

Facility Name & ID Number Nature Trail Health Care Center

0047357 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 74

	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	6,954	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,130	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,084	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
8	SNF	16		4,650	4,666	8
9	SNF/PED					9
10	ICF	15,009	3,187	271	18,467	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,025	3,187	4,921	23,133	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.41%

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 08/01/2005

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

YES Date 08/01/2005 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 74 and days of care provided 4,650

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: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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	129,588	16,293	1,108	146,989		146,989		146,989		1
2	Food Purchase		107,473		107,473	(2,748)	104,725		104,725		2
3	Housekeeping	87,298	10,044	110	97,452		97,452		97,452		3
4	Laundry	34,686	4,397	1,610	40,693		40,693		40,693		4
5	Heat and Other Utilities			53,072	53,072		53,072		53,072		5
6	Maintenance	31,102	42,422	358	73,882	(260)	73,622	89	73,711		6
7	Other (specify):*			5,782	5,782		5,782		5,782		7
8	TOTAL General Services	282,674	180,629	62,040	525,343	(3,008)	522,335	89	522,424		8
B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600		9
10	Nursing and Medical Records	967,727	75,405	11,953	1,055,085		1,055,085		1,055,085		10
10a	Therapy	353,897	26,647	33,013	413,557		413,557		413,557		10a
11	Activities	32,595	2,431	2,276	37,302		37,302	(121)	37,181		11
12	Social Services	17,245	2,685		19,930		19,930		19,930		12
13	CNA Training										13
14	Program Transportation		749	4,505	5,254		5,254		5,254		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,371,464	107,917	58,347	1,537,728		1,537,728	(121)	1,537,607		16
C. General Administration											
17	Administrative	60,890			60,890		60,890		60,890		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			31,822	31,822		31,822	308	32,130		20
21	Clerical & General Office Expenses	80,836	20,312	219,207	320,355		320,355	(31,615)	288,740		21
22	Employee Benefits & Payroll Taxes			528,106	528,106	2,748	530,854		530,854		22
23	Inservice Training & Education										23
24	Travel and Seminar			24,766	24,766		24,766	10,596	35,362		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			66,160	66,160		66,160	(12,770)	53,390		26
27	Other (specify):*										27
28	TOTAL General Administration	141,726	20,312	870,061	1,032,099	2,748	1,034,847	(33,481)	1,001,366		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,795,864	308,858	990,448	3,095,170	(260)	3,094,910	(33,513)	3,061,397		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: 1/1/2006
Ending: 12/31/2006

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

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7

Amount

Infectious Waste Disposal <> Default <> Nursing Admin/Supv 3939
Infectious Waste Disposal <> Default <> Physical Plant
Garbage Service<>Default<>Prod<>Physical Plant 1,843
Garbage Service <> Default <> Physical Plant

5,782

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: 1/1/2006

Page -3.2

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

Ending: 12/31/2006

Meals - adjustment

Sales Tax - adjustment

23,133 Days (Total Patient days)
 3 Mult (3 meals a day)

 69,399 Sub total
 1,821 meals to employess (reported by facility)

 71,220 Add Sub

 107,473 Divide -Pg 3, line 2, column 2
 1.51 Cost per day

107,473 Total Food Cost (page 3,Line 2, col 3)
 0.01 Mult

 1074.73 Sub total
 13.79% Mult (Pvt pay div by total census)
 148 = adjust for nonallowable sale tax
 for page 5A,

1.51 Cost per day
 1,821 mult - meal to employees
 2,748 = adjust for pg 3, line 2, column 5

Reclassification V

Page 3 Line 6
 Repair & Maint <> Vehicles<>Default<>Prod<>Transport Non<>Emergency 83001000003850 (260) Reclass From
 (372 x 70% = 260)
 Page 4 line 38 260.00 Reclass to

