



Facility Name & ID Number Odin Health Care Center

# 0047365 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	12,045	1
2		Skilled Pediatric (SNF/PED)			2
3	66	Intermediate (ICF)	66	24,090	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
		8	SNF			
9	SNF/PED					9
10	ICF	22,674	4,005	168	26,847	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,674	4,005	6,589	33,268	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.07%

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

N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

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

YES  NO

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 6,421

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	160,727	7,644	13,104	181,475		181,475		181,475		1
2	Food Purchase		147,062		147,062		147,062	(89)	146,973		2
3	Housekeeping	114,527	11,263		125,790		125,790		125,790		3
4	Laundry	45,548	7,447		52,995		52,995		52,995		4
5	Heat and Other Utilities			113,966	113,966		113,966	55	114,021		5
6	Maintenance	27,649	47,714	7,081	82,444	(743)	81,701	12,799	94,500		6
7	Other (specify):*			6,776	6,776		6,776		6,776		7
8	<b>TOTAL General Services</b>	<b>348,451</b>	<b>221,130</b>	<b>140,927</b>	<b>710,508</b>	<b>(743)</b>	<b>709,765</b>	<b>12,765</b>	<b>722,530</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,701	13,701		13,701		13,701		9
10	Nursing and Medical Records	1,475,047	122,704	20,575	1,618,326		1,618,326		1,618,326		10
10a	Therapy	590,195	59,183		649,378		649,378		649,378		10a
11	Activities	32,503	3,920	3,335	39,758	3,494	43,252		43,252		11
12	Social Services	37,603	229	2,111	39,943		39,943		39,943		12
13	CNA Training										13
14	Program Transportation	12,376	2,124	14,988	29,488	(11,646)	17,842		17,842		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,147,724</b>	<b>188,160</b>	<b>54,710</b>	<b>2,390,594</b>	<b>(8,152)</b>	<b>2,382,442</b>		<b>2,382,442</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	92,645			92,645		92,645		92,645		17
18	Directors Fees			724	724		724		724		18
19	Professional Services			4,517	4,517		4,517		4,517		19
20	Dues, Fees, Subscriptions & Promotions			22,679	22,679		22,679	(2,824)	19,855		20
21	Clerical & General Office Expenses	150,298	12,348	274,294	436,940		436,940	(107,577)	329,363		21
22	Employee Benefits & Payroll Taxes			473,555	473,555		473,555	11,212	484,767		22
23	Inservice Training & Education										23
24	Travel and Seminar			20,337	20,337		20,337	18,024	38,361		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			91,668	91,668		91,668	(68,301)	23,367		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>242,943</b>	<b>12,348</b>	<b>887,774</b>	<b>1,143,065</b>		<b>1,143,065</b>	<b>(149,466)</b>	<b>993,599</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,739,118</b>	<b>421,638</b>	<b>1,083,411</b>	<b>4,244,167</b>	<b>(8,895)</b>	<b>4,235,272</b>	<b>(136,701)</b>	<b>4,098,571</b>		<b>29</b>

\*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: 1/1/2007

Page -3.1

Facility Name & ID Number Odin Healthcare Center

# 0039503

Ending: 12/31/2007

**SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES**

**Operating Expense - pg 3 Line 7**

	<u>Amount</u>
Infectious Waste Disposal <> Default <> Nursing Admin/Supv 800019000008000	3,326
Infectious Waste Disposal <> Default <> Physical Plant 800019000008210	0
Garbage Service<>Default<>Prod<>Physical Plant 810002000008210	3,451
Garbage Service <> Default <> Physical Plant 810072000008210	0
	<u>6,777</u>

**Health Care Program - pg 3 Line 15**

	<u>Amount</u>
Salaries - Regular <> Non Supervisor <> HHA (General) 700000700203500	0
	<u>0</u>

**General & Administrative - Line 27**

	<u>Amount</u>
N/A	
	<u>0</u>

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

	<u>Amount</u>
N/A	
	<u>0</u>

STATE OF ILLINOIS

Report Period Beginning: 1/1/2007  
Ending: 12/31/2007

Facility Name & ID Number Odin Healthcare Center # 0039503

Meals - adjustment

36,135 Days ( Total Patient days)  
3 Mult (3 meals a day)  
108,405 Sub total  
0 meals to employess (reported by facility)  
108,405 Add Sub  
147,062 Divide -Pg 3, line 2, column 2  
1.36 Cost per day

