

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047357

Facility Name: Nature Trail Health Care Center

Address: 1001 South 34th Street Mount Vernon 62864
 Number City Zip Code

County: Jefferson

Telephone Number: 618-242-5700 **Fax #** 618-242-5705

HFS ID Number: 20-1422332001

Date of Initial License for Current Owners: 10-06-2005

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Martha McDaniel **Telephone Number:** 832-467-6317

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2007 to 12/31/2007 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Chris Stenger</u>	
	(Title) <u>Vice President of Reimbursement</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____	Fax # () _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	

Phone # (217) 782-1630

Facility Name & ID Number Nature Trail Health Care Center# 0047357 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	<u>19</u>	Skilled (SNF)	<u>19</u>	<u>6,935</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>55</u>	Intermediate (ICF)	<u>55</u>	<u>20,075</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>74</u>	TOTALS	<u>74</u>	<u>27,010</u>	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	<u>1,677</u>		<u>5,219</u>	<u>6,896</u>	8
9	SNF/PED					9
10	ICF	<u>13,356</u>	<u>4,080</u>	<u>154</u>	<u>17,590</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,033</u>	<u>4,080</u>	<u>5,373</u>	<u>24,486</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.66%

D. How many bed-hold days during this year were paid by the Department?

N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/AF. 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 5,219Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	134,713	9,811	7,730	152,254		152,254		152,254		1
2	Food Purchase		111,382		111,382	(1,468)	109,914	(92)	109,822		2
3	Housekeeping	87,146	8,684		95,830		95,830		95,830		3
4	Laundry	39,901	4,444	38	44,383		44,383		44,383		4
5	Heat and Other Utilities			75,564	75,564		75,564	(4,443)	71,121		5
6	Maintenance	22,293	42,640	7,331	72,264	(6)	72,258	8,305	80,563		6
7	Other (specify):*			6,752	6,752		6,752		6,752		7
8	TOTAL General Services	284,053	176,961	97,415	558,429	(1,474)	556,955	3,770	560,725		8
	B. Health Care and Programs										
9	Medical Director			6,600	6,600		6,600		6,600		9
10	Nursing and Medical Records	981,546	60,061	14,742	1,056,349		1,056,349		1,056,349		10
10a	Therapy	355,577	59,963	940	416,480		416,480		416,480		10a
11	Activities	33,595	3,485	1,915	38,995		38,995		38,995		11
12	Social Services	15,235	79	2,294	17,608		17,608		17,608		12
13	CNA Training										13
14	Program Transportation		340	10,543	10,883	(10,537)	346		346		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,385,953	123,928	37,034	1,546,915	(10,537)	1,536,378		1,536,378		16
	C. General Administration										
17	Administrative	64,382			64,382		64,382		64,382		17
18	Directors Fees			724	724		724		724		18
19	Professional Services			2,020	2,020		2,020		2,020		19
20	Dues, Fees, Subscriptions & Promotions			20,894	20,894		20,894	(3,187)	17,707		20
21	Clerical & General Office Expenses	123,352	19,628	261,151	404,131		404,131	(77,648)	326,483		21
22	Employee Benefits & Payroll Taxes			346,796	346,796	1,468	348,264	6,389	354,653		22
23	Inservice Training & Education										23
24	Travel and Seminar			16,971	16,971		16,971	11,430	28,401		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			70,341	70,341		70,341	(51,577)	18,764		26
27	Other (specify):*										27
28	TOTAL General Administration	187,734	19,628	718,897	926,259	1,468	927,727	(114,593)	813,134		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,857,740	320,517	853,346	3,031,603	(10,543)	3,021,060	(110,823)	2,910,237		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: 1/1/2007
Ending: 12/31/2007

Facility Name & ID Number Nature Trail Healthcare Center # 0039586

Meals - adjustment

24,486 Days (Total Patient days)
3 Mult (3 meals a day)
73,458 Sub total
981 meals to employess (reported by facility)
74,439 Add Sub
111,382 Divide -Pg 3, line 2, column 2
1.50 Cost per day