Page 3 Line 14
 Salaries <> Regular<>Driver<>Transport Non<>Emergency 700000750403850 0.00 Reclass From
 Salaries Overtime/DbI Time<>Driver<>Transport Non<>Emergency 700500750403850 0.00 Reclass From
 Vacation Pay <> Earned Lve Acc.<>Default<>Prod<>Transport Non<>Emergen 730012000003850 0.00 Reclass From
 Holiday Pay <> Earned Lve Taken<>Default<>Prod<>Transport Non<>Emergen 730013000003850 0.00 Reclass From
 Sick Pay <> Earned Leave Taken<>Default<>Prod<>Transport Non<>Emergenc 730031000003850 0.00
 (21998 x 70% = 15399) 70% is Medical 30% is activities 0.00 total

Page 3 line 11 0.00 Reclass to
 Page 4 line 38 0.00 Reclass to

Page 4 Line 35 Rent
 Lease Exp <> Vehicles<>Default<>Prod<>Transport Non<>Emergency 841005000003850 0.00 Reclass From
 (0 x 70% = 0 lease for Medical)
 Page 4 line 38 0.00 Reclass to

Facility Name & ID Number

Nature Trail Health Care Center

#0047357

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			82,436	82,436		82,436	5,883	88,319			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			121,156	121,156		121,156	(206)	120,950			32
33	Real Estate Taxes			(10,743)	(10,743)		(10,743)	664	(10,079)			33
34	Rent-Facility & Grounds			182,229	182,229		182,229	25	182,254			34
35	Rent-Equipment & Vehicles							8,636	8,636			35
36	Other (specify):*							11,945	11,945			36
37	TOTAL Ownership			375,078	375,078		375,078	26,947	402,025			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		132,213	26,853	159,066	260	159,326	12,219	171,545			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		132,213	67,368	199,581	260	199,841	12,219	212,060			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,795,864	441,071	1,432,894	3,669,829		3,669,829	5,653	3,675,482			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: 1012006
Ending: 12/31/2006

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 <> Bankruptcy Exp Acq <> Cost Non Overhead	0
	<u>-</u>

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

<u>Ancillary Expenses - Line 43 -Column 3</u>	<u>Amount</u>
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	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 <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	0
	<u>-</u>

<u>Rent-Facility & Grounds - Expenses</u>	
Lease Expense Facility-Realty-Default-Prod	34,428
Lease Expense Facility <> Default <> Realty	147,801
	0
	<u>182,229</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				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	(845)	21		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	(188,422)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (189,267)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	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)	194,920		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 194,920		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 5,653		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.			\$ 4,505	14	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)			\$ 4,505		47

Nature Trail Health Care Center

ID# 0047357

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Sales Taxes	\$ (148)	21	1
2	Small Balance Adjustment	(7)	21	2
3	Memorium/ Benevolence	(954)	21	3
4	Depreciation Reconciliation	5,883	30	4
5	Activities Program Receipts	(121)	11	5
6	Property Taxes Adjust to actual	0	33	6
7	Professional liability Insurance	(12,770)	26	7
8	Barber & beauty	0	40	8
9	Public Relations Expenses	0	20	9
10	Non Allowable Advertising	0	20	10
11	Entertainment	(110)	24	11
12	Fresh Start	0	36	12
13	Civic Dues	(250)	20	13
14	Penalties	0	21	14
15	Vending receipts	(627)	21	15
16	Misc Receipts	0	21	16
17	Marketing Wages	0	21	17
18	Marketing Bonus	0	21	18
19	Marketing Holiday	0	21	19
20	Maketing Sick	0	21	20
21	Marketing Vacation	0	21	21
22	Marketing Overtime	0	21	22
23	Marketing Non Worked Wages	0	21	23
24	Donations/ Contributions	(222)	21	24
25	Legal Fees - Bankruptcy	(152)	21	25
26	Legal Structure Management Fees	(178,738)	21	26
27	Undocumented Travel		24	27
28	Interest Income	(206)	32	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	(188,422)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	89	0	0	0	0	0	0	0	0	0	89	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	89	0	0	0	0	0	0	0	0	0	89	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	(121)	0	0	0	0	0	0	0	0	0	0	(121)	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	(121)	0	0	0	0	0	0	0	0	0	0	(121)	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	(250)	558	0	0	0	0	0	0	0	0	0	308	20
21	Clerical & General Office Expenses	(181,693)	150,078	0	0	0	0	0	0	0	0	0	(31,615)	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	(110)	10,706	0	0	0	0	0	0	0	0	0	10,596	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(12,770)	0	0	0	0	0	0	0	0	0	0	(12,770)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(194,823)	161,342	0	0	0	0	0	0	0	0	0	(33,481)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(194,944)	161,431	0	0	0	0	0	0	0	0	0	(33,513)	29

