



Facility Name & ID Number Nature Trail Health Care Ctr

# 0047357 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	0	0	6,524	6,524	8
9	SNF/PED					9
10	ICF	10,062	835	321	11,218	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,062	835	6,845	17,742	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.69%

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

3 (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 74 and days of care provided 3,619

Medicare Intermediary Novitas Solutions Inc

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name &amp; ID Number

Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**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	133,434	14,580	10,421	158,435		158,435		158,435		1
2	Food Purchase		115,220		115,220		115,220	(1,854)	113,366		2
3	Housekeeping	71,260	9,204	3,634	84,098		84,098		84,098		3
4	Laundry	27,817	8,606	48	36,471		36,471		36,471		4
5	Heat and Other Utilities			59,491	59,491		59,491	(3,375)	56,116		5
6	Maintenance	36,482	90,651	9,371	136,504		136,504	16,002	152,506		6
7	Other (specify):* <b>Waste Disposal</b>			6,263	6,263		6,263		6,263		7
8	<b>TOTAL General Services</b>	268,993	238,261	89,228	596,482		596,482	10,773	607,255		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,025,127	69,911	33,275	1,128,313		1,128,313	178,265	1,306,578		10
10a	Therapy	481,481	40,142		521,623		521,623		521,623		10a
11	Activities	47,185	2,257	2,381	51,823		51,823		51,823		11
12	Social Services	29,502		2,377	31,879		31,879		31,879		12
13	CNA Training										13
14	Program Transportation	23,101	3,419	24,048	50,568		50,568		50,568		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,606,396	115,729	69,281	1,791,406		1,791,406	178,265	1,969,671		16
	<b>C. General Administration</b>										
17	Administrative	90,018			90,018		90,018	4,741	94,759		17
18	Directors Fees			525	525		525		525		18
19	Professional Services			35,750	35,750		35,750	(15,874)	19,876		19
20	Dues, Fees, Subscriptions & Promotions			18,999	18,999		18,999	(5,695)	13,304		20
21	Clerical & General Office Expenses	68,832	22,457	220,454	311,743		311,743	(235,607)	76,136		21
22	Employee Benefits & Payroll Taxes			387,526	387,526		387,526	30,433	417,959		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,604	11,604		11,604	27,977	39,581		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			91,682	91,682		91,682	(1,223)	90,459		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	158,850	22,457	766,540	947,847		947,847	(195,248)	752,599		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,034,239	376,447	925,049	3,335,735		3,335,735	(6,210)	3,329,525		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 Ctr

#0047357

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

12/31/2013

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			62,053	62,053		62,053	4,858	66,911			30
31	Amortization of Pre-Op. & Org.			5,609	5,609		5,609		5,609			31
32	Interest			(24,074)	(24,074)		(24,074)		(24,074)			32
33	Real Estate Taxes			30,220	30,220		30,220	(1,405)	28,815			33
34	Rent-Facility & Grounds			247,374	247,374		247,374	26,315	273,689			34
35	Rent-Equipment & Vehicles			123	123		123		123			35
36	Other (specify):* HO Depr/Franchise Tax			250	250		250	29,617	29,867			36
37	<b>TOTAL Ownership</b>			321,555	321,555		321,555	59,385	380,940			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		113,050	56,250	169,300		169,300		169,300			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			125,162	125,162		125,162		125,162			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		113,050	181,412	294,462		294,462		294,462			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,034,239	489,497	1,428,016	3,951,752		3,951,752	53,175	4,004,927			45

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

Facility Name & ID Number Nature Trail Health Care Ctr

# 0047357

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,675)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,383)	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	(179)	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	(505)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(30,036)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(47,698)	21		24
25	Fund Raising, Advertising and Promotional	(6,524)	20		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	(157,506)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (247,506)</b>		<b>\$</b>	<b>30</b>

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)	300,681		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 300,681</b>		<b>36</b>
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ 53,175</b>		<b>37</b>

