

Facility Name & ID Number Nature Trail Healthcare Center

0045765 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	19	Skilled (SNF)	19	6,935	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,075	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	20	0	5,329	5,349	8
9	SNF/PED					9
10	ICF	12,154	4,431	429	17,014	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,174	4,431	5,758	22,363	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.80%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 06/07/1994

J. Was the facility purchased or leased after January 1, 1978?
YES Date 06/07/1994 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 19 and days of care provided _____

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number Nature Trail Healthcare Center # 0045765 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	127,471	11,763	8,463	147,697		147,697		147,697		1
2	Food Purchase		99,621		99,621	(1,013)	98,608		98,608		2
3	Housekeeping	79,266	8,213		87,479		87,479		87,479		3
4	Laundry	36,504	5,111	167	41,782		41,782		41,782		4
5	Heat and Other Utilities			63,817	63,817		63,817	30	63,847		5
6	Maintenance	19,591	28,179	50	47,820		47,820	117	47,937		6
7	Other (specify):* Waste Garbage See pg 3.1			19,164	19,164		19,164		19,164		7
8	TOTAL General Services	262,832	152,887	91,661	507,380	(1,013)	506,367	147	506,514		8
	B. Health Care and Programs										
9	Medical Director			6,669	6,669		6,669		6,669		9
10	Nursing and Medical Records	998,449	73,480	21,834	1,093,763		1,093,763	9,591	1,103,354		10
10a	Therapy	368,396	36,655	5,108	410,159		410,159		410,159		10a
11	Activities	31,322	3,197	2,276	36,795		36,795		36,795		11
12	Social Services	6,407	421	2,276	9,104		9,104		9,104		12
13	CNA Training										13
14	Program Transportation			3,419	3,419	(3,419)					14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,404,574	113,753	41,582	1,559,909	(3,419)	1,556,490	9,591	1,566,081		16
	C. General Administration										
17	Administrative	70,703			70,703		70,703		70,703		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			30,318	30,318		30,318	(3,222)	27,096		20
21	Clerical & General Office Expenses	80,304	9,987	333,697	423,988		423,988	(55,137)	368,851		21
22	Employee Benefits & Payroll Taxes			522,720	522,722	1,013	523,735	(1,013)	522,722		22
23	Inservice Training & Education										23
24	Travel and Seminar			43,059	43,059		43,059	8,730	51,789		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			64,816	64,816		64,816	(60,580)	4,236		26
27	Other (specify):*										27
28	TOTAL General Administration	151,007	9,987	994,610	1,155,606	1,013	1,156,619	(111,222)	1,045,397		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,818,413	276,627	1,127,853	3,222,895	(3,419)	3,219,476	(101,484)	3,117,992		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.

STATE OF ILLINOIS

Report Period:

Beginning: 1/1/2005

Page -3.1

Facility Name & ID Number Nature Trail Health Care Center

#

0039586

Ending: 12/31/2005

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7

Amount

Infectious Waste Disposal <> Default <> Nursing Admin/Supv	17,513
Infectious Waste Disposal <> Default <> Physical Plant	0
Garbage Service<>Default<>Prod<>Physical Plant	1,651
Garbage Service <> Default <> Physical Plant	0
	<u>19,164</u>

Health Care Program - Line 15

Amount

N/A

0

General & Administrative - Line 27

Amount

N/A

0

Inservice Education - Line 23 Column 3 (over \$2,000)

Amount

N/A

0

STATE OF ILLINOIS

Report Period: Beginning: 1012005
Ending: 12/31/2005

Facility Name & ID Number Nature Trail Health Care Center # 0039586

Meals - adjustment

22,363 Days (Total Patient days)
3 Mult (3 meals a day)
67089 Sub total
690 meals to employess (reported by facility)
67779 Add Sub
99,502 Divide -Pg 3, line 2, column 2
1.47 Cost per day

1.47 Cost per day
690 mult - meal to employees
1013 = adjust for pg 2, line 2, column2

Sales Tax - adjustment

99,621 Total Food Cost (page 3,Line 2, col 3)
0.01 Mult
996.21 Sub total
24.48% Mult (Pvt pay div by total census)
244 = adjust for nonallowable sale tax
for page 5A,

122 = adjust for nonallowable sale tax

Reclassification V

Page 3 Line 14
Res/Client Transportation<>Default<>Prod<>Transport 810004000003850
Page 4 line 38

