

		FOR BHF USE					

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**2011  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
FOR LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2011)**

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

<p><b>I. IDPH License ID Number:</b> <u>0047357</u></p> <p><b>Facility Name:</b> <u>SSC Mount Vernon Operating Company LLC dba Nature Trail Healthcare Center</u></p> <p><b>Address:</b> <u>1001 South 34th Street</u> <u>Mount Vernon</u> <u>62864</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Jefferson</u></p> <p><b>Telephone Number:</b> <u>618 242 5700</u> <b>Fax #</b> <u>618 242 1572</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>10/01/2005</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Martha McDaniel</u> <b>Telephone Number:</b> <u>832-467-6317</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Chris Stenger</u> (Title) <u>Vice President of Planning and Reimbursement</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) ( ) _____ Fax # ( ) _____</td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Chris Stenger</u> (Title) <u>Vice President of Planning and Reimbursement</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Chris Stenger</u> (Title) <u>Vice President of Planning and Reimbursement</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____							

Facility Name & ID Number SSC Mount Vernon Operating Company LLC dba Nature Trail Healthcare Center # 0047357 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	5,326	435	5,003	10,764	8	
9	SNF/PED					9	
10	ICF	7,048	918	363	8,329	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	12,374	1,353	5,366	19,093	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.69%

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

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

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 \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary Trailblazer

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number SSC Mount Vernon Operating Company LLC # 0047357 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

**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	115,755	16,563	12,813	145,131		145,131		145,131		1
2	Food Purchase		102,918		102,918		102,918	(1,194)	101,724		2
3	Housekeeping	82,568	9,268	4,351	96,187		96,187		96,187		3
4	Laundry	37,124	10,040		47,164		47,164		47,164		4
5	Heat and Other Utilities			79,628	79,628		79,628	(13,179)	66,449		5
6	Maintenance	42,821	66,942	12,242	122,005		122,005	10,401	132,406		6
7	Other (specify):*			11,237	11,237		11,237		11,237		7
8	<b>TOTAL General Services</b>	<b>278,268</b>	<b>205,731</b>	<b>120,271</b>	<b>604,270</b>		<b>604,270</b>	<b>(3,972)</b>	<b>600,298</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,103,324	75,037	63,468	1,241,829		1,241,829		1,241,829		10
10a	Therapy	609,637	71,262		680,899		680,899		680,899		10a
11	Activities	47,662	2,819	2,549	53,030		53,030		53,030		11
12	Social Services	24,371		2,375	26,746		26,746		26,746		12
13	CNA Training										13
14	Program Transportation	23,020	2,516	10,163	35,699		35,699		35,699		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,808,014</b>	<b>151,634</b>	<b>85,755</b>	<b>2,045,403</b>		<b>2,045,403</b>		<b>2,045,403</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	80,469			80,469		80,469		80,469		17
18	Directors Fees			500	500		500		500		18
19	Professional Services			6,054	6,054		6,054	(288)	5,766		19
20	Dues, Fees, Subscriptions & Promotions			29,133	29,133		29,133	744	29,877		20
21	Clerical & General Office Expenses	118,505	23,778	139,687	281,970		281,970	50,317	332,287		21
22	Employee Benefits & Payroll Taxes			447,517	447,517		447,517	11,891	459,408		22
23	Inservice Training & Education										23
24	Travel and Seminar			17,469	17,469		17,469	39,211	56,680		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			71,395	71,395		71,395	(45,527)	25,868		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>198,974</b>	<b>23,778</b>	<b>711,755</b>	<b>934,507</b>		<b>934,507</b>	<b>56,348</b>	<b>990,855</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,285,256</b>	<b>381,143</b>	<b>917,781</b>	<b>3,584,180</b>		<b>3,584,180</b>	<b>52,376</b>	<b>3,636,556</b>		<b>29</b>

\*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.