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

Sales Tax - adjustment

147,062 Total Food Cost (page 3,Line 2, col 2)  
0.01 Mult  
1470.62 Sub total  
6.02% Mult (Pvt pay div by total census)  
89 = adjust for nonallowable sale tax for page 5A,

Reclassification V

Page 3 Line 6  
Repair & Maint <> Vehicles<>Default<>Prod<>Transp 830010000003850 (743) Reclass From  
(\$743 x 70% = 520.10)  
Page 4 line 38 743.00 Reclass to

Page 3 Line 14 01  
Salaries <> Regular<>Driver<>Transport Non<>Emergency 700000750403850 (11,044) Reclass From  
Salaries Overtime/Dbt Time<>Driver<>Transport Non<>Emergenc 700500750403850 - Reclass From  
Vacation Pay <> Earned Lve Acc.<>Default<>Prod<>Transport N 730012000003850 - Reclass From  
Vacation Pay <> Earned Lve Acc.<>Driver Transport Non-Emergenc 730012750403850 (282)  
Holiday Pay<> Earned Lve Taken Driver Transport Non-Emergenc 730013750403850 (320) total  
(11,646 multiplied by 70% and 30% (70% is Medical 30% is Activities) (11,646)

Activities Page 3 line 11 3,494 Reclass to  
Medical Page 4 line 38 8,152 Reclass to

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

Facility Name &amp; ID Number

Odin Health Care Center

#0047365

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			24,897	24,897		24,897		24,897			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(1,323)	(1,323)		(1,323)	40,540	39,217			32
33	Real Estate Taxes			78,486	78,486		78,486	58,589	137,075			33
34	Rent-Facility & Grounds			725,851	725,851		725,851		725,851			34
35	Rent-Equipment & Vehicles			123	123	102	225	15,533	15,758			35
36	Other (specify):*							16,099	16,099			36
37	<b>TOTAL Ownership</b>			828,034	828,034	102	828,136	130,761	958,897			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					8,793	8,793		8,793			38
39	Ancillary Service Centers		176,233	44,621	220,854		220,854	30,546	251,400			39
40	Barber and Beauty Shops			250	250		250	(250)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,204	54,204		54,204		54,204			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		176,233	99,075	275,308	8,793	284,101	30,296	314,397			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,739,118	597,871	2,010,520	5,347,509		5,347,509	24,356	5,371,865			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: 1/1/2007  
Ending: 12/31/2007

Facility Name & ID Number Odin Healthcare Center # 0039503

**SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES**

**Ownership - Line 36 -Column 3**

		<u>Amount</u>
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	940101940058888	0
		<u>0</u>

**Ancillary Expenses - Line 43 -Column 2**

		<u>Amount</u>
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	800630000003330	0
Ancillary Supplies <> Default <> Laboratory	810041000003330	0
		<u>0</u>

**Ancillary Expenses - Line 43 -Column 3**

		<u>Amount</u>
Contract Svcs - Chgbl <> Default <> Laboratory	652000000003330	
Contract Svcs - Chgbl <> Default <> X/Ray	652000000003332	0
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	810030752993330	0
Professional Services - NonchgPhysicianX/Ray	810030752103332	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	810030752993332	0
Professional Services <> Nonchg<>Medical Director<>Laboratory	810030795003330	0
Professional Services <> Nonchg<>Medical Director<>X/Ray	810030795003332	0
Professional Services Chgble <> Default <> X/Ray	652100000003332	0
Professional Services Chgble <> General / Other <> X/Ray	652100600003332	0
		<u>-</u>

**Rent-Facility & Grounds - Expenses- Line 34 Column 3**

Lease Expense Facility <> Default <> Prod	84101100008220	113,609
Lease Expense Facility <> Default <> Realty	84101000008220	612,242
		<u>725,851</u>

Facility Name & ID Number Odin Health Care Center

# 0047365

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(21)	24		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	(2,502)	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 5A	(325,693)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (328,216)		\$	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)	352,572		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 352,572		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 24,356		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		\$ 14,988	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 14,988		47

