		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: 0034918

Facility Name: TRINITY LIVING CENTER 2

Address: 3302 HORSESHOE LANE (Number) JOLIET (City) 60432 (Zip Code)

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		[ ] PROPRIETARY		[ ] GOVERNMENTAL	
	[X] Charitable Corp.		[ ] Individual		[ ] State
	[ ] Trust		[ ] Partnership		[ ] County
IRS Exemption Code 501c3			[ ] Corporation		[ ] Other
			[ ] "Sub-S" Corp.		
			[ ] Limited Liability Co.		
			[ ] Trust		
			[ ] 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) (Date)
(Type or Print Name) Michele Pink
(Title) Budget Analyst

Paid Preparer
(Signed) (Date)
(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 2 # 0034918 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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	Patient Days by Level of Care and Primary Source of Payment								
		2 Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI Medicaid Primary	5 MMAI Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS	5,507							5,507	13
14	TOTALS	5,507							5,507	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 94.30%

D. How many bed reserve days during this year were paid by the Department? 171 (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 [X]

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

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 [X] Date 10/16/1990 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter certified beds.
number of certified beds

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/25 Fiscal Year: 06/30/25

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

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 **Report Period Beginning:** 07/01/24 **Ending:** 06/30/25

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	8,006		1,530	9,536		9,536		9,536			1
2	Food Purchase		84,166		84,166		84,166		84,166			2
3	Housekeeping	40,033	20,483		60,516		60,516		60,516			3
4	Laundry	48,039			48,039		48,039		48,039			4
5	Heat and Other Utilities			9,399	9,399		9,399	6,179	15,578			5
6	Maintenance		2,997	20,081	23,078		23,078		23,078			6
7	Other (specify):*											7
8	**TOTAL General Services**	96,078	107,646	31,010	234,734		234,734	6,179	240,913			8
	B. Health Care and Programs											
9	Medical Director			21,925	21,925		21,925		21,925			9
10	Nursing and Medical Records	128,370	4,754	7,553	140,677		140,677		140,677			10
10a	Therapy											10a
11	Activities	632,724	17,362		650,086		650,086		650,086			11
12	Social Services											12
13	CNA Training	9,864	15,218		25,082		25,082		25,082			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	770,958	37,334	29,478	837,770		837,770		837,770			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			2,522	2,522		2,522	1,282	3,804			20
21	Clerical & General Office Expenses	19,762	1,725	2,609	24,096		24,096	61,459	85,555			21
22	Employee Benefits & Payroll Taxes			173,238	173,238		173,238	69,960	243,198			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	1,725	188,395	234,888		234,888	325,718	560,606			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	911,804	146,705	248,883	1,307,392		1,307,392	331,897	1,639,289			29

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

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

Facility Name & ID Number TRINITY LIVING CENTER 2 #0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			11,163	11,163		11,163	7,097	18,260			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			200	200		200	2,386	2,586			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			11,363	11,363		11,363	9,483	20,846			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			75,508	75,508		75,508		75,508			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			75,508	75,508		75,508		75,508			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	911,804	146,705	335,754	1,394,263		1,394,263	341,380	1,735,643			45

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

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

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		52	

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	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$		37

***These costs are only allowable if they are necessary to meet minimun 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

TRINITY LIVING CENTER 2

ID# 0034918

Report Period Beginning: 07/01/24

Ending: 06/30/25

	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
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

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 #2	JOLIET			
501c3	100	TRINITY LIVING CENTER #1	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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

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

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 2 # 0034918 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 offic or parent organization costs? (See instructions.) YES [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 OFFICI	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 OFFICI	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

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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.)**

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

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**

	FOR BHF USE ONLY		
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 2 COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0034918

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 provide copies of their original **second installment** tax bill.

Facility Name & ID Numb TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

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?** [X] **(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?** [X] **(a) Own the Equipment** [ ] **(b) Rent equipment from a Related Organization.** [ ] **(c) Rent equipment from Completely Unrelated Organization.**

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

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

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

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RESIDENTIAL	21,780	1984	$	1
2					2
3	TOTALS	21,780		$	3

