

Facility Name & ID Number Nature Trail Health Care Ctr

0047357 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	6,488	6,488	8
9	SNF/PED					9
10	ICF	10,020	1,005	599	11,624	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,020	1,005	7,087	18,112	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.06%

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

4 (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)

NA

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

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

YES NO

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

YES NO

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

Date started 01/01/2005

J. Was the facility purchased or leased after January 1, 1978?

YES Date 01/01/2005 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 19 and days of care provided _____

Medicare Intermediary Novitas Solutions Inc

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number

Nature Trail Health Care Ctr

0047357

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	142,363	16,156	10,462	168,981		168,981		168,981		1
2	Food Purchase		118,463		118,463		118,463	(1,671)	116,792		2
3	Housekeeping	69,984	9,585	4,997	84,566		84,566		84,566		3
4	Laundry	25,951	11,262		37,213		37,213		37,213		4
5	Heat and Other Utilities			66,537	66,537		66,537	(3,409)	63,128		5
6	Maintenance	34,950	131,885	10,237	177,072		177,072	14,984	192,056		6
7	Other (specify):*			6,790	6,790		6,790		6,790		7
8	TOTAL General Services	273,248	287,351	99,023	659,622		659,622	9,904	669,526		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,071,582	70,837	13,243	1,155,662		1,155,662	176,218	1,331,880		10
10a	Therapy	392,450	59,501	78,083	530,034		530,034		530,034		10a
11	Activities	43,310	2,029	2,203	47,542		47,542		47,542		11
12	Social Services	29,222		2,203	31,425		31,425		31,425		12
13	CNA Training										13
14	Program Transportation	30,017	4,146	(8,835)	25,328		25,328		25,328		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,566,581	136,513	94,097	1,797,191		1,797,191	176,218	1,973,409		16
	C. General Administration										
17	Administrative	90,081			90,081		90,081	4,451	94,532		17
18	Directors Fees			525	525		525		525		18
19	Professional Services			8,473	8,473		8,473	3,674	12,147		19
20	Dues, Fees, Subscriptions & Promotions			26,362	26,362		26,362	7,238	33,600		20
21	Clerical & General Office Expenses	115,152	21,982	261,768	398,902		398,902	(291,215)	107,687		21
22	Employee Benefits & Payroll Taxes			409,499	409,499		409,499	22,289	431,788		22
23	Inservice Training & Education										23
24	Travel and Seminar			31,206	31,206		31,206	28,353	59,559		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			83,356	83,356		83,356	3,595	86,951		26
27	Other (specify):*							300	300		27
28	TOTAL General Administration	205,233	21,982	821,189	1,048,404		1,048,404	(221,315)	827,089		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,045,062	445,846	1,014,309	3,505,217		3,505,217	(35,193)	3,470,024		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			75,154	75,154		75,154		75,154			30
31	Amortization of Pre-Op. & Org.			4,611	4,611		4,611		4,611			31
32	Interest			(4,939)	(4,939)		(4,939)	15,602	10,663			32
33	Real Estate Taxes			31,263	31,263		31,263	676	31,939			33
34	Rent-Facility & Grounds			130,500	130,500		130,500	(3,512)	126,988			34
35	Rent-Equipment & Vehicles			123	123		123		123			35
36	Other (specify):*							29,055	29,055			36
37	TOTAL Ownership			236,712	236,712		236,712	41,821	278,533			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		132,228	62,566	194,794		194,794		194,794			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,005	134,005		134,005		134,005			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		132,228	196,571	328,799		328,799		328,799			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,045,062	578,074	1,447,592	4,070,728		4,070,728	6,628	4,077,356			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: 01/01/2014

Ending: 12/31/2014

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	(1,638)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,438)	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	(33)	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	(2,200)	21		18
19	Entertainment	(109)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,858)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,433)	21		24
25	Fund Raising, Advertising and Promotional	(39,498)	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	(193,095)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (302,302)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	308,930		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 308,930		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 6,628		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Nature Trail Health Care Ctr

