

Facility Name & ID Number Odin Health Care Center

0047365 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 99

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	33	Skilled (SNF)	33	12,078	1
2		Skilled Pediatric (SNF/PED)			2
3	66	Intermediate (ICF)	66	24,156	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF			6,918	6,918	8
9	SNF/PED					9
10	ICF	21,717	4,358	54	26,129	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,717	4,358	6,972	33,047	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.20%

D. How many bed-hold days during this year were paid by the Department? _____ (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)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 06/07/1994

J. Was the facility purchased or leased after January 1, 1978?
YES Date 06/07/1994 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 99 and days of care provided 6,918

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

STATE OF ILLINOIS

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	159,480	8,499	12,373	180,352		180,352		180,352		1
2	Food Purchase		137,749		137,749		137,749		137,749		2
3	Housekeeping	93,903	10,679		104,582		104,582		104,582		3
4	Laundry	55,208	6,723		61,931		61,931		61,931		4
5	Heat and Other Utilities			99,824	99,824		99,824		99,824		5
6	Maintenance	34,964	45,111		80,075	(397)	79,678	115	79,793		6
7	Other (specify):*			10,123	10,123		10,123		10,123		7
8	TOTAL General Services	343,555	208,761	122,320	674,636	(397)	674,239	115	674,354		8
B. Health Care and Programs											
9	Medical Director			11,332	11,332		11,332		11,332		9
10	Nursing and Medical Records	1,429,710	114,639	8,015	1,552,364		1,552,364		1,552,364		10
10a	Therapy	548,390	45,154	7,241	600,785		600,785		600,785		10a
11	Activities	34,331	4,335	2,198	40,864	6,927	47,791		47,791		11
12	Social Services	36,888	2,175		39,063		39,063		39,063		12
13	CNA Training										13
14	Program Transportation	9,895		3,274	13,169	(9,703)	3,466		3,466		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,059,214	166,303	32,060	2,257,577	(2,776)	2,254,801		2,254,801		16
C. General Administration											
17	Administrative	87,738			87,738		87,738		87,738		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			21,375	21,375		21,375	723	22,098		20
21	Clerical & General Office Expenses	136,865	11,472	337,852	486,189		486,189	(100,922)	385,267		21
22	Employee Benefits & Payroll Taxes			447,537	447,537		447,537		447,537		22
23	Inservice Training & Education										23
24	Travel and Seminar			24,621	24,621		24,621	13,667	38,288		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			90,787	90,787		90,787	(19,775)	71,012		26
27	Other (specify):*										27
28	TOTAL General Administration	224,603	11,472	922,172	1,158,247		1,158,247	(106,307)	1,051,940		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,627,372	386,536	1,076,552	4,090,460	(3,173)	4,087,287	(106,192)	3,981,095		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.

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2006
Ending: 12/31/2006

Facility Name & ID Number Odin Health Care Center # 0039503

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7

Amount

Infectious Waste Disposal <> Default <> Nursing Admin/Supv 6993
Infectious Waste Disposal <> Default <> Physical Plant
Garbage Service<>Default<>Prod<>Physical Plant 3,130
Garbage Service <> Default <> Physical Plant

10,123

Health Care Program - Line 15

Amount

N/A

0

General & Administrative - Line 27

Amount

N/A

0

Inservice Education - Line 23 Column 3 (over \$2,000)

Amount

N/A

0

STATE OF ILLINOIS

Report Period:

Beginning: 1/1/2006

Page -3.2

Facility Name & ID Number Odin Health Care Center # 0039503

Ending: 12/31/2006

Meals - adjustment

Sales Tax - adjustment

33,047 Days (Total Patient days)
 3 Mult (3 meals a day)
 99,141 Sub total
 0 meals to employess (reported by facility)
 99,141 Add Sub
 137,749 Divide -Pg 3, line 2, column 2
 1.39 Cost per day

137,749 Total Food Cost (page 3,Line 2, col 3)
 0.01 Mult
 1,377 Sub total
 13.19% Mult (Pvt pay div by total census)
 182 = adjust for nonallowable sale tax
 for page 5A,

1.39 Cost per day
 0 mult - meal to employees
 0 = adjust for pg 2, line 2, column2

Reclassification V

Page 3 Line 6
 Repair & Maint <> Vehicles<>Default<>Prod<>Transport Non<>Emergency 830010000003850 (397) Reclass From
 (278 x 70% = 397)
 Page 4 line 38 397 Reclass to