1.50 Cost per day

981 mult - meal to employees

1,467.86 = adjust for pg 2, line 2, column2

Sales Tax - adjustment

111,382 Total Food Cost (page 3,Line 2, col 2)
0.01 Mult
1113.82 Sub total
16.66% Mult (Pvt pay div by total census)
186 = adjust for nonallowable sale tax
for page 5A,
92.781206

Reclassification V

Page 3 Line 6 col 01

Repair & Maint <> Vehicles<>Default<>Prod<>Transp 830010000003850 (6) Reclass From
(8 x 70% = 5.60)
Page 4 line 38 6 Reclass to

Page 3 Line 14 col 01

Salaries <> Regular<>Driver<>Transport Non<>Emergency 700000750403850 - Reclass From
Salaries Overtime/Dbt Time<>Driver<>Transport Non<>Emergen 700500750403850 - Reclass From
Vacation Pay <> Earned Lve Acc.<>Default<>Prod<>Transport N 730012000003850 - Reclass From
(0 x 70% & 30%) 70% is Medical 30% is activities - total

Activities Page 3 line 11 - Reclass to
Medical Page 4 line 38 - Reclass to

Page 4 Line 35 Rent col 03

Lease Exp <> Vehicles<>Default<>Prod<>Transport Non<>Eme 841005000003850 - Reclass From
(0 x 70% = 0 lease for Medical)
Page 4 line 38 - Reclass to

Facility Name & ID Number Nature Trail Health Care Center #0047357 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			34,358	34,358		34,358		34,358		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			(422)	(422)		(422)	27,062	26,640		32
33	Real Estate Taxes			23,256	23,256		23,256	(592)	22,664		33
34	Rent-Facility & Grounds			312,341	312,341		312,341		312,341		34
35	Rent-Equipment & Vehicles							10,541	10,541		35
36	Other (specify):*							11,307	11,307		36
37	TOTAL Ownership			369,533	369,533		369,533	48,318	417,851		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation					10,543	10,543		10,543		38
39	Ancillary Service Centers		147,813	36,794	184,607		184,607	19,301	203,908		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):*		1,597		1,597		1,597		1,597		43
44	TOTAL Special Cost Centers		149,410	77,309	226,719	10,543	237,262	19,301	256,563		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,857,740	469,927	1,300,188	3,627,855		3,627,855	(43,204)	3,584,651		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: 1/1/2007
Ending: 12/31/2007

Facility Name & ID Number Nature Trail Healthcare Center # 0039586

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36 -Column 3

		Amount
Fresh Start Acctg Adj <> Bankruptcy Exp Acq <> Cost Non Overhead	940101940058888	0
		-

Ancillary Expenses - Line 43 -Column 2

		Amount
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	800630000003330	1,597
Ancillary Supplies <> Default <> Laboratory	810041000003330	0
		1597

Ancillary Expenses - Line 43 -Column 3

		Amount
Contract Svcs - Chgbl <> Default <> Laboratory	652000000003330	
Contract Svcs - Chgbl <> Default <> X/Ray	652000000003332	0
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	810030752993330	0
Professional Services - NonchgPhysicianX/Ray	810030752103332	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	810030752993332	0
Professional Services <> Nonchg<>Medical Director<>Laboratory	810030795003330	0
Professional Services <> Nonchg<>Medical Director<>X/Ray	810030795003332	0
Professional Services Chgble <> Default <> X/Ray	652100000003332	0
Professional Services Chgble <> General / Other <> X/Ray	652100600003332	0
		-

Rent-Facility & Grounds - Expenses- Line 34 Column 3

Lease Expense Facility <> Default <> Prod	84101100008220	48,887
Lease Expense Facility <> Default <> Realty	84101000008220	263,454
		312,341