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		SSC Equity Holdings,	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%	\$	\$	1	
2	V	6 Repair & Maintenance		SSC Equity Holdings LLC	100.00%	89	89	2	
3	V	39 Professional Services		SSC Equity Holdings LLC	100.00%	12,219	12,219	3	
4	V	20 Fees, Subscriptions, Promotions		SSC Equity Holdings LLC	100.00%	558	558	4	
5	V	10 Nursing & Medical Records		SSC Equity Holdings LLC	100.00%			5	
6	V	21 Clerical & General Office Exp		SSC Equity Holdings LLC	100.00%	150,078	150,078	6	
7	V	24 Travel & Seminar		SSC Equity Holdings LLC	100.00%	10,706	10,706	7	
8	V	26 Insurance Premium		SSC Equity Holdings LLC	100.00%			8	
9	V	36 Depreciation		SSC Equity Holdings LLC	100.00%	11,945	11,945	9	
10	V	33 Taxes - Property		SSC Equity Holdings LLC	100.00%	664	664	10	
11	V	35 Rental & Leasing		SSC Equity Holdings LLC	100.00%	8,636	8,636	11	
12	V	34 Lease Expense		SSC Equity Holdings LLC	100.00%	25	25	12	
13	V	26 Property Insurance		SSC Equity Holdings LLC	100.00%			13	
14	Total		\$			\$ 194,920	\$ *	194,920	14

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

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2006
Ending: 12/31/2006

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

Related Illinois Nursing Homes
as of
12/31/2006

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 Health Care Center # 0047357 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	N/A								\$	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 Health Care Center # 0047357 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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
2	6	Repair & Maintenance		1	89		1	89	2
3	39	Professional Services		1	12,219		1	12,219	3
4	20	Fees, Subscriptions, Promotions		1	558		1	558	4
5	10	Nursing & Medical Records							5
6	21	Clerical & General Office Exp		1	150,075		1	150,075	6
7	24	Travel & Seminar		1	10,706		1	10,706	7
8	26	Insurance Premium							8
9	36	Depreciation		1	11,945		1	11,945	9
10	33	Taxes - Property		1	664		1	664	10
11	35	Rental & Leasing		1	8,636		1	8,636	11
12	34	Leasse Expense		1	25		1	25	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				\$ 194,917	\$		\$ 194,917	25

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Nature Trail Health Care Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0047357

CONTACT PERSON REGARDING THIS REPORT Lee Grigsby

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

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of total 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 2005.

(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>\$ 22,148.10</u>	<u>\$ 22,148.10</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 22,148.10	\$ 22,148.10

B. Real Estate Tax Cost Allocation:

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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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.