## Odin Health Care Center

ID# 0047365

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

## Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Sales Taxes	\$ (89)	2	1
2	Small Balance Adjustment	0	21	2
3	Memorium/ Benevolence	(420)	21	3
4	Depreciation Reconciliation	0	30	4
5	Activities Program Receipts	0	11	5
6	Property Taxes Adjust to actual	58,604	33	6
7	Professional liability Insurance	(79,528)	26	7
8	Barber & beauty	(250)	40	8
9	Public Relations Expenses		20	9
10	Non Allowable Advertising	(5,763)	20	10
11	Entertainment		24	11
12	Fresh Start	0	36	12
13	Civic Dues	0	20	13
14	Penalties	0	21	14
15	Vending receipts	(2,297)	21	15
16	Misc Receipts	(349)	21	16
17	Marketing Wages 70% Disallowed	(13,936)	21	17
18	Marketing Bonus 70% Disallowed	(2,486)	21	18
19	Marketing Holiday 70% Disallowed	(97)	21	19
20	Marketing Sick	0	21	20
21	Marketing Vacation 70% Disallowed	(950)	21	21
22	Marketing Overtime	0	21	22
23	Marketing Non Worked Wages	0	21	23
24	Donations/ Contributions	(50)	21	24
25	Legal Fees - Bankruptcy	0	21	25
26	Legal Structure Management Fees	(279,406)	21	26
27	Undocumented Travel	0	24	27
28	Interest Income	1,323	32	28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(325,693)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odin Health Care Center# 0047365 Report Period Beginning:01/01/2007Ending: 12/31/2007

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(89)	0	0	0	0	0	0	0	0	0	0	(89)	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	55	0	0	0	0	0	0	0	0	0	55	5
6	Maintenance	0	12,799	0	0	0	0	0	0	0	0	0	12,799	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(89)</b>	<b>12,854</b>	<b>0</b>	<b>12,765</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(5,763)	2,939	0	0	0	0	0	0	0	0	0	(2,824)	20
21	Clerical & General Office Expenses	(302,492)	194,915	0	0	0	0	0	0	0	0	0	(107,577)	21
22	Employee Benefits & Payroll Taxes	0	11,212	0	0	0	0	0	0	0	0	0	11,212	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(21)	18,045	0	0	0	0	0	0	0	0	0	18,024	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(79,528)	11,227	0	0	0	0	0	0	0	0	0	(68,301)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(387,804)</b>	<b>238,338</b>	<b>0</b>	<b>(149,466)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(387,893)</b>	<b>251,192</b>	<b>0</b>	<b>(136,701)</b>	<b>29</b>								



Facility Name & ID Number Odin Health Care Center

# 0047365

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**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%	\$ 55	\$ 55 1
2	V	6 Repair & Maintenance		SSC Equity Holdings LLC	100.00%	12,799	12,799 2
3	V	39 Professional Services		SSC Equity Holdings LLC	100.00%	30,546	30,546 3
4	V	20 Fees, Subscriptions, Promotions		SSC Equity Holdings LLC	100.00%	2,939	2,939 4
5	V	10 Nursing & Medical Records		SSC Equity Holdings LLC	100.00%		
6	V	21 Clerical & General Office Exp		SSC Equity Holdings LLC	100.00%	194,915	194,915 6
7	V	24 Travel & Seminar		SSC Equity Holdings LLC	100.00%	18,045	18,045 7
8	V	26 Insurance Premium		SSC Equity Holdings LLC	100.00%	11,227	11,227 8
9	V	36 Depreciation		SSC Equity Holdings LLC	100.00%	16,099	16,099 9
10	V	33 Taxes - Property		SSC Equity Holdings LLC	100.00%	(15)	(15) 10
11	V	35 Rental & Leasing		SSC Equity Holdings LLC	100.00%	15,533	15,533 11
12	V	32 Intrest Income/Expense		SSC Equity Holdings LLC	100.00%	39,217	39,217 12
13	V	22 P/R Taxes		SSC Equity Holdings LLC	100.00%	11,212	11,212 13
14	Total		\$			\$ 352,572	\$ * 352,572 14

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

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2007  
Ending: 12/31/2007

Facility Name & ID Number: Odin Healthcare Center # 0039503

Related Illinois Nursing Homes  
as of  
12/31/2007

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
------------	--------------------------------	--------------------------

SSC Equity Holdings, LLC

Montebello Healthcare Center	0047340
Nature Trail HealthCare Center	0047357
Odin HealthCare Center	0047365
Mariner Health of Westchester	0047373