Facility Name & ID Number Nature Trail Health Care Center# 0047357

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,468)	22		4
5	Telephone, TV & Radio in Resident Rooms	(4,443)	5		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	(14,687)	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 <u>page 5A</u>	(266,151)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (286,749)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	247,087		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 247,087		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (39,662)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.	x		\$ 10,543	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)			\$ 10,543	47

BHF USE ONLY					
48		49		50	51
					52

Nature Trail Health Care Center

ID# 0047357

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sales Taxes	\$ (92)	2	1
2	Small Balance Adjustment	0	21	2
3	Memorium/ Benevolance	(309)	21	3
4	Depreciation Reconciliation	0	30	4
5	Activities Program Receipts	0	11	5
6	Property Taxes Adjust to actual	(438)	33	6
7	Professional liability Insurance	(59,445)	26	7
8	Barber & beauty	0	40	8
9	Public Relations Expenses		20	9
10	Non Allowable Advertising	(4,997)	20	10
11	Entertainment	(25)	24	11
12	Fresh Start	0	36	12
13	Civic Dues	(250)	20	13
14	Penalties	0	21	14
15	Vending receipts	32	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	Marketing 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	0	21	24
25	Legal Fees - Bankruptcy	0	21	25
26	Back Office Services Fee	(204,153)	21	26
27	Undocumented Travel	0	14	27
28	Interest Income	(422)	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	(270,099)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(92)	0	0	0	0	0	0	0	0	0	0	(92)	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	(4,443)	38	0	0	0	0	0	0	0	0	0	(4,405)	5
6	Maintenance	0	8,305	0	0	0	0	0	0	0	0	0	8,305	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,535)	8,343	0	3,808	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,247)	2,060	0	0	0	0	0	0	0	0	0	(3,187)	20
21	Clerical & General Office Expenses	(219,117)	141,469	0	0	0	0	0	0	0	0	0	(77,648)	21
22	Employee Benefits & Payroll Taxes	(1,468)	7,857	0	0	0	0	0	0	0	0	0	6,389	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(25)	11,455	0	0	0	0	0	0	0	0	0	11,430	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(59,445)	7,868	0	0	0	0	0	0	0	0	0	(51,577)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(285,302)	170,709	0	(114,593)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(289,837)	179,052	0	(110,785)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(422)	27,484	0	0	0	0	0	0	0	0	0	27,062	32
33	Real Estate Taxes	(438)	(154)	0	0	0	0	0	0	0	0	0	(592)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	10,541	0	0	0	0	0	0	0	0	0	10,541	35
36	Other (specify):*	0	11,307	0	0	0	0	0	0	0	0	0	11,307	36
37	TOTAL Ownership	(860)	49,178	0	48,318	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	19,301	0	0	0	0	0	0	0	0	0	19,301	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	19,301	0	19,301	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(290,697)	247,531	0	(43,166)	45								

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 I	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%	\$ 38	\$ 38
2	V	6	Repair & Maintenance	SSC Equity Holdings, LLC	100.00%	8,305	8,305
3	V	39	Professional Services	SSC Equity Holdings, LLC	100.00%	19,301	19,301
4	V	20	Fees, Subscriptions, Promotions	SSC Equity Holdings, LLC	100.00%	2,060	2,060
5	V	10	Nursing & Medical Records	SSC Equity Holdings, LLC	100.00%		
6	V	21	Clerical & General Office Exp	SSC Equity Holdings, LLC	100.00%	141,469	141,469
7	V	24	Travel & Seminar	SSC Equity Holdings, LLC	100.00%	11,455	11,455
8	V	26	Insurance Premium	SSC Equity Holdings, LLC	100.00%	7,868	7,868
9	V	36	Depreciation	SSC Equity Holdings, LLC	100.00%	11,307	11,307
10	V	33	Taxes - Property	SSC Equity Holdings, LLC	100.00%	(154)	(154)
11	V	35	Rental & Leasing	SSC Equity Holdings, LLC	100.00%	10,541	10,541
12	V	32	Intrest Income/Expense	SSC Equity Holdings, LLC	100.00%	27,484	27,484
13	V	22	P/R Taxes	SSC Equity Holdings, LLC	100.00%	7,857	7,857
14	Total		\$			\$ 247,531	\$ * 247,531