(3,419) Reclass From
3,419 Reclass to

Facility Name & ID Number

Nature Trail Healthcare Center

#0045765

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			3,179	3,179		3,179		3,179			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(231)	(231)		(231)	231				32
33	Real Estate Taxes							736	736			33
34	Rent-Facility & Grounds			338,949	338,949		338,949	(56,343)	282,606			34
35	Rent-Equipment & Vehicles			333	333		333	7,184	7,517			35
36	Other (specify):*							9,181	9,181			36
37	TOTAL Ownership			342,230	342,230		342,230	(39,011)	303,219			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					3,419	3,419		3,419			38
39	Ancillary Service Centers		181,478	1,122	182,600		182,600	14,396	196,996			39
40	Barber and Beauty Shops			4,580	4,580		4,580	(4,580)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):* X-Ray/Lab Pg 4.1			11,718	11,718		11,718		11,718			43
44	TOTAL Special Cost Centers		181,478	57,935	239,413	3,419	242,832	9,816	252,648			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,818,413	458,105	1,528,018	3,804,538		3,804,538	(130,679)	3,673,859			45

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

STATE OF ILLINOIS

Report Period: Beginning: 1012005
Ending: 12/31/2005

Facility Name & ID Number Nature Trail Health Care Center # 0039586

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

<u>Ownership - Line 36</u>	<u>Amount</u>
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	0
	-

<u>Ancillary Expenses - Line 43 -Column 2</u>	<u>Amount</u>
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	0
	0

<u>Ancillary Expenses - Line 43 -Column 3</u>	<u>Amount</u>
Contract Svcs - Chgbl <> Default <> Laboratory	0
Consulting / Prof Svcs-Laboratory-Other Medical Professionals	10,742
Consulting / Prof Svcs-X/Ray-Other Medical Professionals	976
Contract Svcs - Chgbl <> Default <> X/Ray	0
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services - NonchgPhysicianX/Ray	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	0
Professional Services <> Nonchg<>Medical Director<>Laboratory	0
Professional Services <> Nonchg<>Medical Director<>X/Ray	0
Professional Services Chgble <> Default <> X/Ray	-
<u>Professional Services Chgble <> General / Other <> X/Ray</u>	<u>0</u>
	<u>11,718</u>

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,013)	22		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	231	32		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	(105,267)			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	(256,291)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (362,340)		\$	30

OHF 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	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))	\$ (362,340)		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.			\$ 3,419	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	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 3,419	47

Nature Trail Healthcare Center

ID# 0045765

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sales Taxes	\$ (728)	21	1
2	Small Balance Adjustment		21	2
3	Memorium/ Benevolance	(776)	21	3
4	Depreciation Reconciliation		30	4
5	Activities Program Receipts		11	5
6	Barber & beauty	(4,580)	40	6
7	Professional liability Insurance	(60,580)	26	7
8	Barber & beauty		40	8
9	Public Relations Expenses		20	9
10	Non Allowable Advertising	(3,829)	20	10
11	Entertainment		24	11
12	Fresh Start		36	12
13	Civic Dues		20	13
14	Penalties		21	14
15	Vending reciepts	(655)	21	15
16	Misc Reciepts	(35)	21	16
17	Marketing Wages		21	17
18	Marketing Bonus		21	18
19	Marketing Holiday		21	19
20	Maketing Sick		21	20
21	Marketing Vacation		21	21
22	Marketing Overtime		21	22
23	Marketing Non Worked Wages		21	23
24	Donations/ Contributions		21	24
25	Legal Fees - Bankruptcy		21	25
26	Legal Structure Management Fees	(181,929)	21	26
27	Property Tax Adjustment to Actual		33	27
28	Travel logs missing		24	28
29				29
30	Transporation		38	30
31	Rent Averaging	-56359	34	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	(309,471)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Nature Trail Healthcare Center# 0045765