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

Nature Trail Health Care Ctr

ID# 0047357

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Back Office Services Fees	\$ (189,585)	21	1
2	Professional Liability Insurance Adj	(4,632)	26	2
3	Real Estate Tax Accrual Adjustment	(1,405)	33	3
4	Remove Rent Averaging	26,315	34	4
5	Adjust Health Insurance to Actual	6,943	22	5
6	Adjust Depreciation to Actual	4,858	30	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>		(157,506)	49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## 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	(1,854)	0	0	0	0	0	0	0	0	0	0	(1,854)	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	(3,383)	8	0	0	0	0	0	0	0	0	0	(3,375)	5
6	Maintenance	0	16,002	0	0	0	0	0	0	0	0	0	16,002	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(5,237)</b>	<b>16,010</b>	<b>0</b>	<b>10,773</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	178,265	0	0	0	0	0	0	0	0	0	178,265	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>178,265</b>	<b>0</b>	<b>178,265</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	0	4,741	0	0	0	0	0	0	0	0	0	4,741	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(30,036)	14,162	0	0	0	0	0	0	0	0	0	(15,874)	19
20	Fees, Subscriptions & Promotions	(6,524)	829	0	0	0	0	0	0	0	0	0	(5,695)	20
21	Clerical & General Office Expenses	(237,788)	2,181	0	0	0	0	0	0	0	0	0	(235,607)	21
22	Employee Benefits & Payroll Taxes	6,943	23,490	0	0	0	0	0	0	0	0	0	30,433	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	27,977	0	0	0	0	0	0	0	0	0	27,977	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(4,632)	3,409	0	0	0	0	0	0	0	0	0	(1,223)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(272,037)</b>	<b>76,789</b>	<b>0</b>	<b>(195,248)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(277,274)</b>	<b>271,064</b>	<b>0</b>	<b>(6,210)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

## 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	4,858	0	0	0	0	0	0	0	0	0	0	4,858	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(1,405)	0	0	0	0	0	0	0	0	0	0	(1,405)	33
34	Rent-Facility & Grounds	26,315	0	0	0	0	0	0	0	0	0	0	26,315	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	29,617	0	0	0	0	0	0	0	0	0	29,617	36
37	<b>TOTAL Ownership</b>	<b>29,768</b>	<b>29,617</b>	<b>0</b>	<b>59,385</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	0	0	0	0	0	0	0	0	0	0	0	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>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>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(247,506)	300,681	0	0	0	0	0	0	0	0	0	53,175	45

**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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	SSC Equity Holdings LLC	100.00%	\$ 8	\$ 8	1
2	V	6 Repair and Maintenance		SSC Equity Holdings LLC	100.00%	16,002	16,002	2
3	V	19 Professional Services		SSC Equity Holdings LLC	100.00%	14,162	14,162	3
4	V	20 Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	829	829	4
5	V	10 Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	178,265	178,265	5
6	V	21 Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	2,181	2,181	6
7	V	24 Travel & Seminar		SSC Equity Holdings LLC	100.00%	27,977	27,977	7
8	V	26 Insurance		SSC Equity Holdings LLC	100.00%	3,409	3,409	8
9	V	36 Depreciation		SSC Equity Holdings LLC	100.00%	29,617	29,617	9
10	V	17 Communications		SSC Equity Holdings LLC	100.00%	4,741	4,741	10
11	V	35 Rental and Lease		SSC Equity Holdings LLC	100.00%			11
12	V	32 Interest Income/Expense		SSC Equity Holdings LLC	100.00%			12
13	V	22 Payroll Taxes		SSC Equity Holdings LLC	100.00%	23,490	23,490	13
14	Total		\$			\$ 300,681	\$ * 300,681	14

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

SSC Equity Holdings LLC

Street Address

5300 W Sam Houston Pkwy N Ste 100

City / State / Zip Code

Houston, TX 77041

Phone Number

( 832-467-6000

Fax Number

( 832-467-6983

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities			\$	\$		8	1
2	6	Repair and Maintenance						16,002	2
3	19	Professional Services						14,162	3
4	20	Fee, Subscriptions and Promos						829	4
5	10	Nursing & Medical Records						178,265	5
6	21	Clerical & Gen Office Exp						2,181	6
7	24	Travel & Seminar						27,977	7
8	26	Insurance						3,409	8
9	36	Drpreiation						29,617	9
10	17	Communications						4,741	10
11	35	Rental and Lease							11
12	32	Interest Income/Expense							12
13	22	Payroll Taxes						23,490	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				\$	\$		300,681	25

Facility Name & ID Number

Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		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 2012 report.		\$	<u>27,272</u>		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>28,815</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>1,543</u>		3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>27,272</u>		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>28,815</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>24,683</u>	8	<b>FOR BHF USE ONLY</b>	
	2009	<u>25,482</u>	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$ 13
	2010	<u>25,482</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2011	<u>25,973</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2012	<u>28,815</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Nature Trail Health Care Ctr COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0047357