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

STATE OF ILLINOIS

Report Period:

Beginning: 1/1/2007

Page -6.1

Facility Name & ID Number: [Nature Trail Healthcare Center](#)

0039586

Ending: 12/31/2007

Related Illinois Nursing Homes
as of
12/31/2007

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

SSC Equity Holdings, LLC

Montebello Healthcare Center	0047340
Nature Trail HealthCare Center	0047357
Odin HealthCare Center	0047365
Mariner Health of Westchester	0047373

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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: 01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

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		\$ 38	\$	1	\$ 38	1
2	6	Repair & Maintenance	1		8,305		1	8,305	2
3	39	Professional Services	1		19,301		1	19,301	3
4	20	Fees, Subscriptions, Promotions	1		2,060		1	2,060	4
5	10	Nursing & Medical Records							5
6	21	Clerical & General Office Exp	1		141,469		1	141,469	6
7	24	Travel & Seminar	1		11,455		1	11,455	7
8	26	Insurance Premium	1		7,868		1	7,868	8
9	36	Depreciation	1		11,307		1	11,307	9
10	33	Taxes - Property	1		(154)		1	(154)	10
11	35	Rental & Leasing	1		10,541		1	10,541	11
12	32	Intrest Income/Expense	1		27,484		1	27,484	12
13	22	P/R Taxes	1		7,857		1	7,857	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				\$ 247,531	\$		\$ 247,531	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 11,638	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.)		\$ 22,818	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 11,180	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 12,076	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.		\$ 23,256	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	19,726	8
	2003	19,979	9
	2004	21,783	10
	2005	22,148	11
	2006	22,818	12
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 Martha McDaniel

TELEPHONE 832-467-6317 FAX #: 832-467-6324

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>22,818.00</u>	\$ <u>22,818.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>22,818.00</u>	\$ <u>22,818.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Nature Trail Health Care Center

0047357 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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:

A. Land.

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

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$	\$ 794,832	4
5			1994		329,317	16,465	20	16,465		206,386	5
6											6
7											7
8											8
	Improvement Type**										
9	Interior Building Improvements		1995		2,325	233	20	233		2,325	9
10	Unit Heaters		1996		642	64	20	64		642	10
11	Flooring - Tile		1996		2,384	119	20	119		1,330	11
12	Heater BaseBoard - 6		1996		502	50	20	50		502	12
13	Drapes / Valances		1996		3,956	396	20	396		3,956	13
14	Smoke Detectors		1996		2,880	288	20	288		2,880	14
15	Sude rails		1996		1,149	57	20	57		593	15
16	Parking Repairs		1997		1,923	96	20	96		987	16
17	Wall Covering		1997		897	45	20	45		481	17
18	Gutters		1997		2,290	115	20	115		1,169	18
19	Beauty Salon		1997		1,040	52	20	52		534	19
20	Sewer Tile		1997		1,575	79	20	79		865	20
21	A/C Heater Unit		1997		591	59	20	59		591	21
22	Water Heater		1997		388	19	20	19		190	22
23	Floor Preparation		1997		650	33	20	33		356	23
24	Floor Covering		1997		1,460	73	20	73		789	24
25	Floor Finishing		1997		250	13	20	13		140	25
26	Water Heater		1997		388	39	20	39		388	26
27	Rebuilding Bathroom		1997		3,825	191	20	191		1,941	27
28	Cabinets / Millwork		1998		161	8	20	8		80	28
29	Heating / Ventilating		1998		592	30	20	30		244	29
30	5 - Heater W/Adapters #86		1999		2,269	227	20	227		1,891	30
31	Repair Water Leak - Kitchen #106		2000		1,334	67	20	67		507	31
32	Repair Water Line - Booster Heater #107		2000		986	49	20	49		372	32
33	Supplemental Schedule 12.1 sent in prior years					69,276			(69,276)		33
34	30 - Amp Filters, W/G System & Use Tax #110 & 111		2001		243	24	10	24		167	34
35	Wanderguard System #112		2001		6,263	626	10	626		4,330	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$	\$ 2,131	37
38	Use Tax %: Thru Wall Heat /Cool Units #117	2001	149	30	5	30		149	38
39	3 Ton Condenser, East Wing & Use Tax 118 & 119	2001	861	57	15	57		371	39
40									40
41	Win Freezer Condenser Instl #123	2002	3,021	201	15	201		1,224	41
42	Instl Grease Interceptor #129	2002	4,871	243	20	243		1,479	42
43	Wanderguard System & Use Tax #132 & 133	2002	6,227	623	10	623		4,153	43
44	CR Inc # 1000017826/ Discount #134	2002	(22)	(2)	10	(2)		(14)	44
45	CR Inc # 1000017900 W/G System Discount #135	2002	(349)	(35)	10	(35)		(230)	45
46	Maglock Brackets #136	2002	151	15	10	15		100	46
47	Maglocks Brackets #137	2002	151	15	10	15		100	47
48	CR Inv 10015138 Corby Push #138	2002	(95)	(9)	10	(9)		(61)	48
49	Wanderguard System & Use Tax #5007 & 2008	2002	1,268	127	10	127		836	49
50	Cr - Labor charge Wanderguard #5009	2002	(1,200)	(120)	10	(120)		(30)	50
51	Charge Excess Discount Wanerguard #5010	2002	52	5	10	5		33	51
52	4: Heat / Cool Units Use Tax #5013 & 5014	2002	1,959	229	5	229		1,145	52
53	Rplc 5 ton AirHandler, Condenser #5021	2002	6,746	281	10	281		1,405	53
54									54
55	New Roof #5030	2003	23,935	2,394	10	2,394		12,168	55
56	Storage Building 10x21 #5031	2003	1,900	190	10	190		918	56
57	Rprc Russes - Kitchen #5034	2003	2,600	173	15	173		837	57
58	Fire Sprinkler Retrofit Apl # 5048	2003	4,644	128	25	128		512	58
59									59
60	Fire Suppression Syst- Kitchen	2004	1,275	128	10	128		512	60
61	Maglock-WanderGuard System	2004	1,493	75	10	75		300	61
62									62
63	Rpr Automatic Transfer Switch	2005	1,953	24	20	24		72	63
64	Rpr Automatic Transfer Switch	2005	2,029	59	20	59		177	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,649,272	\$ 157,285		\$ 88,009	\$ (69,276)	\$ 1,057,755	70

