FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0047357

Facility Name: Nature Trail Health Care Center

Address: 1001 South 34th Street (Number) Mount Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: 618-242-5700 **Fax #** 618-242-1572

HFS ID Number:

Date of Initial License for Current Owners: 10/06/2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Martha McDaniel **Telephone Number:** 832-467-617
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Chris Stenger
(Title) Vice President of Planning and Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,719	808	5,012	9,539	8
9	SNF/PED					9
10	ICF	10,184	1,315	313	11,812	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,903	2,123	5,325	21,351	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.05%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 01/01/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 4,849

Medicare Intermediary Trailblazer

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	128,845	13,713	14,302	156,860		156,860		156,860			1
2	Food Purchase		118,770		118,770		118,770	(58)	118,712			2
3	Housekeeping	96,570	7,530	4,565	108,665		108,665		108,665			3
4	Laundry	48,999	9,197		58,196		58,196		58,196			4
5	Heat and Other Utilities			81,163	81,163		81,163	(9,705)	71,458			5
6	Maintenance	36,965	55,805	7,997	100,767		100,767	8,671	109,438			6
7	Other (specify):*			10,834	10,834		10,834		10,834			7
8	TOTAL General Services	311,379	205,015	118,861	635,255		635,255	(1,092)	634,163			8
	B. Health Care and Programs											
9	Medical Director			7,403	7,403		7,403		7,403			9
10	Nursing and Medical Records	1,013,043	81,027	166,269	1,260,339		1,260,339		1,260,339			10
10a	Therapy	550,034	86,585	160	636,779		636,779		636,779			10a
11	Activities	40,410	3,182	2,282	45,874		45,874		45,874			11
12	Social Services	25,200		2,122	27,322		27,322		27,322			12
13	CNA Training											13
14	Program Transportation	5,375	740	13,761	19,876		19,876		19,876			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,634,062	171,534	191,997	1,997,593		1,997,593		1,997,593			16
	C. General Administration											
17	Administrative	63,847			63,847		63,847		63,847			17
18	Directors Fees			500	500		500		500			18
19	Professional Services			(7,726)	(7,726)		(7,726)	9,997	2,271			19
20	Dues, Fees, Subscriptions & Promotions			27,411	27,411		27,411	1,393	28,804			20
21	Clerical & General Office Expenses	117,402	14,932	266,055	398,389		398,389	(71,896)	326,493			21
22	Employee Benefits & Payroll Taxes			407,175	407,175		407,175	10,437	417,612			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,464	12,464		12,464	38,429	50,893			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			58,722	58,722		58,722	(31,098)	27,624			26
27	Other (specify):*											27
28	TOTAL General Administration	181,249	14,932	764,601	960,782		960,782	(42,738)	918,044			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,126,690	391,481	1,075,459	3,593,630		3,593,630	(43,830)	3,549,800			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Nature Trail Health Care Center #0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			42,422	42,422		42,422	(5,735)	36,687			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(607)	(607)		(607)	7,529	6,922			32
33	Real Estate Taxes			26,531	26,531		26,531	9,166	35,697			33
34	Rent-Facility & Grounds			312,341	312,341		312,341		312,341			34
35	Rent-Equipment & Vehicles							9,928	9,928			35
36	Other (specify):*							11,404	11,404			36
37	**TOTAL Ownership**			380,687	380,687		380,687	32,292	412,979			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		172,641	63,845	236,486		236,486	8,930	245,416			39
40	Barber and Beauty Shops		64		64		64		64			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		172,705	104,360	277,065		277,065	8,930	285,995			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,126,690	564,186	1,560,506	4,251,382		4,251,382	(2,608)	4,248,774			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 Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(9,705)	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	(5,735)	30		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	(58)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(80)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	9,997	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(35,740)	21		24
25	Fund Raising, Advertising and Promotional	(12,128)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(42)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (53,491)		$	30

BHF USE ONLY									
48		49		50		51		52	

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 Amount	2 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)	301,201		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 301,201		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 247,710		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	X		92	10	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 92		47

Nature Trail Health Care Center

ID# 0047357

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Back Office Services	$ (220,801)	21	1
2	Professional Liability Insurance	(38,529)	26	2
3	Real Estate Accrual Adj	9,012	33	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(250,318)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Nature Trail Health Care Center **#** 0047357 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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	(58)	0	0	0	0	0	0	0	0	0	0	(58)	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	(9,705)	0	0	0	0	0	0	0	0	0	0	(9,705)	5
6	Maintenance	0	8,671	0	0	0	0	0	0	0	0	0	8,671	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,763)	8,671	0	0	0	0	0	0	0	0	0	(1,092)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	9,997	0	0	0	0	0	0	0	0	0	0	9,997	19
20	Fees, Subscriptions & Promotions	(42)	1,435	0	0	0	0	0	0	0	0	0	1,393	20
21	Clerical & General Office Expenses	(268,749)	196,853	0	0	0	0	0	0	0	0	0	(71,896)	21
22	Employee Benefits & Payroll Taxes	0	10,437	0	0	0	0	0	0	0	0	0	10,437	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	38,429	0	0	0	0	0	0	0	0	0	38,429	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(38,529)	7,431	0	0	0	0	0	0	0	0	0	(31,098)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(297,323)	254,585	0	0	0	0	0	0	0	0	0	(42,738)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(307,086)	263,256	0	0	0	0	0	0	0	0	0	(43,830)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Nature Trail Health Care Center **#** 0047357 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(5,735)	0	0	0	0	0	0	0	0	0	0	(5,735)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	7,529	0	0	0	0	0	0	0	0	0	7,529	32
33	Real Estate Taxes	9,012	154	0	0	0	0	0	0	0	0	0	9,166	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	9,928	0	0	0	0	0	0	0	0	0	9,928	35
36	Other (specify):*	0	11,404	0	0	0	0	0	0	0	0	0	11,404	36
37	**TOTAL Ownership**	3,277	29,015	0	0	0	0	0	0	0	0	0	32,292	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	8,930	0	0	0	0	0	0	0	0	0	8,930	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	8,930	0	0	0	0	0	0	0	0	0	8,930	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(303,809)	301,201	0	0	0	0	0	0	0	0	0	(2,608)	45

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	SSC Equity Holdings, LLC	100.00%	$	$	1
2	V	6	Repair and Maintenance		SSC Equity Holdings, LLC	100.00%	8,671	8,671	2
3	V	39	Professional Services		SSC Equity Holdings, LLC	100.00%	8,930	8,930	3
4	V	20	Fee, Subscriptions & Promos		SSC Equity Holdings, LLC	100.00%	1,435	1,435	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings, LLC	100.00%			5
6	V	21	Clerical & Gen Office Exp		SSC Equity Holdings, LLC	100.00%	196,853	196,853	6
7	V	24	Travel & Seminar		SSC Equity Holdings, LLC	100.00%	38,429	38,429	7
8	V	26	Insurance		SSC Equity Holdings, LLC	100.00%	7,431	7,431	8
9	V	36	Depreciation		SSC Equity Holdings, LLC	100.00%	11,404	11,404	9
10	V	33	Taxes - Property		SSC Equity Holdings, LLC	100.00%	154	154	10
11	V	35	Rental and Lease		SSC Equity Holdings, LLC	100.00%	9,928	9,928	11
12	V	32	Interest Income/Expense		SSC Equity Holdings, LLC	100.00%	7,529	7,529	12
13	V	22	Payroll Taxes		SSC Equity Holdings, LLC	100.00%	10,437	10,437	13
14	Total			$			$ 301,201	$ * 301,201	14

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

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

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

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

Name of Related Organization: SSC Equity Holdings, LLC
Street Address: 5300 west Sam Houston Parkway N, Ste 100
City / State / Zip Code: Houston, TX 77041
Phone Number: (832-467-6000
Fax Number: (832-467-6983

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities				$	$		$	1
2	6	Repair and Maintenance							8,671	2
3	39	Professional Services							8,930	3
4	20	Fee, Subscriptions & Promos							1,435	4
5	10	Nursing & Medical Records								5
6	21	Clerical & Gen Office Exp							196,853	6
7	24	Travel & Seminar							38,429	7
8	26	Insurance							7,431	8
9	36	Depreciation							11,404	9
10	33	Taxes - Property							154	10
11	35	Rental and Lease							9,928	11
12	32	Interest Income/Expense							7,529	12
13	22	Payroll Taxes							10,437	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					$	$		$ 301,201	25

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number Nature Trail Health Care Center # 0047357 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 14,367	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.)		$ 25,482	2
3. Under or (over) accrual (line 2 minus line 1).		$ 11,115	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 25,482	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.		$ 36,597	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	22,148	8
2006	22,818	9
2007	24,238	10
2008	24,683	11
2009	25,482	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME =Facility 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-36-327-006	PT NE SW Beg 330.6' S of NE	$ 25,482.22	$ 25,482.22
2.		COR, S 175' W 300', S 125' W230'	$	$
3.		N300' E530' to POB - 1001 S.	$	$
4.		34th Street	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 25,482.22	$ 25,482.22

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		2005	1974	$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Repair Automatic Transfer Switch			2005	1,953	170	11.5	170		892	9
10											10
11	12: Thru Wall Window A/C			2006	6,550	1,310	5	1,310		6,004	11
12	Tree Removal - Due to Storm			2006	17,600	1,760	10	1,760		7,920	12
13	Door - 42"			2006	5,245	525	10	525		2,317	13
14	Tree Removal			2006	2,273	222	10.25	222		980	14
15	Repair Sprinkler System			2006	33,750	3,320	10.25	3,320		14,385	15
16											16
17	Katolight Generator			2007	13,781	1,390	10	1,390		5,675	17
18	Electrical Work			2007	1,295	132	10	132		527	18
19	Repair Parking Lot			2007	89	9	10	9		37	19
20	Repair Parking Lot			2007	2,691	269	10	269		1,121	20
21	Interior Improvement			2007	1,710	171	10	171		713	21
22	Interior Improvement			2007	5,520	552	10	552		2,300	22
23	Interior Improvement			2007	2,230	223	10	223		929	23
24	Exterior Repairs			2007	6,852	691	10	691		2,821	24
25	New Dining Room Floor			2007	350	37	9.6	37		137	25
26	New Dining Room Floor			2007	2,094	213	9.83	213		852	26
27	Emergency Generator			2007	2,311	235	9.83	235		940	27
28	Repair Roof and Interior Rooms			2007	10,939	1,076	10.16	1,076		4,663	28
29	New Roof on Front Canopy			2007	3,434	343	10	343		1,431	29
30	New Roof on Kitchen Area			2007	3,450	345	10	345		1,438	30
31	Building Repairs			2007	8,890	896	10	896		3,661	31
32	Sprinkler Upgrade			2007	1,332	148	9	148		469	32
33	Shower Renovation			2007	2,529	281	9	281		890	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 Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	7.5 Ton A/C Unit	2008	$ 5,395	$ 573	9.41	$ 573	$	$ 2,053	37
38	A T &T Circuit Conversion	2008	2,106	261	8	261		586	38
39	Maglock	2008	930	110	8.42	110		285	39
40									40
41	Bed Crash Rails	2009	1,661	237	7	237		277	41
42									42
43	Handrails	2010	10,441	1,635	7	1,635		1,635	43
44	30 Gallon Storage Container	2010	795	148	7	148		148	44
45	Remodel 5 Hallway Bathrooms	2010	4,939	390	6.3	390		390	45
46	Remodel 5 Hallway Bathrooms	2010	7,571	598	6.3	598		598	46
47	Satellite Dish	2010	8,106	225	6	225		225	47
48	Satellite Dish	2010	4,893	69	6	69		69	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 183,705	$ 18,564		$ 18,564	$	$ 67,368	70

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

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 126,996	$ 16,338	$ 16,338	$	7	$ 68,453	71
72	Current Year Purchases	15,526	1,785	1,785		7	1,785	72
73	Fully Depreciated Assets	(6,071)						73
74	Current Year Retirements	(1,319)						74
75	TOTALS	$ 135,132	$ 18,123	$ 18,123	$		$ 70,238	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 318,837	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 36,687	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 36,687	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)	$ 137,606	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 Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SMV Property Holdings, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] 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:	1974	74	1/1/2005	$ 312,341	12		3
4	Additions							4
5								5
6								6
7	TOTAL		74		$ 312,341 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 01/01/2005
Ending 12/31/2016

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

	Fiscal Year Ending	Annual Rent
12.	12/2011	$ 312,341
13.	12/2012	$ 312,341
14.	12/2013	$ 312,341

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 Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	5618	hrs	$ 192,046		$	$	5,618	$ 192,046	1
2	Licensed Speech and Language Development Therapist	10a-3	2208	hrs	103,373				2,208	103,373	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a-3	7619	hrs	254,337				7,619	254,337	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				172,641		172,641	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				$ 549,756		$	$ 172,641	15,445	$ 722,397	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.

STATE OF ILLINOIS

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 400	$	1
2	Cash-Patient Deposits	20,166		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	340,260		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,078		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 361,904	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	36,765		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	183,706		15
16	Equipment, at Historical Cost	141,201		16
17	Accumulated Depreciation (book methods)	(137,603)		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): Leasehold Rights	33,187		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 257,256	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 619,160	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 104,081	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	209,879		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,951		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,482		32
33	Accrued Interest Payable			33
34	Deferred Compensation	31,227		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		773		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 394,393	$	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	Intercompany	1,304,355		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (1,304,355)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (909,962)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,529,122	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 619,160	$	48

***(See instructions.)**

Facility Name & ID Number Nature Trail Health Care Center # 0047357 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,329,502	1
2	Restatements (describe):	15,582	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,345,084	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	184,038	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 184,038	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,529,122	24 *

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

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,602,527	1
2	Discounts and Allowances for all Levels	(1,640,838)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,961,689	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,068,113	6
7	Oxygen	2,083	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,070,196	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	790	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	353,528	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,239	19
20	Radiology and X-Ray	10,648	20
21	Other Medical Services	3,119	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 403,324	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		211	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 211	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,435,420	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	635,255	31
32	Health Care	1,997,593	32
33	General Administration	960,782	33
	B. Capital Expense		
34	Ownership	380,687	34
	C. Ancillary Expense		
35	Special Cost Centers	236,550	35
36	Provider Participation Fee	40,515	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,251,382	40
41	**Income before Income Taxes (line 30 minus line 40)****	184,038	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 184,038	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,014	1,223	$ 32,123	$ 26.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,244	11,039	259,681	23.52	3
4	Licensed Practical Nurses	13,792	15,010	271,038	18.06	4
5	CNAs & Orderlies	39,435	42,911	434,453	10.12	5
6	CNA Trainees					6
7	Licensed Therapist	13,234	15,454	550,034	35.59	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,565	1,701	22,111	13.00	9
10	Activity Assistants	1,421	1,607	18,299	11.39	10
11	Social Service Workers	1,822	2,021	25,200	12.47	11
12	Dietician					12
13	Food Service Supervisor	1,894	2,085	29,741	14.26	13
14	Head Cook	6,205	6,725	63,783	9.48	14
15	Cook Helpers/Assistants	3,910	4,084	35,321	8.65	15
16	Dishwashers					16
17	Maintenance Workers	2,535	2,942	36,965	12.56	17
18	Housekeepers	9,499	10,330	96,570	9.35	18
19	Laundry	5,339	5,996	48,999	8.17	19
20	Administrator	1,555	1,789	63,644	35.58	20
21	Assistant Administrator					21
22	Other Administrative	3,254	3,594	83,035	23.10	22
23	Office Manager					23
24	Clerical	2,022	2,309	34,570	14.97	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	1,248	1,304	15,748	12.08	31
32	Other Health Care(specify)	556	556	5,375	9.67	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	120,544	132,680	$ 2,126,690 *	$ 16.03	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 13,110	1-3	35
36	Medical Director		7,403	9-3	36
37	Medical Records Consultant		497	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,876	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		160	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,108	11-3	44
45	Social Service Consultant		2,122	12-3	45
46	Other(specify) Admin		163,424	10-3	46
47	Xray & Laboratory		53,348	39-3	47
48	Physician/Psychiatrist		167	39-3	48
49	TOTAL (lines 35 - 48)		$ 245,215		49

C. CONTRACT NURSES

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

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laurie Ellis	Administrator	0	$ 34,643
Cindy russell	Interim Admin	0	30,204
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,847

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sevarus Corp	Survey Tracking	$ 1,461
Cymber Polanski	Admin Filing	463
Old Seville Waste Consulting	Bio Waste Exp Reduction	347
EEOC	Journal Entry Adjustment	(9,997)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ (7,726)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,486
Unemployment Compensation Insurance	24,007
FICA Taxes	151,739
Employee Health Insurance	136,195
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insruance	2,268
Other Benefits	4,479
TOTAL (agree to Schedule V, line 22, col.8)	$ 407,174

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,735
Health Care Worker Background Check	3,077
(Indicate # of checks performed)	
Patient Background Checks	
Non Allowable Advertisng	7,711
Dues	3,994
Other Licenses	1,629
Publications/Subscriptions	3,223
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	42
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,411

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	10,113
Seminar Expense	2,351
Home Office Allocation	38,429
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 50,893

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Nature Trail Health Care Center # 0047357 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	Amount of Expense Amortized Per Year								
					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 Center **#** 0047357 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assn $3,994**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,378** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **40,515**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BDO Seidman, LLC**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.