therapy	\$ 22,085		
	IV Therapy CA	\$ (22,085)		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose testing	\$ -		
	Glucose testing CA	\$ -		
	Outpatient therapy Medicare	\$ -		
	Total Other Resident Revenue - Medicare	\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	NurseFac-Aids
	Lab	-		
	Lab CA			
	Oxygen	\$ 1,488		\$ 48
	Oxygen CA	\$ (1,488)		\$ (48)
	Equipment rental	\$ -		
	Equipment rental CA	\$ -		
	Pen Therapy	\$ -		
	Pen Therapy CA	\$ -		
	Therapy Beds	\$ -		
	Therapy Beds CA	\$ -		
	Radiology	\$ -		
	Radiology CA	\$ -		
	Medical Transportation	\$ -		
	Medical Transportation CA	\$ -		
	Glucose Testing	\$ -		
	Glucose Testing CA	\$ -		
	IV therapy	\$ 50,071		\$ 6,299
	IV therapy CA	\$ (50,071)		\$ (6,299)
	Flu shot revenue	\$ 2,329		
	Outpatient therapy	\$ -		
	prior period revenue	\$ 26,348		
	rounding	\$ (1)		
	Total Other Resident Revenue	\$ 28,676	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	NurseFac-Aids
	INTEREST INCOME		\$ 12		
	Total Interest Income		\$ 12	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	NurseFac-Aids
	MEALS	\$ -		
	TELEVISION INCOME	\$ -		
	CONCESSIONS / VENDING INCOME	\$ -		
	RESIDENT LATE FEE REVENUE	\$ -		
	RESIDENT ATTORNEY FEE REVENUE	\$ -		
	TELEPHONE INCOME	\$ -		
	OTHER INCOME	\$ 1		
	OPTUM DIVIDENDS REVENUE	\$ -		
	Total Other Revenue	\$ 1	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2017	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	493,139
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,648,414
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	32,187
5. Prepaid Expenses			\$	377,161
a. Prepaid Insurance	298,695			
b. Prepaid Property Taxes	76,981			
c. Prepaid Expenses Other	1,484			
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(1,262,188)
Due From (to) Related Parties	(464,545)			
Other Owners reserves	(797,642)			
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,288,714
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost 394,946		\$	333,321
	Accum. Depreciation 61,625	Net		
4. Leasehold Improvements	*Historical Cost 696,856		\$	250,652
	Accum. Depreciation 446,204	Net		
5. Non-Movable Equipment	*Historical Cost 7,990		\$	2,600
	Accum. Depreciation 5,391	Net		
6. Movable Equipment	*Historical Cost 494,456		\$	174,280
	Accum. Depreciation 320,176	Net		
7. Motor Vehicles	*Historical Cost 9,580		\$	1,985
	Accum. Depreciation 7,595	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
Construction in Progress				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	762,838

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2017	32	37
Account			Amount	
Total Brought Forward:			\$	3,051,552
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
3. Buildings			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
4. Non-Movable Equipment			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
5. Movable Equipment			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
6. Motor Vehicles			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	456,194
3. Organization Expense			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	43,000
Patient Trust Funds				40,445
Long Term Deposit - primecare				2,555
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address		Amount	Loan Date	
7. Other Assets (<i>itemize</i>)			\$	
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	499,194
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	3,550,746

* 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	9/30/2017	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	253,241
2. Notes Payable (<i>itemize</i>)				\$	
Working Capital Line of Credit					
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	197,487
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	1,117,544
Related Party Payables		593,714			
Accrued Expenses		(28,249)			
Accrued Resident User Fees		259,513			
Accrued Workers Comp Expense		292,565			
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,568,272

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2017	Page 34	of 37
Account				Amount	
Total Brought Forward:				1,568,272	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
Name of Lender		Purpose	Amount	Date Due	\$
2. Mortgages Payable					
\$					
3. Loans from Owners or Related Parties (<i>itemize</i>)					
\$					
Name and Address of Lender		Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)					
Patient Trust Funds			40,445	\$ 40,445	
B-5. Total Long-Term Liabilities (Lines B1 thru 4)					
\$ 40,445					
C. Total All Liabilities (Lines A-13 + B-5)					
\$ 1,608,717					

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

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2017	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	1,000
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	1,005,538
6. Gain or Loss for Period			\$	935,492
7. Total Net Worth			\$	1,942,030
C. Total Reserves and Net Worth			\$	1,942,030
D. Total Liabilities, Reserves, and Net Worth			\$	3,550,746

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2017	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2016			\$	
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	15,371,012
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	14,435,521
D. Net Income or Deficit			\$	935,492
E. Balance			\$	935,492
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
	Name and Address <i>(No., City, State, Zip)</i>	Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
	Purpose		Amount	
3. Total Deductions			\$	
H. Balance at End of Period			\$	935,492
				09/30/17

I. Preparer's/Reviewer's Certification

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2017	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> NurseFac-Aids		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
iCare Management, LLC				
Address			Phone Number	
341 Bidwell Street, Manchester, CT 06040			860-570-2140	