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
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	30	0	0	0	0	0	0	0	0	0	30	5
6	Maintenance	0	117	0	0	0	0	0	0	0	0	0	117	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	147	0	0	0	0	0	0	0	0	0	147	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	9,591	0	0	0	0	0	0	0	0	0	9,591	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	9,591	0	0	0	0	0	0	0	0	0	9,591	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	(3,829)	607	0	0	0	0	0	0	0	0	0	(3,222)	20
21	Clerical & General Office Expenses	(184,123)	128,986	0	0	0	0	0	0	0	0	0	(55,137)	21
22	Employee Benefits & Payroll Taxes	(1,013)	0	0	0	0	0	0	0	0	0	0	(1,013)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	8,730	0	0	0	0	0	0	0	0	0	8,730	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(60,580)	0	0	0	0	0	0	0	0	0	0	(60,580)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(249,545)	138,323	0	0	0	0	0	0	0	0	0	(111,222)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(249,545)	148,061	0	0	0	0	0	0	0	0	0	(101,484)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Nature Trail Healthcare Center# 0045765

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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	231	0	0	0	0	0	0	0	0	0	0	231	32
33	Real Estate Taxes	0	736	0	0	0	0	0	0	0	0	0	736	33
34	Rent-Facility & Grounds	(56,359)	16	0	0	0	0	0	0	0	0	0	(56,343)	34
35	Rent-Equipment & Vehicles	0	7,184	0	0	0	0	0	0	0	0	0	7,184	35
36	Other (specify):*	0	9,181	0	0	0	0	0	0	0	0	0	9,181	36
37	TOTAL Ownership	(56,128)	17,117	0	(39,011)	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	14,396	0	0	0	0	0	0	0	0	0	14,396	39
40	Barber and Beauty Shops	(4,580)	0	0	0	0	0	0	0	0	0	0	(4,580)	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	(4,580)	14,396	0	9,816	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(310,253)	179,574	0	(130,679)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SSC Equity Holdings LLC	100	See Attachment Page 6.1		Sava Senior Care	Atlanta, GA.	Management

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	5 Utilities	\$	SSC Equity Holdings LLC	100.00%	\$ 30	\$	30	1
2	V	6 Repair & Maintenance		SSC Equity Holdings LLC	100.00%	117		117	2
3	V	39 Professional Services		SSC Equity Holdings LLC	100.00%	14,396		14,396	3
4	V	20 Fees, Subscriptions, Promotions		SSC Equity Holdings LLC	100.00%	607		607	4
5	V	10 Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	9,591		9,591	5
6	V	21 Clerical & General Office Exp		SSC Equity Holdings LLC	100.00%	128,986		128,986	6
7	V	24 Travel & Seminar		SSC Equity Holdings LLC	100.00%	8,730		8,730	7
8	V	26 Insurance Premium		SSC Equity Holdings LLC	100.00%				8
9	V	36 Depreciation		SSC Equity Holdings LLC	100.00%	9,181		9,181	9
10	V	33 Taxes - Property		SSC Equity Holdings LLC	100.00%	736		736	10
11	V	35 Rental & Leasing		SSC Equity Holdings LLC	100.00%	7,184		7,184	11
12	V	34 Lease Expense		SSC Equity Holdings LLC	100.00%	16		16	12
13	V	26 Property Insurance		SSC Equity Holdings LLC	100.00%				13
14	Total		\$			\$ 179,574	\$ *	179,574	14

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

**Related Illinois Nursing Homes
as of
12/31/2005**

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
------------	--------------------------------	--------------------------

SSC Equity Holdings LLC

Montebello Healthcare Center	0031468
Nature Trail HealthCare Center	0039586
Odin HealthCare Center	0039503
Mariner Health of Westchester	0042374

Facility Name & ID Number

Nature Trail Healthcare Center

#

0045765

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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 Nature Trail Healthcare Center

0045765 Report Period Beginning: 01/01/2005

Ending: 2/31/2005

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 SSC Equity Holdings LLC
 Street Address One Ravine Dr. Suite 1500
 City / State / Zip Code Atlanta, GA 30346
 Phone Number (770) 379-8203
 Fax Number (770) 399-1971

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	5	Utilities	1		\$ 30	\$	1	\$ 30	1
2	6	Repair & Maintenance	1		117		1	117	2
3	39	Professional Services	1		14,396		1	14,396	3
4	20	Fees, Subscriptions, Promotions	1		607		1	607	4
5	10	Nursing & Medical Records	1		9,591		1	9,591	5
6	21	Clerical & General Office Exp	1		128,986		1	128,986	6
7	24	Travel & Seminar	1		8,730		1	8,730	7
8	26	Insurance Premium	1				1	0	8
9	36	Depreciation	1		9,181		1	9,181	9
10	33	Taxes - Property	1		736		1	736	10
11	35	Rental & Leasing	1		7,184		1	7,184	11
12	34	Lease Expense	1		16		1	16	12
13	26	Property Insurance							13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 179,574	\$		\$ 179,574	25

