



Facility Name & ID Number TRINITY LIVING CENTER #2

# 0034918 Report Period Beginning: 7/1/08 Ending: 6/30/09

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	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,537			5,537	13
14	TOTALS	5,537			5,537	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.81%

D. How many bed-hold days during this year were paid by the Department? 281 (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

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/09 Fiscal Year: 6/30/09

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

Facility Name &amp; ID Number

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

	Operating Expenses	Costs 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
	<b>A. General Services</b>										
1	Dietary	3,942		1,339	5,281		5,281		5,281		1
2	Food Purchase		56,456		56,456		56,456		56,456		2
3	Housekeeping	19,710	15,658		35,368		35,368		35,368		3
4	Laundry	23,652			23,652		23,652		23,652		4
5	Heat and Other Utilities			10,125	10,125		10,125	3,254	13,379		5
6	Maintenance		5,328	15,236	20,564		20,564		20,564		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	47,304	77,442	26,700	151,446		151,446	3,254	154,700		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,270	11,270		11,270		11,270		9
10	Nursing and Medical Records	40,541	1,190	210	41,941		41,941		41,941		10
10a	Therapy										10a
11	Activities	306,392	1,091		307,483		307,483		307,483		11
12	Social Services										12
13	CNA Training	620			620		620		620		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	347,553	2,281	11,480	361,314		361,314		361,314		16
	<b>C. General Administration</b>										
17	Administrative	30,118			30,118		30,118	63,959	94,077		17
18	Directors Fees										18
19	Professional Services			6,360	6,360		6,360	6,190	12,550		19
20	Dues, Fees, Subscriptions & Promotions			511	511		511	277	788		20
21	Clerical & General Office Expenses	10,630	3,115	4,681	18,426		18,426	10,015	28,441		21
22	Employee Benefits & Payroll Taxes			90,548	90,548		90,548	21,909	112,457		22
23	Inservice Training & Education										23
24	Travel and Seminar			852	852		852	4,454	5,306		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			7,977	7,977		7,977	1,014	8,991		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	40,748	3,115	110,929	154,792		154,792	107,818	262,610		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	435,605	82,838	149,109	667,552		667,552	111,072	778,624		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			30,282	30,282		30,282	3,964	34,246		30
31	Amortization of Pre-Op. & Org.			1,260	1,260		1,260		1,260		31
32	Interest			9,453	9,453		9,453	7,039	16,492		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			40,995	40,995		40,995	11,003	51,998		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
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			45,312	45,312		45,312		45,312		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			45,312	45,312		45,312		45,312		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	435,605	82,838	235,416	753,859		753,859	122,075	875,934		45

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



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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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	<b>Total</b>	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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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

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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		60,021		4	2,401	2
3	17 ADMIN SALARIES	PROGRAM SIZE	100		1,279,697		4	51,188	3
4	19 PROFESSIONAL SERVICES	PROGRAM SIZE	100		154,753		4	6,190	4
5	20 SUBSCRIPTIONS	PROGRAM SIZE	100		6,931		4	277	5
6	21 CLERICAL/GENERAL OFFICE	PROGRAM SIZE	100		186,491		4	7,460	6
7	22 BENEFITS & PR TAXES	PROGRAM SIZE	100		473,268		4	18,931	7
8	24 TRANSPORTATION	PROGRAM SIZE	100		21,885		4	875	8
9	26 INSURANCE	PROGRAM SIZE	100		25,340		4	1,014	9
10	30 DEPRECIATION	PROGRAM SIZE	100		67,282		4	2,691	10
11	32 INTEREST	PROGRAM SIZE	100		175,987		4	7,039	11
12	MAINTENANCE								12
13	5 UTILITIES	PROGRAM SIZE	100		21,327		4	853	13
14	17 MAINT SALARIES	PROGRAM SIZE	100		319,274		4	12,771	14
15	21 CLERICAL/GENERAL OFFICE	PROGRAM SIZE	100		63,869		4	2,555	15
16	22 BENEFITS & PR TAXES	PROGRAM SIZE	100		74,445		4	2,978	16
17	24 TRANSPORTATION	PROGRAM SIZE	100		89,485		4	3,579	17
18	30 DEPRECIATION	PROGRAM SIZE	100		31,820		4	1,273	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,051,875	\$		\$ 122,075	25