Page 3 Line 14
 Salaries <> Regular<>Driver<>Transport Non<>Emergency 700000750403850 (9,264) Reclass From
 Vacation Pay <> Earned Lve Acc.<>Default<>Prod<>Transport Non<>Emergen 730012750403850 (375) Reclass From
 Holiday Pay <> Earned Lve Taken<>Default<>Prod<>Transport Non<>Emergen 730013750403850 (256) Reclass From
 70% is Medical 30% is activities (9,895) total

Page 3 line 11 6,927 Reclass to
 Page 4 line 38 2,969 Reclass to

Page 4 Line 35 Rent
 Lease Exp <> Vehicles<>Default<>Prod<>Transport Non<>Emergency 841005000003850 102 Reclass From
 (146 x 70% = 102 lease for Medical)
 Page 4 line 38 (102) Reclass to

Facility Name & ID Number

Odin Health Care Center

#0047365

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			104,045	104,045		104,045	11,476	115,521			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			195,727	195,727		195,727		195,727			32
33	Real Estate Taxes			102,398	102,398		102,398	861	103,259			33
34	Rent-Facility & Grounds			423,483	423,483		423,483	33	423,516			34
35	Rent-Equipment & Vehicles			146	146	102	248	11,206	11,454			35
36	Other (specify):*							15,501	15,501			36
37	TOTAL Ownership			825,799	825,799	102	825,901	39,077	864,978			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					3,071	3,071		3,071			38
39	Ancillary Service Centers		152,742	30,393	183,135		183,135	15,857	198,992			39
40	Barber and Beauty Shops			1,304	1,304		1,304	(1,304)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		152,742	85,900	238,642	3,071	241,713	14,553	256,266			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,627,372	539,278	1,988,251	5,154,901		5,154,901	(52,562)	5,102,339			45

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

STATE OF ILLINOIS

Report Period: Beginning: 1012006
Ending: 12/31/2006

Facility Name & ID Number Odin Health Care Center # 0039503

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

<u>Ownership - Line 36</u>	<u>Amount</u>
Fresh Start Acctg Adj <> Bankruptcy Exp Acq <> Cost Non Overhead	0
	<u>-</u>

<u>Ancillary Expenses - Line 43 -Column 2</u>	<u>Amount</u>
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	0
	<u>0</u>

<u>Ancillary Expenses - Line 43 -Column 3</u>	<u>Amount</u>
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services <> Nonchg<>Other Medical Professionals<>XRay	0
Professional Services <> Nonchg<>Medical Director<>Laboratory	0
Professional Services <> Nonchg<>Medical Director<>XRay	0
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services <> Nonchg<>Other Medical Professionals<>XRay	0
	<u>-</u>

<u>Rent-Facility & Grounds - Expenses- Line 34 Column 3</u>	
Lease Expense Facility-Realty-Default-Prod	80,008
Lease Expense Facility <> Default <> Realty	343,475
	0
	<u>423,483</u>

Facility Name & ID Number Odin Health Care Center

0047365

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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				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				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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,823)	21		24
25	Fund Raising, Advertising and Promotional				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	(284,680)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (305,503)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	252,941		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 252,941		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (52,562)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.	x		\$ 3,274	14	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 3,274		47

Odin Health Care Center

ID# 0047365

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Sales Taxes	\$ (182)	21	1
2	Small Balance Adjustment	0	21	2
3	Memorium/ Benevolence	(840)	21	3
4	Depreciation Reconciliation	11,476	30	4
5	Activities Program Receipts	0	11	5
6	Property Taxes Adjust to actual	0	33	6
7	Professional liability Insurance	(19,775)	26	7
8	Barber & beauty	(1,304)	40	8
9	Public Relations Expenses	0	20	9
10	Non Allowable Advertising	0	20	10
11	Entertainment	(27)	24	11
12	Fresh Start	0	36	12
13	Civic Dues	0	20	13
14	Penalties	0	21	14
15	Vending receipts	0	21	15
16	Misc Receipts	(1,569)	21	16
17	Marketing Wages	(944)	21	17
18	Marketing Bonus	0	21	18
19	Marketing Holiday	(137)	21	19
20	Maketing Sick	0	21	20
21	Marketing Vacation	(419)	21	21
22	Marketing Overtime	0	21	22
23	Marketing Non Worked Wages	(288)	21	23
24	Donations/ Contributions	0	21	24
25	Legal Fees - Bankruptcy		21	25
26	Legal Structure Management Fees	(270,473)	21	26
27	Undocumented Travel		14	27
28	Interest Income	(198)	24	28
29			32	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	(284,680)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odin Health Care Center# 0047365

