

Facility Name & ID Number Nature Trail Health Care Center0047357

0047357 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	19	Skilled (SNF)	19	6,935	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,075	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	67	49	4,920	5,036	8
9	SNF/PED					9
10	ICF	14,445	3,721	69	18,235	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,512	3,770	4,989	23,271	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.16%

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

70 (Do not include bed-hold days in Section B.)

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

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 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 4,868

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	131,284	11,857	12,029	155,170		155,170		155,170		1
2	Food Purchase		117,013		117,013		117,013	(2,127)	114,886		2
3	Housekeeping	107,040	7,747	3,116	117,903		117,903		117,903		3
4	Laundry	52,527	7,288		59,815		59,815		59,815		4
5	Heat and Other Utilities			80,158	80,158		80,158	(8,467)	71,691		5
6	Maintenance	24,176	45,748	5,165	75,089		75,089	7,942	83,031		6
7	Other (specify):*			8,425	8,425		8,425		8,425		7
8	TOTAL General Services	315,027	189,653	108,893	613,573		613,573	(2,652)	610,921		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,027,282	73,640	10,545	1,111,467	(32)	1,111,435		1,111,435		10
10a	Therapy	439,844	83,375		523,219		523,219		523,219		10a
11	Activities	40,936	2,746	2,320	46,002		46,002		46,002		11
12	Social Services	23,340		2,307	25,647		25,647		25,647		12
13	CNA Training										13
14	Program Transportation		836	48,803	49,639		49,639		49,639		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,531,402	160,597	71,175	1,763,174	(32)	1,763,142		1,763,142		16
	C. General Administration										
17	Administrative	72,772			72,772		72,772		72,772		17
18	Directors Fees			500	500		500		500		18
19	Professional Services			10,988	10,988		10,988	(8,078)	2,910		19
20	Dues, Fees, Subscriptions & Promotions			21,036	21,036		21,036	600	21,636		20
21	Clerical & General Office Expenses	129,471	12,561	258,218	400,250		400,250	(129,572)	270,678		21
22	Employee Benefits & Payroll Taxes			381,630	381,630		381,630	8,275	389,905		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,314	9,314		9,314	24,079	33,393		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			70,710	70,710		70,710	(48,029)	22,681		26
27	Other (specify):*										27
28	TOTAL General Administration	202,243	12,561	752,396	967,200		967,200	(152,725)	814,475		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,048,672	362,811	932,464	3,343,947	(32)	3,343,915	(155,377)	3,188,538		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Nature Trail Health Care Center

#0047357

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			39,443	39,443		39,443		39,443			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(4,797)	(4,797)		(4,797)	16,532	11,735			32
33	Real Estate Taxes			26,033	26,033		26,033	175	26,208			33
34	Rent-Facility & Grounds			312,341	312,341		312,341		312,341			34
35	Rent-Equipment & Vehicles							8,664	8,664			35
36	Other (specify):*							12,076	12,076			36
37	TOTAL Ownership			373,020	373,020		373,020	37,447	410,467			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		170,063	44,465	214,528	32	214,560	8,440	223,000			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		170,063	84,980	255,043	32	255,075	8,440	263,515			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,048,672	532,874	1,390,464	3,972,010		3,972,010	(109,490)	3,862,520			45

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

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	(2,033)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,467)	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	(94)	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	(100)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,078)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,967)	21		24
25	Fund Raising, Advertising and Promotional	(18,217)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(96)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (74,052)		\$	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)	237,686		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 237,686		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 163,634		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	X		32	10	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 32		47

BHF USE ONLY							
48		49		50		51	52

Nature Trail Health Care Center

ID# 0047357

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Back Office Service Fee	\$ (219,682)	21	1
2	Professional Liability Insurance	(53,441)	26	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(273,123)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	(2,127)	0	0	0	0	0	0	0	0	0	0	(2,127)	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	(8,467)	0	0	0	0	0	0	0	0	0	0	(8,467)	5
6	Maintenance	0	7,942	0	0	0	0	0	0	0	0	0	7,942	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,594)	7,942	0	(2,652)	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	(8,078)	0	0	0	0	0	0	0	0	0	0	(8,078)	19
20	Fees, Subscriptions & Promotions	(96)	696	0	0	0	0	0	0	0	0	0	600	20
21	Clerical & General Office Expenses	(274,966)	145,394	0	0	0	0	0	0	0	0	0	(129,572)	21
22	Employee Benefits & Payroll Taxes	0	8,275	0	0	0	0	0	0	0	0	0	8,275	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	24,079	0	0	0	0	0	0	0	0	0	24,079	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(53,441)	5,412	0	0	0	0	0	0	0	0	0	(48,029)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(336,581)	183,856	0	(152,725)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(347,175)	191,798	0	(155,377)	29								

