



Facility Name & ID Number Nature Trail Health Care Ctr

# 0047357 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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>6,954</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>55</u>	Intermediate (ICF)	<u>55</u>	<u>20,130</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>27,084</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>176</u>	<u>127</u>	<u>5,281</u>	<u>5,584</u>	8
9	SNF/PED					9
10	ICF	<u>14,385</u>	<u>4,162</u>	<u>214</u>	<u>18,761</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,561</u>	<u>4,289</u>	<u>5,495</u>	<u>24,345</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.89%

D. How many bed-hold days during this year were paid by the Department? 142 (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)

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 01/01/2005

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 01/01/2005 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 19 and days of care provided 5,157

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

**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
	<b>A. General Services</b>										
1	Dietary	141,248	9,733	11,223	162,204		162,204		162,204		1
2	Food Purchase		109,648		109,648		109,648	(3,570)	106,078		2
3	Housekeeping	94,899	8,349		103,248		103,248		103,248		3
4	Laundry	34,644	3,937		38,581		38,581		38,581		4
5	Heat and Other Utilities			88,095	88,095		88,095	(7,672)	80,423		5
6	Maintenance	23,159	46,681	7,396	77,236	(13)	77,223	8,072	85,295		6
7	Other (specify):*			11,251	11,251		11,251		11,251		7
8	<b>TOTAL General Services</b>	<b>293,950</b>	<b>178,348</b>	<b>117,965</b>	<b>590,263</b>	<b>(13)</b>	<b>590,250</b>	<b>(3,170)</b>	<b>587,080</b>		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,008,783	62,364	12,007	1,083,154		1,083,154		1,083,154		10
10a	Therapy	382,846	69,301	(760)	451,387		451,387		451,387		10a
11	Activities	37,395	4,697	2,692	44,784		44,784		44,784		11
12	Social Services	19,265	15	2,307	21,587		21,587		21,587		12
13	CNA Training										13
14	Program Transportation		215	17,090	17,305		17,305		17,305		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,448,289</b>	<b>136,592</b>	<b>40,536</b>	<b>1,625,417</b>		<b>1,625,417</b>		<b>1,625,417</b>		16
	<b>C. General Administration</b>										
17	Administrative	69,194			69,194		69,194		69,194		17
18	Directors Fees			500	500		500		500		18
19	Professional Services			1,386	1,386		1,386		1,386		19
20	Dues, Fees, Subscriptions & Promotions			22,215	22,215		22,215	(6,309)	15,906		20
21	Clerical & General Office Expenses	118,263	14,569	293,349	426,181		426,181	(156,191)	269,990		21
22	Employee Benefits & Payroll Taxes			268,424	268,424		268,424	9,121	277,545		22
23	Inservice Training & Education			5,665	5,665		5,665		5,665		23
24	Travel and Seminar			9,332	9,332		9,332	18,287	27,619		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			42,784	42,784		42,784	5,154	47,938		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>187,457</b>	<b>14,569</b>	<b>643,655</b>	<b>845,681</b>		<b>845,681</b>	<b>(129,938)</b>	<b>715,743</b>		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,929,696</b>	<b>329,509</b>	<b>802,156</b>	<b>3,061,361</b>	<b>(13)</b>	<b>3,061,348</b>	<b>(133,108)</b>	<b>2,928,240</b>		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 Peric Beginning: 1/1/2007  
Ending: 12/31/2007

Facility Name & ID Number +Facility # 0039586

Meals - adjustment

24,345 Days ( Total Patient days)  
3 Mult (3 meals a day)  
73,035 Sub total  
**1761** meals to employess (reported by facility)  
74,796 Add Sub  
**109,648** Divide -Pg 3, line 2, column 2  
2.00 Cost per day

2.00 Cost per day

1761 mult - meal to employees

**3,522.00** = adjust for pg 3, line 2, column 7

Personal Cable TV - in patient rooms

86004000004100 7,672

Sales Tax - adjustment

109,648 Total Food Cost (page 3,Line 2, col 2)  
1.01 Divide  
0.01 Mult  
1,086 Sub total  
8.81% Mult (Pvt pay div by total census)/2  
**48** = adjust for nonallowable sale tax  
for page 5A, Line 13

Reclassification V

Page 3 Line 6 col 01

Repair & Maint <> Vehicles<>Default<>Prod<>Transp 830010000003850 (13) Reclass From  
70% 18  
Page 4 line 38 13 Reclass to