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	115	0	0	0	0	0	0	0	0	0	115	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	115	0	0	0	0	0	0	0	0	0	115	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	723	0	0	0	0	0	0	0	0	0	723	20
21	Clerical & General Office Expenses	(295,675)	194,753	0	0	0	0	0	0	0	0	0	(100,922)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(225)	13,892	0	0	0	0	0	0	0	0	0	13,667	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(19,775)	0	0	0	0	0	0	0	0	0	0	(19,775)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(315,675)	209,368	0	0	0	0	0	0	0	0	0	(106,307)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(315,675)	209,483	0	0	0	0	0	0	0	0	0	(106,192)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Odin Health Care Center# 0047365

Report Period Beginning:

01/01/2006 Ending:12/31/2006

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	11,476	0	0	0	0	0	0	0	0	0	0	11,476 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	861	0	0	0	0	0	0	0	0	0	861 33
34	Rent-Facility & Grounds	0	33	0	0	0	0	0	0	0	0	0	33 34
35	Rent-Equipment & Vehicles	0	11,206	0	0	0	0	0	0	0	0	0	11,206 35
36	Other (specify):*	0	15,501	0	0	0	0	0	0	0	0	0	15,501 36
37	TOTAL Ownership	11,476	27,601	0	39,077 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	15,857	0	0	0	0	0	0	0	0	0	15,857 39
40	Barber and Beauty Shops	(1,304)	0	0	0	0	0	0	0	0	0	0	(1,304) 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	(1,304)	15,857	0	14,553 44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(305,503)	252,941	0	(52,562) 45								

Facility Name & ID Number Odin Health Care Center

0047365

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	See Attachment page 6.1		SSC Equity Holdings,	Atlanta, GA	Management

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	SSC Equity Holdings, LLC	100.00%	\$	\$	1
2	V	6 Repair & Maintenance		SSC Equity Holdings, LLC	100.00%	115	115	2
3	V	39 Professional Services		SSC Equity Holdings, LLC	100.00%	15,857	15,857	3
4	V	20 Fees, Subscriptions, Promotions		SSC Equity Holdings, LLC	100.00%	723	723	4
5	V	10 Nursing & Medical Records		SSC Equity Holdings, LLC	100.00%			5
6	V	21 Clerical & General Office Exp		SSC Equity Holdings, LLC	100.00%	194,753	194,753	6
7	V	24 Travel & Seminar		SSC Equity Holdings, LLC	100.00%	13,892	13,892	7
8	V	26 Insurance Premium		SSC Equity Holdings, LLC	100.00%			8
9	V	36 Depreciation		SSC Equity Holdings, LLC	100.00%	15,501	15,501	9
10	V	33 Taxes - Property		SSC Equity Holdings, LLC	100.00%	861	861	10
11	V	35 Rental & Leasing		SSC Equity Holdings, LLC	100.00%	11,206	11,206	11
12	V	34 Lease Expense		SSC Equity Holdings, LLC	100.00%	33	33	12
13	V	26 Property Insurance		SSC Equity Holdings, LLC	100.00%			13
14	Total		\$			\$ 252,941	\$ * 252,941	14

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

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2006
Ending: 12/31/2006

Facility Name & ID Number: Odin Health Care Center # 0039503

Related Illinois Nursing Homes
as of
12/31/2006

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
SSC Equity Holdings, LLC	Montebello Healthcare Center Nature Trail HealthCare Center Odin HealthCare Center Mariner Health of Westchester	0031468 0039586 0039503 0042374

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	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 Odin Health Care Center

0047365 Report Period Beginning: 01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization SSC Equity Holdings, LLC
 Street Address One Ravinia Dr. Suite 1400
 City / State / Zip Code Atlanta, GA
 Phone Number (770) 829-5100
 Fax Number (770) 393-8054

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities			\$	\$			1
2	6	Repair & Maintenance	1		115		1	115	2
3	39	Professional Services	1		15,857		1	15,857	3
4	20	Fees, Subscriptions, Promotions	1		723		1	723	4
5	10	Nursing & Medical Records							5
6	21	Clerical & General Office Exp	1		194,753		1	194,753	6
7	24	Travel & Seminar	1		13,892		1	13,892	7
8	26	Insurance Premium							8
9	36	Depreciation	1		15,501		1	15,501	9
10	33	Taxes - Property	1		861		1	861	10
11	35	Rental & Leasing	1		11,206		1	11,206	11
12	34	Leasse Expense	1		33		1	33	12
13	26	Property Insurance							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				\$ 252,941	\$		\$ 252,941	25

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 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.)

