



Facility Name & ID Number Nature Trail Health Care Ctr

# 0047357 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	6,796	6,796	8
9	SNF/PED					9
10	ICF	10,820	790	219	11,829	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,820	790	7,015	18,625	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.96%

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

36 (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 3,543

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: 12/31/2015 Fiscal Year: 12/31/2015

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

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	134,291	13,490	47,553	195,334	(18,710)	176,624	(18,710)	157,914		1
2	Food Purchase		77,504		77,504	18,710	96,214	18,369	114,583		2
3	Housekeeping	51,197	6,168	14,974	72,339		72,339		72,339		3
4	Laundry	22,700	6,946	9,709	39,355		39,355		39,355		4
5	Heat and Other Utilities			82,119	82,119		82,119	(3,587)	78,532		5
6	Maintenance	36,232	79,561	11,183	126,976		126,976	13,025	140,001		6
7	Other (specify):*			7,702	7,702		7,702		7,702		7
8	<b>TOTAL General Services</b>	244,420	183,669	173,240	601,329		601,329	9,097	610,426		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			31,200	31,200		31,200		31,200		9
10	Nursing and Medical Records	994,245	78,422	12,219	1,084,886		1,084,886	130,248	1,215,134		10
10a	Therapy	456,318	55,548	966	512,832		512,832		512,832		10a
11	Activities	46,155	2,380	2,722	51,257		51,257		51,257		11
12	Social Services	29,629		2,628	32,257		32,257		32,257		12
13	CNA Training										13
14	Program Transportation	27,718	3,400	11,943	43,061		43,061		43,061		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,554,065	139,750	61,678	1,755,493		1,755,493	130,248	1,885,741		16
	<b>C. General Administration</b>										
17	Administrative	95,352			95,352		95,352	2,200	97,552		17
18	Directors Fees			591	591		591		591		18
19	Professional Services			13,356	13,356		13,356	4,085	17,441		19
20	Dues, Fees, Subscriptions & Promotions			30,552	30,552		30,552	451	31,003		20
21	Clerical & General Office Expenses	171,451	16,511	269,631	457,593		457,593	(330,510)	127,083		21
22	Employee Benefits & Payroll Taxes			354,251	354,251		354,251	18,437	372,688		22
23	Inservice Training & Education										23
24	Travel and Seminar			25,231	25,231		25,231	13,506	38,737		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			100,427	100,427		100,427	90,162	190,589		26
27	Other (specify):* <b>Franchise Tax/State Income Tax</b>							375	375		27
28	<b>TOTAL General Administration</b>	266,803	16,511	794,039	1,077,353		1,077,353	(201,294)	876,059		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,065,288	339,930	1,028,957	3,434,175		3,434,175	(61,949)	3,372,226		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 &amp; ID Number

Nature Trail Health Care Ctr

#0047357

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

## 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			77,328	77,328		77,328	(65)	77,263			30
31	Amortization of Pre-Op. & Org.			4,611	4,611		4,611		4,611			31
32	Interest			662	662		662	14,354	15,016			32
33	Real Estate Taxes			31,497	31,497		31,497	(2,229)	29,268			33
34	Rent-Facility & Grounds			204,163	204,163		204,163	(12,134)	192,029			34
35	Rent-Equipment & Vehicles			51	51		51		51			35
36	Other (specify):*							20,072	20,072			36
37	<b>TOTAL Ownership</b>			318,312	318,312		318,312	19,998	338,310			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		146,349	57,721	204,070		204,070		204,070			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			132,281	132,281		132,281		132,281			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		146,349	190,002	336,351		336,351		336,351			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,065,288	486,279	1,537,271	4,088,838		4,088,838	(41,951)	4,046,887			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: 01/01/2015

Ending: 12/31/2015

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	(321)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,607)	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	(20)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(376)	24		19
20	Contributions	(527)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,696)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(39,190)	21		24
25	Fund Raising, Advertising and Promotional	(80,989)	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	(138,946)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (270,672)</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)	228,721		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 228,721</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (41,951)</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: 01/01/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Rent Averaging	\$ (12,134)	34	1
2	Reclass Franchise Tax & State Inc Tax to Line 27	(375)	33	2
3	Reclass Franchise Tax & State Inc Tax to Line 27	375	27	3
4	Real Estate Accrual Adjustment	(1,854)	33	4
5	Back Office Service Fee	(211,248)	21	5
6	Professional Liability Adj	86,355	26	6
7	Depreciation Adj	(65)	30	7
8	Reclass Food Cost from Outsource Services	(18,710)	1	8
9	Reclass Food Cost from Outsource Services	18,710	2	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>	(138,946)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

## 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	(18,710)	0	0	0	0	0	0	0	0	0	0	(18,710)	1
2	Food Purchase	18,369	0	0	0	0	0	0	0	0	0	0	18,369	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	(3,607)	20	0	0	0	0	0	0	0	0	0	(3,587)	5
6	Maintenance	0	13,025	0	0	0	0	0	0	0	0	0	13,025	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(3,948)</b>	<b>13,045</b>	<b>0</b>	<b>9,097</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	130,248	0	0	0	0	0	0	0	0	0	130,248	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>130,248</b>	<b>0</b>	<b>130,248</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	0	2,200	0	0	0	0	0	0	0	0	0	2,200	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,696)	10,781	0	0	0	0	0	0	0	0	0	4,085	19
20	Fees, Subscriptions & Promotions	0	451	0	0	0	0	0	0	0	0	0	451	20
21	Clerical & General Office Expenses	(331,954)	1,444	0	0	0	0	0	0	0	0	0	(330,510)	21
22	Employee Benefits & Payroll Taxes	0	18,437	0	0	0	0	0	0	0	0	0	18,437	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(376)	13,882	0	0	0	0	0	0	0	0	0	13,506	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	86,355	3,807	0	0	0	0	0	0	0	0	0	90,162	26
27	Other (specify):*	375	0	0	0	0	0	0	0	0	0	0	375	27
28	<b>TOTAL General Administration</b>	<b>(252,296)</b>	<b>51,002</b>	<b>0</b>	<b>(201,294)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(256,244)</b>	<b>194,295</b>	<b>0</b>	<b>(61,949)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2015 Ending:

12/31/2015

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	(65)	0	0	0	0	0	0	0	0	0	0	(65)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	14,354	0	0	0	0	0	0	0	0	0	14,354	32
33	Real Estate Taxes	(2,229)	0	0	0	0	0	0	0	0	0	0	(2,229)	33
34	Rent-Facility & Grounds	(12,134)	0	0	0	0	0	0	0	0	0	0	(12,134)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	20,072	0	0	0	0	0	0	0	0	0	20,072	36
37	<b>TOTAL Ownership</b>	<b>(14,428)</b>	<b>34,426</b>	<b>0</b>	<b>19,998</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)	(270,672)	228,721	0	0	0	0	0	0	0	0	0	(41,951)	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	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 Care Center	Westchester			
		Brentwood Sub Acute Health Care 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%	\$ 20	\$	20	1
2	V	6 Repair and Maintenance		SSC Equity Holdings LLC	100.00%	13,025		13,025	2
3	V	19 Professional Services		SSC Equity Holdings LLC	100.00%	10,781		10,781	3
4	V	20 Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	451		451	4
5	V	10 Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	130,248		130,248	5
6	V	21 Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	1,444		1,444	6
7	V	24 Travel & Seminar		SSC Equity Holdings LLC	100.00%	13,882		13,882	7
8	V	26 Insurance		SSC Equity Holdings LLC	100.00%	3,807		3,807	8
9	V	36 Depreciation		SSC Equity Holdings LLC	100.00%	20,072		20,072	9
10	V	17 Communications		SSC Equity Holdings LLC	100.00%	2,200		2,200	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%	14,354		14,354	12
13	V	22 Payroll Taxes		SSC Equity Holdings LLC	100.00%	18,437		18,437	13
14	Total		\$			\$ 228,721	\$ *	228,721	14

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

Facility Name &amp; ID Number

Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

## 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	100	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

Facility Name &amp; ID Number

Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

## 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 Holding Company LLC	100	Centennial Healthcare 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	Austll				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 &amp; ID Number

Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

## 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 Holding Company LLC	100	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 & RehabCharlotte	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 & RehabDurham	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 Waynesvil	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 &amp; ID Number

Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

## 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 Holding Company LLC	100	Brian Center Health & Rehab Hertfort	Hertford				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:

01/01/2015

Ending:

12/31/2015

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 Holding Company LLC	100	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 Nor	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 Nortl	Pleasanton				13
14			Retama Manor Nursing Center Pleasanton Soutl	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 N	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 &amp; ID Number

Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

## 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 Holding Company LLC	100	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:

01/01/2015

Ending:

12/31/2015

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 Holding Company LLC	100	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: 01/01/2015 Ending: 12/31/2015

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:

01/01/2015

Ending: 2/31/2015

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

( 832-467-6982

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			\$ 20	\$		\$	1
2	6	Repair and Maintenance			13,025				2
3	19	Professional Services			10,781				3
4	20	Fee, Subscriptions and Promos			451				4
5	10	Nursing & Medical Records			130,248				5
6	21	Clerical & Gen Office Exp			1,444				6
7	24	Travel & Seminar			13,882				7
8	26	Insurance			3,807				8
9	36	Drpreiation			20,072				9
10	17	Communications			2,200				10
11	35	Rental and Lease							11
12	32	Interest Income/Expense			14,354				12
13	22	Payroll Taxes			18,437				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				\$ 228,721	\$		\$	25

Facility Name & ID Number

Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

**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**					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 2014 report.		\$	<u>30,963</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>29,109</u>		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(1,854)</u>		3														
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>31,122</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>29,268</u>		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<u>25,482</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</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>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	<u>25,973</u>	9																
	2012	<u>28,084</u>	10																
	2013	<u>28,815</u>	11																
	2014	<u>29,791</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.**

## 2014 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) 467-6982

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(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>29,109.00</u>	\$ <u>29,109.00</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>29,109.00</u></u>	\$ <u><u>29,109.00</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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				\$	\$		\$	\$	\$	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		1,793	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		16,720	12
13	Door - 42"	2006		5,245	525	10	525		4,939	13
14	Tree Removal	2006		2,273	220	10.25	220		2,072	14
15	Repair Sprinkler System	2006		33,750	3,293	10.25	3,293		30,732	15
16										16
17	Katolight Generator	2007		13,781	1,378	10	1,378		12,518	17
18	Electrical Work	2007		1,295	131	10	131		1,175	18
19	Repair Parking Lot	2007		89	9	10	9		81	19
20	Repair Parking Lot	2007		2,691	267	10	267		2,446	20
21	Interior Improvement	2007		1,710	170	10	170		1,555	21
22	Interior Improvement	2007		5,520	547	10	547		5,018	22
23	Interior Improvement	2007		2,230	221	10	221		2,027	23
24	Exterior Repairs	2007		6,852	685	10	685		6,224	24
25	New Dining Room Floor	2007		350	36	9.6	36		317	25
26	New Dining Room Floor	2007		2,094	211	9.83	211		1,901	26
27	Emergency Generator	2007		2,311	233	9.83	233		2,097	27
28	Repair Roof and Interior Rooms	2007		10,939	1,067	10.16	1,067		9,961	28
29	New Roof on Front Canopy	2007		3,434	343	10	343		3,148	29
30	New Roof on Kitchen Area	2007		3,450	345	10	345		3,163	30
31	Building Repairs	2007		8,890	889	10	889		8,075	31
32	Sprinkler Upgrade	2007		1,332	147	9	147		1,197	32
33	Shower Renovation	2007		2,529	278	9	278		2,274	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:

01/01/2015

Ending:

12/31/2015

**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	\$	\$ 4,874	37
38	A T & T Circuit Conversion	2008	2,106	258	8	258		1,870	38
39	Maglock	2008	930	109	8.42	109		823	39
40									40
41	Bed Crash Rails	2009	1,661	235	7	235		1,446	41
42									42
43	Handrails	2010	10,441	1,492	7	1,492		9,074	43
44	30 Gallon Storage Container	2010	795	110	7	110		694	44
45	Remodel 5 Hallway Bathrooms (Contracted Total)-Carpentry	2010	4,939	770	6.3	770		4,234	45
46	Floor and Wall Mosaic Ceramic Tile for Bathroom Remodel	2010	7,571	1,180	6.3	1,180		6,490	46
47	Satellite Dish	2010	8,106	1,333	6	1,333		6,885	47
48	Satellite Dish	2010	4,893	815	6	815		4,145	48
49									49
50	Replace Shower Floor Liner, walls and fixtures - 5 bathrooms	2011	12,400	2,067	5.92	2,067		10,506	50
51	Replace Shower Floor Liner, walls and fixtures - 5 bathrooms	2011	3,306	551	5.92	551		2,801	51
52	2: Door Closers/Hinges	2011	1,125	188	5.83	188		938	52
53	Fire Alarm Horn Strobe Detector	2011	4,081	680	5.92	680		3,458	53
54	Replace Rooftop Unit Compressor	2011	1,245	192	6.42	192		1,069	54
55	Walkway Safety Bars	2011	1,715	286	5.83	286		1,429	55
56	Wall Mounted Kitchen Cabinet	2011	3,042	507	5.92	507		2,577	56
57	Marble Tops, Recessed bowls and faucets - 5 bath updates	2011	1,376	226	6	226		1,169	57
58	Maglock	2011	1,497	225	6.58	225		1,292	58
59	Annunciator	2011	3,661	619	5.75	619		3,042	59
60	Hand Rail	2011	8,988	1,610	5.42	1,610		7,378	60
61	Replace cement board and tile in bath areas	2011	3,419	622	5.33	622		2,797	61
62	Replace cement board and tile in bath areas	2011	3,419	651	5.08	651		2,768	62
63	3: Dry Pendent Sprinkler Heads	2011	2,495	483	5	483		2,012	63
64									64
65	10 Ton Heat/Cool Roof Top Unit	2012	25,200	5,125	5	5,125		20,075	65
66	Portable Storage	2012	2,000	436	10	436		1,563	66
67	Kitchen Hood System	2012	8,541	2,092	10	2,092		6,449	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 271,215	\$ 36,360		\$ 36,360	\$	\$ 237,841	70

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

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

# 0047357

Report Period Beginning:

01/01/2015 Ending: 12/31/2015

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 271,215	\$ 36,360		\$ 36,360	\$	\$ 237,841	1
2	2: Thru Wall A/C Units	2013	1,502	368	4	368		1,134	2
3	Kichen Hood Syst - Bal Due	2013	6,608	1,618	4	1,618		4,990	3
4	Fire Alarm System Deposit	2013	12,475	3,327	3.75	3,327		9,148	4
5	Fire Alarm System Install	2013	12,475	3,481	3.5	3,481		8,994	5
6	5 Ton Kitchen A/C Unit	2013	2,850	814	3.5	814		2,036	6
7	Basement Sprinkler System	2013	4,400	1,288	3.5	1,288		3,112	7
8	Lvt Flooring Entry & Dining Room	2013	6,930	2,248	3	2,248		4,682	8
9	Fire Rated Door	2013	2,226	722	3	722		1,504	9
10									10
11									11
12	Facility Sign	2014	3,342	1,143	3	1,143		2,199	12
13	Polycom Phones	2014	521	169	3	169		352	13
14	2 Brick Pillars for New Sign	2014	2,316	237	9.75	237		416	14
15	A/C Compressor	2014	1,721	142	12	142		237	15
16	Lvt Flooring Entry & Dining Room Balance Due	2014	7,262	726	10	726		1,514	16
17	Install 3 Mixing Valves	2014	2,545	255	10	255		276	17
18									18
19	12,000 BTUH Heat Pump Mini Split System	2015	2,800	117	10	117		117	19
20	2 - 2 Ton Ductless Air Conditioners	2015	6,000	186	10.75	186		186	20
21	Water Heater	2015	6,902	230	10	230		230	21
22	3 Mixing Valve	2015	2,545	85	10	85		85	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 356,635	\$ 53,516		\$ 53,516	\$	\$ 279,053	34

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

Facility Name & ID Number Nature Trail Health Care Ctr

# 0047357

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	\$ 152,275	\$ 21,658	\$ 21,658	\$		\$ 127,463	71
72	Current Year Purchases	30,475	2,089	2,089			2,089	72
73	Fully Depreciated Assets	(7,030)						73
74								74
75	TOTALS	\$ 175,720	\$ 23,747	\$ 23,747	\$		\$ 129,552	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)	\$ 532,355	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 77,263	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 77,263	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)	\$ 408,605	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: 01/01/2015

Ending: 12/31/2015

**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>192,029</u>	<u>12</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>74</u>		\$ <u>192,029</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. 2016                                      \$ 203,767

13. 2017                                      \$ 203,767

14. 2018                                      \$ 203,767

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

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

(Attach a schedule detailing the breakdown of movable equipment)

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

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

\* 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: 01/01/2015 Ending: 12/31/2015  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

**B. EXPENSES**

ALLOCATION OF COSTS (d)

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

<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		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	4809	hrs	\$ 175,136		\$	\$	4,809	\$ 175,136	1
2	Licensed Speech and Language Development Therapist	10a-03	444	hrs	22,796				444	22,796	2
3	Licensed Recreational Therapist	10a-03		hrs							3
4	Licensed Physical Therapist	10a-03	6768	hrs	258,386				6,768	258,386	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				146,349		146,349	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>				\$ 456,318		\$	\$ 146,349	12,021	\$ 602,667	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: 01/01/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(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	26,231		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	889,673		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,025		6
7	Other Prepaid Expenses	7,766		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 926,095	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	48,281		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	356,635		15
16	Equipment, at Historical Cost	175,720		16
17	Accumulated Depreciation (book methods)	(408,670)		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):	6,562		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 178,528	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,104,623	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 175,508	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	320,832		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,530		32
33	Accrued Interest Payable			33
34	Deferred Compensation	24,774		34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Other Accruals</u>	59,729		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 628,373	\$	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	<u>CLO &amp; Intercompany</u>	(767,532)		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ (767,532)	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ (139,159)	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,243,782	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,104,623	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 969,532	1
2	Restatements (describe):	136,229	2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 1,105,761	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	138,021	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>	\$ 138,021	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>	\$ 1,243,782	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,111,150	1
2	Discounts and Allowances for all Levels	(1,286,630)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,824,520</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,130,489	6
7	Oxygen	662	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,131,151</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	655	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	224,044	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,337	19
20	Radiology and X-Ray	23,135	20
21	Other Medical Services	5,767	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 269,938</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>		26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Receipts</u>	1,250	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,250</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,226,859</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	601,329	31
32	Health Care	1,755,493	32
33	General Administration	1,077,353	33
<b>B. Capital Expense</b>			
34	Ownership	318,312	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	204,070	35
36	Provider Participation Fee	132,281	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,088,838</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>138,021</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 138,021</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,464,863	44
45	Private Pay - Net Inpatient Revenue	132,156	45
46	Medicare - Net Inpatient Revenue	779,147	46
47	Other-(specify) <u>HMO/Insurance</u>	1,606	47
48	Other-(specify) <u>VA/Hospice/Charity</u>	446,748	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 2,824,520</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: 01/01/2015

Ending: 12/31/2015

**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	2,024	2,248	\$ 70,298	\$ 31.27	1
2	Assistant Director of Nursing	472	700	15,736	22.48	2
3	Registered Nurses	9,943	10,514	252,264	23.99	3
4	Licensed Practical Nurses	12,233	13,380	257,567	19.25	4
5	CNAs & Orderlies	33,019	35,017	370,616	10.58	5
6	CNA Trainees					6
7	Licensed Therapist	10,822	12,021	456,318	37.96	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,946	2,124	31,938	15.04	9
10	Activity Assistants	1,034	1,148	14,217	12.38	10
11	Social Service Workers	1,872	2,088	29,629	14.19	11
12	Dietician					12
13	Food Service Supervisor	1,268	1,661	22,309	13.43	13
14	Head Cook	5,582	5,929	65,268	11.01	14
15	Cook Helpers/Assistants	4,435	4,824	46,714	9.68	15
16	Dishwashers					16
17	Maintenance Workers	1,928	2,080	36,232	17.42	17
18	Housekeepers	4,711	5,228	51,197	9.79	18
19	Laundry	2,378	2,597	22,700	8.74	19
20	Administrator	1,968	2,088	100,019	47.90	20
21	Assistant Administrator					21
22	Other Administrative	3,808	4,176	166,784	39.94	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	1,914	2,131	27,764	13.03	31
32	Other Health C: <u>Medicare Coord</u>	1,912	2,245	27,718	12.35	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	103,269	112,199	\$ 2,065,288 *	\$ 18.41	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	\$ 28,053	1-3	35
36	Medical Director	31,200	9-3	36
37	Medical Records Consultant	4,121	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,115	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	966	10a-3	42
43	Speech Therapy Consultant			43
44	Activity Consultant	2,722	11-3	44
45	Social Service Consultant	2,628	12-3	45
46	Other(specify) <u>Admin</u>	20,243	10-3	46
47	<u>Xray &amp; Laboratory</u>	45,462	39-3	47
48	<u>Dentis/Physician/Psychiatrist</u>	5,797	39-3	48
49	TOTAL (lines 35 - 48)	\$ 146,307		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: 01/01/2015

Ending: 12/31/2015

**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	
Tim Bledsoe	Administrator	0	\$ 95,352	Workers' Compensation Insurance	\$ 51,103	IDPH License Fee	\$	
				Unemployment Compensation Insurance	87,901	Advertising: Employee Recruitment	8,408	
				FICA Taxes	145,134	Health Care Worker Background Check	5,235	
				Employee Health Insurance	58,209	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Publications and Manuals	893	
				Life Insurance	1,689	Professional Dues	5,922	
				Other Benefits	10,215	Other Licenses	3,376	
				Home Office Payroll Taxes	18,437	Fees, Subscriptions and Promotions	451	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 95,352					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount				Less: Public Relations Expense ( )	
			\$				Non-allowable advertising 6,718	
							Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
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	\$ 140			\$	Out-of-State Travel	\$ 2,528	
Burgeon Legal Group	Legal	6,136						
Illinois State Police	Patient Background Cks	1,700						
Cass Info Services	Background Checks	1,488				In-State Travel	18,822	
Compsych Corp	Employee Assistance Prog	1,209						
Duane Morris LLP	Legal	764						
Equifax New Hire Reporting	Back Ground Checks	655				Seminar Expense	3,505	
Talx	Unemployment	35						
LexisNexis/Equifax/Laminex	Data Management	58				Home Office Allocation	13,882	
National Research Corp	Facility Survey Prog	1,171						
						Entertainment Expense ( )		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 13,356				\$ 38,737	

\* 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												
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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. IllinoisHealth Care Association \$5423
- (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. \$ 13,844 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. \$ 132,281  
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? 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) 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.