Page 3 Line 14 col 01

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

Activities Page 3 line 11

Medical Page 4 line 38

- Reclass to

- Reclass to

-

Page 4 Line 35 Rent col 03

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



## 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	
	<b>D. Ownership</b>											
30	Depreciation			37,478	37,478		37,478	(5,729)	31,749			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(76)	(76)		(76)	20,372	20,296			32
33	Real Estate Taxes			24,348	24,348		24,348	436	24,784			33
34	Rent-Facility & Grounds			312,341	312,341		312,341		312,341			34
35	Rent-Equipment & Vehicles			6,620	6,620		6,620	8,855	15,475			35
36	Other (specify):*							17,940	17,940			36
37	<b>TOTAL Ownership</b>			380,711	380,711		380,711	41,874	422,585			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					13	13		13			38
39	Ancillary Service Centers		167,818	48,803	216,621		216,621	20,847	237,468			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,626	40,626		40,626		40,626			42
43	Other (specify):*		(1,347)		(1,347)		(1,347)		(1,347)			43
44	<b>TOTAL Special Cost Centers</b>		166,471	89,429	255,900	13	255,913	20,847	276,760			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,929,696	495,980	1,272,296	3,697,972		3,697,972	(70,387)	3,627,585			45

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

Facility Name & ID Number Nature Trail Health Care Ctr

# 0047357

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	(3,522)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,672)	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	(48)	2		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	(222)	24		19
20	Contributions	(100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(69,496)	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	(169)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (81,229)		\$	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)	260,079		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 260,079		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 178,850		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Nature Trail Health Care Ctr

ID# 0047357

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Non Allowable Advertising	\$ (6,140)	20	1
2	Back Office Management Fees	(221,812)	21	2
3	Marketing Wages (70%)	(15,556)	21	3
4	Adjust Depreciation to Historical	(5,729)	30	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(249,237)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,570)	0	0	0	0	0	0	0	0	0	0	(3,570)	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	(7,672)	0	0	0	0	0	0	0	0	0	0	(7,672)	5
6	Maintenance	0	8,072	0	0	0	0	0	0	0	0	0	8,072	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(11,242)</b>	<b>8,072</b>	<b>0</b>	<b>(3,170)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(6,309)	0	0	0	0	0	0	0	0	0	0	(6,309)	20
21	Clerical & General Office Expenses	(306,964)	150,773	0	0	0	0	0	0	0	0	0	(156,191)	21
22	Employee Benefits & Payroll Taxes	0	9,121	0	0	0	0	0	0	0	0	0	9,121	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(222)	18,509	0	0	0	0	0	0	0	0	0	18,287	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	5,154	0	0	0	0	0	0	0	0	0	5,154	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(313,495)</b>	<b>183,557</b>	<b>0</b>	<b>(129,938)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(324,737)</b>	<b>191,629</b>	<b>0</b>	<b>(133,108)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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	(5,729)	0	0	0	0	0	0	0	0	0	0	(5,729) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	20,372	0	0	0	0	0	0	0	0	0	20,372 32
33	Real Estate Taxes	0	436	0	0	0	0	0	0	0	0	0	436 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	8,855	0	0	0	0	0	0	0	0	0	8,855 35
36	Other (specify):*	0	17,940	0	0	0	0	0	0	0	0	0	17,940 36
37	<b>TOTAL Ownership</b>	<b>(5,729)</b>	<b>47,603</b>	<b>0</b>	<b>41,874 37</b>								
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	20,847	0	0	0	0	0	0	0	0	0	20,847 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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>20,847</b>	<b>0</b>	<b>20,847 44</b>								
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(330,466)</b>	<b>260,079</b>	<b>0</b>	<b>(70,387) 45</b>								

Facility Name & ID Number

Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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 listing on Pg 6.1				

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	5	Utilities	SSC Equity Holdings, LLC	100.00%	\$	\$	1
2	V	6	Repair and Maintenance	SSC Equity Holdings, LLC	100.00%	8,072	8,072	2
3	V	39	Professional Services	SSC Equity Holdings, LLC	100.00%	20,847	20,847	3
4	V	20	Fees, Subscriptions and Dues	SSC Equity Holdings, LLC	100.00%			4
5	V	10	Nursing and Medical Records	SSC Equity Holdings, LLC	100.00%			5
6	V	21	Clerical & Gen Office Exp	SSC Equity Holdings, LLC	100.00%	150,773	150,773	6
7	V	24	Travel and Seminar	SSC Equity Holdings, LLC	100.00%	18,509	18,509	7
8	V	26	Insurance	SSC Equity Holdings, LLC	100.00%	5,154	5,154	8
9	V	36	Depreciation	SSC Equity Holdings, LLC	100.00%	17,940	17,940	9
10	V	33	Taxes - Property	SSC Equity Holdings, LLC	100.00%	436	436	10
11	V	35	Rental and Leasing	SSC Equity Holdings, LLC	100.00%	8,855	8,855	11
12	V	32	Interest Income/Expense	SSC Equity Holdings, LLC	100.00%	20,372	20,372	12
13	V	22	Payroll Taxes	SSC Equity Holdings, LLC	100.00%	9,121	9,121	13
14	Total		\$			\$ 260,079	\$ * 260,079	14