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**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										
										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				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1		X	REFINANCED 1990 BOND	EST 5,129	7/97	\$ 663,334	\$ 271,250	7/2019	0.0588	\$ 10,713	1								
2			FOR ORIGINAL								2								
3			CONSTRUCTION								3								
4											4								
5											5								
<b>Working Capital</b>																			
6											6								
7											7								
8											8								
9	<b>TOTAL Facility Related</b>					\$ 663,334	\$ 271,250			\$ 10,713	9								
<b>B. Non-Facility Related*</b>																			
10											10								
11											11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>					\$ 663,334	\$ 271,250			\$ 10,713	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.)





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**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 grounds (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 #3/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	<b>TOTALS</b>	<b>#VALUE!</b>		\$	<b>3</b>

**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	\$ 370,321
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	TILE REPLACED		1995	2,161		7			2,161
10	FLOOR REPLACED		1998	11,409		7			11,409
11	PAINTING AND STAINING		1998	19,547		7			19,547
12	ASPHALT		1999	1,570		7			1,570
13	CARPET		2003	613		7	88	88	570
14	CONDENSOR		2003	2,688		10	269	268	1,474
15	PAINTING AND STAINING		2003	2,400		10	240	240	1,320
16	WATER SOFTENER		2004	3,695		10	370	370	2,035
17	CARPET		2004	1,047		10	105	105	472
18	FLOORING		2007	10,045		10	1,005	1,005	2,512
19	BATHROOM & KITCHEN REMODELING		2007	30,808		10	3,081	3,080	7,700
20	CARPET & TILE		2007	13,799		10	1,380	1,380	2,070
21	PAVING		2009	2,100		10	105	105	105
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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)	\$	695,570	\$		\$	26,626	\$	26,624	\$	423,266	70

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

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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	\$ 19,196	\$	\$ 2,740	\$ 2,740		\$ 13,354	71
72	Current Year Purchases	12,817		916	916		916	72
73	Fully Depreciated Assets	6,910					6,910	73
74								74
75	TOTALS	\$ 38,923	\$	\$ 3,656	\$ 3,656		\$ 21,180	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)	\$ 734,493	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)	\$ 30,282	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 30,282	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 444,446	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 '94	\$ 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	<b>TOTAL</b>				\$ _____			7

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	<b>TOTAL</b>		\$ _____	\$ _____	21

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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**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. <u>CLASSROOM PORTION:</u></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 <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="text" value="40"/></p> <p>IN OTHER FACILITY <input type="text"/></p> <p>HOURS PER CNA <u>40</u></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)		310		310
4	Clinical Wages (b)		310		310
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 620	\$	\$ 620
10	SUM OF line 9, col. 1 and 2 (e)	\$	620		

**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	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>1</b>

- (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.

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			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	<b>TOTAL</b>			\$		\$	\$		\$	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.**

Facility Name & ID Number **TRINITY LIVING CENTER #2**

# **0034918**

Report Period Beginning: **7/1/08**

Ending: **6/30/09**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **6/30/09** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$ 3,592,959	1
2	Cash-Patient Deposits		434,726	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )		2,314,303	3
4	Supply Inventory (priced at )		493,229	4
5	Short-Term Investments		1,413,300	5
6	Prepaid Insurance		62,353	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	\$ 8,310,870	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		365,649	12
13	Land		2,230,445	13
14	Buildings, at Historical Cost		19,808,152	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		4,071,264	16
17	Accumulated Depreciation (book methods)		(11,257,690)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 15,217,820	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	\$ 23,528,690	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$	\$ 615,178	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		434,726	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		142,244	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	\$ 1,192,148	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		5,068,870	39
40	Mortgage Payable			40
41	Bonds Payable		5,325,000	41
42	Deferred Compensation		2,275,062	42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 12,668,932	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$	\$ 13,861,080	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 9,667,610	\$ 9,667,610	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 9,667,610	\$ 23,528,690	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>9,552,232</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>9,552,232</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>115,378</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>115,378</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>9,667,610</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number TRINITY LIVING CENTER #2

# 0034918

Report Period Beginning: 7/1/08

Ending:

6/30/09

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 869,088	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 869,088	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Medicar	149	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 149	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 869,237	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	151,446	31
32	Health Care	361,314	32
33	General Administration	154,792	33
<b>B. Capital Expense</b>			
34	Ownership	40,995	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	45,312	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 753,859	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	115,378	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 115,378	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 #2**

# **0034918**

Report Period Beginning:

7/1/08

Ending:

6/30/09

**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	Director of Nursing		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses	2,004	2,358	40,541	17.19	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	80	80	620	7.75	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,223	3,755	54,261	14.45	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	365	365	3,942	10.80	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,825	1,825	19,710	10.80	18
19	Laundry	2,190	2,190	23,652	10.80	19
20	Administrator	642	707	17,803	25.18	20
21	Assistant Administrator	614	693	12,315	17.77	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	945	1,065	10,630	9.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	949	1,012	13,866	13.70	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	19,796	22,062	238,265	10.80	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	32,633	36,112	\$ 435,605 *	\$ 12.06	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	Dietary Consultant	30	\$ 1,339	1:3	35
36	Medical Director	as needed	9,270	9:3	36
37	Medical Records Consultant	6	210	10:3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychological</u>	as needed	2,000	9:3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	36	\$ 12,819		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
LISA DILLON	Admin/FTE 33%		\$ 17,803	Workers' Compensation Insurance	\$ 21,318	IDPH License Fee	\$	
VALERIE EASTER	Asst Admin/FTE 33%		12,315	Unemployment Compensation Insurance		Advertising: Employee Recruitment	0	
				FICA Taxes	31,774	Health Care Worker Background Check	224	
				Employee Health Insurance	16,931	(Indicate # of checks performed <u>14</u> )		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Membership	150	
				Retirement	16,800	Subscription & Reference	137	
				Staff Incentive/Merit Plan	3,725	Allocated Subscription - Admin	277	
				Allocated Benefits Admin	18,931			
				Allocated Benefits Maint	2,978			
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 30,118	TOTAL (agree to Schedule V, line 22, col.8)	\$ 112,457	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 788	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	498
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	354
C. Professional Services							Allocated Seminars/Travel - Admin	875
Vendor/Payee	Type		Amount				Allocated Seminars/Travel - Maint	3,579
McEnerney & Associates	AUDITING		\$ 965				Entertainment Expense	( )
ADP	PAYROLL PROCESSING		5,395				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 5,306
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 6,360	TOTAL		\$		

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number TRINITY LIVING CENTER #2

# 0034918

Report Period Beginning:

7/1/08

Ending: 6/30/09

**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 action 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 No NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO No 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. \$ 45,312  
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 benefits 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. \$ 149
- 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
- (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 2009, 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  
 FY09  
 SCHEDULE 21G

<b>NAME</b>	<b>JOB TITLE</b>	<b>DATE</b>	<b>LOCATION</b>	<b>SPONSOR</b>	<b>TITLE</b>	<b>COST</b>
Lisa Dillon	Director			National Association of QMRP's	NAQ Conference 2008	50.00
Lisa Dillon	Director	11/5/2008	Bloomington, IL	IHCA	IHCA's Dietary Symposium	66.66
Lisa Dillon	Director	5/8/2009	Joliet, IL	First Presbyterian Church	Leadership That Inspires	34.50
Val Easter	Assoc Director	5/8/2009	Joliet, IL	First Presbyterian Church	Leadership That Inspires	34.50
Carrissa White	QMRP	5/8/2009	Joliet, IL	First Presbyterian Church	Leadership That Inspires	34.50
Anne Huston	Team Leader	5/8/2009	Joliet, IL	First Presbyterian Church	Leadership That Inspires Evidence-Based Assessment & Intervention Strategies for Fall	34.50
Vicki LeGrett	Team Leader	6/8/2009	Joliet, IL	Summit Professional Education	Prevention Evidence-Based Assessment & Intervention Strategies for Fall	49.66
Val Easter	Assoc Director	6/8/2009	Joliet, IL	Summit Professional Education	Prevention	49.66
						353.98

TRINITY SERVICES, INC

SCHEDULE TO RECONCILE  
P 19 L 43

NET INCOME TLC #2	115,378
NET INCOME ALL OTHER DEPTS	<u>1,562,836</u>
TOTAL NET INCOME PER FEDERAL TAX RETURN	1,678,214