## 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	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			52,827	52,827		52,827		52,827			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(2,892)	(2,892)		(2,892)	7	(2,885)			32
33	Real Estate Taxes			26,715	26,715		26,715	(2,354)	24,361			33
34	Rent-Facility & Grounds			312,341	312,341		312,341		312,341			34
35	Rent-Equipment & Vehicles			123	123		123	9,452	9,575			35
36	Other (specify):*							12,721	12,721			36
37	<b>TOTAL Ownership</b>			389,114	389,114		389,114	19,826	408,940			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		127,213	49,966	177,179		177,179	12,104	189,283			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	<b>TOTAL Special Cost Centers</b>		127,213	90,481	217,694		217,694	12,104	229,798			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,285,256	508,356	1,397,376	4,190,988		4,190,988	84,306	4,275,294			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,158)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,179)	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	(36)	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				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(288)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	56,081	21		24
25	Fund Raising, Advertising and Promotional	(6,048)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 35,372		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	315,031		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 315,031		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 350,403		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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		(19)	10 43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ (19)	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

SSC Mount Vernon Operating Company LLC dba Nature Trail Healthcare Center

ID# 0047357

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Back Office Services	\$ (212,328)	21	1
2	Professional Liability	(51,302)	26	2
3	Real Estate Taxes - Accrual Adj	(2,467)	33	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	<b>Total</b>	(266,097)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number SSC Mount Vernon Operating Company LLC dba Nature T# 0047357

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

## 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	(1,194)	0	0	0	0	0	0	0	0	0	0	(1,194)	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	(13,179)	0	0	0	0	0	0	0	0	0	0	(13,179)	5
6	Maintenance	0	10,401	0	0	0	0	0	0	0	0	0	10,401	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(14,373)</b>	<b>10,401</b>	<b>0</b>	<b>(3,972)</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	(288)	0	0	0	0	0	0	0	0	0	0	(288)	19
20	Fees, Subscriptions & Promotions	0	744	0	0	0	0	0	0	0	0	0	744	20
21	Clerical & General Office Expenses	(162,295)	212,612	0	0	0	0	0	0	0	0	0	50,317	21
22	Employee Benefits & Payroll Taxes	0	11,891	0	0	0	0	0	0	0	0	0	11,891	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	39,211	0	0	0	0	0	0	0	0	0	39,211	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(51,302)	5,775	0	0	0	0	0	0	0	0	0	(45,527)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(213,885)</b>	<b>270,233</b>	<b>0</b>	<b>56,348</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(228,258)</b>	<b>280,634</b>	<b>0</b>	<b>52,376</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number SSC Mount Vernon Operating Company LLC dba Nature# 0047357

Report Period Beginning:

01/01/2011 Ending:

12/31/2011

## 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)	
	<b>D. Ownership</b>													
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	7	0	0	0	0	0	0	0	0	0	7	32
33	Real Estate Taxes	(2,467)	113	0	0	0	0	0	0	0	0	0	(2,354)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	9,452	0	0	0	0	0	0	0	0	0	9,452	35
36	Other (specify):*	0	12,721	0	0	0	0	0	0	0	0	0	12,721	36
37	<b>TOTAL Ownership</b>	<b>(2,467)</b>	<b>22,293</b>	<b>0</b>	<b>19,826</b>	<b>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	12,104	0	0	0	0	0	0	0	0	0	12,104	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>12,104</b>	<b>0</b>	<b>12,104</b>	<b>44</b>								
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(230,725)</b>	<b>315,031</b>	<b>0</b>	<b>84,306</b>	<b>45</b>								

