

		FOR BHF USE					

LL1

2025

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2025)

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: 0034900

Facility Name: TRINITY LIVING CENTER 1

Address: 3360 UGLAND DRIVE JOLIET 60432

County: WILL

Telephone Number: 815-485-6197 Fax # 815-485-5975

HFS ID Number:

Date of Initial License for Current Owners: 10/17/90

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code 501c3

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: CHERYL JONES Telephone Number: 815-485-6197
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/24 to 06/30/25 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.

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Michele Pink

(Title) Budget Analyst

Paid Preparer

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number TRINITY LIVING CENTER 1 # 0034900 Report Period Beginning: 07/01/24 Ending: 06/30/25

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	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS	5,575							5,575	13
14	TOTALS	5,575							5,575	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 95.46%

D. How many bed reserve days during this year were paid by the Department? 10 (Do not include bed reserve 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 ☒ Date 10/17/1990 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter certified beds.
number of certified beds _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 07/01/24 Fiscal Year: 06/30/25
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number

TRINITY LIVING CENTER 1

#

0034900

Report Period Beginning:

07/01/24

Ending:

06/30/25

Page 3

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	
	A. General Services											
1	Dietary	8,311		1,530	9,841		9,841		9,841			1
2	Food Purchase		86,039		86,039		86,039		86,039			2
3	Housekeeping	41,555	21,447		63,002		63,002		63,002			3
4	Laundry	49,866			49,866		49,866		49,866			4
5	Heat and Other Utilities			10,361	10,361		10,361	6,179	16,540			5
6	Maintenance		3,023	31,926	34,949		34,949		34,949			6
7	Other (specify):*											7
8	TOTAL General Services	99,732	110,509	43,817	254,058		254,058	6,179	260,237			8
	B. Health Care and Programs											
9	Medical Director			23,108	23,108		23,108		23,108			9
10	Nursing and Medical Records	128,370	13,190	57,767	199,327		199,327		199,327			10
10a	Therapy											10a
11	Activities	629,665	16,622		646,287		646,287		646,287			11
12	Social Services											12
13	CNA Training	9,804	19,808		29,612		29,612		29,612			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	767,839	49,620	80,875	898,334		898,334		898,334			16
	C. General Administration											
17	Administrative	25,006			25,006		25,006	160,895	185,901			17
18	Directors Fees											18
19	Professional Services			3,675	3,675		3,675	18,535	22,210			19
20	Dues, Fees, Subscriptions & Promotions			3,992	3,992		3,992	1,282	5,274			20
21	Clerical & General Office Expenses	19,762	1,384	2,787	23,933		23,933	61,459	85,392			21
22	Employee Benefits & Payroll Taxes			172,688	172,688		172,688	69,960	242,648			22
23	Inservice Training & Education											23
24	Travel and Seminar							11,248	11,248			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			6,351	6,351		6,351	2,339	8,690			26
27	Other (specify):*											27
28	TOTAL General Administration	44,768	1,384	189,493	235,645		235,645	325,718	561,363			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	912,339	161,513	314,185	1,388,037		1,388,037	331,897	1,719,934			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			32,205	32,205		32,205	7,097	39,302			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			199	199		199	2,386	2,585			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			32,404	32,404		32,404	9,483	41,887			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			68,844	68,844		68,844		68,844			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			68,844	68,844		68,844		68,844			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	912,339	161,513	415,433	1,489,285		1,489,285	341,380	1,830,665			45

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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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 Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
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 Amount	2 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
37	(sum of SUBTOTALS 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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			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
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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. Use Page 6-Supplemental as 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			
501c3	100	TRINITY LIVING CENTER #2	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.