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

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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		\$ 2,649,272	\$ 157,285		\$ 88,009	\$ (69,276)	\$ 1,057,755	1
2	Thru wall windows A/CA	2006	6,550	764	5	764	(0)	1,528	2
3	Tree Removal/Due to Storm	2006	17,600	880	10	880		1,760	3
4	Door "42	2006	5,245	219	10	219	0	438	4
5	Tree Removal	2006	2,273	92	10	92	(0)	184	5
6	Repair Sprinkler System	2006	33,750	1,107	10	1,107	0	2,214	6
7									7
8	Electrical Work	2007	1,295	132	9.8	132		132	8
9	Dining Room Floor	2007	350	30	9.5	30		30	9
10	Dining Room Floor	2007	2,094	231	9.8	231	0	231	10
11	Emergency Generator	2007	2,311	255	9.8	255		255	11
12	Sprinkler Upgrade	2007	1,332	37	9	37		37	12
13	Shower Renovation	2007	2,529	70	9	70		70	13
14	Caretracker install 4 Kiosks	2007	2,673	891	3	891	(0)	891	14
15	Use Tax: Caretracker 4 Kiosks	2007	200	67	3	67		67	15
16	Installation Norstar ICS	2007	11,590	3,220	3	3,220		3,220	16
17	Katolight Generator	2007	13,781	1,390	9.9	1,390	0	1,390	17
18	Repair Parking Lot	2007	2,780	278	10	278	0	278	18
19	Interior Improvements - Reception Area	2007	1,710	171	10	171		171	19
20	Interior Improvements - New Office Space	2007	5,520	552	10	552		552	20
21	Interior Improvements - Add Wall in Dining Area	2007	2,230	223	10	223		223	21
22	Exterior Repairs - Siding, Soffits, and Shutters	2007	6,852	691	9.9	691	0	691	22
23	Repair Roof	2007	10,939	1,524	7.18	1,524	(0)	1,524	23
24	New Roof on Front Canopy	2007	3,434	429	8	429	(0)	429	24
25	New Roof on Kitchen	2007	3,450	431	8	431		431	25
26	Building Repairs - Windows, Canopies, Doors	2007	8,890	1,046	8.5	1,046	0	1,046	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,798,651	\$ 172,014		\$ 102,738	\$ (69,276)	\$ 1,075,546	34

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

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	\$ 492,802	\$ 20,199	\$ 20,199	\$ 0		\$ 246,208	71
72	Current Year Purchases	72,651	10,931	10,931	(0)		11,060	72
73	Fully Depreciated Assets	(214,200)						73
74								74
75	TOTALS	\$ 351,253	\$ 31,130	\$ 31,130	\$ 0		\$ 257,267	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)	\$ 3,200,150	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 203,144	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 34,358	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (69,275)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,332,813	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	\$ 1,662	86
87	O/H Allocation 12/01/1996	568	28	596	87
88	O/H Allocation 08/01/1997	277	14	291	88
89	O/H Allocation 10/01/1997	965	48	1,013	89
90					90
91	TOTALS	\$ 3,393	\$ 169	\$ 3,562	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:		74	01/01/2005	\$ 312,341	20		3
4	Additions							4
5								5
6								6
7	TOTAL		74		\$ 312,341			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.	<u>/2008</u>	\$ <u> </u>
13.	<u>/2009</u>	\$ <u> </u>
14.	<u>/2010</u>	\$ <u> </u>

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: \$ 17,431 Description: See Schedule 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			\$ _____	\$ _____	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: 1/1/2007

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Facility Name & ID Number

Nature Trail Healthcare Center

0039586

Ending: 12/31/2007

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 - Default <> SNF NonCert	84100000001011	Specialty Mattress/ Beds	2,852.00	03/10/03
Lease Exp - Eqpt - <> Default <> Prod Oxygen	84100000002022	Oxygen Concentrators	1,058.57	03/10/03
Lease Exp - Eqpt - <> Default <> Physical Therapy	84100000002200	Therapy Equipment	9,095.36	03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Activities	84100000007000			03/11/03
Lease Exp - Eqpt - Nonmedical <> Default <> Dietary	84100000007030	Diswasher		03/01/03
Lease Exp - Eqpt - Nonmedical <> Default <> Housekeeping / Janitoria	84100000007040			03/03/03
Lease Exp <> Eqpt<>Default<>Prod<>SNF Non Certified	84100000001011	Oxygen		03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Laundry	84100000007050			03/04/03
Lease Exp - Eqpt - Nonmedical <> Default <> Nursing Admin/Supv	84100000008000	Mattress		03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Administrative	84100000008100	Copiers, Stamp machine Cable	4,425.00	03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plant	84100000008210	SNF Supplies		03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	84100000008220			04/35/03
Lease Exp - Other <> Default <> Administrative	84102000008100			03/21/03
			17,430.93 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 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. <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	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a - 01	4593 hrs	\$ 134,681		\$		4,593	\$ 134,681	1
2	Licensed Speech and Language Development Therapist	10a - 01	1808 hrs	73,523				1,808	73,523	2
3	Licensed Recreational Therapist	10a - 01	hrs							3
4	Licensed Physical Therapist	10a - 01	5091 hrs	140,263				5,091	140,263	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 prescrpts				147,813		147,813	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			\$ 348,467		\$	\$ 147,813	11,492	\$ 496,280	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 Health Care Center# 0047357Report Period Beginning: 01/01/2007