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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 Health Care Center	Hamilton			
		Nature Trail Health Care Center	Mount Vernon			
		Odin Health Care Center	Odin			
		Westchester Health and Rehab 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%	10,401	10,401	2
3	V	39	Professional Services	SSC Equity Holdings LLC	100.00%	12,104	12,104	3
4	V	20	Fee, Subscriptions and Promos	SSC Equity Holdings LLC	100.00%	744	744	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%	212,612	212,612	6
7	V	24	Travel & Seminar	SSC Equity Holdings LLC	100.00%	39,211	39,211	7
8	V	26	Insurance	SSC Equity Holdings LLC	100.00%	5,775	5,775	8
9	V	36	Depreciation	SSC Equity Holdings LLC	100.00%	12,721	12,721	9
10	V	33	Taxes - Property	SSC Equity Holdings LLC	100.00%	113	113	10
11	V	35	Rental and Lease	SSC Equity Holdings LLC	100.00%	9,452	9,452	11
12	V	32	Interest Income/Expense	SSC Equity Holdings LLC	100.00%	7	7	12
13	V	22	Payroll Taxes	SSC Equity Holdings LLC	100.00%	11,891	11,891	13
14	Total		\$			\$ 315,031	\$ *	315,031 14

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



Facility Name & ID Number SSC Mount Vernon Operating Company LL # 0047357 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 SSC Mount Vernon Operating Company LLC dba Nature ' # 0047357 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 Pkwy 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			\$	\$		\$	1
2	6	Repair & Maintenance						10,401	2
3	39	Professional Services						12,104	3
4	20	Fee, Subscriptions & Promos						744	4
5	10	Nursing & Med Records							5
6	21	Clerical & General Office Exp						212,612	6
7	24	Travel & Seminar						39,211	7
8	26	Insurance						5,775	8
9	36	Depreciation						12,721	9
10	33	Taxes - Property						113	10
11	35	Rental & Lease						9,452	11
12	32	Interest Income/Expense						7	12
13	22	Payroll Taxes						11,891	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				\$	\$		\$ 315,031	25

Facility Name & ID Number

SSC Mount Vernon Operating Company LLC

# 0047357

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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

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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2010 report.		\$	<b>25,482</b>		<b>1</b>
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>25,973</b>		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>491</b>		<b>3</b>
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>23,757</b>		<b>4</b>
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>		\$			<b>5</b>
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>		\$			<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>24,248</b>		<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	<b>22,818</b>	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	2007	<b>24,238</b>	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2010 \$ <b>13</b>
	2008	<b>24,683</b>	<b>10</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$ <b>14</b>
	2009	<b>25,482</b>	<b>11</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$ <b>15</b>
	2010	<b>25,482</b>	<b>12</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$ <b>16</b>