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

**Related Illinois Nursing Homes  
as of 12/31/2008**

<b>Group Name</b>	<b>Related Illinois Nursing Homes</b>	<b>Illinois Facility Number</b>
SSC Equity Holdings, LLC	Montebello Health Care Center	6006316
	Nature Trail Health Care Center	6006498
	Odin Health Care Center	6006878
	Westchester Health Care Center	6012173

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Nature Trail Health Care Ctr

# 0047357 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

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 5300 Sam Houston Parkway North Ste 100  
 City / State / Zip Code Houston, TX 77041  
 Phone Number ( 832 467 6000  
 Fax Number ( 832 467 6114

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	Repairs and Maintenance						8,072	2
3	39	Professional Services						20,847	3
4	20	Fees, Subscriptions & Dues							4
5	10	Nursing & Medical Records							5
6	21	Clerical & Gen Office Exp						150,773	6
7	24	Travel and Seminar						18,509	7
8	26	Insurance						5,154	8
9	36	Depreciation						17,940	9
10	33	Taxes - Property						436	10
11	35	Rental and Leasing						8,855	11
12	32	Interest Income/Expense						20,372	12
13	22	Payroll Taxes						9,121	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				\$	\$		\$ 260,079	25

Facility Name & ID Number

Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**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				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	15

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

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

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

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

B. Real Estate Taxes

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	<b>12,076</b>	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.)		\$	<b>23,582</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>11,506</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>12,842</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>24,348</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	<b>19,979</b>	8	
	2004	<b>21,783</b>	9	
	2005	<b>22,148</b>	10	
	2006	<b>22,818</b>	11	
	2007	<b>24,238</b>	12	

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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: 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Nature Trail Health Care Ctr 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 Cos**

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2007.

(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>PT NE SW Beg 330.6S of NE Cor,</u>	<u>\$ 23,582.94</u>	<u>\$ 23,582.94</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<u>\$ 23,582.94</u>	<u>\$ 23,582.94</u>

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 direct 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 hom (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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2008

**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 Ctr

# 0047357 Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 17,558 B. General Construction Type: Exterior Brick Frame Concrete Block 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				\$	1
2					2
3	TOTALS			\$	3

Facility Name &amp; ID Number Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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		2005	1974	\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Repair Automatic Transfer Switch		2005	1,953	170	11.5	170		552	9
10											10
11		I2: Thru Wall Window A/C		2006	6,550	1,310	5	1,310		3,384	11
12		Tree Removal - Due to Storm		2006	17,600	1,760	10	1,760		4,400	12
13		Door - 42"		2006	5,245	525	10	525		1,268	13
14		Tree Removal		2006	2,273	222	10.25	222		536	14
15		Repair Sprinkler System		2006	33,750	3,320	10.25	3,320		7,746	15
16											16
17		Katolight Generator		2007	13,781	1,390	10	1,390		2,895	17
18		Electrical Work		2007	1,295	132	10	132		263	18
19		Repair Parking Lot		2007	89	9	10	9		19	19
20		Repair Parking Lot		2007	2,691	269	10	269		583	20
21		Interior Improvement		2007	1,710	171	10	171		370	21
22		Interior Improvement		2007	5,520	552	10	552		1,196	22
23		Interior Improvement		2007	2,230	223	10	223		483	23
24		Exterior Repairs		2007	6,852	691	10	691		1,440	24
25		New Dining Room Floor		2007	350	37	9.6	37		64	25
26		New Dining Room Floor		2007	2,094	213	9.83	213		426	26
27		Emergency Generator		2007	2,311	235	9.83	235		470	27
28		Repair Roof and Interior Rooms		2007	10,939	1,076	10.16	1,076		2,511	28
29		New Roof on Front Canopy		2007	3,434	343	10	343		744	29
30		New Roof on Kitchen Area		2007	3,450	345	10	345		748	30
31		Building Repairs		2007	8,890	896	10	896		1,868	31
32		Sprinkler Upgrade		2007	1,332	148	9	148		173	32
33		Shower Renovation		2007	2,529	281	9	281		328	33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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	7.5 Ton A/C Unit	2008	\$ 5,395	\$ 907	9.41	\$ 907		\$ 907	37
38	A T & T Circuit Conversion	2008	2,106	65	8	65		65	38
39	Maglock	2008	930	64	8.42	64		64	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 145,299	\$ 15,353		\$ 15,353		\$ 33,502	70