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	RAYMOND MCSHANE	BOD						1
2	GREGORY GEUTHER	BOD						2
3	THANE DYKSTRA	BOD						3
4	BARBARA HALL	BOD						4
5	CHRISTINE FALVEY	BOD						5
6	JANICE AGAZZI	BOD						6
7	RON STRICKLIN	BOD						7
8	TIM GUNTER	BOD						8
9	JO REXER	BOD						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

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 1 # 0034900 Report Period Beginning: 07/01/24 Ending: 06/30/25

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 ☐

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

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

	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		123,229		4	4,929	2
3	17	ADMIN SALARIES	PROGRAM SIZE	100		3,126,966	3,126,966	4	125,079	3
4	19	PROFESSIONAL SERVICES	PROGRAM SIZE	100		460,322		4	18,413	4
5	20	SUBSCRIPTIONS	PROGRAM SIZE	100		31,417		4	1,257	5
6	21	CLERICAL/GENERAL OFFICE	PROGRAM SIZE	100		1,357,339		4	54,294	6
7	22	BENEFITS & PR TAXES	PROGRAM SIZE	100		1,567,086		4	62,683	7
8	24	TRANSPORTATION	PROGRAM SIZE	100		37,952		4	1,518	8
9	26	INSURANCE	PROGRAM SIZE	100		54,297		4	2,172	9
10	30	DEPRECIATION	PROGRAM SIZE	100		69,455		4	2,778	10
11	32	INTEREST	PROGRAM SIZE	100		41,861		4	1,674	11
12		MAINTENANCE								12
13	5	UTILITIES	PROGRAM SIZE	100		31,250		4	1,250	13
14	17	MAINT SALARIES	PROGRAM SIZE	100		895,410	895,410	4	35,816	14
15	19	PROFESSIONAL SERVICES	PROGRAM SIZE	100		3,038		4	122	15
16	20	SUBSCRIPTIONS	PROGRAM SIZE	100		625		4	25	16
17	21	CLERICAL/GENERAL OFFICE	PROGRAM SIZE	100		179,122		4	7,165	17
18	22	BENEFITS & PR TAXES	PROGRAM SIZE	100		181,918		4	7,277	18
19	24	TRANSPORTATION	PROGRAM SIZE	100		243,253		4	9,730	19
20	26	INSURANCE	PROGRAM SIZE	100		4,168		4	167	20
21	30	DEPRECIATION	PROGRAM SIZE	100		107,975		4	4,319	21
22	32	INTEREST	PROGRAM SIZE	100		17,808		4	712	22
23										23
24										24
25	TOTALS					\$ 8,534,491	\$ 4,022,376		\$ 341,380	25

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	
	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				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2025 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
Assessed Value from Real Estate Tax Bill:	2024		8		
Real Estate Tax Bill for Calendar Year:	2020		9		
	2021		10		
	2022		11		
	2023		12		
	2024		13		
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TRINITY LIVING CENTER 1 COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0034900

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies 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 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 #2 / ICF / 5,494 SQ FT / 16 BEDS AVAILABLE