Ending:

12/31/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2007

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 400	\$	1
2	Cash-Patient Deposits	175,992		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	482,953		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	175		6
7	Other Prepaid Expenses	33,887		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 693,407	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	36,749		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	136,868		15
16	Equipment, at Historical Cost	96,580		16
17	Accumulated Depreciation (book methods)	(35,408)		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>Leasehold Rights</u>	50,017		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 284,806	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 978,213	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 102,543	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	191,709		30
31	Accrued Taxes Payable (excluding real estate taxes)	251		31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,258		32
33	Accrued Interest Payable			33
34	Deferred Compensation	31,227		34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule 17.1</u>	(4,655)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 341,334	\$	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 Attached Schedule 17.1</u>	332,860		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 332,860	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 674,194	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 304,019	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 978,213	\$	48

*(See instructions.)

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2007 Page -17.1
Ending: 12/31/2007

Facility Name & ID Number Nature Trail Healthcare Center # 0039586

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

OTHER CURRENT ASSETS: AMOUNT

OTHER CURRENT LIABILITIES:		AMOUNT		
Benefits Dedctns - Employee	Employee Dedctns 401K Marine	201400201460000	-	17 36-1
Misc Dedctns - Employee	Flexible Spending AccountDefault-D	201500201510000	-	
Misc Dedctns - Employee	Union DuesDefault-Dept	201500201520000	-	
Misc Dedctns - Employee	MiscellaneousDefault-Dept	201500201530000	-	
Accrued Other	Accrued OtherDefault-Dept	221000221220000	66.30	
Accrued Other	PC Maintenance AccrualDefault-Dept	221000221040000	-	
Accrued Other	Accrued Legal FeesDefault-Dept	221000221230000	-	
Accrued Other	Telephone Maintenance AccrualDefault-Dept	221000221280000	-	
Accrued Other	Engineering ReserveDefault-Dept	221000221420000	(4,800.00)	
Accrued Taxes	Other TaxesDefault-Dept	220100220110000	-	
Accrued Taxes	State Sales & UseDefault-Dept	220100220130000	232.57	
Accrued Taxes	City Sales & UseDefault-Dept	220100220140000	46.50	
Franchise Tax Payable	Franchise TaxDefault-Dept	226200226200000	(200.00)	

Total 0 Difference

Reconcile with schedule XV, line 9:

OTHER NON-CURRENT ASSETS: pg 17 line 23 Col 1

Leasehold RightsContract RightsDefault-Dept	185200185200000	8,898
Leasehold RightsContract RightsDefault-Dept	185200185210000	41,119
Asset ClearingPS AM Capital Expenditures-FSRRealty	174900171008220	-
Asset ClearingPS AM Capital Expenditures SSCRealty	174900171018220	-

Total 50,017 Difference

Reconcile with schedule XV, line 23:

Total (4,655) Difference

Reconcile with schedule XV, line 36:

OTHER NON-CURRENT LIABILITIES::

Capital Lease ObligationsCLODefault-Dept	238000238000000	-	
Intercompany Revolver - SSCDefault-ProdDefault-Dept	240500000000000	(138,579)	17 43-1
Intercompany - RevolverDefault-ProdDefault-Dept	240000000000000	-	
L/T Benefits ReservePLGL Post-Petition ClaimsDefault-Dept	260000210140000	90,562	
L/T Benefits ReserveWorkers Comp Post-Petition ClmDefault	260000210160000	50,346	
Other Non-Current LbyDeferred CLO Gain/LossDefault-Dept	260500225030000	247,216	
Other Non-Current LbyRent AccrualDefault-Dept	260500260540000	83,315	
Other Non-Current LbyOtherDefault-Dept	260500260550000	-	