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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	225,000	1994	\$ 50,246	1
2					2
3	TOTALS	225,000		\$ 50,246	3

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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 BHF 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	\$	\$ 731,597	4
5		1994		329,317	16,465	20	16,465		189,921	5
6										6
7										7
8										8
Improvement Type**										
9	Interior Building Improvements	1995		2,325	233	20	233		2,661	9
10	Unit Heaters	1996		642	64	20	64		666	10
11	Flooring - Tile	1996		2,384	119	20	119		1,211	11
12	Heater BaseBoard - 6	1996		502	50	20	50		503	12
13	Drapes / Valances	1996		3,956	396	20	396		3,960	13
14	Smoke Detectors	1996		2,880	288	20	288		2,946	14
15	Sude rails	1996		1,149	57	20	57		536	15
16	Parking Repairs	1997		1,923	96	20	96		891	16
17	Wall Covering	1997		897	45	20	45		436	17
18	Gutters	1997		2,290	115	20	115		1,054	18
19	Beauty Salon	1997		1,040	52	20	52		482	19
20	Sewer Tile	1997		1,575	79	20	79		786	20
21	A/C Heater Unit	1997		591	59	20	59		539	21
22	Water Heater	1997		388	19	20	19		171	22
23	Floor Preparation	1997		650	33	20	33		323	23
24	Floor Covering	1997		1,460	73	20	73		716	24
25	Floor Finishing	1997		250	13	20	13		127	25
26	Water Heater	1997		388	39	20	39		357	26
27	Rebuilding Bathroom	1997		3,825	191	20	191		1,750	27
28	Cabinets / Millwork	1998		161	8	20	8		72	28
29	Heating / Ventilating	1998		592	30	20	30		214	29
30	5 - Heater W/Adapters #86	1999		2,269	227	20	227		1,664	30
31	Repair Water Leak - Kitchen #106	2000		1,334	67	20	67		440	31
32	Repair Water Line - Booster Heater #107	2000		986	49	20	49		323	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		143	34
35	Wanderguard System #112	2001		6,263	626	10	626		3,704	35
36		2001		58	6	10	6		23	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

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	\$	\$ 2,273		37
38	Use Tax %: Thru Wall Heat /Cool Units #117	2001	149	30	5	30		159		38
39	3 Ton Condenser, East Wing & Use Tax 118 & 119	2001	861	57	15	57		314		39
40										40
41	Win Freezer Condenser Instl #123	2002	3,021	201	15	201		1,023		41
42	Instl Grease Interceptor #129	2002	4,871	243	20	243		1,236		42
43	Wanderguard System & Use Tax #132 & 133	2002	6,227	623	10	623		3,530		43
44	CR Inc # 1000017826/ Discount #134	2002	(22)	(2)	10	(2)		(12)		44
45	CR Inc # 1000017900 W/G Svsstem Discount #135	2002	(349)	(35)	10	(35)		(195)		45
46	Maglock Brackets #136	2002	151	15	10	15		85		46
47	Maglocks Brackets #137	2002	151	15	10	15		85		47
48	CR Inv 10015138 Corby Push #138	2002	(95)	(9)	10	(9)		(52)		48
49	Wanderguard System & Use Tax #5007 & 2008	2002	1,268	127	10	127		709		49
50	Cr - Labor charge Wanderguard #5009	2002	(1,200)	(120)	10	(120)		90		50
51	Charge Excess Discount Wanerguard #5010	2002	52	5	10	5		28		51
52	4: Heat / Cool Units Use Tax #5013 & 5014	2002	1,959	229	5	229		916		52
53	Rplc 5 ton AirHandler, Condenser #5021	2002	6,746	281	10	281		1,124		53
54										54
55	New Roof #5030	2003	23,935	2,394	10	2,394		9,774		55
56	Storage Building 10x21 #5031	2003	1,900	190	10	190		728		56
57	Rprc Russes - Kitchen #5034	2003	2,600	173	15	173		664		57
58	Fire Sprinkler Retrofit Apl # 5048	2003	4,644	128	25	128		384		58
59										59
60	Fire Suppression Svst- Kitchen	2204	1,275	128	10	128		384		60
61	Maglock-WanderGuard System	2004	1,493	75	10	75		225		61
62										62
63	Rpr Automatic Transfer Switch	2005	1,953	24	20	24		48		63
64	Rpr Automatic Transfer Switch	2005	2,029	59	20	59		118		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)	\$ 971,854		70