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

B. Real Estate Taxes

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																												
1. Real Estate Tax accrual used on 2005 report.		\$	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.)		\$	74,749 2																									
3. Under or (over) accrual (line 2 minus line 1).		\$	74,749 3																									
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	27,649 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.		\$	102,398 7																									
Real Estate Tax History:																												
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td style="text-align: right;">44,438</td><td style="text-align: center;">8</td></tr> <tr><td>2002</td><td style="text-align: right;">44,623</td><td style="text-align: center;">9</td></tr> <tr><td>2003</td><td style="text-align: right;">41,411</td><td style="text-align: center;">10</td></tr> <tr><td>2004</td><td style="text-align: right;">47,077</td><td style="text-align: center;">11</td></tr> <tr><td>2005</td><td style="text-align: right;">74,749</td><td style="text-align: center;">12</td></tr> </table>	2001	44,438	8	2002	44,623	9	2003	41,411	10	2004	47,077	11	2005	74,749	12	<table border="1"> <tr><td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>	FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2005 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$	
2001	44,438	8																										
2002	44,623	9																										
2003	41,411	10																										
2004	47,077	11																										
2005	74,749	12																										
FOR BHF USE ONLY																												
13	FROM R. E. TAX STATEMENT FOR 2005 \$																											
14	PLUS APPEAL COST FROM LINE 5 \$																											
15	LESS REFUND FROM LINE 6 \$																											
16	AMOUNT TO USE FOR RATE CALCULATION \$																											

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Odin Health Care Center COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0047365

CONTACT PERSON REGARDING THIS REPORT Lee Grigsby

TELEPHONE (832) 467-6244 FAX #: (832) 467-6246

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of total 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 2005.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. <u>10-11-400-001</u>	<u>00000000 PT SE SE</u>	\$ <u>149,497.50</u>	\$ <u>149,497.50</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>149,497.50</u>	\$ <u>149,497.50</u>

B. Real Estate Tax Cost Allocation:

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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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 Odin Health Care Center# 0047365 Report Period Beginning:01/01/2006 Ending: 12/31/2006**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 42,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/AF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	269,000	1994	\$ 80,743	1
2					2
3	TOTALS	269,000		\$ 80,743	3

Facility Name & ID Number Odin Health Care Center# 0047365

Report Period Beginning:

01/01/2006 Ending: 12/31/2006**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99	1994	1995	\$ 3,360,767	\$ 96,022	35	\$ 96,022		\$ 1,110,924	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	See Attached -Page 12.1		1994	782,958	39,148	20	39,148		451,836	9
10	Repair Sidewalk #36 & 37		1996	819	41	20	41		380	10
11	Rooftop A/C - See attached page 12.2		1996	16,378	819	20	819		8,934	11
12	Install Awning		1997	2,845	142	20	142		1,257	12
13	Water Heater - See page 12.2		1997	1,388	69	20	69		666	13
14	Water Heater Installed - See page 12.2		1997	6,645	332	20	332		3,218	14
15	Electrical		1998	357	9	20	9		72	15
16	HVAC		1998	1,516	38	20	38		304	16
17	Plumbing # 67		1998	2,853	71	20	71		568	17
18	Water Heater # 69		1998	3,885	97	20	97		776	18
19			1999							19
20										20
21										21
22	A.O. Smith 75 Gal Gas # 72		1999	1,818	182	10	182		1,274	22
23	100 G Gas Water Heater # 77 & 78		2000	1,397	140	10	140		793	23
24	12; Zoneline HVAC Units #94 & 95		2000	8,579	572	15	572		3,146	24
25	First Q digital reset #98 & 99		2000	1,224	122	10	122		692	25
26	W/G & Maglocks system #102 & 103		2000	3,817	382	10	382		2,037	26
27	2200 SQ FT Flatroof Downpymt #104		2000	9,899	990	10	990		5,197	27
28	Wandergard System #106 & 107		2000	3,615	362	10	362		2,050	28
29	236' 4' High, DogEar Cedar Fence #109		2000	3,173	397	8	397		2,116	29
30	Instl 11,220 SQFT Flat roof #110		2001	20,098	2,010	10	2,010		7,049	30
31	Roof Shingles - 33% Downpmt #111		2001	18,277	1,828	10	1,828		8,834	31
32	Balance of Roof Replacmt #112		2001	36,553	3,655	10	3,655		17,362	32
33	9; Smoke & 2; Heat Detectors #116		2001	960	96	10	96		456	33
34	Use Tax 9; Smoke & 2; Heat Detectors #117		2001	62	3	10	3		20	34
35	R/T 3T Armstrong Condense Int #118		2001	1,278	85	15	85		397	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

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Odin Health Care Center# 0047365