CONTACT PERSON REGARDING THIS REPORT Martha McDaniel

TELEPHONE 832467-6317 FAX #: 832-467-6983

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-36-327-006</u>	<u>PT NE SW Beg 330.6' S of NE</u>	\$ <u>28,815.00</u>	\$ <u>28,815.00</u>
2. _____	<u>COR, S 175' W 300'S 125' W 230'</u>	\$ _____	\$ _____
3. _____	<u>N 300'E 530'to POB - 1001 S</u>	\$ _____	\$ _____
4. _____	<u>34th Street</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>28,815.00</u></u>	\$ <u><u>28,815.00</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?                 YES        X   NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,558 B. General Construction Type: Exterior Brick Frame 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 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	175	11.5	175		1,443	9
10										10
11		2006		6,550		5			6,550	11
12	Tree Removal - Due to Storm	2006		17,600	1,760	10	1,760		13,200	12
13	Door - 42"	2006		5,245	525	10	525		3,890	13
14	Tree Removal	2006		2,273	209	10.25	209		1,632	14
15	Repair Sprinkler System	2006		33,750	3,122	10.25	3,122		24,146	15
16										16
17	Katolight Generator	2007		13,781	1,308	10	1,308		9,762	17
18	Electrical Work	2007		1,295	124	10	124		914	18
19	Repair Parking Lot	2007		89	8	10	8		63	19
20	Repair Parking Lot	2007		2,691	253	10	253		1,913	20
21	Interior Improvement	2007		1,710	161	10	161		1,215	21
22	Interior Improvement	2007		5,520	519	10	519		3,923	22
23	Interior Improvement	2007		2,230	210	10	210		1,585	23
24	Exterior Repairs	2007		6,852	650	10	650		4,854	24
25	New Dining Room Floor	2007		350	34	9.6	34		244	25
26	New Dining Room Floor	2007		2,094	200	9.83	200		1,478	26
27	Emergency Generator	2007		2,311	221	9.83	221		1,631	27
28	Repair Roof and Interior Rooms	2007		10,939	1,012	10.16	1,012		7,826	28
29	New Roof on Front Canopy	2007		3,434	343	10	343		2,461	29
30	New Roof on Kitchen Area	2007		3,450	345	10	345		2,473	30
31	Building Repairs	2007		8,890	844	10	844		6,297	31
32	Sprinkler Upgrade	2007		1,332	140	9	140		904	32
33	Shower Renovation	2007		2,529	265	9	265		1,717	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

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

# 0047357

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**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	\$ 540	9.41	\$ 540	\$	\$ 3,739	37
38	A T & T Circuit Conversion	2008	2,106	247	8	247		1,354	38
39	Maglock	2008	930	104	8.42	104		611	39
40									40
41	Bed Crash Rails	2009	1,661	226	7	226		977	41
42									42
43	Handrails	2010	10,441	1,436	7	1,436		6,091	43
44	30 Gallon Storage Container	2010	795	105	7	105		475	44
45	Remodel 5 Hallway Bathrooms (Contracted Total)-Carpentry	2010	4,939	744	6.3	744		2,694	45
46	Floor and Wall Mosaic Ceramic Tile for Bathroom Remodel	2010	7,571	1,141	6.3	1,141		4,130	46
47	Satellite Dish	2010	8,106	1,292	6	1,292		4,220	47
48	Satellite Dish	2010	4,893	792	6	792		2,514	48
49									49
50	Replace Shower Floor Liner, walls and fixtures - 5 bathrooms	2011	12,400	2,006	5.92	2,006		6,372	50
51	Replace Shower Floor Liner, walls and fixtures - 5 bathrooms	2011	3,306	535	5.92	535		1,699	51
52	2: Door Closers/Hinges	2011	1,125	413	5.83	413		563	52
53	Fire Alarm Horn Strobe Detector	2011	4,081	660	5.92	660		2,097	53
54	Replace Rooftop Unit Compressor	2011	1,245	185	6.42	185		686	54
55	Walkway Safety Bars	2011	1,715	629	5.83	629		858	55
56	Wall Mounted Kitchen Cabinet	2011	3,042	492	5.92	492		1,563	56
57	Marble Tops, Recessed bowls and faucets - 5 bath updates	2011	1,376	219	6	219		716	57
58	Maglock	2011	1,497	217	6.58	217		842	58
59	Annunciator	2011	3,661	1,220	5.75	1,220		1,805	59
60	Hand Rail	2011	8,988	3,210	5.42	3,210		4,159	60
61	Replace cement board and tile in bath areas	2011	3,419	1,212	5.33	1,212		1,554	61
62	Replace cement board and tile in bath areas	2011	3,419	1,180	5.08	1,180		1,465	62
63	3: Dry Pendent Sprinkler Heads	2011	2,495	853	5	853		1,046	63
64									64
65	10 Ton Heat/Cool Roof Top Unit	2012	25,200	4,961	5	4,961		9,824	65
66	Portable Storage	2012	2,000	574	10	574		691	66
67	Kitchen Hood System	2012	8,541	2,195	10	2,195		2,266	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 271,215	\$ 39,816		\$ 39,816	\$	\$ 165,132	70