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	16,532	0	0	0	0	0	0	0	0	0	16,532	32
33	Real Estate Taxes	0	175	0	0	0	0	0	0	0	0	0	175	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	8,664	0	0	0	0	0	0	0	0	0	8,664	35
36	Other (specify):*	0	12,076	0	0	0	0	0	0	0	0	0	12,076	36
37	TOTAL Ownership	0	37,447	0	37,447	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	8,440	0	0	0	0	0	0	0	0	0	8,440	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	8,440	0	8,440	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(347,175)	237,685	0	(109,490)	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SSC Equity Holdings LLC	100	Montebello Healthcare Center	Hamilton			
		Nature Trail Healthcare Center	Mount Vernon			
		Odin Healthcare Center	Odin			
		Westchester Healthcare Center	Westchester			

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%	7,942	7,942	2
3	V	39	Professional Services	SSC Equity Holdings LLC	100.00%	8,440	8,440	3
4	V	20	Fee, Subscriptions & Promos	SSC Equity Holdings LLC	100.00%	696	696	4
5	V	10	Nursing & Medical Records	SSC Equity Holdings LLC	100.00%			5
6	V	21	Clerical & Gen Office Exp	SSC Equity Holdings LLC	100.00%	145,394	145,394	6
7	V	24	Travel & Seminar	SSC Equity Holdings LLC	100.00%	24,079	24,079	7
8	V	26	Insurance	SSC Equity Holdings LLC	100.00%	5,412	5,412	8
9	V	36	Depreciation	SSC Equity Holdings LLC	100.00%	12,076	12,076	9
10	V	33	Taxes - Property	SSC Equity Holdings LLC	100.00%	175	175	10
11	V	35	Rental and Lease	SSC Equity Holdings LLC	100.00%	8,664	8,664	11
12	V	32	Interest Income/Expense	SSC Equity Holdings LLC	100.00%	16,532	16,532	12
13	V	22	Payroll Taxes	SSC Equity Holdings LLC	100.00%	8,275	8,275	13
14	Total		\$			\$ 237,685	\$ * 237,685	14

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

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 Center

0047357

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 5300 W Sam Houston Parkway N, Ste 100
 City / State / Zip Code Houston, TX 77041
 Phone Number (832 467 6000
 Fax Number (832 467 6983

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			\$	\$		0	1
2	6	Repair and Maintenance						7,942	2
3	39	Professional Services						8,440	3
4	20	Fee, Subscriptions & Promos						696	4
5	10	Nursing & Medical Records						0	5
6	21	Clerical & Gen Office Exp						145,394	6
7	24	Travel & Seminar						24,079	7
8	26	Insurance						5,412	8
9	36	Depreciation						12,076	9
10	33	Taxes - Property						175	10
11	35	Rental and Lease						8,664	11
12	32	Interest Income/Expense						16,532	12
13	22	Payroll Taxes						8,275	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				\$	\$		237,685	25

Facility Name & ID Number

Nature Trail Health Care Center

0047357

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

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
Improvement Type**										
9	Repair Automatic Transfer Switch	2005		1,953	170	11.5	170		722	9
10										10
11	12: Thru Wall Window A/C	2006		6,550	1,310	5	1,310		4,694	11
12	Tree Removal - Due to Storm	2006		17,600	1,760	10	1,760		6,160	12
13	Door - 42"	2006		5,245	525	10	525		1,792	13
14	Tree Removal	2006		2,273	222	10.25	222		758	14
15	Repair Sprinkler System	2006		33,750	3,320	10.25	3,320		11,066	15
16										16
17	Katolight Generator	2007		13,781	1,390	10	1,390		4,285	17
18	Electrical Work	2007		1,295	132	10	132		395	18
19	Repair Parking Lot	2007		89	9	10	9		28	19
20	Repair Parking Lot	2007		2,691	269	10	269		852	20
21	Interior Improvement	2007		1,710	171	10	171		542	21
22	Interior Improvement	2007		5,520	552	10	552		1,748	22
23	Interior Improvement	2007		2,230	223	10	223		706	23
24	Exterior Repairs	2007		6,852	691	10	691		2,130	24
25	New Dining Room Floor	2007		350	37	9.6	37		100	25
26	New Dining Room Floor	2007		2,094	213	9.83	213		639	26
27	Emergency Generator	2007		2,311	235	9.83	235		705	27
28	Repair Roof and Interior Rooms	2007		10,939	1,076	10.16	1,076		3,587	28
29	New Roof on Front Canopy	2007		3,434	343	10	343		1,087	29
30	New Roof on Kitchen Area	2007		3,450	345	10	345		1,093	30
31	Building Repairs	2007		8,890	896	10	896		2,764	31
32	Sprinkler Upgrade	2007		1,332	148	9	148		321	32
33	Shower Renovation	2007		2,529	281	9	281		609	33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 7.5 Ton A/C Unit	2008	\$ 5,395	\$ 573	9.41	\$ 573	\$	\$ 1,480	37
38 A T & T Circuit Conversion	2008	2,106	261	8	261		326	38
39 Maglock	2008	930	110	8.42	110		175	39
40								40
41								41
42								42
43 Bed Crash Rails	2009	1,661	40	7	40		40	43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 146,960	\$ 15,301		\$ 15,301	\$	\$ 48,803	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 118,792	\$ 17,140	\$ 17,140	\$	7	\$ 52,043	71
72	Current Year Purchases	14,941	1,392	1,392	(0)	7	1,392	72
73	Fully Depreciated Assets	(6,737)				7		73
74								74
75	TOTALS	\$ 126,996	\$ 18,532	\$ 18,532	\$ (0)		\$ 53,435	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)	\$ 273,956	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,833	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 33,833	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 102,238	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>1/1/2005</u>	\$ <u>312,341</u>	<u>12</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>74</u>		\$ <u>312,341</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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. 12/2010 \$ 312,341

13. 12/2011 \$ 312,341

14. 12/2012 \$ 312,341

* 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.

