

Facility Name & ID Number TRINITY LIVING CENTER #2

0034918 Report Period Beginning: 7/1/14 Ending: 6/30/15

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	5,434			5,434
14	TOTALS	5,434			5,434

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.05%

D. How many bed-hold days during this year were paid by the Department? 255 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/17/1990

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/16/1990 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/15 Fiscal Year: 6/30/15

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

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	4,011		1,575	5,586	5,586		5,586		1	
2	Food Purchase		65,459		65,459	65,459		65,459		2	
3	Housekeeping	20,057	20,207		40,264	40,264		40,264		3	
4	Laundry	24,068			24,068	24,068		24,068		4	
5	Heat and Other Utilities			7,147	7,147	7,147	4,258	11,405		5	
6	Maintenance		8,835	16,751	25,586	25,586		25,586		6	
7	Other (specify):*									7	
8	TOTAL General Services	48,136	94,501	25,473	168,110	168,110	4,258	172,368		8	
	B. Health Care and Programs										
9	Medical Director			13,358	13,358	13,358		13,358		9	
10	Nursing and Medical Records	30,696	1,325	160	32,181	32,181		32,181		10	
10a	Therapy									10a	
11	Activities	305,894	2,446		308,340	308,340		308,340		11	
12	Social Services									12	
13	CNA Training	1,320			1,320	1,320		1,320		13	
14	Program Transportation		3,773		3,773	3,773		3,773		14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	337,910	7,544	13,518	358,972	358,972		358,972		16	
	C. General Administration										
17	Administrative	24,808			24,808	24,808	76,358	101,166		17	
18	Directors Fees									18	
19	Professional Services			4,558	4,558	4,558	13,262	17,820		19	
20	Dues, Fees, Subscriptions & Promotions			1,685	1,685	1,685	192	1,877		20	
21	Clerical & General Office Expenses	7,642	1,386	1,559	10,587	10,587	24,470	35,057		21	
22	Employee Benefits & Payroll Taxes			89,214	89,214	89,214	29,278	118,492		22	
23	Inservice Training & Education									23	
24	Travel and Seminar			241	241	241	5,103	5,344		24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			5,427	5,427	5,427	1,544	6,971		26	
27	Other (specify):*									27	
28	TOTAL General Administration	32,450	1,386	102,684	136,520	136,520	150,207	286,727		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	418,496	103,431	141,675	663,602	663,602	154,465	818,067		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:

7/1/14

Ending:

6/30/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			30,450	30,450	30,450	10,380	40,830				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,794	8,794	8,794	2,019	10,813				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			39,244	39,244	39,244	12,399	51,643				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,668	49,668	49,668		49,668				42
43	Other (specify):* DT Transport		4,571		4,571	4,571		4,571				43
44	TOTAL Special Cost Centers		4,571	49,668	54,239	54,239		54,239				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	418,496	108,002	230,587	757,085	757,085	166,864	923,949				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: **7/1/14**

Ending: **6/30/15**

VI. ADJUSTMENT DETAIL

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

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

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

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

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

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

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

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

BHF USE ONLY						
48		49		50		51
						52

TRINITY LIVING CENTER #2

ID# 0034918

Report Period Beginning: 7/1/14

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TRINITY LIVING CENTER #2# 0034918

Report Period Beginning:

7/1/14

Ending:

6/30/15

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TRINITY LIVING CENTER #2

0034918

Report Period Beginning:

7/1/14

Ending:

6/30/15

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

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			
	100	TRINITY LIVING CENTER #3	JOLIET			

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		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)	
		Item							
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:

7/1/14

Ending:

6/30/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number TRINITY LIVING CENTER #2 # 0034918 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 #2

