

Facility Name & ID Number TRINITY LIVING CENTER #3

0034926 Report Period Beginning: 7/1/07 Ending: 6/30/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,730			5,730	13
14	TOTALS	5,730			5,730	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.85%

D. How many bed-hold days during this year were paid by the Department? 53 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 10/17/90

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/16/90 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 6/30/08 Fiscal Year: 6/30/08

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number TRINITY LIVING CENTER #3 # 0034926 Report Period Beginning: 7/1/07 Ending: 6/30/08

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	3,938		1,465	5,403		5,403		5,403		1
2	Food Purchase		47,678		47,678		47,678		47,678		2
3	Housekeeping	19,692	27,229		46,921		46,921		46,921		3
4	Laundry	23,630			23,630		23,630		23,630		4
5	Heat and Other Utilities			10,199	10,199		10,199	2,777	12,976		5
6	Maintenance		4,050	23,160	27,210		27,210		27,210		6
7	Other (specify):*										7
8	TOTAL General Services	47,260	78,957	34,824	161,041		161,041	2,777	163,818		8
B. Health Care and Programs											
9	Medical Director			7,978	7,978		7,978		7,978		9
10	Nursing and Medical Records	35,432	3,163	175	38,770		38,770		38,770		10
10a	Therapy										10a
11	Activities	288,852	2,378		291,230		291,230		291,230		11
12	Social Services										12
13	CNA Training	900			900		900		900		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	325,184	5,541	8,153	338,878		338,878		338,878		16
C. General Administration											
17	Administrative	30,693			30,693		30,693	62,016	92,709		17
18	Directors Fees										18
19	Professional Services			5,756	5,756		5,756	7,685	13,441		19
20	Dues, Fees, Subscriptions & Promotions			623	623		623	764	1,387		20
21	Clerical & General Office Expenses	10,873	2,907	6,907	20,687		20,687	11,191	31,878		21
22	Employee Benefits & Payroll Taxes			76,914	76,914		76,914	24,554	101,468		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,134	1,134		1,134	3,966	5,100		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			7,743	7,743		7,743	1,206	8,949		26
27	Other (specify):*										27
28	TOTAL General Administration	41,566	2,907	99,077	143,550		143,550	111,382	254,932		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	414,010	87,405	142,054	643,469		643,469	114,159	757,628		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

TRINITY LIVING CENTER #3

#0034926

Report Period Beginning:

7/1/07

Ending:

6/30/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			30,074	30,074		30,074	4,010	34,084			30
31	Amortization of Pre-Op. & Org.			1,260	1,260		1,260		1,260			31
32	Interest			10,226	10,226		10,226	3,655	13,881			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			41,560	41,560		41,560	7,665	49,225			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,166	49,166		49,166		49,166			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			49,166	49,166		49,166		49,166			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	414,010	87,405	232,780	734,195		734,195	121,824	856,019			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **TRINITY LIVING CENTER #3**

0034926

Report Period Beginning: **7/1/07**

Ending: **6/30/08**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

TRINITY LIVING CENTER #3

ID# 0034926

Report Period Beginning: 7/1/07

Ending: 6/30/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
TRINITY SERVICES, INC	100	TRINITY LIVING CENTER #1	JOLIET			
501 c3	100	TRINITY LIVING CENTER #2	JOLIET			
	100	TRINITY LIVING CENTER #3	JOLIET			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TRINITY LIVING CENTER #3 # 0034926 Report Period Beginning: 7/1/07 Ending: 6/30/08

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **TRINITY LIVING CENTER #3**

0034926 Report Period Beginning: **7/1/07**

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	ADMINISTRATION				\$	\$			1
2	5 UTILITIES	PROGRAM SIZE	100		48,823		4	1,953	2
3	17 ADMIN SALARIES	PROGRAM SIZE	100		1,253,602		4	50,144	3
4	19 PROFESSIONAL SERVICES	PROGRAM SIZE	100		192,130		4	7,685	4
5	20 SUBSCRIPTIONS	PROGRAM SIZE	100		19,100		4	764	5
6	21 CLERICAL/GENERAL OFFICE	PROGRAM SIZE	100		196,865		4	7,875	6
7	22 BENEFITS & PR TAXES	PROGRAM SIZE	100		546,728		4	21,869	7
8	24 TRANSPORTATION	PROGRAM SIZE	100		23,835		4	953	8
9	26 INSURANCE	PROGRAM SIZE	100		30,152		4	1,206	9
10	30 DEPRECIATION	PROGRAM SIZE	100		66,788		4	2,672	10
11	32 INTEREST	PROGRAM SIZE	100		91,380		4	3,655	11
12	MAINTENANCE								12
13	5 UTILITIES	PROGRAM SIZE	100		20,588		4	824	13
14	17 MAINT SALARIES	PROGRAM SIZE	100		296,794		4	11,872	14
15	21 CLERICAL/GENERAL OFFICE	PROGRAM SIZE	100		82,906		4	3,316	15
16	22 BENEFITS & PR TAXES	PROGRAM SIZE	100		67,115		4	2,685	16
17	24 TRANSPORTATION	PROGRAM SIZE	100		75,323		4	3,013	17
18	30 DEPRECIATION	PROGRAM SIZE	100		33,440		4	1,338	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,045,569	\$		\$ 121,824	25