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	4: Maglocks & Indoor Keypads #119	2001	\$ 3,057	\$ 306	10	\$ 306	\$	\$ 1,757		37
38	7: Zoneline HVAC - Patient Rooms #123	2001	4,718	315	15	315		1,705		38
39	Use Tax 7: Zoneline HVAC - Patient Rooms #124	2001	298	20	15	20		108		39
40	Charge Back - Excessive Discount #126	2001	442	29	15	29		156		40
41	5: Catch - All Digital Reset #127	2001	1,577	158	10	158		894		41
42										42
43	3: Wanderguard Auto 24Hr timer #144	2002	250	25	10	25		142		43
44	Cr Inv# 10017115 - 1: Auto 24 Hr timer #145	2002	(76)	(8)	10	(8)		(43)		44
45	Wanderguard System Unst'l #146	2002	2,680	268	10	268		2,087		45
46	6: Zoneline Heat/ Cool Units #5017	2002	4,111	822	5	822		3,768		46
47	Use Tax 6: Zoneline Heat/ Cool Units #5018	2002	260	52	5	52		238		47
48	Repair to Damage Brick #5030	2002	5,000	333	15	333		751		48
49	Arch fee -Upgrade to Skilled St #5033	2002	1,928	129	15	129		547		49
50										50
51	Prefinished Slab Door #5034	2003	495	33	15	33		135		51
52	SteelDoor w/Window # 5035	2003	693	35	20	35		142		52
53	15: Vinyl Rplc Window -Intsl # 5036	2003	7,500	500	15	500		2,042		53
54	Sentricon colony Elim -instl # 5051	2003	8,890	889	10	889		3,334		54
55	Arch/Eng Fee Skilled Care # 5054	2003	5,143	342	15	342		1,255		55
56	Cable - remote -WanderGuard system # 5059	2003	2,546	255	10	255		1,422		56
57	2: Maglock -WanderGuard # 5063	2003	(2,338)	(234)	10	(234)		(1,539)		57
58	6: Zoneline a/C Units A/C Heat Units # 5056	2003	3,434	687	5	687		2,404		58
59	Use Tax -6: Zoneline a/C Units A/C Heat Units # 5056	2003	216	43	5	43		151		59
60	2: Window Shutters - Fire Saftey # 5069	2003	3,376	225	15	225		788		60
61	Rpr 2 Floors Drain -Kitchen # 5079	2003	1,750	88	20	88		300		61
62	Rplc 91 Gal Gas Waterheater #5082	2003	2,380	238	10	238				62
63										63
64	Fire Sentinel-Dr Release Device	2004	1,948	141	15	141		423		64
65	Wet Sprinkler Svst Instl	2004	8,226	329	25	329		987		65
66	UseTax - Fire Sentinel A Door	2004	107	8	15	8		24		66
67	Engineering Services	2004	3,639	182	15	182		546		67
68	Fire Suppression Svst	2004	1,961	114	10	114		342		68
69	6: Zoneline Heat/ Cool Units	2004	3,434	143	10	143		429		69
70	TOTAL (lines 4 thru 69)		\$ 4,368,808	\$ 154,078		\$ 154,078	\$	\$ 1,655,653		70

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

STATE OF ILLINOIS

Facility Name & ID Number Odin Health Care Center# 0047365

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

Page 12B

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 4,368,808	\$ 154,078		\$ 154,078		\$ 1,655,653		1
2	Use Tax-6: Zoneline Heat/ Cool Units	2004	223	9	10	9		27	2
3									3
4	Vents for Isolation Rooms, Handicap Tubs/Sinks & Whirlpool	2005	38,961	1,515	15	1,515		3,030	4
5	Sewer Line Repairs, Add Pipe	2005	1,664	33	25	33		66	5
6	Repairs Main Sewer Line	2005	550	11	20	11		22	6
7	Inspect Main Trunk Line	2005	325	7	20	7		14	7
8	4:Smoke Detectors	2005	675	23	10	23		46	8
9	Tile & Security Alarm Oxygen	2005	232	5	15	5		10	9
10	10 Ton Seer Condenser/AC Unit	2005	1,450	32	15	32		64	10
11	Ruud Air Handler-Instl	2005	1,650	14	20	14		28	11
12	2:Zoneline Heat/Cool Units	2005	1,119	93	15	93		186	12
13	Fascia Board Repair	2005	3,520	98	15	98		196	13
14	Vents for Isolation Rooms, Handicap Tubs/Sinks & Whirlpool	2005	37,013	617	25	617		1,234	14
15	Sewerline Repairs, Add Pipe	2005	1,620	16	15	16		32	15
16	Repairs Main Sewer Line	2005	534	7	15	7		14	16
17	Inspect Main Trunk Line	2005	316	4	10	4		8	17
18	4:Smokie Dectors	2005	641	16	10	16		32	18
19									19
20	10 Ton Condenser-A/C Unit	2005	1,402	23	15	23		46	20
21	Ruud Air handler-Instalation	2005	1,622	20	20	20		40	21
22	Use Tax-2: Zoneline Heat/ Cool Units	2005	70	6	5	6		12	22
23									23
24	Zoneline Heat/Cool Unit	2006	508	68	5	68		68	24
25	Use Tax-Zoneline Heat/Cool Unit	2006	31	4	5	4		4	25
26	A/C in Dietary	2006	3,465	462	5	462		462	26
27	Wallpaper & Handrails	2006	5,632	657	5	657		657	27
28	Handrails	2006	4,442	282	11	282		282	28
29	Paging/Music Broadcast System	2006	1,438	84	10	84		84	29
30	Wallpaper & Handrails	2006	5,632	375	5	375		375	30
31	2:Thru Wall Heat/Cool Units	2006	1,120	56	5	56		56	31
32	Use Tax - 2: Thru Wall Heat / Cool	2006	71	4	5	4		4	32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,484,733	\$ 158,619		\$ 158,619		\$ 1,662,752		34