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases? YES

H. Are you presently operating under a sale and leaseback arrangement? NO

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? NO

J. 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.

K. 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: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

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	RESIDENTIAL	21,780	1984	\$	1
2					2
3	TOTALS	21,780		\$	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$	\$	593,688
5										
6										
7										
8										
	Improvement Type**									
9	TILE FLOOR IN BEDROOM NOS. 115, 118, 128, 129, 133, 134			2019	7,297		10	730	730	4,014
10	136, AND 137									
11	REMOVE & REPLACE CONCRETE STOOP AND SIDEWALK			2020	5,875		10	588	588	2,645
12	IONIZATION UNITS IN UTILITY ROOM			2020	3,735		10	374	374	1,682
13	6 WALL HUNG LAVATORIES, BATH HEATER FANS IN ALL			2022	457,440		20	22,872	22,872	80,052
14	BATHROOMS (4), DRYWALL OF ALL BATHROOMS,									
15	ELECTRICAL REPLACEMENT IN ALL BATHROOMS, NEW									
16	HARDWARE IN ALL BATHROOMS, NEW PLUMBING									
17	FIXTURES IN ALL BATHROOMS, REPLACEMENT OF									
18	FLOORING IN ALL BATHROOMS, NEW CUSTOM TILE									
19	IN ALL BATHROOMS, INSTALLATION OF NEW KITCHEN									
20	CABINETS, NEW QUARTZ KITCHEN COUNTERTOPS,									
21	INSULATION OF ENTIRE FACILITY INCLUDING									
22	BASEMENT, NEW INTERIOR DOORS AND HARDWARE									
23	IN ENTIRE FACILITY, NEW WINDOWS IN THE ENTIRE									
24	FACILITY, NEW PAINTING IN THE ENTIRE FACILITY,									
25	NEW ROOF, NEW SOFFIT, FACIA AND GUTTERS OF									
26	ENTIRE EXTERIOR OF FACILITY, FRAMING CHANGES									
27	FOR INTERIOR DOORS, SUBFLOOR AND UNDER-									
28	LAYMENT REPLACEMENT IN ALL BATHROOMS AND									
29	KITCHEN.									
30	2 BUILT-IN DISHWASHERS, 3 KEYED SCHLAGE LOCKS,			2022	123,320		20	6,166	6,166	15,415
31	3 REFRIGERATORS, 2 WASHING MACHINES, 2 DRYERS,									
32	ADDITIONAL COUNTERTOP IN KITCHEN, 4 ADDITIONAL									
33	KITCHEN CABINETS, CHALK BOARD PAINT AND FRAMING									
34	IN KITCHEN, ELECTRICAL MODIFICATION IN KITCHEN,									
35	ENTIRE HOUSE SIDING, FIRE DETECTION SYSTEM,									
36	continued on page 12A									

*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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	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	FIRE EXTINGUISHER BRACKETS, HVAC CHECK AND		\$	\$		\$	\$	\$	37
38	CLEANING SYSTEM, HVAC REPLACEMENT OF FLOOR								38
39	REGISTERS, INPRO MATERIAL IN KITCHEN, LEAF								39
40	SCREENS FOR GUTTERS, LVT FLOOR ON BACKSPLASH								40
41	IN KITCHEN, MIRRORS IN ALL BATHROOMS, NEW								41
42	BI-SWING DOOR IN NURSE'S OFFICE, NEW CABINETS								42
43	IN NURSE'S OFFICE, NEW TILE IN KITCHEN, PAINTING								43
44	IN NURSE'S OFFICE, REPLACEMENT OF ALL								44
45	EMERGENCY LIGHTING, SHELVING IN ALL CLOSETS,								45
46	TRIMWORK IN KITCHEN, WATER SOFTENER AND								46
47	CONDITIONING SYSTEM								47
48	INSTALLATION OF NEW DRAIN LEADING FROM SUMP PU	2023	2,100		10	210	210	315	48
49	REMOVE & REPLACE EXTERIOR DOOR AND INSTALLATI	2023	2,928		10	293	293	439	49
50	OF ADDITIONAL SHELVING IN CLOSETS								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)		\$ 1,196,383	\$		\$ 31,233	\$ 31,233	\$ 698,250	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 6,804	\$	\$ 972	\$ 972		\$ 4,086	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 6,804	\$	\$ 972	\$ 972		\$ 4,086	75

D. Vehicle Costs. (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)	\$ 1,203,187	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)	\$ 32,205	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 32,205	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 702,336	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

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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

40

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

80

80

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		3,268		3,268
4	Clinical Wages (b)		6,536		6,536
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 9,804	\$	\$ 9,804
10	SUM OF line 9, col. 1 and 2 (e)	\$ 9,804			

- (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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

- (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.)