ID# 0047357

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Back Office Service Fee	\$ (190,559)	21	1
2	Rent Averaging	(3,512)	34	2
3	Real Estate Tax Accrual Adj	976	33	3
4	Reclass Franchise Tax	(300)	33	4
5	Reclass Franchise Tax	300	27	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(193,095)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,671)	0	0	0	0	0	0	0	0	0	0	(1,671)	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	(3,438)	29	0	0	0	0	0	0	0	0	0	(3,409)	5
6	Maintenance	0	14,984	0	0	0	0	0	0	0	0	0	14,984	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,109)	15,013	0	9,904	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	176,218	0	0	0	0	0	0	0	0	0	176,218	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	176,218	0	176,218	16								
	C. General Administration													
17	Administrative	0	4,451	0	0	0	0	0	0	0	0	0	4,451	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,858)	5,532	0	0	0	0	0	0	0	0	0	3,674	19
20	Fees, Subscriptions & Promotions	0	7,238	0	0	0	0	0	0	0	0	0	7,238	20
21	Clerical & General Office Expenses	(292,690)	1,475	0	0	0	0	0	0	0	0	0	(291,215)	21
22	Employee Benefits & Payroll Taxes	0	22,289	0	0	0	0	0	0	0	0	0	22,289	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(109)	28,462	0	0	0	0	0	0	0	0	0	28,353	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,595	0	0	0	0	0	0	0	0	0	3,595	26
27	Other (specify):*	300	0	0	0	0	0	0	0	0	0	0	300	27
28	TOTAL General Administration	(294,357)	73,042	0	(221,315)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(299,466)	264,273	0	(35,193)	29								

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	15,602	0	0	0	0	0	0	0	0	0	15,602	32
33	Real Estate Taxes	676	0	0	0	0	0	0	0	0	0	0	676	33
34	Rent-Facility & Grounds	(3,512)	0	0	0	0	0	0	0	0	0	0	(3,512)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	29,055	0	0	0	0	0	0	0	0	0	29,055	36
37	TOTAL Ownership	(2,836)	44,657	0	41,821	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	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	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(302,302)	308,930	0	6,628	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		Montebello Health Care Center	Hamilton	SSC Equity Holdings LLC		Holding Company
		Nature Trail Health Care Center	Mount Vernon	SSC Administrative Services LLC		Back Office Service
		Odin Health Care Center	Odin	SSC Consulting Services		Operations and Con
		Westchester Health and Rehab Center	Westchester			
		Brentwood Sub Acute Healthcare Center	Burbank			

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%	\$ 29	\$	29	1
2	V	6 Repair and Maintenance		SSC Equity Holdings LLC	100.00%	14,984		14,984	2
3	V	19 Professional Services		SSC Equity Holdings LLC	100.00%	5,532		5,532	3
4	V	20 Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	7,238		7,238	4
5	V	10 Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	176,218		176,218	5
6	V	21 Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	1,475		1,475	6
7	V	24 Travel & Seminar		SSC Equity Holdings LLC	100.00%	28,462		28,462	7
8	V	26 Insurance		SSC Equity Holdings LLC	100.00%	3,595		3,595	8
9	V	36 Depreciation		SSC Equity Holdings LLC	100.00%	29,055		29,055	9
10	V	17 Communications		SSC Equity Holdings LLC	100.00%	4,451		4,451	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%	15,602		15,602	12
13	V	22 Payroll Taxes		SSC Equity Holdings LLC	100.00%	22,289		22,289	13
14	Total		\$			\$ 308,930	\$ *	308,930	14

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

Facility Name & ID Number

Nature Trail Health Care Ctr

0047357

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holdings Company LLC		Cedar Crest	Montgomery				1
2			Fairview Health & Rehab Center	Birmingham				2
3			Montrose Bay Healthcare Center	Fairhope				3
4			South Haven Health & Rehab Center	Montgomery				4
5			Warren Manor	Selma				5
6			Woodley Manor	Montgomery				6
7			Excell Health Care Center	Oakland				7
8			Flagship Health care Center	Newport Beach				8
9			Tarzana Health & Rehab Center	Tarzana				9
10			Diamond Ridge Health Care Center	Pittsburgh				10
11			Courtyard Care Center	San Jose				11
12			Mission Carmichael Health Care Center	Carmichael				12
13			AlpineLiving Center	Thornton				13
14			Boulder Manor	Boulder				14
15			Pearl Street Health Care Center	Englewood				15
16			Applewood Living Center	Longmont				16
17			Fort Collins Health Care Center	Fort Collins				17
18			Spring Creek Healthcare Center	Fort Collins				18
19			Berthoud Living Center	Berthoud				19
20			Sierra Vista Health Care Center	Loveland				20
21			Windsor Health Care Center	Windsor				21
22			San Juan Living Center	Montrose				22
23			Four Corners Health Care Center	Durango				23
24			Palisade Living Center	Palisade				24
25			Colonial Columns Nursing Center	Colorado Springs				25
26			Cedarwood Health Care Center	Colorado Springs				26
27			Minnequa Medicenter	Pueblo				27
28			Terrace Gaedens Healthcare Center	Colorado Springs				28
29			Aspen Living Cente	Colorado Springs				29
30			Belmont Lodge	Pueblo				30

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0047357

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VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holdings Company LLC		Centennial Heathcare Center	Greeley				1
2			Kenton Manor	Greeley				2
3			Stering Living Center	Sterling				3
4			Sunset Manor	Brush				4
5			Yuma Life Care Center	Yuma				5
6			Jewell Care Center of Denver	Denver				6
7			Monaco Parkway	Denver				7
8			Garden Square at Spring Creek	Fort Collins				8
9			Pendleton Health & Rehab	Mystic				9
10			Bride Brook Health & Rehab	Niantic				10
11			Brian Center Nursing Care Austell	Austill				11
12			Brian Center Health & Rehab Canton	Canton				12
13			Northeast Atlanta Healty & Rehab	Atlanta				13
14			Brighton Place West	Topeka				14
15			Indian Creek Healht Care Center	Overland Park				15
16			SE Massachusetts Health & Rehab	New Bedford				16
17			Methuen Health & Rehab Center	Methuen				17
18			Patuxent River Health & Rehab Center	Laurel				18
19			Arcola Health & Rehab Center	Silver Spring				19
20			Glen Burnie Health & Rehab Center	Glen Burnie				20
21			Overlea Health & Rehab Center	Baltimore				21
22			Bethesda Health & Rehab Center	Bethesda				22
23			Summit Park Health & Rehab Center	Catonsville				23
24			North Arundel Health & Rehab Center	Glen Burnie				24
25			Bel Air Health & Rehab Center	Bel Air				25
26			Forest Hill Health & Rehab Center	Forest Hill				26
27			Heritage Harbour Health & Rehab Center	Annapolis				27
28			Cambridge East	Madison Heights				28
29			Cambridge North	Clawson				29
30			Cambridge South	Beverly Hills				30

Facility Name & ID Number

Nature Trail Health Care Ctr

0047357

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holdings Company LLC		Clarkston	Clarkston				1
2			Clinton-Aire Healthcare Center	Clinton Township				2
3			Crestmont NursingCare Center	Fenton				3
4			Heritage Manor	Flint				4
5			Hope Health Care Center	Westland				5
6			Warren Woods Health Care Center	Warren				6
7			Superior Woods Health Care Center	Ypsilanti				7
8			Countrybrook Living Center	Brook Haven				8
9			Brian Center Health & Rehab Eden	Eden				9
10			Brian Center Nursing Care Lexington	Lexington				10
11			Brian Center Health & Rehab Hickory East	Hickory				11
12			Brian Center Health & Rehab Wilson	Wilson				12
13			Randolph Health & Rehab Center	Asheboro				13
14			Brian Center Health & Rehab Winston Salem	Winston Salem				14
15			Brian Center Health & Rehab Charlotte	Charlotte				15
16			Brian Center Health & Rehab Windsor	Windsor				16
17			Maple Leaf Health Care	Statesville				17
18			Brian Center Health & Rehab Weaverville	Weaverville				18
19			Brian Center Health & Rehab Lincolnton	Lincolnton				19
20			Brian Center Health & Rehab Wallace	Wallace				20
21			Brian Center Health & Rehab Monroe	Monroe				21
22			Brian Center Health & Rehab Durham	Durham				22
23			Brian Center Health & Rehab Goldsboro	Goldsboro				23
24			Brian Center Health & Rehab Cabarrus	Concord				24
25			Brian Center Nursing Care Shamrock	Charlotte				25
26			Brian Center Nursing Care Hickory	Hickory				26
27			Brian Center Health & Rehab Center Waynesvi	Waynesville				27
28			Brian Center Health & Rehab Clayton	Clayton				28
29			Brian Center Health & Rehab Brevard	Bervard				29
30			Brian Center Health & Rehab Yanceyville	Yanceyville				30

Facility Name & ID Number

Nature Trail Health Care Ctr

0047357

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holdings Company LLC		Brian Center Health & Rehab Hertfort	Hertfort				1
2			Brian Center Health & Rehab Spruce Pine	Spruce Pine				2
3			Brian Center Health & Rehab Hendersonville	Hendersonville				3
4			Brian Center Health & Rehab Salisbury	Salisbury				4
5			Mariner Health Care of Wilmington	Wilmington				5
6			Silver Stream Health & Rehab	Wilmington				6
7			Kenansville Health & Rehab	Kenansville				7
8			Charlotte Apts	Charlotte				8
9			Forest City Health & Rehab	Forest City				9
10			Arbor Manor Living Center	Fremont				10
11			Crete Manor	Crete				11
12			Haven Home	Kenesaw				12
13			Pawnee Manor	Pawnee City				13
14			Pierce Manor	Pierce				14
15			West Point Living Center	West Point				15
16			North Hills Health & Rehab	Wexford				16
17			West Hills Health & Rehab	Coraopolis				17
18			Broomall Health & Rehab	Broomall				18
19			Seneca Health & Rehab	Senaca				19
20			Sumter East Health & Rehab	Sumter				20
21			Golden Age Inman	Inman				21
22			Inman Healthcare	Inman				22
23			Lebanon Health & REhab	Lebanon				23
24			Greenhills Health & Rehab	Nashville				24
25			Norris Health & Rehab	Andersonville				25
26			Newport Health & Rehab	Newport				26
27			Cheyenne Healthcare	Cheyenne				27
28			Poplar Living Center	Casper				28
29			Sheridan Manor	Sheridan				29
30			Huntington Health Care	Huntington				30

Facility Name & ID Number

Nature Trail Health Care Ctr

0047357

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holdings Company LLC		Bastrop Nursing Center	Bastrop				1
2			Care Inn of La Grange	La Grange				2
3			Kountze Nursing Center	Kountze				3
4			Retama Manor Nursing Center San Antonio No	San Antonio				4
5			Retama Manor Nursing Center San Antonio We	San Antonio				5
6			Retama Manor Nursing Center Alice	Alice				6
7			Retama Manor Nursing Center Edinburg	Edinburg				7
8			Retama Manor Nursing Center Harlingen	Harlingen				8
9			Retama Manor Nursing Center Jourdanton	Jourdanton				9
10			Retama Manor Nursing Center Laredo South	Laredo				10
11			Retama Manor Nursing Center Laredo West	Laredo				11
12			Retama Manor Nursing Center McAllen	McAllen				12
13			Retama Manor Nursing Center Pleasanton Nort	Pleasanton				13
14			Retama Manor Nursing Center Pleasanton Sout	Pleasanton				14
15			Retama Manor Nursing Center Rio Grande City	Rio Grande City				15
16			Retama Manor Nursing Center Robstown	Robstown				16
17			Retama Manor Nursing Center Weslaco	Weslaco				17
18			Weatherford health Care Center	Weatherford				18
19			Peach Tree Place	Weatherford				19
20			Retama Manor Nursing Center Raymondville	Raymondville				20
21			Memorial City Health and Rehab	Houston				21
22			Jacinto City Healthcare Center	Houston				22
23			Spring Branch Healthcare Center	Houston				23
24			Retama Manor Nursing Center Corpus Christi	Corpus Christi				24
25			Downtown Health & Rehab	Fort Worth				25
26			Lakeshore Village Healthcare Center	Waco				26
27			Deer Creek of Wimberley	Wimberley				27
28			La Paloma Nursing Center	San Diego				28
29			Pine Arbor	Silsbee				29
30			Las Palmas Healthcare Center	McAllen				30

Facility Name & ID Number

Nature Trail Health Care Ctr

0047357

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holdings Company LLC		Hilltop Village	Kerville				1
2			Silver Creek Manor	San Antonio				2
3			Alpine Terrace	Kerrville				3
4			Edgewater Care Center	Kerrville				4
5			Arlington Heights Health & Rehab	Fort Worth				5
6			The Meadows Health & Rehab	Dallas				6
7			Northgate Health & Rehab	San Antonio				7
8			Interlochen Health & Rehab	Arlington				8
9			First Colony Health & Rehab	Missouri City				9
10			Cypresswood Health & Rehab	Houston				10
11			Northwest Health & Rehab	Houston				11
12			The Westbury Place	Houston				12
13			Westchase Health & Rehab	Houston				13
14			Woodwind Lakes Health & Rehab	Houston				14
15			Pasadena Care Center	Pasadena				15
16			Bay Villa	Bay City				16
17			Alice Health care Center	Alice				17
18			Bangs Nursing Home	Bangs				18
19			Brazosview	Richmond				19
20			Courtyards at Fort Worth	Fort Worth				20
21			Faith Memorial	Pasadena				21
22			Golden Years	Marlin				22
23			Greenview Manor	Waco				23
24			Hillview Health & Rehab	Goldthwaite				24
25			Levelland Health Care	Levelland				25
26			Longmeadow Health Care	Justin				26
27			Memorial Medical Nursing Center	San Antonio				27
28			Mount Pleasant	Mount Pleasant				28
29			North Park Health & Rehab	McKinney				29
30			Pampa Health Care Center	Pampa				30

Facility Name & ID Number

Nature Trail Health Care Ctr

0047357

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holdings Company LLC		Park Highlands Health Care Center	Athens				1
2			Pleasant Springs Health Care Center	Mount Pleasant				2
3			Sweeny Health Care Center	Sweeny				3
4			Texoma Health Care Center	Sherman				4
5			The Park in Plano	Plano				5
6			Ashland Health & Rehab	Ashland				6
7			Southpointe Health Care Center	Greenfield				7
8			Virginia Highlands Health & Rehab Center	Germantown				8
9			Grande Prairie Health & Rehab Center	Pleasant Prairie				9
10			Pleasant Valley Health Care Center	Derry				10
11			The Village at Alameda	Albuquerque				11
12			Hobbs Healthcare Center	Hobbs				12
13			Lake Mead Health Care Center	Henderson				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

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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:

01/01/2014

Ending: 2/31/2014

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	
5	Utilities				\$ 29	\$		\$	1
6	Repair and Maintenance				14,984				2
19	Professional Services				5,532				3
20	Fee, Subscriptions and Promos				7,238				4
10	Nursing & Medical Records				176,218				5
21	Clerical & Gen Office Exp				1,475				6
24	Travel & Seminar				28,462				7
26	Insurance				3,595				8
36	Drpreiation				29,055				9
17	Communications				4,451				10
35	Rental and Lease								11
32	Interest Income/Expense				15,602				12
22	Payroll Taxes				22,289				13
									14
									15
									16
									17
									18
									19
									20
									21
									22
									23
									24
25	TOTALS				\$ 308,930	\$		\$	25

Facility Name & ID Number

Nature Trail Health Care Ctr

0047357

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2013 report.		\$	<u>28,815</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>29,791</u>		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>976</u>		3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>30,963</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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>31,939</u>		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>25,482</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2010	<u>25,482</u>	9																
	2011	<u>25,973</u>	10																
	2012	<u>28,815</u>	11																
	2013	<u> </u>	12																

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Nature Trail Health Care Ctr COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0047357

CONTACT PERSON REGARDING THIS REPORT Martha McDaniel

TELEPHONE 832 467 6317 FAX #: 832 467 6983

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-36-327-006</u>	<u>PT NE SW Beg 330.6' S of NE</u>	\$ <u>29,791.00</u>	\$ <u>29,791.00</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. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>29,791.00</u></u>	\$ <u><u>29,791.00</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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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
Improvement Type**										
9	Repair Automatic Transfer Switch	2005		1,953	175	11.5	175		1,618	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		14,960	12
13	Door - 42"	2006		5,245	525	10	525		4,415	13
14	Tree Removal	2006		2,273	220	10.25	220		1,852	14
15	Repair Sprinkler System	2006		33,750	3,293	10.25	3,293		27,439	15
16										16
17	Katolight Generator	2007		13,781	1,378	10	1,378		11,140	17
18	Electrical Work	2007		1,295	131	10	131		1,045	18
19	Repair Parking Lot	2007		89	9	10	9		72	19
20	Repair Parking Lot	2007		2,691	267	10	267		2,179	20
21	Interior Improvement	2007		1,710	170	10	170		1,385	21
22	Interior Improvement	2007		5,520	547	10	547		4,470	22
23	Interior Improvement	2007		2,230	221	10	221		1,806	23
24	Exterior Repairs	2007		6,852	685	10	685		5,539	24
25	New Dining Room Floor	2007		350	36	9.6	36		281	25
26	New Dining Room Floor	2007		2,094	211	9.83	211		1,690	26
27	Emergency Generator	2007		2,311	233	9.83	233		1,864	27
28	Repair Roof and Interior Rooms	2007		10,939	1,067	10.16	1,067		8,894	28
29	New Roof on Front Canopy	2007		3,434	343	10	343		2,804	29
30	New Roof on Kitchen Area	2007		3,450	345	10	345		2,818	30
31	Building Repairs	2007		8,890	889	10	889		7,186	31
32	Sprinkler Upgrade	2007		1,332	147	9	147		1,051	32
33	Shower Renovation	2007		2,529	278	9	278		1,995	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 & ID Number Nature Trail Health Care Ctr

0047357

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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	\$ 568	9.41	\$ 568	\$	\$ 4,307	37
38	A T & T Circuit Conversion	2008	2,106	258	8	258		1,612	38
39	Maglock	2008	930	109	8.42	109		720	39
40									40
41	Bed Crash Rails	2009	1,661	234	7	234		1,212	41
42									42
43	Handrails	2010	10,441	1,492	7	1,492		7,582	43
44	30 Gallon Storage Container	2010	795	110	7	110		585	44
45	Remodel 5 Hallway Bathrooms (Contracted Total)-Carpentry	2010	4,939	770	6.3	770		3,464	45
46	Floor and Wall Mosaic Ceramic Tile for Bathroom Remodel	2010	7,571	1,180	6.3	1,180		5,310	46
47	Satellite Dish	2010	8,106	1,333	6	1,333		5,552	47
48	Satellite Dish	2010	4,893	815	6	815		3,330	48
49									49
50	Replace Shower Floor Liner, walls and fixtures - 5 bathrooms	2011	12,400	2,067	5.92	2,067		8,439	50
51	Replace Shower Floor Liner, walls and fixtures - 5 bathrooms	2011	3,306	551	5.92	551		2,250	51
52	2: Door Closers/Hinges	2011	1,125	188	5.83	188		750	52
53	Fire Alarm Horn Strobe Detector	2011	4,081	680	5.92	680		2,778	53
54	Replace Rooftop Unit Compressor	2011	1,245	192	6.42	192		878	54
55	Walkway Safety Bars	2011	1,715	286	5.83	286		1,143	55
56	Wall Mounted Kitchen Cabinet	2011	3,042	507	5.92	507		2,070	56
57	Marble Tops, Recessed bowls and faucets - 5 bath updates	2011	1,376	226	6	226		942	57
58	Maglock	2011	1,497	225	6.58	225		1,067	58
59	Annunciator	2011	3,661	619	5.75	619		2,423	59
60	Hand Rail	2011	8,988	1,610	5.42	1,610		5,768	60
61	Replace cement board and tile in bath areas	2011	3,419	622	5.33	622		2,176	61
62	Replace cement board and tile in bath areas	2011	3,419	651	5.08	651		2,117	62
63	3: Dry Pendent Sprinkler Heads	2011	2,495	483	5	483		1,529	63
64									64
65	10 Ton Heat/Cool Roof Top Unit	2012	25,200	5,125	5	5,125		14,949	65
66	Portable Storage	2012	2,000	436	10	436		1,127	66
67	Kitchen Hood System	2012	8,541	2,092	10	2,092		4,358	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 271,215	\$ 36,359		\$ 36,359	\$	\$ 201,491	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	\$ 36,359		\$ 36,359	\$	\$ 201,491	1
2	2: Thru Wall A/C Units	2013	1,502	368	4	368		766	2
3	Kichen Hood Syst - Bal Due	2013	6,608	1,618	4	1,618		3,371	3
4	Fire Alarm System Deposit	2013	12,475	3,327	3.75	3,327		5,822	4
5	Fire Alarm System Install	2013	12,475	3,481	3.5	3,481		5,512	5
6	5 Ton Kitchen A/C Unit	2013	2,850	814	3.5	814		1,221	6
7	Basement Sprinkler System	2013	4,400	1,287	3.5	1,287		1,824	7
8	Lvt Flooring Entry & Dining Room	2013	6,930	2,247	3	2,247		2,435	8
9	Fire Rated Door	2013	2,226	722	3	722		782	9
10									10
11									11
12	Facility Sign	2014	3,342	1,050	3	1,050		1,050	12
13	Polycom Phones	2014	521	183	3	183		183	13
14	2 Brick Pillars for New Sign	2014	2,315	178	9.75	178		178	14
15	A/C Compressor	2014	1,721	95	12	95		95	15
16	Lvt Flooring Entry & Dining Room Balance Due	2014	7,262	787	10	787		787	16
17	Install 3 Mixing Valves	2014	2,545	21	10	21		21	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)		\$ 338,387	\$ 52,537		\$ 52,537	\$	\$ 225,538	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	\$ 178,546	\$ 18,961	\$ 18,961	\$		\$ 109,179	71
72	Current Year Purchases	11,177	3,656	3,656			3,656	72
73	Fully Depreciated Assets	(37,448)						73
74								74
75	TOTALS	\$ 152,275	\$ 22,617	\$ 22,617	\$		\$ 112,835	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)	\$ 490,662	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 75,154	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 75,154	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)	\$ 338,373	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.

Facility Name & ID Number Nature Trail Health Care Ctr

0047357

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

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>10/11/2013</u>	\$ <u>126,988</u>	<u>12</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>74</u>		\$ <u>126,988</u>			7

10. Effective dates of current rental agreement:

Beginning 06/02/2014

Ending 05/31/2026

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. <u> </u> /2015	\$ <u>156,778</u>
-------------------------------------	-------------------

13. <u> </u> /2016	\$ <u>159,914</u>
-------------------------------------	-------------------

14. <u> </u> /2017	\$ <u>164,711</u>
-------------------------------------	-------------------

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

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

9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental?

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a-03	3039	hrs	\$ 86,578		\$	\$	3,039	\$ 86,578	1
2	Licensed Speech and Language Development Therapist	10a-03	1227	hrs	63,308				1,227	63,308	2
3	Licensed Recreational Therapist	10a-03		hrs							3
4	Licensed Physical Therapist	10a-03	6327	hrs	242,564				6,327	242,564	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				132,228		132,228	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				\$ 392,450		\$	\$ 132,228	10,593	\$ 524,678	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Nature Trail Health Care Ctr

0047357

Report Period Beginning: 01/01/2014

Ending:

12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 400	\$	1
2	Cash-Patient Deposits	(61,171)		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	777,934		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	235		6
7	Other Prepaid Expenses	8,867		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 726,265	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	46,660		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	338,389		15
16	Equipment, at Historical Cost	152,276		16
17	Accumulated Depreciation (book methods)	(338,373)		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):	8,838		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 207,790	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 934,055	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 212,687	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	256,435		30
31	Accrued Taxes Payable (excluding real estate taxes)	142		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,661		32
33	Accrued Interest Payable			33
34	Deferred Compensation	24,572		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accruals</u>	43,511		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 568,008	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>CLO & Intercompany</u>	(603,485)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (603,485)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (35,477)	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 969,532	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 934,055	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,318,900	1
2	Restatements (describe):	(147,101)	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,171,799	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(256,020)	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) <u>Contributed Capital</u>	53,753	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (202,267)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 969,532	24 *

* This must agree with page 17, line 47.

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

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

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

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 3,661,591	1	
2	Discounts and Allowances for all Levels	(1,120,301)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,541,290	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	955,165	6	
7	Oxygen	792	7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 955,957	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	
13	Barber and Beauty Care		13	
14	Non-Patient Meals	2,667	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	271,807	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	16,054	19	
20	Radiology and X-Ray	25,236	20	
21	Other Medical Services	828	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 316,592	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***		25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	<u>Miscellaneous Receipts</u>	869	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 869	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,814,708	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	659,622	31	
32	Health Care	1,797,191	32	
33	General Administration	1,048,404	33	
B. Capital Expense				
34	Ownership	236,712	34	
C. Ancillary Expense				
35	Special Cost Centers	194,794	35	
36	Provider Participation Fee	134,005	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,070,728	40	
41	Income before Income Taxes (line 30 minus line 40)**	(256,020)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (256,020)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,267,731	44
45	Private Pay - Net Inpatient Revenue	161,256	45
46	Medicare - Net Inpatient Revenue	511,122	46
47	Other-(specify) <u>HMO/Ins</u>	9,199	47
48	Other-(specify) <u>VA/Hospice</u>	591,982	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,541,290	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: 01/01/2014

Ending: 12/31/2014

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	2,027	2,083	\$ 67,884	\$ 32.59	1
2	Assistant Director of Nursing	1,883	2,091	48,349	23.12	2
3	Registered Nurses	10,279	11,367	261,890	23.04	3
4	Licensed Practical Nurses	12,043	12,977	250,305	19.29	4
5	CNAs & Orderlies	35,613	38,520	415,986	10.80	5
6	CNA Trainees					6
7	Licensed Therapist	9,378	10,593	392,450	37.05	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,956	2,180	32,083	14.72	9
10	Activity Assistants	838	919	11,227	12.22	10
11	Social Service Workers	1,851	2,083	29,222	14.03	11
12	Dietician					12
13	Food Service Supervisor	1,921	2,089	29,902	14.31	13
14	Head Cook	5,870	6,240	70,149	11.24	14
15	Cook Helpers/Assistants	4,008	4,348	42,313	9.73	15
16	Dishwashers					16
17	Maintenance Workers	1,915	2,059	34,951	16.97	17
18	Housekeepers	6,875	7,429	69,984	9.42	18
19	Laundry	2,766	2,954	25,951	8.79	19
20	Administrator	1,939	2,130	94,892	44.55	20
21	Assistant Administrator					21
22	Other Administrative	3,667	3,947	110,340	27.96	22
23	Office Manager					23
24	Clerical					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	1,893	2,127	27,167	12.77	31
32	Other Health Care(specify)	2,214	2,347	30,017	12.79	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	108,936	118,483	\$ 2,045,062 *	\$ 17.26	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	\$ 9,597	1-3	35
36	Medical Director	7,200	9-3	36
37	Medical Records Consultant	720	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,638	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	87	10a-3	42
43	Speech Therapy Consultant			43
44	Activity Consultant	2,204	11-3	44
45	Social Service Consultant	2,203	12-3	45
46	Other(specify) <u>Admin</u>	20,079	10-3	46
47	<u>XRay & Lab</u>	51,059	39-3	47
48	<u>Dentist/Physician/Psychiatrist</u>	4,667	39-3	48
49	TOTAL (lines 35 - 48)	\$ 102,454		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

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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Nature Trail Health Care Ctr

0047357

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 \$ 4545
- (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. \$ 15,100 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? X YES _____ 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. \$ 134,005
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. \$ _____ Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 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? N/A
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.