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

**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	
1	Totals from Page 12A, Carried Forward		\$ 271,215	\$ 39,816		\$ 39,816	\$	\$ 165,132	1
2	2: Thru Wall A/C Units	2013	1,502	398		398		398	2
3	Kichen Hood Syst - Bal Due	2013	6,608	1,753		1,753		1,753	3
4	Fire Alarm System Deposit	2013	12,475	2,495		2,495		2,495	4
5	Fire Alarm System Install	2013	12,475	2,031		2,031		2,031	5
6	5 Ton Kitchen A/C Unit	2013	2,850	407		407		407	6
7	Basement Sprinkler System	2013	4,400	537		537		537	7
8	Lvt Flooring Entry & Dining Room	2013	6,930	187		187		187	8
9	Fire Rated Door	2013	2,226	60		60		60	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 320,681	\$ 47,684		\$ 47,684	\$	\$ 173,000	34

\*\*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	\$ 164,983	\$ 17,166	\$ 17,166	\$		\$ 125,602	71
72	Current Year Purchases	13,563	2,061	2,061			2,061	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 178,546	\$ 19,227	\$ 19,227	\$		\$ 127,663	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)	\$ 499,227	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 66,911	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,911	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)	\$ 300,663	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: SSC Equity 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>273,689</u>	<u>1</u>		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>74</b>		\$ <b>273,689</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 01/01/2005

Ending 12/31/2016

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

Fiscal Year Ending                      Annual Rent

12.                     /2014                      \$ 284,637

13.                     /2015                      \$ 296,022

14.                     /2016                      \$ 307,863

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2013 Ending: 12/31/2013  
**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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

	Service	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5	6	7	8
			Units of Service	Cost	Units	Cost	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
1	Licensed Occupational Therapist	10a-03	5202 hrs	\$ 175,139		\$	\$		5,202	\$ 175,139	1	
2	Licensed Speech and Language Development Therapist	10a-03	2129 hrs	99,663					2,129	99,663	2	
3	Licensed Recreational Therapist	10a-03	hrs								3	
4	Licensed Physical Therapist	10a-03	5601 hrs	206,678					5,601	206,678	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					113,050		113,050	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	<b>TOTAL</b>			\$ 481,480		\$	\$	113,050	12,932	\$ 594,530	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 &amp; ID Number Nature Trail Health Care Ctr

# 0047357

Report Period Beginning: 01/01/2013

Ending:

12/31/2013

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(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	(2,363)		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	632,141		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,902		6
7	Other Prepaid Expenses	2,177		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 636,257	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	36,154		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	320,682		15
16	Equipment, at Historical Cost	178,543		16
17	Accumulated Depreciation (book methods)	(300,664)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	55,953		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	16,360		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 307,028	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 943,285	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 118,003	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	184,495		30
31	Accrued Taxes Payable (excluding real estate taxes)	(418)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,489		32
33	Accrued Interest Payable			33
34	Deferred Compensation	61,126		34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36		80,023		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 472,718	\$	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		(848,333)		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ (848,333)	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ (375,615)	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,318,900	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 943,285	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 1,484,951	1
2	Restatements (describe):	(8,920)	2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 1,476,031	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(157,131)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (157,131)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,318,900	24 *

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

Facility Name & ID Number Nature Trail Health Care Ctr# 0047357Report Period Beginning: 01/01/2013Ending: 12/31/2013

**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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,662,883	1
2	Discounts and Allowances for all Levels	(1,264,227)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,398,656</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,056,154	6
7	Oxygen	3,192	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,059,346</b>	8
<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	2,749	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	255,188	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	44,980	19
20	Radiology and X-Ray	31,731	20
21	Other Medical Services	1,795	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 336,443</b>	23
<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>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Vending Receipts</u>	176	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 176</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,794,621</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	596,482	31
32	Health Care	1,791,406	32
33	General Administration	948,097	33
<b>B. Capital Expense</b>			
34	Ownership	321,305	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	169,300	35
36	Provider Participation Fee	125,162	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>\$ 3,951,752</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(157,131)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (157,131)</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 975,041	44
45	Private Pay - Net Inpatient Revenue	146,266	45
46	Medicare - Net Inpatient Revenue	838,327	46
47	Other-(specify)	570	47
48	Other-(specify)	438,452	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 2,398,656</b>	49