12345678										
	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 prescrpts							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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 14,315,291	1
2	Cash-Patient Deposits		477,527	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		12,177,172	3
4	Supply Inventory (priced at)		674,202	4
5	Short-Term Investments			5
6	Prepaid Insurance		120,330	6
7	Other Prepaid Expenses		383,850	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 28,148,372	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		21,654,026	12
13	Land		3,082,966	13
14	Buildings, at Historical Cost		38,930,410	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		11,644,669	16
17	Accumulated Depreciation (book methods)		(35,105,655)	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)	\$	\$ 40,206,416	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 68,354,788	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 4,223,100	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		477,527	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			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)	\$	\$ 4,700,627	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,069,158	39
40	Mortgage Payable		312,266	40
41	Bonds Payable			41
42	Deferred Compensation		8,751,382	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 11,132,806	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 15,833,433	46
47	TOTAL EQUITY(page 18, line 24)	\$ 52,521,355	\$ 52,521,355	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 52,521,355	\$ 68,354,788	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 52,755,998	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 52,755,998	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(234,643)	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)	\$ (234,643)	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)	\$ 52,521,355	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number TRINITY LIVING CENTER 1

0034900

Report Period Beginning: 07/01/24

Ending:

06/30/25

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,254,642	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,254,642	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			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,254,642	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	254,058	31
32	Health Care	898,334	32
33	General Administration	235,645	33
	B. Capital Expense		
34	Ownership	32,404	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	68,844	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,489,285	40
41	Income before Income Taxes (line 30 minus line 40)**	(234,643)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (234,643)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,057,996.96	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify) Social Security Benefits	196,644.74	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,254,642	56

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	3,458	3,869	128,370	33.18	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	480	480	9,804	20.43	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,894	4,324	139,539	32.27	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	365	365	8,311	22.77	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,825	1,825	41,555	22.77	18
19	Laundry	2,190	2,190	49,866	22.77	19
20	Administrator	461	540	25,006	46.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	896	1,048	19,762	18.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	1,177	1,378	39,222	28.46	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	16,504	19,802	450,904	22.77	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	31,250	35,821	\$ 912,339 *	\$ 25.47	34

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	19	\$ 1,530	1:3	35
36	Medical Director	as needed	15,733	9:3	36
37	Medical Records Consultant				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) Psychologist	as needed	7,375	9:3	46
47	Other Contract Residential Aide	1,444	57,767	10:3	47
48					48
49	TOTAL (lines 35 - 48)	1,463	\$ 82,405		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberTRINITY LIVING CENTER 1# 0034900Report Period Beginning:07/01/24Ending:06/30/25Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

LISA DILON

ADMIN FTE 50%

\$ 12,424

KIMBERLY KWAK

ADMIN FTE 50%

12,582

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 25,006

B. Administrative - Other

Description

Amount

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

ADP

Payroll Processing

\$ 3,675

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 3,675

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 6,631

Unemployment Compensation Insurance

FICA Taxes

68,620

Employee Health Insurance

68,111

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Retirement

28,750

Staff Incentive/Merit Plan

576

Allocated Benefits - Admin

62,683

Allocated Benefits - Maint

7,277

TOTAL (agree to Schedule V, line 22, col.8)

\$ 242,648

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$

Advertising: Employee Recruitment

Health Care Worker Background Check

46

(Indicate # of checks performed 2)

Patient Background Checks

Association Dues (total from pg 22, #4)

Fines and Fees

3,946

Allocated Subscription - Admin

1,282

Subscription & Reference

Less: Public Relations Expense

()

PAC and Lobbying payments

()

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 5,274

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

Allocated Seminars/Travel - Admin

1,518

Allocated Seminars/Travel - Maint

9,730

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 11,248

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name

Amount

Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$

N/A

Line
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

68,844

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

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.

\$
- (12)

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.

\$

Zero

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?

Yes

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

Zero
- (13)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

Cukierski & Associates, LLC
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

One administrator oversees the Trinity Living Centers (#1 & #2). In Fiscal Year 2025, Lisa Dillon held the position as Administrator from July 1, 2024 to December 3, 2024. Kimberly Kwak held the position as Administrator from December 4, 2024 to June 30, 2025.

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 TO RECONCILE
P 19 L 43

NET INCOME TLC #1	(\$234,643.00)
NET INCOME ALL OTHER DEPTS	<u>\$4,068,814.17</u>
TOTAL NET INCOME PER FEDERAL TAX RETURN	\$3,834,171.17