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

STATE OF ILLINOIS

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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	
1	Totals from Page 12A, Carried Forward		\$ 2,649,330	\$ 157,291		\$ 88,015	\$ (69,276)	\$ 971,854	1
2	Thru wall windows A/CA	2006	6,550	764	5	764	(0)	764	2
3	Tree Removal/Due to Storm	2006	17,600	880	10	880		880	3
4	Door "42	2006	5,245	219	10	219	0	219	4
5	Tree Removal	2006	2,273	92	10	92	(0)	92	5
6	Repair Sprinkler System	2006	33,750	1,107	10	1,107	0	1,107	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	TOTAL (lines 1 thru 33)		\$ 2,714,748	\$ 160,353		\$ 91,077	\$ (69,276)	\$ 974,916	34

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

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	\$ 2,649,330	\$ 157,291	\$ 88,015	\$ (69,276)		\$ 971,854	71
72	Current Year Purchases	65,419	3,062	3,062			3,062	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,714,749	\$ 160,353	\$ 91,077	\$ (69,276)		\$ 974,916	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	2	
	Reference	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)	\$ 5,479,743	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 320,706	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 182,154	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (138,552)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,949,832	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	\$ 744	86
87	O/H Allocation 12/01/1996	568	28	259	87
88	O/H Allocation 08/01/1997	277	14	148	88
89	O/H Allocation 10/01/1997	965	48	416	89
90					90
91	TOTALS	\$ 3,393	\$ 169	\$ 1,567	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:	74	01/01/2005	\$ 282,590	20		3
4	Additions						4
5							5
6							6
7	TOTAL	74		\$ 282,590			7

10. Effective dates of current rental agreement:

Beginning 01/01/2005
 Ending 12/31/2024

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

Fiscal Year Ending Annual Rent

12. /2007 \$
 13. /2008 \$
 14. /2009 \$

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.

STATE OF ILLINOIS

Report Period: Beginning: 1012006

Page -14.1

Facility Name & ID Number

Nature Trail Health Care Center

0039586

Ending: 12/31/2006

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

Page/Line/Col

Name of G/L	G/L #	EQUIPMENT	Amount	Ref From
Lease Exp - Eqpt - Nonmedical <> Default <> NonCert	841000000001011	Specialty Matress/ Beds		03/10/03
Lease Exp - Eqpt - <> Default <> Prod Oxygen	841000000002022	Concentrators	424.00	
Lease Exp <> Eqpt<>Default<>Prod<>SNF Non Certified	841000000001011	Oxygen	1,462.00	
Lease Exp - Eqpt-Physical Therapy-Default-Prod	841000000002200	PT Equip.	10.00	
Lease Exp - Eqpt - <> Default <> Equip Rental	841000000002102			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 <> Housekeeping	841000000007040			03/03/03
Lease Exp - Eqpt - Nonmedical <> Default <> Laundry	841000000007050			03/04/03
Lease Exp - Eqpt - Nonmedical <> Default <> Nursing Admi	841000000008000	Mattress		03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Administrative	841000000008100	Copies, Stamp machine Cable		03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plan	841000000008210	SNF Supplies	358.00	03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	841000000008220			04/35/03
Lease Exp - Other <> Default <> Administrative	841020000008100			03/21/03

2,254.00 Grand Total

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 checked="" 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="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</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			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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	10a-03	4681	hrs	\$ 126,953					4,681	\$ 126,953	1
2	Licensed Speech and Language Development Therapist	10a-03	2006	hrs	73,414					2,006	73,414	2
3	Licensed Recreational Therapist	10a-03		hrs								3
4	Licensed Physical Therapist	10a-03	4060	hrs	105,980					4,060	105,980	4
5	Physician Care			visits								5
6	Dental Care			visits								6
7	Work Related Program			hrs								7
8	Habilitation			hrs								8
9	Pharmacy	39		# of prescripts				132,213			132,213	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				\$ 306,347			\$ 132,213		10,747	\$ 438,560	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.