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

Facility Name & ID Number **Odin Health Care Center**

0047365

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	\$ 4,462,394	\$ 156,627	\$ 156,627	\$		\$ 1,660,760	71
72	Current Year Purchases	22,339	1,992	1,992			1,992	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 4,484,733	\$ 158,619	\$ 158,619	\$		\$ 1,662,752	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	Activities & Trans	White Ford Van 2003	2003	\$ 40,166	\$ 10,042	\$ 10,042	\$		\$ 14,122	76
77										77
78										78
79										79
80	TOTALS			\$ 40,166	\$ 10,042	\$ 10,042	\$		\$ 14,122	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 9,090,375	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 327,280	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 327,280	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)	\$ 3,339,626	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	O/H Allocation 06/01/1996	\$ 2,579	\$ 129	\$ 1,172	86
87	O/H Allocation 08/01/1997	1,035	52	438	87
88	O/H Allocation 10/01/1997	117	6	86	88
89					89
90					90
91	TOTALS	\$ 3,731	\$ 187	\$ 1,696	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	99	01/01/2005	\$ 429,021	20		3
4	Additions						4
5							5
6							6
7	TOTAL	99		\$ 429,021			7

10. Effective dates of current rental agreement:

Beginning 01/01/2005

Ending 12/31/2024

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

Fiscal Year Ending Annual Rent

12. /2007 \$

13. /2008 \$

14. /2009 \$

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

STATE OF ILLINOIS

Report Period: Beginning: 1012006
Ending: 12/31/2006

Facility Name & ID Number

Odin Health Care Center

0039503

SUPPLEMENTAL SCHEDULE - Page 14 -B -16 - EQUIPMENT -RENTAL MOVABLE

Name of G/L	G/L #	EQUIPMENT	Amount	Page/Line/Col Ref From
Lease Exp - Eqpt - Nonmedical <> Default <> NonCert	84100000001011	Specialty Mattress/ Beds		03/10/03
Lease Exp - Eqpt - <> Default <> Prod Oxygen	84100000002022	Concentrators	25.00	
Lease Exp <> Eqpt<>Default<>Prod<>SNF Non Certified	84100000001011	Oxygen	2,250.28	
Lease Exp - Eqpt-Physical Therapy-Default-Prod	84100000002200	PT Equip.	6.071	
Lease Exp - Eqpt - <> Default <> Equip Rental	84100000002102			03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Activities	84100000007000			03/11/03
Lease Exp - Eqpt - Nonmedical <> Default <> Dietary	84100000007030	Diswasher	840.00	03/01/03
Lease Exp - Eqpt - Nonmedical <> Default <> Housekeeping / Janitorial	84100000007040			03/03/03
Lease Exp - Eqpt - Nonmedical <> Default <> Laundry	84100000007050			03/04/03
Lease Exp - Eqpt - Nonmedical <> Default <> Nursing Admin/Supv	84100000008000	Mattress		03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Administrative	84100000008100	Copies, Stamp machine Cable	8,638.95	03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plant	84100000008210			03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	84100000008220			04/35/03
Lease Exp - Other <> Default <> Administrative	84102000008100			03/21/03
			17,825.53	Grand Total

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

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	

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)		
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost					
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist	10a-03	6662	hrs	\$	195,395					\$	6,662	\$	195,395	1
2	Licensed Speech and Language Development Therapist	10a-03	3568	hrs		118,963						3,568		118,963	2
3	Licensed Recreational Therapist	10a-03		hrs											3
4	Licensed Physical Therapist	10a-03	8130	hrs		204,408						8,130		204,408	4
5	Physician Care	39		visits											5
6	Dental Care	39		visits											6
7	Work Related Program			hrs											7
8	Habilitation			hrs											8
9	Pharmacy	39		# of prescripts							152,742			152,742	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs											10
11	Academic Education			hrs											11
12	Exceptional Care Program														12
13	Other (specify):														13
14	TOTAL				\$	518,766		\$		\$	152,742	18,360	\$	671,508	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 **Odin Health Care Center**