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7/1/14

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	ADMINISTRATION				\$	\$		\$	1
2	5 UTILITIES	PROGRAM SIZE	100		78,296		4	3,132	2
3	17 ADMIN SALARIES	PROGRAM SIZE	100		1,604,142	1,604,142	4	64,166	3
4	19 PROFESSIONAL SERVICES	PROGRAM SIZE	100		331,554		4	13,262	4
5	20 SUBSCRIPTIONS	PROGRAM SIZE	100		4,808		4	192	5
6	21 CLERICAL/GENERAL OFFICE	PROGRAM SIZE	100		468,917		4	18,757	6
7	22 BENEFITS & PR TAXES	PROGRAM SIZE	100		668,713		4	26,749	7
8	24 TRANSPORTATION	PROGRAM SIZE	100		25,951		4	1,038	8
9	26 INSURANCE	PROGRAM SIZE	100		38,606		4	1,544	9
10	30 DEPRECIATION	PROGRAM SIZE	100		225,676		4	9,027	10
11	32 INTEREST	PROGRAM SIZE	100		50,480		4	2,019	11
12	MAINTENANCE								12
13	5 UTILITIES	PROGRAM SIZE	100		28,162		4	1,126	13
14	17 MAINT SALARIES	PROGRAM SIZE	100		304,807	304,807	4	12,192	14
15	21 CLERICAL/GENERAL OFFICE	PROGRAM SIZE	100		142,814		4	5,713	15
16	22 BENEFITS & PR TAXES	PROGRAM SIZE	100		63,229		4	2,529	16
17	24 TRANSPORTATION	PROGRAM SIZE	100		101,628		4	4,065	17
18	30 DEPRECIATION	PROGRAM SIZE	100		33,836		4	1,353	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,171,619	\$ 1,908,949		\$ 166,864	25

Facility Name & ID Number

TRINITY LIVING CENTER #2

0034918

Report Period Beginning:

7/1/14

Ending:

6/30/15

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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	IDFA 1997 BOND		X	REFINANCED 1990 BOND	EST 5,129	7/97	\$ 663,334	\$	7/2019	0.0588	\$ 8,794	1						
2				FOR ORIGINAL								2						
3				CONSTRUCTION								3						
4												4						
5												5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 663,334	\$			\$ 8,794	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 663,334	\$			\$ 8,794	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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2014 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 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2010	_____	8	FOR BHF USE ONLY		
	2011	_____	9			
	2012	_____	10			
	2013	_____	11			
	2014	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2014 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

2014 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 2014 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 2014.

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

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 a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Number TRINITY LIVING CENTER #2

0034918 Report Period Beginning:

7/1/14 Ending:

6/30/15

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

TLC #3 / ICF / 5,494 SQ FT / 16 BEDS AVAILABLE

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

1. Total Amount Incurred: _____ 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	<u>RESIDENTIAL</u>	<u>21,780</u>	<u>1984</u>	\$	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	\$ 19,404	\$ 19,404	\$ 488,584	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	TILE REPLACED	1995		2,161		7			2,161	9
10	FLOOR REPLACED	1998		11,409		7			11,409	10
11	PAINTING AND STAINING	1998		19,547		7			19,547	11
12	ASPHALT	1999		1,570		7			1,570	12
13	CARPET	2003		613		7			613	13
14	CONDENSOR	2003		2,688		10			2,688	14
15	PAINTING AND STAINING	2003		2,400		10			2,400	15
16	WATER SOFTENER	2004		3,695		10			3,695	16
17	CARPET	2004		1,047		10	53	53	1,047	17
18	FLOORING	2007		10,045		10	1,004	1,004	8,539	18
19	BATHROOM & KITCHEN REMODELING	2007		30,808		10	3,081	3,081	26,183	19
20	CARPET & TILE	2007		13,799		10	1,380	1,380	10,349	20
21	PAVING	2009		2,100		10	210	210	1,365	21
22	HEATER	2011		4,161		10	416	416	1,872	22
23	CONCRETE	2012		7,857		10	786	786	2,751	23
24	FURNACE & A/C	2013		18,783		10	1,878	1,878	4,695	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:

7/1/14

Ending:

6/30/15

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 726,371	\$		\$ 28,212	\$ 28,212	\$ 589,468	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	\$ 14,112	\$	\$ 2,016	\$ 2,016		\$ 12,735	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	19,196		222	222		19,196	73
74								74
75	TOTALS	\$ 33,308	\$	\$ 2,238	\$ 2,238		\$ 31,931	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)	\$ 759,679	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,450	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 30,450	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 621,399	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: 7/1/14 Ending: 6/30/15
 XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	660	330		990
4	Clinical Wages (b)		330		330
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 660	\$ 660	\$	\$ 1,320
10	SUM OF line 9, col. 1 and 2 (e)	\$ 1,320			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	3