STATE OF ILLINOIS

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Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	83,136		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	125,554		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	93		6
7	Other Prepaid Expenses	93,854		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 303,037	\$	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	67,372		15
16	Equipment, at Historical Cost	23,928		16
17	Accumulated Depreciation (book methods)	(6,699)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	45,607		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Asset Clearing	35,918		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 166,126	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 469,163	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 151,387	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	111,336		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,377		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	See Attached Sched 17.1	114,604		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 388,704	\$	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	See Attached Sched 17.1	(2,176,719)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (2,176,719)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (1,788,015)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,257,178	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 469,163	\$	48

*(See instructions.)

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2006 Page -17.1
Ending: 12/31/2006

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

SUPPLEMENTAL SCHEDULE OF ASSETS & LIABILITIES

<u>OTHER CURRENT ASSETS:</u>	<u>AMOUNT</u>	
	0	Difference
Reconcile with schedule XV, line 9:	0	0

<u>OTHER NON-CURRENT ASSETS:</u>		
17 23-1 Excess Reorganized Value <> Excess Reorg Value <> Default		
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	35,918	
	35,918	Difference
Reconcile with schedule XV, line 23:	35,918	-

<u>OTHER CURRENT LIABILITIES:</u>	<u>AMOUNT</u>	
Misc Dedctns - Employee <> Other Deductions <> Default		17 36-1
Misc Dedctns - Employee <> Miscellaneous<> Default		
Accruals - Insurance <> Accrue HMO Ins <> Default	27	
Accruals - Insurance <> Self Funded Ins Accr <> Default	(56,094)	
Accruals - Insurance <> Basic Life <> Default	(152)	
Accrued InsurancePLGL Post-Petition ClaimsDefault-Dept	(8,824)	
Accruals - Insurance <> Lt Dsbly <> Default	(67)	
Accruals - Insurance <> Dental Ins <> Default		
Accruals - Insurance <> Executive Supp Life <> Default	(165)	
Accruals - Insurance <> Short Term Disability <> Default	37	
Accruals - Insurance <> Dependent Life <> Default-Dept	(27)	
Accruals - Insurance <> Accidental Death Dismemberment <> Default-Dept	(19)	
Accruals - Insurance <> NES Insurance <> Default-Dept	(1,610)	
Accruals -other Default -Dept-Suspense Allocation	(12,525)	
Accrued Other <> Default	(3,959)	
Deferred Income-Default-Dept-Deferred CLO Gain/Loss	(31,227)	
	(114,605)	Difference
Reconcile with schedule XV, line 36:	(114,605)	-

<u>OTHER NON-CURRENT LIABILITIES::</u>		
I/C - Interunit Asset Transfer-Default-Dept-Default-Prod	121,655	17 43-1
Intercompany - Revolver <> Default <> Default	2,410,108	
Intercompany Revolver - SSC-Default-Dept-Default-Prod	(37,294)	
L/T Benefits Reserve-Default-Dept-PLGL Post-Petition Claims	(4,878)	
Other Non-Current Lby <> Rent Accrual <> Default	(34,428)	
Other Non-Current Lby-Default-Dept-Deferred CLO Gain/Loss	(278,443)	
	2,176,720	Difference
Reconcile with schedule XV, line 43:	2,176,720	0

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,506,970	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,506,970	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(89,427)	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)	\$ (89,427)	17
B. Transfers (Itemize):			
18	Move R/E	(160,365)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (160,365)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,257,178	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning: 01/01/2006

