

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0034900</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>TRINITY LIVING CENTER #1</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/10</u> to <u>06/30/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>3360 UGLAND DRIVE</u> <u>JOLIET</u> <u>60432</u>																																																	
Number City Zip Code																																																	
County: <u>WILL</u>																																																	
Telephone Number: <u>815-485-6197</u> Fax # <u>815-485-5975</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td><td><u>10/17/11</u></td></tr><tr><td>(Type or Print Name) <u>CHERYL DILLON</u></td><td>(Date)</td></tr><tr><td>(Title) _____</td><td></td></tr><tr><td>(Signed) _____</td><td>(Date)</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) _____</td><td></td></tr><tr><td>(Firm Name & Address) _____</td><td></td></tr><tr><td>(Telephone) <u>()</u></td><td>Fax # <u>()</u></td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	<u>10/17/11</u>	(Type or Print Name) <u>CHERYL DILLON</u>	(Date)	(Title) _____		(Signed) _____	(Date)	Paid Preparer	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>()</u>	Fax # <u>()</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																													
Officer or Administrator of Provider	(Signed) _____				<u>10/17/11</u>																																												
	(Type or Print Name) <u>CHERYL DILLON</u>				(Date)																																												
	(Title) _____																																																
	(Signed) _____			(Date)																																													
Paid Preparer	(Print Name and Title) _____																																																
	(Firm Name & Address) _____																																																
	(Telephone) <u>()</u>	Fax # <u>()</u>																																															
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																																
Date of Initial License for Current Owners: <u>10/17/90</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code <u>501 c 3</u></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501 c 3</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____		
☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL																																												
☒	Charitable Corp.	☐	Individual	☐	State																																												
☐	Trust	☐	Partnership	☐	County																																												
IRS Exemption Code <u>501 c 3</u>		☐	Corporation	☐	Other _____																																												
		☐	"Sub-S" Corp.																																														
		☐	Limited Liability Co.																																														
		☐	Trust																																														
		☐	Other _____																																														
In the event there are further questions about this report, please contact:																																																	
Name: <u>CHERYL DILLON</u> Telephone Number: <u>815-485-6197</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number TRINITY LIVING CENTER #1

0034900 Report Period Beginning: 07/01/10 Ending: 06/30/11

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	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	5,229			5,229	13
14	TOTALS	5,229			5,229	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.54%

D. How many bed-hold days during this year were paid by the Department? 368 (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)
N/A

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 10/17/1990

J. Was the facility purchased or leased after January 1, 1978?
YES