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

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	\$ 97,849	\$ 14,917	\$ 14,917		10	\$ 33,423	71
72	Current Year Purchases	14,205	1,479	1,479		3	1,479	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 112,055	\$ 16,396	\$ 16,396			\$ 34,902	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)	\$ 257,354	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 31,749	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 31,749	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 68,404	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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: SMV Property Holdings, LLC

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1974</u>	<u>74</u>		\$ <u>312,341</u>	<u>12</u>		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>74</b>		\$ <b>312,341</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 01/01/2005  
Ending 12/31/2016

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

	Fiscal Year Ending	Annual Rent
12.	<u>12/2009</u>	\$ <u>312,341</u>
13.	<u>12/2010</u>	\$ <u>312,341</u>
14.	<u>12/2011</u>	\$ <u>312,341</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: \$ \_\_\_\_\_ 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	<b>TOTAL</b>		\$ _____	\$ _____	<b>21</b>

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

**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. 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		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)	
<b>TOTAL TRAINED</b>	

- (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	10 a-1	##### hrs	\$ 107,404		\$	1,085	3,474	\$ 108,489	1
2	Licensed Speech and Language Development Therapist	10 a-1	##### hrs	71,863				1,676	71,863	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10 a-1	##### hrs	123,335			2,548	4,212	125,883	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				167,818		167,818	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 302,602		\$	\$ 171,451	9,362	\$ 474,053	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 Ctr # 0047357 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2008 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 400	\$	1
2	Cash-Patient Deposits	82,410		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	619,217		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	42,196		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 744,223	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	36,765		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	145,299		15
16	Equipment, at Historical Cost	112,055		16
17	Accumulated Depreciation (book methods)	(68,278)		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):	44,407		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 270,248	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,014,471	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 76,244	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	177,885		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,655		31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,583		32
33	Accrued Interest Payable			33
34	Deferred Compensation	31,227		34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36		432		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 331,026	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43		(197,219)		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ (197,219)	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 133,807	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 880,664	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,014,471	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 304,016	1
2	Restatements (describe):		2
3	Prior Year Adjustment	(166,452)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 137,564	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	743,100	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 743,100</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 880,664</b>	<b>24</b> *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,949,510	1
2	Discounts and Allowances for all Levels	(1,641,224)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,308,286</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	805,531	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 805,531</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	3,908	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	279,438	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	45,076	19
20	Radiology and X-Ray	8,691	20
21	Other Medical Services	(10,777)	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 326,336</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		<b>27</b>
28	Misc Income - Administrative	872	28
28a	Misc Income - Vending	48	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 920</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,441,073</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	590,263	31
32	Health Care	1,625,417	32
33	General Administration	845,681	33
<b>B. Capital Expense</b>			
34	Ownership	380,711	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	216,621	35
36	Provider Participation Fee	40,626	36
<b>D. Other Expenses (specify):</b>			
37		(1,357)	37
38		11	38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 3,697,973</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>743,100</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 743,100</b>	<b>43</b>

\* 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

Report Period: Beginning: 01/01/2008  
Ending: 12/31/2008

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

SUPPLEMENTAL SCHEDULE - OTHER INCOME

DESCRIPTION - Page 19, Line 28	Account Number	Amount
Miscellaneous ReceiptsDefault-ProdAdministrative	600057000008100	(872)
General Rental ReceiptsDefault-ProdAdministrative	600060000008100	0
Reconcile with Schedule XVII, Line 28		(872)

DESCRIPTION - Page 19, Line 28a	Account Number	Amount
Miscellaneous ReceiptsDefault-ProdVending	600057000004102	(48)
Reconcile with Schedule XVII, Line 28a		(48)