Facility Name & ID Number

Nature Trail Healthcare Center

0045765

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$				\$						
2																		
3																		
4																		
5																		
	Working Capital																	
6																		
7																		
8																		
9	TOTAL Facility Related						\$	\$			\$							
	B. Non-Facility Related*																	
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$			\$							
15	TOTALS (line 9+line14)						\$	\$			\$							

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 2004 report.		\$	25,276	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.)		\$	21,783	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,493)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	12,580	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.		\$	9,087	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2000	19,494	8
	2001	19,329	9
	2002	19,726	10
	2003	19,979	11
	2004	21,783	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Nature Trail Healthcare Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0045765

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE 832-467-6244 FAX #: 832-467-6246

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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. <u>06-36-327-006</u>	<u>771-079-04-PT NE SW-BEG 330.6"</u>	\$ <u>21,782.64</u>	\$ <u>21,782.64</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>21,782.64</u>	\$ <u>21,782.64</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 X NO

If YES, attach an explanation & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Nature Trail Healthcare Center

0045765

Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,558 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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).

N/A

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>225,000</u>	<u>1994</u>	<u>\$ 50,246</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	225,000		\$ 50,246	3

Facility Name & ID Number Nature Trail Healthcare Center

0045765

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	74	1994		\$ 2,213,241	\$ 63,235	35	\$ 63,235	\$	\$ 668,362	4
5		1994		329,317	16,465	20	16,465		173,456	5
6										6
7										7
8										8
	Improvement Type**									
9	Interior Building Improvements	1995		2,325	233	20	233		2,428	9
10	Unit Heaters	1996		642	64	20	64		602	10
11	Flooring - Tile	1996		2,384	119	20	119		1,092	11
12	Heater BaseBoard - 6	1996		502	50	20	50		453	12
13	Drapes / Valances	1996		3,956	396	20	396		3,564	13
14	Smoke Detectors	1996		2,880	288	20	288		2,658	14
15	Sude rails	1996		1,149	57	20	57		479	15
16	Parking Repairs	1997		1,923	96	20	96		795	16
17	Wall Covering	1997		897	45	20	45		391	17
18	Gutters	1997		2,290	115	20	115		939	18
19	Beauty Salon	1997		1,040	52	20	52		430	19
20	Sewer Tile	1997		1,575	79	20	79		707	20
21	A/C Heater Unit	1997		591	59	20	59		480	21
22	Water Heater	1997		388	19	20	19		152	22
23	Floor Preparation	1997		650	33	20	33		290	23
24	Floor Covering	1997		1,460	73	20	73		643	24
25	Floor Finishing	1997		250	13	20	13		114	25
26	Water Heater	1997		388	39	20	39		318	26
27	Rebuilding Bathroom	1997		3,825	191	20	191		1,559	27
28	Cabinets / Millwork	1998		161	8	20	8		64	28
29	Heating / Ventilating	1998		592	30	20	30		184	29
30	5 - Heater W/Adapters #86	1999		2,269	227	20	227		1,437	30
31	Repair Water Leak - Kitchen #106	2000		1,334	67	20	67		373	31
32	Repair Water Line - Booster Heater #107	2000		986	49	20	49		274	32
33	See Attached 12.1 Supplemental				69,276			(69,276)		33
34	30 - Amp Filters, W/G System & Use Tax #110 & 111	2001		243	24	10	24		119	34
35	Wanderguard System #112	2001		6,263	626	10	626		3,078	35
36		2001		58	6	10	6		29	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