**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.**



**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).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		1,062	9
10										10
11	12: Thru Wall Window A/C	2006		6,550	546	5	546		6,550	11
12	Tree Removal - Due to Storm	2006		17,600	1,760	10	1,760		9,680	12
13	Door - 42"	2006		5,245	525	10	525		2,841	13
14	Tree Removal	2006		2,273	222	10.25	222		1,201	14
15	Repair Sprinkler System	2006		33,750	3,320	10.25	3,320		17,705	15
16										16
17	Katolight Generator	2007		13,781	1,390	10	1,390		7,064	17
18	Electrical Work	2007		1,295	132	10	132		658	18
19	Repair Parking Lot	2007		89	9	10	9		46	19
20	Repair Parking Lot	2007		2,691	269	10	269		1,390	20
21	Interior Improvement	2007		1,710	171	10	171		884	21
22	Interior Improvement	2007		5,520	552	10	552		2,852	22
23	Interior Improvement	2007		2,230	223	10	223		1,152	23
24	Exterior Repairs	2007		6,852	691	10	691		3,512	24
25	New Dining Room Floor	2007		350	37	9.6	37		173	25
26	New Dining Room Floor	2007		2,094	213	9.83	213		1,065	26
27	Emergency Generator	2007		2,311	235	9.83	235		1,175	27
28	Repair Roof and Interior Rooms	2007		10,939	1,076	10.16	1,076		5,739	28
29	New Roof on Front Canopy	2007		3,434	343	10	343		1,774	29
30	New Roof on Kitchen Area	2007		3,450	345	10	345		1,782	30
31	Building Repairs	2007		8,890	896	10	896		4,557	31
32	Sprinkler Upgrade	2007		1,332	148	9	148		617	32
33	Shower Renovation	2007		2,529	281	9	281		1,171	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 and Improvement Costs-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	\$ 573	9.41	\$ 573	\$	\$ 2,626	37
38	A T & T Circuit Conversion	2008	2,106	260	8	260		847	38
39	Maglock	2008	930	110	8.42	110		396	39
40									40
41	Bed Crash Rails	2009	1,661	237	7	237		514	41
42									42
43	Handrails	2010	10,441	1,510	7	1,510		3,145	43
44	30 Gallon Storage Container	2010	795	111	7	111		259	44
45	Remodel 5 Hallway Bathrooms (Contracted Total)-Carpentry	2010	4,939	780	6.3	780		1,170	45
46	Floor and Wall Mosaic Ceramic Tile for Bathroom Remodel	2010	7,571	1,195	6.3	1,195		1,793	46
47	Satellite Dish	2010	8,106	1,351	6	1,351		1,576	47
48	Satellite Dish	2010	4,893	827	6	827		896	48
49									49
50	Replace Shower Floor Liner, walls and fixtures - 5 bathrooms	2011	12,400	2,270	5.92	2,270		2,270	50
51	Replace Shower Floor Liner, walls and fixtures - 5 bathrooms	2011	3,306	605	5.92	605		605	51
52	2: Door Closers/Hinges	2011	1,125	193	5.83	193		193	52
53	Fire Alarm Horn Strobe Detector	2011	4,081	747	5.92	747		747	53
54	Replace Rooftop Unit Compressor	2011	1,245	307	6.42	307		307	54
55	Walkway Safety Bars	2011	1,715	294	5.83	294		294	55
56	Wall Mounted Kitchen Cabinet	2011	3,042	557	5.92	557		557	56
57	Marble Tops, Recessed bowls and faucets - 5 bath updates	2011	1,376	267	6	267		268	57
58	Maglock	2011	1,497	398	6.58	398		398	58
59	Annunciator	2011	3,661	584	5.75	584		584	59
60	Hand Rail	2011	8,988	968	5.42	968		968	60
61	Replace cement board and tile in bath areas	2011	3,419	321	5.33	321		321	61
62	Replace cement board and tile in bath areas	2011	3,419	168	5.08	168		168	62
63	3: Dry Pendent Sprinkler Heads	2011	2,495	83	5	83		83	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 235,474	\$ 28,270		\$ 28,270	\$	\$ 95,635	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 141,203	\$ 16,906	\$ 16,906	\$		\$ 87,144	71
72	Current Year Purchases	16,343	2,042	2,042			2,042	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 157,546	\$ 18,948	\$ 18,948	\$		\$ 89,186	75

D. Vehicle Costs. (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)	\$ 393,020	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 47,218	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,218	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)	\$ 184,821	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>01/01/2005</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. /2012 \$ 312,341

13. /2013 \$ 312,341

14. /2014 \$ 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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.

Facility Name &amp; ID Number

SSC Mount Vernon Operating Company LLC dba Nature Trail Healthc # 0047357 Report Period Beginning:

01/01/2011 Ending:

12/31/2011

## 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	6153 hrs	\$ 223,594		\$		6,153	\$ 223,594	1
2	Licensed Speech and Language Development Therapist	10a-3	2101 hrs	98,804				2,101	98,804	2
3	Licensed Recreational Therapist	10a-3	hrs							3
4	Licensed Physical Therapist	10a-3	8538 hrs	284,348				8,538	284,348	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				127,213		127,213	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			\$ 606,746		\$	\$ 127,213	16,792	\$ 733,959	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 SSC Mount Vernon Operating Company LLC dba Nature T# 0047357Report Period Beginning: 01/01/2011Ending: 12/31/2011

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 400	\$	1
2	Cash-Patient Deposits	19,689		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	766,704		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,801		6
7	Other Prepaid Expenses	4,253		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>	\$ 792,847	\$	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	235,475		15
16	Equipment, at Historical Cost	157,545		16
17	Accumulated Depreciation (book methods)	(184,822)		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):	27,578		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 272,541	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,065,388	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 85,665	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	215,413		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,691		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,973		32
33	Accrued Interest Payable			33
34	Deferred Compensation	61,947		34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	Franchise Tax	302		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 416,991	\$	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		(985,267)		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ (985,267)	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ (568,276)	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,633,664	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,065,388	\$	48

\*(See instructions.)

## XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,529,122</b>	<b>1</b>
<b>2</b>	Restatements (describe):	<b>46,393</b>	<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,575,515</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>58,149</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>58,149</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,633,664</b>	<b>24</b> *

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

Facility Name & ID Number SSC Mount Vernon Operating Company LLC dba # 0047357 Report Period Beginning: 01/01/2011Ending: 12/31/2011**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	\$ 3,920,362	1
2	Discounts and Allowances for all Levels	(1,415,944)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,504,418</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,322,095	6
7	Oxygen	9,543	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,331,638</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	2,349	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	300,053	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	49,941	19
20	Radiology and X-Ray	34,532	20
21	Other Medical Services	25,977	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 412,852</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>		27
28	<u>Miscellaneous Income</u>	229	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 229</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,249,137</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	604,270	31
32	Health Care	2,045,403	32
33	General Administration	934,507	33
<b>B. Capital Expense</b>			
34	Ownership	389,114	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	177,179	35
36	Provider Participation Fee	40,515	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,190,988</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>58,149</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 58,149</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.

Facility Name & ID Number SSC Mount Vernon Operating Company LLC dba Nature 1

# 0047357

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

**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	1,778	1,858	\$ 69,961	\$ 37.65	1
2	Assistant Director of Nursing	840	903	29,735	32.93	2
3	Registered Nurses	7,783	8,913	214,225	24.04	3
4	Licensed Practical Nurses	18,049	19,375	353,583	18.25	4
5	CNAs & Orderlies	36,945	39,601	409,388	10.34	5
6	CNA Trainees					6
7	Licensed Therapist	13,988	16,908	609,637	36.06	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,977	2,108	30,802	14.61	9
10	Activity Assistants	1,274	1,404	16,859	12.01	10
11	Social Service Workers	1,687	1,854	24,370	13.14	11
12	Dietician					12
13	Food Service Supervisor	2,001	2,085	30,505	14.63	13
14	Head Cook	4,902	5,202	50,043	9.62	14
15	Cook Helpers/Assistants	3,939	4,166	35,207	8.45	15
16	Dishwashers					16
17	Maintenance Workers	1,990	2,111	42,820	20.28	17
18	Housekeepers	8,351	9,125	82,568	9.05	18
19	Laundry	4,039	4,335	37,124	8.56	19
20	Administrator	1,874	2,050	79,054	38.56	20
21	Assistant Administrator					21
22	Other Administrative	3,196	3,400	85,059	25.02	22
23	Office Manager					23
24	Clerical	1,843	1,979	34,862	17.62	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	1,885	2,120	26,434	12.47	31
32	Other Health Care(specify)	1,777	1,996	23,020	11.53	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	120,118	131,493	\$ 2,285,256 *	\$ 17.38	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	\$ 11,248	1-3	35
36	Medical Director	7,200	9-3	36
37	Medical Records Consultant		10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,878	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	2,359	11-3	44
45	Social Service Consultant	2,375	12-3	45
46	Other(specify)	46,078	10-3	46
47		47,784	39-3	47
48		481	39-3	48
49	TOTAL (lines 35 - 48)	\$ 121,403		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 SSC Mount Vernon Operating Company LLC dba Nature Trail Health # 0047357 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Health Care Association \$7744
- (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. \$ 13,944 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? yes Indicate the amount. \$ 1,158
- (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? 0  
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? 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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.