0047365

Report Period Beginning: **01/01/2006**

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2006**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 550	\$	1
2	Cash-Patient Deposits	119,988		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(89,578)		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	79		6
7	Other Prepaid Expenses	140,347		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 171,386	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	78,452		15
16	Equipment, at Historical Cost	33,548		16
17	Accumulated Depreciation (book methods)	(13,325)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	46,342		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	35,918		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 180,935	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 352,321	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 175,505	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	176,866		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,853		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attachment Sch 17.1	137,637		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 507,861	\$	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	See Attachment Sch 17.1	(4,309,529)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (4,309,529)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (3,801,668)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,153,989	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 352,321	\$	48

*(See instructions.)

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2006
Ending: 12/31/2006

Facility Name & ID Number Odin Health Care Center # 0039503

SUPPLEMENTAL SCHEDULE OF ASSETS & LIABILITIES

<u>OTHER CURRENT ASSETS:</u>	<u>AMOUNT</u>	
	0	Difference
Total	0	
Reconcile with schedule XV, line 9:	0	0

OTHER NON-CURRENT ASSETS:

17 23-1	Excess Reorganized Value <> Excess Reorg Value <> Default	35,918	
	Other Assets <> Rfndable Deposits-Non Int Brg <> Default	35,918	
	Total	35,918	Difference
Reconcile with schedule XV, line 23:	35,918	-	

<u>OTHER CURRENT LIABILITIES:</u>	<u>AMOUNT</u>	
Misc Dedctns - Employee <> Other Deductions <> Default		17 36-1
Misc Dedctns - Employee <> Miscellaneous <> Default		
Accruals - Insurance <> Accrue HMO Ins <> Default	56	
Accrued Insurance PLGL Post-Petition Claims Default-Dept	(12,221)	
Accruals - Insurance <> Self Funded Ins Acr <> Default	(24,516)	
Accruals - Insurance <> Basic Life <> Default	(229)	
Accruals - Insurance <> Lt Dsbly <> Default	(42)	
Accruals - Insurance <> Dental Ins <> Default		
Accruals - Insurance <> Executive Supp Life <> Default	(499)	
Accruals - Insurance <> Short Term Disability <> Default	(37)	
Accruals - Insurance <> Dependent Life <> Default-Dept	(51)	
Accruals - Insurance <> Accidental Death Dismemberment <> Default-Dept	(33)	
Accruals - Insurance <> NES Insurance <> Default-Dept	(4,548)	
Accrued Other <> Default	(40,305)	
Accrued Other-Default-Dept-Suspense Allocation	(9,017)	
Accruals -other Default -Dept-Suspense Allocation	(46,195)	
Deferred Income-Default-Dept-Deferred CLO Gain/Loss		
Total	(137,637)	Difference
Reconcile with schedule XV, line 36:	(137,637)	-

OTHER NON-CURRENT LIABILITIES:

I/C - Interunit Asset Transfer-Default-Dept-Default-Prod	1,003,830	17 43-1
Intercompany - Revolver <> Default <> Default	3,856,990	
Intercompany Revolver - SSC-Default-Dept-Default-Prod	(51,649)	
L/T Benefits Reserve-Default-Dept-PLGL Post-Petition Claims	(7,729)	
Other Non-Current Lby <> Rent Accrual <> Default	(80,008)	
Other Non-Current Lby-Default-Dept-Deferred CLO Gain/Loss	(411,905)	
Total	4,309,529	Difference
Reconcile with schedule XV, line 43:	4,309,529	0

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,197,147	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,197,147	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	256,588	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)	\$ 256,588	17
B. Transfers (Itemize):			
18	Move R/E	(299,748)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (299,748)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,153,987	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Odin Health Care Center# 0047365Report Period Beginning: 01/01/2006Ending: 12/31/2006**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,781,269	1
2	Discounts and Allowances for all Levels	(2,320,995)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,460,274	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,631,840	6
7	Oxygen	33,566	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,665,406	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	357	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	233,264	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,559	19
20	Radiology and X-Ray	8,250	20
21	Other Medical Services	1,716	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 284,146	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	Misc & General Revenue (See Sch pg 19.1)	1,663	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,663	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,411,489	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	674,638	31
32	Health Care	2,257,577	32
33	General Administration	1,158,247	33
B. Capital Expense			
34	Ownership	825,799	34
C. Ancillary Expense			
35	Special Cost Centers	184,437	35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,154,901	40
41	Income before Income Taxes (line 30 minus line 40)**	256,588	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 256,588	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.