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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	\$ 4,168,010	1
2	Discounts and Allowances for all Levels	(1,774,577)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,393,433	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	954,014	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 954,014	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	4,825	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	191,381	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,517	19
20	Radiology and X-Ray	6,379	20
21	Other Medical Services	4,039	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 232,141	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		693	28
28a		121	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 814	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,580,402	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	525,343	31
32	Health Care	1,537,728	32
33	General Administration	1,032,099	33
B. Capital Expense			
34	Ownership	375,078	34
C. Ancillary Expense			
35	Special Cost Centers	159,066	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)*	\$ 3,669,829	40
41	Income before Income Taxes (line 30 minus line 40)**	(89,427)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (89,427)	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.

STATE OF ILLINOIS

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

SUPPLEMENATAL INCOME SCHEDULE

<u>DESCRIPTION Line 19 26a 1 & 19 28 1</u>	<u>AMOUNT</u>	
Personal Purchase Receipts <> Default <> Vending	0	
Miscellaneous Receipts<>Default<>Prod<>Vending	(627.00)	
Miscellaneous Receipts<>Default<>Prod<>Administrative	(66)	
Total	(693.00)	Difference
Reconcile with schedule XVII, line 28:	(693)	0

<u>DESCRIPTIONS Line 19 28a 1</u>		
Personal Purchase Receipts <> Default <> Patient Personal Pu	-	
Personal Purchase Receipts <> Default <> Miscellaneous Rece	-	
Personal Purchase Expense <> Default <> Patient Personal Pu	-	
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-	
Activity Programs Receipts <> Default <> Other Misc Rev	-	
Miscellaneous Receipts<>Default<>Prod<>Activities	(121)	
Total	(121)	Difference
Reconcile with schedule XVII, line 28a:	(121)	-

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

12/31/2006

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	2,094	2,094	\$ 57,599	\$ 27.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,914	5,914	116,531	19.70	3
4	Licensed Practical Nurses	14,036	14,036	215,051	15.32	4
5	CNAs & Orderlies	48,097	48,097	458,658	9.54	5
6	CNA Trainees					6
7	Licensed Therapist	6,848	6,848	155,652	22.73	7
8	Rehab/Therapy Aides	5,274	5,274	193,931	36.77	8
9	Activity Director	2,084	2,084	22,686	10.89	9
10	Activity Assistants	1,460	1,460	9,692	6.64	10
11	Social Service Workers	1,467	1,467	17,245	11.76	11
12	Dietician					12
13	Food Service Supervisor	3,516	3,516	64,756	18.42	13
14	Head Cook	6,325	6,325	54,404	8.60	14
15	Cook Helpers/Assistants	5,683	5,683	42,853	7.54	15
16	Dishwashers					16
17	Maintenance Workers	2,196	2,196	23,001	10.47	17
18	Housekeepers	10,069	10,069	87,298	8.67	18
19	Laundry	5,318	5,318	35,731	6.72	19
20	Administrator	2,081	2,081	63,826	30.67	20
21	Assistant Administrator					21
22	Other Administrative	1,282	1,282	19,153	14.94	22
23	Office Manager					23
24	Clerical	4,652	4,652	61,055	13.12	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	1,003	1,003	10,460	10.43	31
32	Other Health Care Management Coord	1,896	1,896	40,413	21.31	32
33	Other(specify) Marketing & Transportation					33
34	TOTAL (lines 1 - 33)	131,295	131,295	\$ 1,749,995 *	\$ 13.33	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	105	\$ 6,642	1-3	35
36	Medical Director	100	6,600	9-3	36
37	Medical Records Consultant	43	1,971	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	54	2,360	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	70	2,276	11-3	44
45	Social Service Consultant	73	2,276	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	445	\$ 22,124		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

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 Association- \$3,641.00
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 5,079 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 benefit: on Schedule V. \$ 2,748 Has any meal income been offset against related costs? No Indicate the amount. \$
- (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 \$5,000, 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.