\* 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 Ctr

# 0047357

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

**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	1,829	1,925	\$ 63,354	\$ 32.91	1
2	Assistant Director of Nursing	1,932	2,127	50,270	23.63	2
3	Registered Nurses	13,045	13,726	315,050	22.95	3
4	Licensed Practical Nurses	8,271	9,187	163,333	17.78	4
5	CNAs & Orderlies	35,026	37,551	406,689	10.83	5
6	CNA Trainees					6
7	Licensed Therapist	10,600	13,334	481,481	36.11	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,980	2,207	33,167	15.03	9
10	Activity Assistants	1,041	1,148	14,018	12.21	10
11	Social Service Workers	1,935	2,087	29,502	14.14	11
12	Dietician					12
13	Food Service Supervisor	1,931	2,085	30,569	14.66	13
14	Head Cook	5,725	6,064	67,547	11.14	14
15	Cook Helpers/Assistants	3,639	3,753	35,319	9.41	15
16	Dishwashers					16
17	Maintenance Workers	1,963	2,087	36,482	17.48	17
18	Housekeepers	7,096	7,839	71,260	9.09	18
19	Laundry	2,997	3,183	27,817	8.74	19
20	Administrator	1,973	2,093	87,332	41.73	20
21	Assistant Administrator					21
22	Other Administrative	1,903	2,087	58,419	27.99	22
23	Office Manager					23
24	Clerical	528	642	13,100	20.40	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	1,836	2,127	26,430	12.43	31
32	Other Health Care(specify)	1,824	1,973	23,100	11.71	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	107,074	117,225	\$ 2,034,239 *	\$ 17.35	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	\$ 9,556	1-3	35
36	Medical Director	7,200	9-3	36
37	Medical Records Consultant	500	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,718	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	2,381	11-3	44
45	Social Service Consultant	2,377	12-3	45
46	Other(specify) <u>Admin</u>	72,960	10-3	46
47	<u>Xray &amp; Lab</u>	42,472	39-3	47
48	<u>Dentist/Physician/Psychiatrist</u>	1,866	39-3	48
49	TOTAL (lines 35 - 48)	\$ 144,030		49

**C. CONTRACT NURSES**

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

Facility Name & ID Number Nature Trail Health Care Ctr

# 0047357

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Verna M Germanceri	Administrator		\$ 81,885	Workers' Compensation Insurance	\$ 44,673	IDPH License Fee	\$ 1,990	
Linda L Cox	Interim Admin		8,133	Unemployment Compensation Insurance	79,316	Advertising: Employee Recruitment	4,915	
				FICA Taxes	147,346	Health Care Worker Background Check	2,029	
				Employee Health Insurance	110,702	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Publications and Manuals	1,923	
				Life Ins	2,213	Dues	1,999	
				Other Benefits	10,218	Other Licenses	448	
				Home Office PR Taxes	23,490			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 90,018	TOTAL (agree to Schedule V, line 22, col.8)		\$ 13,304		
B. Administrative - Other							Less: Public Relations Expense ( )	
Description			Amount				Non-allowable advertising ( )	
			\$				Yellow page advertising ( )	
							TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				\$ 417,958	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Sevarus Corp/Point Right	Survey Tracking		\$ 880			\$	Out-of-State Travel	\$ 2,856
Schutjer Bogar LLC	Legal		26,461					
Illinois State Police	Patient Background Cks		830				In-State Travel	3,710
Cass Info Services	Background Checks		373					
Old Seville Exp Reduction	Bio WasteExp Reduction		81					
CT Corp	Litigation Tracking		257				Seminar Expense	5,039
GenPact	Reengineering Cost Analysis		661				Home Office Travel and Seminar	27,977
Talx	Unemployment		671					
LexisNexis/Equifax/Laminex	Data Management		147				Entertainment Expense ( )	
Waste Reduction Consult	Waste Reduction		1,140				(agree to Sch. V, line 24, col. 8)	
National Research Corp			673				TOTAL	\$ 39,582
Ogletree Deakins			3,576					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 35,750	TOTAL			\$	

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 \$1709
- (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? 12 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,256 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. \$ 125,162  
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? 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 (Corporate Level)
- (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.