Facility Name & ID Number Nature Trail Healthcare Center

0045765

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Thru Wall Heat / Cool Units #116	2001	\$ 2,131	\$ 426	5	\$ 426	\$	\$ 1,847	37
38	Use Tax %: Thru Wall Heat /Cool Units #117	2001	149	30	5	30		129	38
39	3 Ton Condenser, East Wing & Use Tax 118 & 119	2001	861	57	15	57		257	39
40									40
41	Win Freezer Condenser Instl #123	2002	3,021	201	15	201		822	41
42	Instl Grease Interceptor #129	2002	4,871	243	20	243		993	42
43	Wanderguard System & Use Tax #132 & 133	2002	6,227	623	10	623		2,907	43
44	CR Inc # 1000017826/ Discount #134	2002	(22)	(2)	10	(2)		(10)	44
45	CR Inc # 1000017900 W/G System Discount #135	2002	(349)	(35)	10	(35)		(160)	45
46	Maglock Brackets #136	2002	151	15	10	15		70	46
47	Maglocks Brackets #137	2002	151	15	10	15		70	47
48	CR Inv 10015138 Corby Push #138	2002	(95)	(9)	10	(9)		(43)	48
49	Wanderguard System & Use Tax #5007 & 2008	2002	1,268	127	10	127		582	49
50	Cr - Labor charge Wanderguard #5009	2002	(1,200)	(120)	10	(120)		210	50
51	Charge Excess Discount Wanerguard #5010	2002	52	5	10	5		23	51
52	4: Heat / Cool Units Use Tax #5013 & 5014	2002	1,959	229	5	229		687	52
53	Rplc 5 ton AirHandler, Condenser #5021	2002	6,746	281	10	281		843	53
54									54
55	New Roof #5030	2003	23,935	2,394	10	2,394		7,380	55
56	Storage Building 10x21 #5031	2003	1,900	190	10	190		538	56
57	Rprc Russes - Kitchen #5034	2003	2,600	173	15	173		491	57
58	Fire Sprinkler Retrofit Apl # 5048	2003	4,644	128	25	128		256	58
59									59
60	Fire Suppression Syst- Kitchen	2204	1,275	128	10	128		256	60
61	Maglock-WanderGuard System	2004	1,493	75	10	75		150	61
62									62
63	Rpr Automatic Transfer Switch	2005	1,953	24	20	24		24	63
64	Rpr Automatic Transfer Switch	2005	2,029	59	20	59		59	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,649,330	\$ 157,291		\$ 88,015	\$ (69,276)	\$ 883,851	70

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

Facility Name & ID Number Nature Trail Healthcare Center

0045765

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 491,979	\$ 33,643	\$ 33,643	\$		\$ 218,644	71
72	Current Year Purchases	8,396	8,396	809	(7,587)		809	72
73	Fully Depreciated Assets		212,634		(212,634)			73
74								74
75	TOTALS	\$ 254,673	\$ 254,673	\$ 34,452	\$ (220,221)		\$ 219,453	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,954,249	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 411,964	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 122,467	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (289,497)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,103,304	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	O/H Allocation 06/01/1996	\$ 1,583	\$ 79	\$ 665	86
87	O/H Allocation 12/01/1996	568	28	231	87
88	O/H Allocation 08/01/1997	277	14	134	88
89	O/H Allocation 10/01/1997	965	48	368	89
90					90
91	TOTALS	\$ 3,393	\$ 169	\$ 1,398	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: SSC Submaster Holdings LLC

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:			<u>01/01/2005</u>	\$ <u>282,590</u>	<u>20</u>		3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>282,590</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 15,850 Description: See Attachment pg 14.1

(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	<u>N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning 01012005

Ending 12062024

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

Fiscal Year Ending Annual Rent

12. /2006 \$ _____

13. /2007 \$ _____

14. /2008 \$ _____

* 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.

STATE OF ILLINOIS

Report Period: Beginning: 12/1/2005

Page -14.1

Facility Name & ID Number

Nature Trail Health Care Center

0039586

Ending: 12/31/2005

SUPPLEMENTAL SCHEDULE - Page 14 -B -16 - EQUIPMENT -RENTAL MOVABLE

Name of G/L	G/L #	EQUIPMENT	Amount	Page/Line/Col Ref From
Lease Exp - Eqpt - Nonmedical <> Default <> NonCert	841000000001011	Specialty Mattress	6,636.00	03/10/03
Lease Exp - Eqpt - <> Default <> Equip Rental	841000000002102		1,221.00	03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Activities	841000000007000			03/11/03
Lease Exp - Eqpt - Nonmedical <> Default <> Dietary	841000000007030	Diswasher		03/01/03
Lease Exp - Eqpt - Nonmedical <> Default <> Housekeepin	841000000007040			03/03/03
Lease Exp - Eqpt - Nonmedical <> Default <> Laundry	841000000007050			03/04/03
Lease Exp - Eqpt - Nonmedical <> Default <> Nursing Adm	841000000008000	Mattress		03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Administrativ	841000000008100	Copies, Stamp machine Cable	7,660.00	03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plar	841000000008210			03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	841000000008220	Parking Lot	333.00	04/35/03
Lease Exp - Other <> Default <> Administrative	841020000008100			03/21/03
			15,850.00 Grand Total	