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-3	4623 hrs	\$ 154,112		\$		4,623	\$ 154,112	1
2	Licensed Speech and Language Development Therapist	10a-3	1845 hrs	83,799				1,845	83,799	2
3	Licensed Recreational Therapist	10a-3	hrs							3
4	Licensed Physical Therapist	10a-3	6018 hrs	194,000				6,018	194,000	4
5	Physician Care	39	visits							5
6	Dental Care	39	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				170,063		170,063	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			\$ 431,911		\$	\$ 170,063	12,486	\$ 601,974	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: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 400	\$	1
2	Cash-Patient Deposits	64,609		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	441,293		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	68,287		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 574,589	\$	10
B. Long-Term Assets				
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	146,960		15
16	Equipment, at Historical Cost	126,996		16
17	Accumulated Depreciation (book methods)	(102,110)		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>	38,797		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 247,408	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 821,997	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 77,230	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	219,545		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,465		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,683		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>Miscellaneous</u>	5,370		36
37	<u>Rounding</u>	2		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 380,522	\$	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>InterCompany</u>	(888,027)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (888,027)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (507,505)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,329,502	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 821,997	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 880,664	1
2	Restatements (describe):	24,839	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 905,503	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	423,999	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)	\$ 423,999	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)	\$ 1,329,502	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	\$ 4,902,943	1
2	Discounts and Allowances for all Levels	(1,684,911)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,218,032	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	837,841	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 837,841	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	2,476	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	311,993	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,071	19
20	Radiology and X-Ray	6,715	20
21	Other Medical Services	(16,002)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 340,253	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 Receipts - Admin	(166)	28
28a	Misc Receipts - Vending	49	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (117)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,396,009	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	613,573	31
32	Health Care	1,763,174	32
33	General Administration	967,200	33
B. Capital Expense			
34	Ownership	373,020	34
C. Ancillary Expense			
35	Special Cost Centers	214,528	35
36	Provider Participation Fee	40,515	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,972,010	40
41	Income before Income Taxes (line 30 minus line 40)**	423,999	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 423,999	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 Health Care Center

0047357

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	1,975	2,095	\$ 61,117	\$ 29.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,075	9,994	224,070	22.42	3
4	Licensed Practical Nurses	16,033	18,146	308,122	16.98	4
5	CNAs & Orderlies	39,413	43,100	422,546	9.80	5
6	CNA Trainees					6
7	Licensed Therapist	10,762	12,502	439,844	35.18	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,820	2,092	25,317	12.10	9
10	Activity Assistants	1,398	1,441	15,619	10.84	10
11	Social Service Workers	1,742	1,910	23,340	12.22	11
12	Dietician					12
13	Food Service Supervisor	1,669	1,896	25,442	13.42	13
14	Head Cook	6,576	7,124	69,406	9.74	14
15	Cook Helpers/Assistants	3,962	4,232	36,436	8.61	15
16	Dishwashers					16
17	Maintenance Workers	1,908	2,157	24,176	11.21	17
18	Housekeepers	10,022	10,970	107,040	9.76	18
19	Laundry	5,919	6,389	52,527	8.22	19
20	Administrator	1,634	2,087	72,772	34.87	20
21	Assistant Administrator					21
22	Other Administrative	4,149	4,604	93,961	20.41	22
23	Office Manager					23
24	Clerical	2,273	2,572	35,510	13.81	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	1,127	1,127	11,426	10.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	121,457	134,438	\$ 2,048,671 *	\$ 15.24	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		\$ 11,813	1-3	35
36	Medical Director		7,200	9-3	36
37	Medical Records Consultant		1,444	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,518	10-3	39
40	Physical Therapy Consultant			10a-3	40
41	Occupational Therapy Consultant			10a-3	41
42	Respiratory Therapy Consultant			10a-3	42
43	Speech Therapy Consultant			10a-3	43
44	Activity Consultant		2,307	11-3	44
45	Social Service Consultant		2,307	12-3	45
46	Other(specify) <u>Administrative</u>		13,346	10-3	46
47	<u>Xray & Laboratory</u>		42,981	39-3	47
48	<u>Dentist/Physician/Psychiatrist</u>		399	39-3	48
49	TOTAL (lines 35 - 48)		\$ 85,315		49

C. CONTRACT NURSES

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

Facility Name & ID Number Nature Trail Health Care Center

0047357

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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 \$3,831
- (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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,414 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. \$ 40,515
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. \$ 0 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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
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? _____
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? Yes
Firm Name: BDO Seidman, LLC
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.