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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: 7/1/14

Ending:

6/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/15 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$ 8,529,030	1
2	Cash-Patient Deposits		268,343	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		4,313,618	3
4	Supply Inventory (priced at)		698,466	4
5	Short-Term Investments			5
6	Prepaid Insurance		328,002	6
7	Other Prepaid Expenses		138,321	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$ 14,275,780	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		462,446	12
13	Land		2,959,840	13
14	Buildings, at Historical Cost		27,830,675	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		7,820,849	16
17	Accumulated Depreciation (book methods)		(19,408,262)	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)	\$	\$ 19,665,548	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$ 33,941,328	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 967,036	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		268,343	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)	\$	\$ 1,235,379	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		1,610,222	39
40	Mortgage Payable		3,150,523	40
41	Bonds Payable			41
42	Deferred Compensation		4,055,716	42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,816,461	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$ 10,051,840	46
47	TOTAL EQUITY(page 18, line 24)	\$ 23,889,488	\$ 23,889,488	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 23,889,488	\$ 33,941,328	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 23,781,832	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 23,781,832	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	107,656	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)	\$ 107,656	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)	\$ 23,889,488	24 *

* This must agree with page 17, line 47.

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	\$ 864,741	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 864,741	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)	\$ 864,741	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	168,110	31
32	Health Care	358,972	32
33	General Administration	136,520	33
B. Capital Expense			
34	Ownership	39,244	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	49,668	36
D. Other Expenses (specify):			
37	<u>DT Transport</u>	4,571	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 757,085	40
41	Income before Income Taxes (line 30 minus line 40)**	107,656	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 107,656	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 738,283	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Social Security Benefits</u>	126,458	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 864,741	49

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

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

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

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

Facility Name & ID Number TRINITY LIVING CENTER #2

0034918

Report Period Beginning:

7/1/14

Ending:

6/30/15

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	1,329	1,671	30,696	18.37
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees	160	160	1,320	8.25
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	2,819	3,155	45,003	14.26
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	365	365	4,011	10.99
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	1,825	1,825	20,057	10.99
19	Laundry	2,190	2,190	24,068	10.99
20	Administrator	626	693	12,000	17.32
21	Assistant Administrator	455	693	12,808	18.48
22	Other Administrative				22
23	Office Manager				23
24	Clerical	588	693	7,642	11.03
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,676	1,784	24,015	13.46
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	18,479	21,553	236,876	10.99
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	30,512	34,782	\$ 418,496 *	\$ 12.03

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	35	\$ 1,575	1:3
36	Medical Director	as needed	11,358	9:3
37	Medical Records Consultant			
38	Nurse Consultant			
39	Pharmacist Consultant			
40	Physical Therapy Consultant			
41	Occupational Therapy Consultant			
42	Respiratory Therapy Consultant			
43	Speech Therapy Consultant			
44	Activity Consultant			
45	Social Service Consultant			
46	Other(specify) <u>Psychologist</u>	as needed	2,000	9:3
47				
48				
49	TOTAL (lines 35 - 48)	35	\$ 14,933	

C. CONTRACT NURSES

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

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

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

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 49,668
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
 - 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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Cukierski & Kowal, LLC
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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 23, QUESTION 12 - SALARY ALLOCATION

One administrator and admin assistant oversee the Trinity Living Centers (#1, #2 & #3). In Fiscal Year 2015, Jamie Kovalcik held the administrator position and Valerie Easter held the admin assistant position. In addition, in order for the facilities to run properly and to comply with all of the various rules and regulations, habilitation aides must also perform the following duties for the period of time indicated:

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

TRINITY SERVICES, INC

SCHEDULE TO RECONCILE

P 19 L 43

NET INCOME TLC #2	\$ 107,656.00
NET INCOME ALL OTHER DEPTS	<u>\$ 3,952,894.00</u>
TOTAL NET INCOME PER FEDERAL TAX RETURN	\$ 4,060,550.00