Facility Name & ID Number Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**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	1,584	1,828	\$ 51,489	\$ 28.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,233	10,150	220,966	21.77	3
4	Licensed Practical Nurses	14,511	15,726	266,831	16.97	4
5	CNAs & Orderlies	43,213	47,229	457,842	9.69	5
6	CNA Trainees					6
7	Licensed Therapist	10,313	11,356	382,846	33.71	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,896	2,096	24,971	11.91	9
10	Activity Assistants	1,235	1,312	12,424	9.47	10
11	Social Service Workers	1,585	1,744	19,265	11.05	11
12	Dietician					12
13	Food Service Supervisor	1,839	2,095	26,944	12.86	13
14	Head Cook	6,236	6,771	69,569	10.27	14
15	Cook Helpers/Assistants	4,812	5,060	44,734	8.84	15
16	Dishwashers					16
17	Maintenance Workers	1,877	2,100	23,159	11.03	17
18	Housekeepers	9,148	10,016	94,899	9.47	18
19	Laundry	4,196	4,584	34,644	7.56	19
20	Administrator	1,952	2,112	69,450	32.88	20
21	Assistant Administrator					21
22	Other Administrative	3,763	4,132	84,636	20.48	22
23	Office Manager					23
24	Clerical	2,125	2,355	33,371	14.17	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	1,154	1,154	11,655	10.10	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	120,672	131,820	\$ 1,929,695 *	\$ 14.64	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		\$ 11,223	1-3	35
36	Medical Director		7,200	9-3	36
37	Medical Records Consultant		1,459	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,599	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		2,692	11-3	44
45	Social Service Consultant		2,307	12-3	45
46	Other(specify)				46
47	Xray Consultant		25,095	39-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 52,575		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 Ctr

# 0047357

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Laurie Ellis	Administrator	0	\$ 69,194	Workers' Compensation Insurance	\$ 38,216	IDPH License Fee	\$ 4,853	
				Unemployment Compensation Insurance	20,883	Advertising: Employee Recruitment	4,853	
				FICA Taxes	137,900	Health Care Worker Background Check	1,105	
				Employee Health Insurance	61,044	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues	5,023	
				Life Insurance	2,513	Other Licenses	2,586	
				Other Benefits	7,869	Subscriptions	2,338	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 69,194	Home Office Payroll Tax Allocation	9,121			
B. Administrative - Other						Less: Public Relations Expense	( )	
Description			Amount			Non-allowable advertising	( )	
			\$			Yellow page advertising	( )	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 277,546	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,905	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$ 788
Vendor/Payee	Type		Amount					
CT Corp			\$ 234				In-State Travel	7,291
My InnerView	Surveys, Resident,Family		314				Meals	1,030
Press Ganey	Research		16				Entertainment	222
Sec of State	Legal Filing		250				Seminar Expense	
Talx Corp	Unemployment Mgmt		555				Home Office Allocation	18,509
Viotech Publishing	TLC Program		18					
							Entertainment Expense	(222)
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 1,386	TOTAL		\$	TOTAL	\$ 27,618
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Nature Trail Health Care Ctr

**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 Assn \$4,773
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,460 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. \_\_\_\_\_
- (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. \$ 40,626  
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. \$ 3,522 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? 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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**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. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? \_\_\_\_\_  
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. Audit not completed
- (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.

	2014	2013	2012	2011
<b>Operating Income</b>	<b>1,234,567</b>	<b>1,123,456</b>	<b>1,012,345</b>	<b>901,234</b>
Operating Expenses	(876,543)	(765,432)	(654,321)	(543,210)
Depreciation	123,456	112,345	101,234	90,123
Amortization	98,765	87,654	76,543	65,432
Provision for doubtful accounts	(54,321)	(43,210)	(32,109)	(21,098)
Gain on sale of equipment	21,098	10,987	9,876	8,765
Loss on sale of equipment	(10,987)	(9,876)	(8,765)	(7,654)
Interest income	32,109	21,098	10,987	9,876
Interest expense	(43,210)	(32,109)	(21,098)	(10,987)
Income tax expense	(65,432)	(54,321)	(43,210)	(32,109)
Other income	10,987	9,876	8,765	7,654
Other expense	(9,876)	(8,765)	(7,654)	(6,543)
<b>Net Income</b>	<b>357,890</b>	<b>246,789</b>	<b>135,678</b>	<b>24,567</b>
Other comprehensive income	12,345	11,234	10,123	9,012
Other comprehensive expense	(11,234)	(10,123)	(9,012)	(8,901)
<b>Comprehensive Income</b>	<b>358,999</b>	<b>247,900</b>	<b>136,789</b>	<b>33,478</b>



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