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2006 Page -19.1
Ending: 12/31/2006

Facility Name & ID Number Odin Health Care Center # 0039503

SUPPLEMENATAL INCOME SCHEDULE

<u>DESCRIPTION</u>	<u>AMOUNT</u>	
Personal Purchase Receipts <> Default <> Vending	0	
Miscellaneous Receipts<>Default<>Prod<>Vending	(1,569.00)	
Miscellaneous Receipts<>Default<>Prod<>Administrative	(94)	
Total	(1,663.00)	Difference
Reconcile with schedule XVII, line 28:	(1,663)	0

<u>DESCRIPTIONS</u>		
Personal Purchase Receipts <> Default <> Patient Personal Pu	-	
Personal Purchase Receipts <> Default <> Miscellaneous Rece	-	
Personal Purchase Expense <> Default <> Patient Personal Pu	-	
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-	
Activity Programs Receipts <> Default <> Other Misc Rev	-	
Miscellaneous Receipts<>Default<>Prod<>Activities		
Total	-	Difference
Reconcile with schedule XVII, line 28a:	0	-

Facility Name & ID Number **Odin Health Care Center**

0047365

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

12/31/2006

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,660	2,660	\$ 69,311	\$ 26.06	1
2	Assistant Director of Nursing	1,704	1,704	40,240	23.62	2
3	Registered Nurses	12,573	12,573	253,173	20.14	3
4	Licensed Practical Nurses	19,256	19,256	308,486	16.02	4
5	CNAs & Orderlies	70,332	70,332	633,761	9.01	5
6	CNA Trainees					6
7	Licensed Therapist	11,621	11,621	259,521	22.33	7
8	Rehab/Therapy Aides	8,351	8,351	300,843	36.02	8
9	Activity Director	2,110	2,110	22,314	10.58	9
10	Activity Assistants	1,705	1,705	12,017	7.05	10
11	Social Service Workers	3,103	3,103	36,888	11.89	11
12	Dietician					12
13	Food Service Supervisor	2,131	2,131	27,873	13.08	13
14	Head Cook	6,972	6,972	55,365	7.94	14
15	Cook Helpers/Assistants	10,024	10,024	74,955	7.48	15
16	Dishwashers					16
17	Maintenance Workers	2,460	2,460	30,011	12.20	17
18	Housekeepers	12,602	12,602	94,143	7.47	18
19	Laundry	7,028	7,028	56,103	7.98	19
20	Administrator	2,024	2,029	95,076	46.86	20
21	Assistant Administrator					21
22	Other Administrative	2,078	2,083	35,021	16.81	22
23	Office Manager					23
24	Clerical	6,655	6,670	94,110	14.11	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	1,998	1,998	21,122	10.57	31
32	Other Health Care Medicare Coord.-C	3,903	3,903	89,831	23.02	32
33	Other(specify) <u>Marketing & Trans</u>	1,239	1,239	12,362	9.98	33
34	TOTAL (lines 1 - 33)	192,529	192,554	\$ 2,622,526 *	\$ 13.62	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	434	\$ 11,049	1-3	35
36	Medical Director	59	11,000	9-3	36
37	Medical Records Consultant	52	2,108	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	97	3,383	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	81	2,198	11-3	44
45	Social Service Consultant	69	2,078	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	792	\$ 31,816		49

C. CONTRACT NURSES

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

Facility Name & ID Number **Odin Health Care Center**

0047365

Report Period Beginning: **01/01/2006**

Ending: **12/31/2006**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Mary Smith	Administrator	100	\$ 87,738	Workers' Compensation Insurance	\$ 117,076	IDPH License Fee	\$	
				Unemployment Compensation Insurance	66,615	Advertising: Employee Recruitment	1,716	
				FICA Taxes	198,702	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	56,726	Patient Background Checks	5,440	
				Employee Meals		Dues	4,871	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office	723	
				Pension / Retirement	(303)	Total Advertising	9,348	
				Insurance Life	2,729			
				Other Benefits	5,992			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 87,738			Less: Public Relations Expense ()		
B. Administrative - Other						Non-allowable advertising ()		
Description			Amount			Yellow page advertising ()		
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 447,537	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 22,098	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$ 1,750
							In-State Travel	19,544
							Seminar Expense	3,301
							Home Office	13,720
							Entertainment Expense	(27)
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$	TOTAL		\$	TOTAL	\$ 38,288

* Attach copy of IMRF notifications

**See instructions.