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1990	1990	$ 593,688	$	30	$	$	$ 593,688	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REMOVE & REPLACE CONCRETE PATIO			2019	4,540		10	454	454	2,497	9
10	TILE FLOOR IN BEDROOM NOS. 109, 115, 118, 119, 126,			2019	11,782		10	1,178	1,178	6,479	10
11	143, 136, AND 137										11
12	INSTALL CONCRETE SIDEWALK			2020	2,330		10	233	233	1,049	12
13	IONIZATION UNITS IN UTILITY ROOM			2020	3,735		10	374	374	1,682	13
14	6 WALL HUNG LAVATORIES, NEW KITCHEN CABINETS			2022	77,512		20	3,876	3,876	13,565	14
15	INSTALLED, NEW WINDOWS INSTALLED IN ENTIRE										15
16	FACILITY										16
17	NEW ROOF ON BUILDING			2024	59,826		10	2,991	2,991	2,991	17
18	NEW TRIM ON WINDOWS IN ENTIRE FACILITY			2025	22,448		10	1,122	1,122	1,122	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

*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

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		$ 775,861	$		$ 10,228	$ 10,228	$ 623,073	70

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

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

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	$ 6,533	$	$ 935	$ 935		$ 2,964	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 6,533	$	$ 935	$ 935		$ 2,964	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)	$ 782,394	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)	$ 11,163	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,163	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 626,037	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.

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

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? ☐ YES ☐ NO
   If NO, see instructions.

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

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2026	$
13.	/2027	$
14.	/2028	$

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.

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] 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: 40
- IN OTHER FACILITY:
- COMMUNITY COLLEGE:
- HOURS PER CNA: 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM: 80
- IN OTHER FACILITY:
- HOURS PER CNA: 80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		3,288		3,288
4	Clinical Wages (b)		6,576		6,576
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 9,864	$	$ 9,864
10	SUM OF line 9, col. 1 and 2 (e)	$ 9,864			

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

(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.

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

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

	1	2		3	4	5	6	7	8	
	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.

Facility Name & ID Number TRINITY LIVING CENTER 2 **#** 0034918 **Report Period Beginning:** 07/01/24 **Ending:** 06/30/25

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/25 **(last day of reporting year)**

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

		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.)**

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 52,622,331	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 52,622,331	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(100,976)	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)**	$ (100,976)	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 2 # 0034918 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,293,287	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,293,287	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)**	$ 1,293,287	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	234,734	31
32	Health Care	837,770	32
33	General Administration	234,888	33
	B. Capital Expense		
34	Ownership	11,363	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	75,508	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,394,263	40
41	**Income before Income Taxes (line 30 minus line 40)****	(100,976)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (100,976)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 1,107,156.70	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**	186,130.31	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)	$ 1,293,287	56

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 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	9,864	20.55	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,894	4,325	139,539	32.26	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	365	365	8,006	21.93	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,825	1,825	40,033	21.94	18
19	Laundry	2,190	2,190	48,039	21.94	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)	1,856	2,080	62,242	29.92	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	17,079	19,646	430,943	21.94	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	32,504	36,368	$ 911,804 *	$ 25.07	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	19	$ 1,530	1:3	35
36	Medical Director	as needed	14,551	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	7,374	9:3	46
47	Other Contract Residential Aide	188	7,553	10:3	47
48					48
49	TOTAL (lines 35 - 48)	207	$ 31,008		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

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	68,820
Employee Health Insurance	67,951
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement	28,750
Staff Incentive/Merit Plan	1,086
Allocated Benefits - Admin	62,683
Allocated Benefits - Maint	7,277
TOTAL (agree to Schedule V, line 22, col.8)	$ 243,198

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	23
(Indicate # of checks performed 1)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	
Fines and Fees	2,489
Allocated Subscription - Admin	1,282
Subscription & Reference	10
Less: Public Relations Expense	( )
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,804

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	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,248

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number TRINITY LIVING CENTER 2 # 0034918 Report Period Beginning: 07/01/24 Ending: 06/30/25

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 expens 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. $ 75,508
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 t the Department, in addition to the daily rate, been properly classifie 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 agains 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 othe 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

TRINITY SERVICES, INC
SUPPLEMENTAL SCHEDULE
PAGE 22, QUESTION 8 - SALARY ALLOCATION

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:

FUNCTION	Average Hours per Day
Cook Helper	1
Housekeeping	5
Laundry	6

TRINITY SERVICES, INC

SCHEDULE TO RECONCILE
P 19 L 43

NET INCOME TLC #2	($100,976.00)
NET INCOME ALL OTHER DEPTS	$4,068,814.17
TOTAL NET INCOME PER FEDERAL TAX RETURN	$3,967,838.17