Facility Name & ID Number **TRINITY LIVING CENTER #3** # **0034926** Report Period Beginning: **7/1/07** Ending: **6/30/08**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6		7	8	9	10	
						Original	Balance					
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO									
	A. Directly Facility Related											
	Long-Term											
1	IDFA 1997 BOND		X	REFINANCED 1990 BOND	EST 5,129	7/97	\$ 663,334	\$ 313,600	7/2019	0.0588	\$ 11,486	1
2				FOR ORIGINAL								2
3				CONSTRUCTION								3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 663,334	\$ 313,600			\$ 11,486	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 663,334	\$ 313,600			\$ 11,486	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number **TRINITY LIVING CENTER #3**

0034926 Report Period Beginning: **7/1/07** Ending: **6/30/08**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1.	Real Estate Tax accrual used on 2007 report.		\$	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	3
4.	Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
	2003	8		
	2004	9		
	2005	10		
	2006	11		
	2007	12		
			FOR BHF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 2007 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TRINITY LIVING CENTER #3 COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0034926

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2008

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,494 B. General Construction Type: Exterior BRICK Frame CLASS C Number of Stories ONE

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable)

TLC #1/ICF/5,494 SQ FT/16 BEDS AVAILABLE
TLC #2/ICF/5,494 SQ FT/16 BEDS AVAILABLE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: 29,226 2. Number of Years Over Which it is Being Amortized: 20
 3. Current Period Amortization: 1,260 4. Dates Incurred: 1990

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>RESIDENTIAL</u>	<u>1/2 ACRE</u>	<u>1984</u>	\$	<u>1</u>
2					<u>2</u>
3	<u>TOTALS</u>	<u>1/2 ACRE</u>		\$	<u>3</u>

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	1990	1990	\$ 593,688		30	\$ 19,983	\$ 19,983	\$ 350,339	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	FLOORING REPLACED		1998	6,175		7			6,175	9
10	CARPETING		1998	9,474		7			9,474	10
11	PAINTING AND STAINING		1998	11,150		7			11,150	11
12	SEPTIC		1998	19,000		7			19,000	12
13	SEPTIC		2001	48,350		30	1,611	1,611	12,086	13
14	CARPETING		2003	613		7	88	88	482	14
15	A/C UNIT		2003	2,250		10	225	225	1,011	15
16	ROOF REPAIR		2004	1,810		10	181	181	816	16
17	WATER HEATER		2005	10,825		10	1,083	1,083	3,790	17
18	FLOORING		2007	11,184		10	1,118	1,118	1,677	18
19	BATHROOM REMODELING		2007	21,808		10	2,181	2,181	3,271	19
20	CARPETING		2007	3,162		10	316	316	474	20
21	CARPET AND TILE		2008	13,799		10	690	690	690	21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 753,288	\$		\$ 27,476	\$ 27,476	\$ 420,435	70

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 17,902	\$	\$ 2,557	\$ 2,557		\$ 12,736	71
72	Current Year Purchases	569		41	41		41	72
73	Fully Depreciated Assets	24,647					24,647	73
74								74
75	TOTALS	\$ 43,118	\$	\$ 2,598	\$ 2,598		\$ 37,424	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 796,406	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,074	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 30,074	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 457,859	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	LAND IMPROVEMENTS '91	\$ 8,983	\$	\$ 8,983	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 8,983	\$	\$ 8,983	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="text" value="40"/></p> <p>IN OTHER FACILITY <input type="text"/></p> <p>COMMUNITY COLLEGE <input type="text"/></p> <p>HOURS PER CNA <input type="text" value="40"/></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="text" value="40"/></p> <p>IN OTHER FACILITY <input type="text"/></p> <p>HOURS PER CNA <input type="text" value="40"/></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	300	300		600
4	Clinical Wages (b)		300		300
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 300	\$ 600	\$	\$ 900
10	SUM OF line 9, col. 1 and 2 (e)	\$ 900			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	2

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$					\$	1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Other (specify):													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$		\$			\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number TRINITY LIVING CENTER #3

0034926

Report Period Beginning: 7/1/07

Ending:

6/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/08

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 4,220,035	1
2	Cash-Patient Deposits		283,035	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		2,226,936	3
4	Supply Inventory (priced at)		423,150	4
5	Short-Term Investments		1,394,126	5
6	Prepaid Insurance		116,419	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 8,663,701	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		375,354	12
13	Land		2,288,974	13
14	Buildings, at Historical Cost		19,618,889	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		4,316,554	16
17	Accumulated Depreciation (book methods)		(10,772,215)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$ 15,827,556	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 24,491,257	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 654,726	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		283,035	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		153,587	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$ 1,091,348	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		7,104,501	39
40	Mortgage Payable			40
41	Bonds Payable		5,775,000	41
42	Deferred Compensation		2,203,493	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 15,082,994	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 16,174,342	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,316,915	\$ 8,316,915	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,316,915	\$ 24,491,257	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,992,317	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,992,317	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,324,598	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,324,598	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,316,915	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number TRINITY LIVING CENTER #3