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 type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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

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

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

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

	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	10a-03	3817 hrs	\$ 90,450		\$		3,817	\$ 90,450	1
2	Licensed Speech and Language Development Therapist	10a-03	1930 hrs	60,565				1,930	60,565	2
3	Licensed Recreational Therapist	10a-03	hrs							3
4	Licensed Physical Therapist	10a-03	3995 hrs	89,305				3,995	89,305	4
5	Physician Care	39	visits							5
6	Dental Care	39	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				69,182		69,182	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 240,320		\$	\$ 69,182	9,742	\$ 309,502	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 Nature Trail Healthcare Center

0045765

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(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	\$ 400	\$	1
2	Cash-Patient Deposits	27,993		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	138,525		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	235		6
7	Other Prepaid Expenses	111,361		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 278,514	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,953		15
16	Equipment, at Historical Cost	7,499		16
17	Accumulated Depreciation (book methods)	(817)		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): <u>Lease Hold Rights</u>	47,150		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 55,785	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 334,299	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 151,161	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,163		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,106		31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,087		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attachment pg 17.1</u>	168,255		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 437,772	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attachment pg 17.1</u>	(2,610,443)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (2,610,443)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (2,172,671)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,506,970	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 334,299	\$	48

*(See instructions.)

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2005 Page -17.1

Facility Name & ID Number Nature Trail Health Care Center # 0039586

Ending: #####

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

<u>OTHER CURRENT ASSETS:</u>	<u>AMOUNT</u>	
	Total <u>0</u>	Difference
Reconcile with schedule XV, line 9:	<input style="width: 50px;" type="text" value="0"/>	<input style="width: 50px;" type="text" value="0"/>

<u>OTHER CURRENT LIABILITIES:</u>	<u>AMOUNT</u>	
Misc Dedctns - Employee <> Other Deductions <> Default	22	
Accruals - Insurance <> Accrue HMO Ins <> Default	22	
Accruals - Insurance <> Self Funded Ins Accr <> Default	53,485	
Accruals - Insurance <> Basic Life <> Default	504	
Accruals - Insurance <> Lt Dsbly <> Default	134	
Accruals - Insurance <> Executive Supp Life <> Default	145	
Accruals - Insurance <> Short Term Disability <> Default	355	
Accruals - Insurance <> Dependent Life <> Default-Dept	2	
Accruals - Insurance <> Accidental Death Dismemberment <> Default-Dept	17	
Accruals - Insurance <> NES Insurance <> Default-Dept	95	
Accrued Other <> Default	66,600	
Accrued Other-Default-Dept-Suspense Allocation	46,875	
	Total <u>168,255</u>	Difference
Reconcile with schedule XV, line 36:	<input style="width: 50px;" type="text" value="168,255"/>	<input style="width: 50px;" type="text" value="-"/>

<u>OTHER NON-CURRENT ASSETS:</u>		
Excess Reorganized Value <> Excess Reorg Value <> Default		
Other Assets <> Rfndable Deposits-Non Int Brg <> Default		
	Total <u>-</u>	Difference
Reconcile with schedule XV, line 23:	<input style="width: 50px;" type="text" value="0"/>	<input style="width: 50px;" type="text" value="-"/>

<u>OTHER NON-CURRENT LIABILITIES:</u>		
I/C - Interunit Asset Transfer-Default-Dept-Default-Prod	181,088	
Intercompany - Revolver <> Default <> Default	2,541,568	
Intercompany Revolver - SSC-Default-Dept-Default-Prod	(12,181)	
L/T Benefits Reserve-Default-Dept-PLGL Post-Petition Claims	(38,976)	
Other Non-Current Lby <> Rent Accrual <> Default	(61,056)	
	Total <u>2,610,443</u>	Difference
Reconcile with schedule XV, line 43:	<input style="width: 50px;" type="text" value="2,610,443"/>	<input style="width: 50px;" type="text" value="0"/>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,210,659	1
2	Restatements (describe):		2
3	<u>Asset Transfer</u>	451,631	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,662,290	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(155,320)	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)	\$ (155,320)	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)	\$ 2,506,970	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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,022,582	1
2	Discounts and Allowances for all Levels	(1,831,236)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,191,346	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,092,706	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,092,706	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	5,574	13
14	Non-Patient Meals	4,406	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	275,339	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	79,802	19
20	Radiology and X-Ray	7,002	20
21	Other Medical Services	(7,618)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 364,505	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc Receipts -</u>	655	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 655	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,649,218	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	507,380	31
32	Health Care	1,559,909	32
33	General Administration	1,155,606	33
	B. Capital Expense		
34	Ownership	342,230	34
	C. Ancillary Expense		
35	Special Cost Centers	198,898	35
36	Provider Participation Fee	40,515	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,804,538	40
41	Income before Income Taxes (line 30 minus line 40)**	(155,320)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (155,320)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Nature Trail Healthcare Center