Total 332,860 Difference

Reconcile with schedule XV, line 43:

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,257,178	1
2	Restatements (describe):		2
3	Correction of reported amount in prior year	(2,412,375)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (155,197)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	459,213	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)	\$ 459,213	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)	\$ 304,016	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Nature Trail Health Care Center# 0047357Report Period Beginning: 01/01/2007Ending: 12/31/2007**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	\$ 4,690,199	1
2	Discounts and Allowances for all Levels	(1,716,330)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,973,869	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	873,162	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 873,162	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	3,976	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	196,827	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,903	19
20	Radiology and X-Ray	9,549	20
21	Other Medical Services	(6,250)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 240,005	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	Misc. Vending	32	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 32	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,087,068	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	558,688	31
32	Health Care	1,567,519	32
33	General Administration	905,396	33
B. Capital Expense			
34	Ownership	369,533	34
C. Ancillary Expense			
35	Special Cost Centers	226,719	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,627,855	40
41	Income before Income Taxes (line 30 minus line 40)**	459,213	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 459,213	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 # 0039586

SUPPLEMENATAL INCOME SCHEDULE

DESCRIPTION - Line 19 26a 1 & 19 28 1

AMOUNT

Miscellaneous Receipts<>Default<>Prod<>Administrative	600057000008100	
General Rental Receipts<>Default<>Prod<>Administrative	600060000008100	
Miscellaneous Receipts<>Default<>Prod<>Vending	600057000004102	(32)

Total (32.00) Difference

Reconcile with schedule XVII, line 28: (32) 0

DESCRIPTIONS - Line 19 28a 1

Miscellaneous Receipts<>Default<>Prod<>Activities	600057000007000
---	-----------------

Total - Difference

Reconcile with schedule XVII, line 28a: 0 -

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

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	1,847	2,015	\$ 56,124	\$ 27.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,082	11,287	236,446	20.95	3
4	Licensed Practical Nurses	11,725	12,822	197,320	15.39	4
5	CNAs & Orderlies	45,626	49,870	480,359	9.63	5
6	CNA Trainees					6
7	Licensed Therapist	10,545	11,702	355,577	30.39	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,832	2,088	23,254	11.14	9
10	Activity Assistants	1,288	1,434	10,342	7.21	10
11	Social Service Workers	1,326	1,455	15,235	10.47	11
12	Dietician					12
13	Food Service Supervisor	1,730	2,093	30,672	14.65	13
14	Head Cook	5,711	6,310	57,512	9.11	14
15	Cook Helpers/Assistants	5,212	5,617	46,529	8.28	15
16	Dishwashers					16
17	Maintenance Workers	1,869	2,123	22,293	10.50	17
18	Housekeepers	8,763	9,532	87,146	9.14	18
19	Laundry	5,099	5,532	39,901	7.21	19
20	Administrator	1,888	2,072	61,495	29.68	20
21	Assistant Administrator					21
22	Other Administrative	4,441	4,921	96,459	19.60	22
23	Office Manager					23
24	Clerical	2,205	2,356	29,780	12.64	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	979	1,111	11,296	10.17	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,168	134,340	\$ 1,857,740 *	\$ 13.83	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	144	\$ 7,730	1-3	35
36	Medical Director	192	6,600	9-3	36
37	Medical Records Consultant	32	2,860	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,408	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	36	1,915	11-3	44
45	Social Service Consultant	36	2,294	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	536	\$ 23,808		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

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 Assoc. \$4,395.60
- (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? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,680 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. N/A
- (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. \$ 1,468 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? No 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? No
- 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? Yes
Firm Name: BDO Seidman, LLC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. The audit is currently underway
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.