0034926

Report Period Beginning: 7/1/07

Ending:

Page 19
6/30/08

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 864,081	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 864,081	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicar	914	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 914	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 864,995	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	161,041	31
32	Health Care	338,878	32
33	General Administration	143,550	33
B. Capital Expense			
34	Ownership	41,560	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	49,166	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 734,195	40
41	Income before Income Taxes (line 30 minus line 40)**	130,800	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 130,800	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number TRINITY LIVING CENTER #3

0034926

Report Period Beginning:

7/1/07

Ending:

6/30/08

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1			\$	\$	1
2					2
3	1,912	2,211	35,432	16.03	3
4					4
5					5
6	120	120	900	7.50	6
7					7
8					8
9					9
10	3,363	3,868	53,639	13.87	10
11					11
12					12
13					13
14					14
15	365	365	3,938	10.79	15
16					16
17					17
18	1,825	1,825	19,692	10.79	18
19	2,190	2,190	23,630	10.79	19
20	635	698	17,640	25.27	20
21	593	684	13,053	19.08	21
22					22
23					23
24	920	1,067	10,873	10.19	24
25					25
26					26
27					27
28	1,939	2,103	28,983	13.78	28
29					29
30	16,985	19,113	206,230	10.79	30
31					31
32					32
33					33
34	30,847	34,244	\$ 414,010 *	\$ 12.09	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	33	\$ 1,465	1:3	35
36	as needed	6,961	9:3	36
37	5	175	10:3	37
38				38
39	1	17	9:3	39
40				40
41				41
42				42
43				43
44				44
45				45
46	as needed	1,000	9:3	46
47				47
48				48
49	39	\$ 9,618		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51				51
52				52
53		\$		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 49,166
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 914
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McEnerney & Associates The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not yet completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

TRINITY SERVICES, INC
SUPPLEMENTAL SCHEDULE
PAGE 23, QUESTION 12 - SALARY ALLOCATION

One administrator oversees the Trinity Living Centers (#1, #2 & #3). In Fiscal Year 2008, Lisa Dillon held the position. In addition, in order for the facilities to run properly and to comply with all of the various rules and regulations, habilitation aides must also perform the following duties for the period of time indicated:

<u>FUNCTION</u>	<u>Average Hours per Day</u>
Cook Helper	1
Housekeeping	5
Laundry	6

TRINITY SERVICES, INC
SCHEDULE OF ORGANIZATION & PRE-OPERATING COSTS

BOND ISSUANCE	25,234.00
UTILITIES	1,196.00
RESEARCH & DESIGN	1,225.00
INSURANCE	171.00
OTHER	<u>1,400.00</u>
TOTAL	<u>29,226.00</u>

TRINITY SERVICES, INC
 FY08
 SCHEDULE 21G

NAME	JOB TITLE	DATE	LOCATION	SPONSOR	TITLE	COST
Lisa Dillon	Director	8/6 - 8/10/07	Atlanta, GA	National Association of QMRP's	NAQ Conference 2008 7 Key Components of Abuse and Neglect Detection and Prevention	68.00
Lisa Dillon	Director	3/12/2008	Arlington Heights, IL	IARF	Illinois Nursing Home Association Annual Convention	61.66
Lisa Dillon	Director	4/3 - 4/4/08	Peoria, IL	Illinois Nursing Home Assoc	Illinois Nursing Home Association Annual Convention	65.00
Val Easter	Assoc Director	4/3 - 4/4/08	Peoria, IL	Illinois Nursing Home Assoc	Illinois Nursing Home Association Annual Convention	65.00
Lisa Dillon	Director	4/11/2008	Joliet, IL	First Presbyterian Church	Maximum Impact	23.00
Michelle Branch	Team Leader	4/11/2008	Joliet, IL	First Presbyterian Church	Maximum Impact	23.00
Vicki LeGrett	Team Leader	4/11/2008	Joliet, IL	First Presbyterian Church	Maximum Impact	23.00
Rajeshwari Vyas	Team Leader	8/8/2008	Tinley Park, IL	Will County Health Dept	Food Certification Class Prevention of Abuse & Neglect	40.00
Carrissa White	QMRP	5/16/2008	Online course	Minot State University		100.00
						468.66

TRINITY SERVICES, INC

SCHEDULE TO RECONCILE

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NET INCOME TLC #3	130,800
NET INCOME ALL OTHER DEPTS	<u>1,193,798</u>
TOTAL NET INCOME PER FEDERAL TAX RETURN	1,324,598