0045765

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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	1,380	1,387	\$ 46,244	\$ 33.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,680	6,716	144,822	21.56	3
4	Licensed Practical Nurses	14,970	15,049	227,522	15.12	4
5	CNAs & Orderlies	47,333	47,586	467,085	9.82	5
6	CNA Trainees					6
7	Licensed Therapist	7,582	8,236	201,900	24.51	7
8	Rehab/Therapy Aides	3,059	3,324	116,895	35.17	8
9	Activity Director	2,097	2,102	22,939	10.91	9
10	Activity Assistants	1,258	1,261	8,384	6.65	10
11	Social Service Workers	730	730	6,234	8.54	11
12	Dietician					12
13	Food Service Supervisor	2,090	2,099	37,134	17.69	13
14	Head Cook	6,078	6,105	58,606	9.60	14
15	Cook Helpers/Assistants	6,120	6,147	52,921	8.61	15
16	Dishwashers					16
17	Maintenance Workers	2,110	2,156	27,274	12.65	17
18	Housekeepers	9,081	9,170	86,656	9.45	18
19	Laundry	5,433	5,457	43,745	8.02	19
20	Administrator	3,120	3,123	99,694	31.92	20
21	Assistant Administrator					21
22	Other Administrative	1,351	1,353	19,101	14.12	22
23	Office Manager					23
24	Clerical	4,286	4,290	67,507	15.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,848	1,856	30,889	16.64	31
32	Other Health C: Medicare Case Mg	3,123	3,123	52,862	16.93	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	129,729	131,270	\$ 1,818,414 *	\$ 13.85	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	515	\$ 8,463	1-3	35
36	Medical Director	240	6,600	9-3	36
37	Medical Records Consultant	27	1,256	10-3	37
38	Nurse Consultant	198	9,591	10-7	38
39	Pharmacist Consultant	53	2,292	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	41	2,276	11-3	44
45	Social Service Consultant	41	2,276	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,115	\$ 32,754		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kathy Lynn Berck	Abministatr		\$ 15,355	Workers' Compensation Insurance	\$ 76,529	IDPH License Fee	\$	
Henry H. Douglas	Administrator-Intern		35,202	Unemployment Compensation Insurance	79,143	Advertising: Employee Recruitment	19,153	
Brown, Suzanne	Administrator		5,855	FICA Taxes	118,844	Health Care Worker Background Check (Indicate # of checks performed _____)	2,053	
Ellis, Lori	Administrator		14,293	Employee Health Insurance	239,389	Other Licenses Fees	2,150	
				Employee Meals		Dues	3,122	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	607	
				Pension/Retirment	4	Total Advertising	3,840	
				Insurance Life	2,178			
				Other Benefits	6,635			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,703	TOTAL (agree to Schedule V, line 22, col.8)		\$ 27,096		
B. Administrative - Other						Less: Public Relations Expense ()		
Description			Amount			Non-allowable advertising (3,829)		
			\$			Yellow page advertising ()		
						TOTAL (agree to Sch. V, line 20, col. 8)		
						\$ 27,096		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$ 0
							In-State Travel	40,072
							Home Office	8,730
							Seminar Expense	3,003
							Entertainment Expense	(16)
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$	TOTAL		\$	TOTAL	\$ 51,789

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Nature Trail Healthcare Center

0045765

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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? Yes
If YES, give association name and amount. Illinois health Care Associatin - \$3,063.60
- (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? N/A
- (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? N/A
- (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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,643 Line 10
- (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. N/A
- (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. \$ 40,515
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? No 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. \$ 1,013 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,013
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? N/A
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees