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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0047357

Facility Name: Nature Trail Healthcare Ctr

Address: 1001 S 34th St (Number) M 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
  - [ ] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [X] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Martha McDaniel **Telephone Number:** 832-467-6317
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 01/01/2012 to 12/31/2012 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 Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	6,954	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,130	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,084	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	11	12	5,569	5,592	8
9	SNF/PED					9
10	ICF	12,698	931	113	13,742	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,709	943	5,682	19,334	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.39%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 74 and days of care provided 3,425

Medicare Intermediary Novitas Solutions Inc

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Nature Trail Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	121,200	16,600	11,194	148,994		148,994		148,994			1
2	Food Purchase		106,687		106,687		106,687	(1,479)	105,208			2
3	Housekeeping	71,317	8,667	2,889	82,873		82,873		82,873			3
4	Laundry	27,920	7,733	392	36,045		36,045		36,045			4
5	Heat and Other Utilities			58,959	58,959		58,959	2,082	61,041			5
6	Maintenance	29,729	83,586	11,136	124,451		124,451	12,554	137,005			6
7	Other (specify):*			7,054	7,054		7,054		7,054			7
8	TOTAL General Services	250,166	223,273	91,624	565,063		565,063	13,157	578,220			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,084,071	96,073	30,907	1,211,051		1,211,051	207,075	1,418,126			10
10a	Therapy	540,687	68,496		609,183		609,183		609,183			10a
11	Activities	46,240	1,995	2,487	50,722		50,722		50,722			11
12	Social Services	26,372		2,388	28,760		28,760		28,760			12
13	CNA Training											13
14	Program Transportation	22,355	2,603	17,069	42,027		42,027		42,027			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,719,725	169,167	60,051	1,948,943		1,948,943	207,075	2,156,018			16
	C. General Administration											
17	Administrative	86,821			86,821		86,821	9,030	95,851			17
18	Directors Fees			525	525		525		525			18
19	Professional Services			10,078	10,078		10,078	15,586	25,664			19
20	Dues, Fees, Subscriptions & Promotions			26,244	26,244		26,244	(6,960)	19,284			20
21	Clerical & General Office Expenses	92,871	21,398	187,350	301,619		301,619	117,197	418,816			21
22	Employee Benefits & Payroll Taxes			294,363	294,363		294,363	33,898	328,261			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,314	13,314		13,314	31,685	44,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			91,155	91,155		91,155	(47,392)	43,763			26
27	Other (specify):*											27
28	TOTAL General Administration	179,692	21,398	623,029	824,119		824,119	153,044	977,163			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,149,583	413,838	774,704	3,338,125		3,338,125	373,276	3,711,401			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 Healthcare Ctr #0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			48,760	48,760		48,760	292	49,052			30
31	Amortization of Pre-Op. & Org.			5,609	5,609		5,609		5,609			31
32	Interest			(3,758)	(3,758)		(3,758)	(79)	(3,837)			32
33	Real Estate Taxes			30,445	30,445		30,445	(2,361)	28,084			33
34	Rent-Facility & Grounds			312,341	312,341		312,341	8,191	320,532			34
35	Rent-Equipment & Vehicles			123	123		123		123			35
36	Other (specify):*							24,692	24,692			36
37	**TOTAL Ownership**			393,520	393,520		393,520	30,735	424,255			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		145,328	58,526	203,854		203,854		203,854			39
40	Barber and Beauty Shops		189		189		189		189			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			199,947	199,947		199,947		199,947			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		145,517	258,473	403,990		403,990		403,990			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,149,583	559,355	1,426,697	4,135,635		4,135,635	404,011	4,539,646			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 Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,453)	2		4
5	Telephone, TV & Radio in Resident Rooms	2,077	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	(26)	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	(1,430)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,147)	21		24
25	Fund Raising, Advertising and Promotional	(7,885)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (22,864)		$	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)	326,734	21	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 326,734		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 303,870		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					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Nature Trail Healthcare Ctr

ID# 0047357

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Back Office Services Fees	$ (195,916)	21	1
2	Professional Liability Insurance Adj	(48,444)	26	2
3	Real Estate Tax Accrual Adjustment	(2,361)	33	3
4	Remove Rent Averaging	8,191	34	4
5	Adjust Health Insurance to Actual	11,645	22	5
6	Adjust Depreciation to Actual	292	30	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(226,593)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Nature Trail Healthcare Ctr **#** 0047357 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,479)	0	0	0	0	0	0	0	0	0	0	(1,479)	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	2,077	5	0	0	0	0	0	0	0	0	0	2,082	5
6	Maintenance	0	12,554	0	0	0	0	0	0	0	0	0	12,554	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	598	12,559	0	0	0	0	0	0	0	0	0	13,157	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	207,075	0	0	0	0	0	0	0	0	0	207,075	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	207,075	0	0	0	0	0	0	0	0	0	207,075	16
	C. General Administration													
17	Administrative	0	9,030	0	0	0	0	0	0	0	0	0	9,030	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,586	0	0	0	0	0	0	0	0	0	15,586	19
20	Fees, Subscriptions & Promotions	(7,885)	925	0	0	0	0	0	0	0	0	0	(6,960)	20
21	Clerical & General Office Expenses	115,241	1,956	0	0	0	0	0	0	0	0	0	117,197	21
22	Employee Benefits & Payroll Taxes	11,645	22,253	0	0	0	0	0	0	0	0	0	33,898	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	31,685	0	0	0	0	0	0	0	0	0	31,685	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(48,444)	1,052	0	0	0	0	0	0	0	0	0	(47,392)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	70,557	82,487	0	0	0	0	0	0	0	0	0	153,044	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	71,155	302,121	0	0	0	0	0	0	0	0	0	373,276	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Nature Trail Healthcare Ctr # 0047357 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	292	0	0	0	0	0	0	0	0	0	0	292	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(79)	0	0	0	0	0	0	0	0	0	(79)	32
33	Real Estate Taxes	(2,361)	0	0	0	0	0	0	0	0	0	0	(2,361)	33
34	Rent-Facility & Grounds	8,191	0	0	0	0	0	0	0	0	0	0	8,191	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	24,692	0	0	0	0	0	0	0	0	0	24,692	36
37	**TOTAL Ownership**	6,122	24,613	0	0	0	0	0	0	0	0	0	30,735	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	77,277	326,734	0	0	0	0	0	0	0	0	0	404,011	45

Facility Name & ID Number Nature Trail Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SSC Equity Holdings LLC	100	Montebello Health Care Center	Hamilton			
		Nature Trail Health Care Center	Mount Vernon			
		Odin Health Care Center	Odin			
		Westchester Health & 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. [X] 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%	$ 5	$ 5	1
2	V	6	Repair and Maintenance		SSC Equity Holdings LLC	100.00%	12,554	12,554	2
3	V	19	Professional Services		SSC Equity Holdings LLC	100.00%	15,586	15,586	3
4	V	20	Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	925	925	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	207,075	207,075	5
6	V	21	Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	1,956	1,956	6
7	V	24	Travel & Seminar		SSC Equity Holdings LLC	100.00%	31,685	31,685	7
8	V	26	Insurance		SSC Equity Holdings LLC	100.00%	1,052	1,052	8
9	V	36	Drpreiation		SSC Equity Holdings LLC	100.00%	24,692	24,692	9
10	V	17	Communications		SSC Equity Holdings LLC	100.00%	9,030	9,030	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%	(79)	(79)	12
13	V	22	Payroll Taxes		SSC Equity Holdings LLC	100.00%	22,253	22,253	13
14	Total			$			$ 326,734	$ * 326,734	14

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

Facility Name & ID Number Nature Trail Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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 Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 W Sam Houston Pkwy N Ste 100
City / State / Zip Code: Houston, TX 77041
Phone Number: (832-467-6000
Fax Number: (832-467-6983

	1 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				$	$		$ 5	1
2	6	Repair and Maintenance							12,554	2
3	19	Professional Services							15,586	3
4	20	Fee, Subscriptions and Promos							925	4
5	10	Nursing & Medical Records							207,075	5
6	21	Clerical & Gen Office Exp							1,956	6
7	24	Travel & Seminar							31,685	7
8	26	Insurance							1,052	8
9	36	Drpreiation							24,692	9
10	17	Communications							9,030	10
11	35	Rental and Lease								11
12	32	Interest Income/Expense							(79)	12
13	22	Payroll Taxes							22,253	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					$	$		$ 326,734	25

Facility Name & ID Number Nature Trail Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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 Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 23,757	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.)		$ 28,084	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,327	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 27,272	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.		$ 31,599	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	24,238	8
	2008	24,683	9
	2009	25,482	10
	2010	25,482	11
	2011	25,973	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Nature Trail Healthcare Ctr COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0047357

CONTACT PERSON REGARDING THIS REPORT Martha McDaniel

TELEPHONE 832 467 6317 FAX #: 832 467 6983

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(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	$ 28,084.42	$ 28,084.42
2.		COR, S 175' W 300'S 125' W 230'	$	$
3.		N 300'E 530'to POB - 1001 S	$	$
4.		34th Street	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 28,084.42	$ 28,084.42

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	207	11.5	207		1,268	9
10											10
11	12: Thru Wall Window A/C			2006	6,550		5			6,550	11
12	Tree Removal - Due to Storm			2006	17,600	1,760	10	1,760		11,440	12
13	Door - 42"			2006	5,245	525	10	525		3,366	13
14	Tree Removal			2006	2,273	222	10.25	222		1,423	14
15	Repair Sprinkler System			2006	33,750	3,320	10.25	3,320		21,025	15
16											16
17	Katolight Generator			2007	13,781	1,390	10	1,390		8,454	17
18	Electrical Work			2007	1,295	132	10	132		790	18
19	Repair Parking Lot			2007	89	9	10	9		55	19
20	Repair Parking Lot			2007	2,691	269	10	269		1,659	20
21	Interior Improvement			2007	1,710	171	10	171		1,055	21
22	Interior Improvement			2007	5,520	552	10	552		3,404	22
23	Interior Improvement			2007	2,230	223	10	223		1,375	23
24	Exterior Repairs			2007	6,852	691	10	691		4,203	24
25	New Dining Room Floor			2007	350	37	9.6	37		210	25
26	New Dining Room Floor			2007	2,094	213	9.83	213		1,278	26
27	Emergency Generator			2007	2,311	235	9.83	235		1,410	27
28	Repair Roof and Interior Rooms			2007	10,939	1,076	10.16	1,076		6,814	28
29	New Roof on Front Canopy			2007	3,434	343	10	343		2,118	29
30	New Roof on Kitchen Area			2007	3,450	345	10	345		2,128	30
31	Building Repairs			2007	8,890	896	10	896		5,454	31
32	Sprinkler Upgrade			2007	1,332	148	9	148		765	32
33	Shower Renovation			2007	2,529	281	9	281		1,452	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 Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 3,199	37
38	A T &T Circuit Conversion	2008	2,106	261	8	261		1,107	38
39	Maglock	2008	930	110	8.42	110		506	39
40									40
41	Bed Crash Rails	2009	1,661	237	7	237		751	41
42									42
43	Handrails	2010	10,441	1,510	7	1,510		4,654	43
44	30 Gallon Storage Container	2010	795	111	7	111		370	44
45	Remodel 5 Hallway Bathrooms (Contracted Total)-Carpentry	2010	4,939	780	6.3	780		1,950	45
46	Floor and Wall Mosaic Ceramic Tile for Bathroom Remodel	2010	7,571	1,196	6.3	1,196		2,989	46
47	Satellite Dish	2010	8,106	1,351	6	1,351		2,927	47
48	Satellite Dish	2010	4,893	827	6	827		1,723	48
49									49
50	Replace Shower Floor Liner, walls and fixtures - 5 bathrooms	2011	12,400	2,096	5.92	2,096		4,366	50
51	Replace Shower Floor Liner, walls and fixtures - 5 bathrooms	2011	3,306	559	5.92	559		1,164	51
52	2: Door Closers/Hinges	2011	1,125	(43)	5.83	(43)		150	52
53	Fire Alarm Horn Strobe Detector	2011	4,081	690	5.92	690		1,437	53
54	Replace Rooftop Unit Compressor	2011	1,245	194	6.42	194		501	54
55	Walkway Safety Bars	2011	1,715	(65)	5.83	(65)		229	55
56	Wall Mounted Kitchen Cabinet	2011	3,042	514	5.92	514		1,071	56
57	Marble Tops, Recessed bowls and faucets - 5 bath updates	2011	1,376	229	6	229		496	57
58	Maglock	2011	1,497	227	6.58	227		625	58
59	Annunciator	2011	3,661	1	5.75	1		585	59
60	Hand Rail	2011	8,988	(19)	5.42	(19)		949	60
61	Replace cement board and tile in bath areas	2011	3,419	21	5.33	21		342	61
62	Replace cement board and tile in bath areas	2011	3,419	117	5.08	117		285	62
63	3: Dry Pendent Sprinkler Heads	2011	2,495	110	5	110		193	63
64									64
65	10 Ton Heat/Cool Roof Top Unit	2012	25,200	4,863	5	4,863		4,863	65
66	Portabel Storage	2012	2,000	117	10	117		117	66
67	Replc Fire Alarm Control Panel	2012	3,576	119	10	119		119	67
68	Kitchen Hood System	2012	8,541	71	10	71		71	68
69									69
70	TOTAL (lines 4 thru 69)		$ 274,791	$ 29,802		$ 29,802	$	$ 125,435	70

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

Facility Name & ID Number Nature Trail Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 157,546	$ 18,353	$ 18,353	$		$ 107,539	71
72	Current Year Purchases	7,437	897	897			897	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 164,983	$ 19,250	$ 19,250	$		$ 108,436	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)	$ 439,774	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 49,052	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 49,052	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)	$ 233,871	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 Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	01/01/2005	$ 320,532	12		3
4	Additions							4
5								5
6								6
7	TOTAL		74		$ 320,532 **			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.	/2013	$ 333,353
13.	/2014	$ 346,687
14.	/2015	$ 360,555

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 Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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-1	5284	hrs	$ 181,111		$	$	5,284	$ 181,111	1
2	Licensed Speech and Language Development Therapist	10a-1	2047	hrs	94,595				2,047	94,595	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a-1	8159	hrs	264,980				8,159	264,980	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				145,328		145,328	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				$ 540,686		$	$ 145,328	15,490	$ 686,014	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 Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	26,368		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	808,317		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,043		6
7	Other Prepaid Expenses	3,594		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 839,722	$	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	262,675		15
16	Equipment, at Historical Cost	164,981		16
17	Accumulated Depreciation (book methods)	(217,683)		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):	23,839		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 270,577	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,110,299	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 90,321	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	177,445		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,826		31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,155		32
33	Accrued Interest Payable			33
34	Deferred Compensation	61,947		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Taxes (Other)	39,649		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 416,343	$	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		(790,995)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (790,995)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (374,652)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,484,951	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,110,299	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,633,664	1	
2	Restatements (describe):	61,402	2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,695,066	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(210,115)	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)**	$ (210,115)	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)**	$ 1,484,951	24	*

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

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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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,566,497	1
2	Discounts and Allowances for all Levels	(1,203,530)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,362,967	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,081,521	6
7	Oxygen	10,072	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,091,593	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,804	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	359,974	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,149	19
20	Radiology and X-Ray	41,486	20
21	Other Medical Services	28,293	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 470,706	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	Vending Revenue	254	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 254	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,925,520	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	565,063	31
32	Health Care	1,948,943	32
33	General Administration	824,119	33
	B. Capital Expense		
34	Ownership	393,520	34
	C. Ancillary Expense		
35	Special Cost Centers	204,043	35
36	Provider Participation Fee	199,947	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,135,635	40
41	**Income before Income Taxes (line 30 minus line 40)****	(210,115)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (210,115)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,288,810	44
45	Private Pay - Net Inpatient Revenue	134,186	45
46	Medicare - Net Inpatient Revenue	582,582	46
47	Other-(specify)	29,144	47
48	Other-(specify)	328,245	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,362,967	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.**

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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	1,706	1,930	$ 68,893	$ 35.70	1
2	Assistant Director of Nursing	1,777	1,926	45,565	23.66	2
3	Registered Nurses	9,143	9,785	214,287	21.90	3
4	Licensed Practical Nurses	17,210	18,850	336,683	17.86	4
5	CNAs & Orderlies	35,878	38,729	391,677	10.11	5
6	CNA Trainees					6
7	Licensed Therapist	12,712	15,490	540,687	34.91	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,980	2,167	32,082	14.80	9
10	Activity Assistants	1,046	1,163	14,158	12.17	10
11	Social Service Workers	1,792	1,894	26,372	13.92	11
12	Dietician					12
13	Food Service Supervisor	1,845	2,090	29,138	13.94	13
14	Head Cook	4,962	5,315	52,780	9.93	14
15	Cook Helpers/Assistants	4,451	4,628	39,281	8.49	15
16	Dishwashers					16
17	Maintenance Workers	1,530	1,815	29,729	16.38	17
18	Housekeepers	7,199	7,822	71,317	9.12	18
19	Laundry	3,109	3,245	27,920	8.60	19
20	Administrator	1,962	2,206	86,821	39.36	20
21	Assistant Administrator					21
22	Other Administrative	1,959	2,087	56,959	27.29	22
23	Office Manager					23
24	Clerical	1,936	2,122	35,913	16.92	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	1,865	2,152	26,966	12.53	31
32	Other Health Care(specify)	1,691	1,902	22,355	11.75	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,753	127,318	$ 2,149,583 *	$ 16.88	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		$ 9,890	1-3	35
36	Medical Director		7,200	9-3	36
37	Medical Records Consultant		623	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,110	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,370	11-3	44
45	Social Service Consultant		2,388	12-3	45
46	Other(specify) Admin		42,315	10-3	46
47	Xray/& Laboratory		49,009	39-3	47
48	Dentist/Physician/Psychiatrist		199	39-3	48
49	TOTAL (lines 35 - 48)		$ 118,104		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gina Higgings	Administrator	0	$ 46,501
Linda L Cox	Interim Admin	0	40,320
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,821

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	$ 763
ADP Inc	WOTC Tracking	824
Illinois State Police	Patient Background Cks	1,380
My Innerview	Resident Survey	70
Old Seville Exp Reduction	Bio WasteExp Reduction	159
CT Corp	Litigation Tracking	256
GenPact	Reengineering Cost Analysis	4,194
Talx	Unemployment	683
LexisNexis	Data Management	8
Waste Reduction Consult	Waste Reduction	1,741
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 10,078

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,516
Unemployment Compensation Insurance	68,498
FICA Taxes	157,123
Employee Health Insurance	41,893
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Ins Life	2,459
Other Benefits	7,519
Home Office PR Taxes	22,253
TOTAL (agree to Schedule V, line 22, col.8)	$ 328,261

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,210
Advertising: Employee Recruitment	3,750
Health Care Worker Background Check	4,736
(Indicate # of checks performed)	
Patient Background Checks	
Other Licenses	
Publications & Manuals	3,462
Home Office Dues & Sub	925
Dues	3,201
Non Allowable Adv	7,885
Less: Public Relations Expense	( )
Non-allowable advertising	(7,885)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,284

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,987
In-State Travel	6,940
Seminar Expense	4,387
Home Office Allocation	31,685
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 44,999

**See instructions.

Facility Name & ID Number Nature Trail Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Healthcare Ctr # 0047357 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Healthcare Assn $2891**

(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. $ **15,390** 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. $ **199,947**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,453**

(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? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

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