Facility Name & ID Number      Odin Health Care Center      #      0047365      Report Period Beginning:      01/01/2007      Ending:      12/31/2007

## 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: 01/01/2007

Ending: 2/31/2007

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 Ravine Dr, Suite 1500  
 City / State / Zip Code Atlanta, GA 30346  
 Phone Number ( 770-379-8203  
 Fax Number ( 770-399-1971

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		\$ 55	\$	1	55	1
2	6	Repair & Maintenance	1		12,799		1	12,799	2
3	39	Professional Services	1		30,546		1	30,546	3
4	20	Fees, Subscriptions, Promotions	1		2,939		1	2,939	4
5	10	Nursing & Medical Records							5
6	21	Clerical & General Office Exp	1		194,915		1	194,915	6
7	24	Travel & Seminar	1		18,045		1	18,045	7
8	26	Insurance Premium	1		11,227		1	11,227	8
9	36	Depreciation	1		16,099		1	16,099	9
10	33	Taxes - Property	1		(15)		1	(15)	10
11	35	Rental & Leasing	1		15,533		1	15,533	11
12	32	Intrest Income/Expense	1		39,217		1	39,217	12
13	22	P/R Taxes	1		11,212		1	11,212	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				\$ 352,572	\$		\$ 352,572	25

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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



**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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,

**2006 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 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-11-400-001</u>	<u>00000000 PT SE SE</u>	<u>\$ 137,089.72</u>	<u>\$ 137,089.72</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<u>\$ 137,089.72</u>	<u>\$ 137,089.72</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 42,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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/A

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

**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	\$	\$ 1,206,946	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	See Attached -Page 12.1		1994	782,958	39,148	20	39,148		490,984	9
10	Repair Sidewalk #36 & 37		1996	819	41	20	41		421	10
11	Rooftop A/C - See attached page 12.2		1996	16,378	819	20	819		9,753	11
12	Install Awning		1997	2,845	142	20	142		1,399	12
13	Water Heater - See page 12.2		1997	1,388	69	20	69		735	13
14	Water Heater Installed - See page 12.2		1997	6,645	332	20	332		3,550	14
15	Electrical		1998	357	9	20	9		81	15
16	HVAC		1998	1,516	38	20	38		342	16
17	Plumbing # 67		1998	2,853	71	20	71		639	17
18	Water Heater # 69		1998	3,885	97	20	97		873	18
19	A.O. Smith 75 Gal Gas # 72		1999	1,818	182	10	182		1,456	19
20	100 G Gas Water Heater # 77 & 78		2000	1,397	140	10	140		933	20
21	12: Zonline HVAC Units #94 & 95		2000	8,579	572	15	572		3,718	21
22	First Q digital reset #98 & 99		2000	1,224	122	10	122		814	22
23	W/G & Maglocks system #102 & 103		2000	3,817	382	10	382		2,419	23
24	2200 SQ FT Flatroof Downpmt #104		2000	9,899	990	10	990		6,187	24
25	Wandergard System #106 & 107		2000	3,615	362	10	362		2,412	25
26	236' 4' High, DogEar Cedar Fence #109		2000	3,173	397	8	397		2,513	26
27	Instl 11,220 SQFT Flat roof #110		2001	20,098	2,010	10	2,010		9,059	27
28	Roof Shingles - 33% Downpmt #111		2001	18,277	1,828	10	1,828		10,662	28
29	Balance of Roof Replacmt #112		2001	36,553	3,655	10	3,655		21,017	29
30	9: Smoke & 2: Heat Detectors #116		2001	960	96	10	96		552	30
31	Use Tax 9: Smoke & 2: Heat Detectors #117		2001	62	3	10	3		23	31
32	R/T 3T Armstong Condense Int #118		2001	1,278	85	15	85		482	32
33										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

## STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Odin Health Care Center# 0047365

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	\$	\$ 2,063		37
38	7: Zoneline HVAC - Patient Rooms #123	2001	4,718	315	15	315		2,020		38
39	Use Tax 7: Zoneline HVAC - Patient Rooms #124	2001	298	20	15	20		128		39
40	Charge Back - Excessive Discount #126	2001	442	29	15	29		185		40
41	5: Catch - All Digital Reset #127	2001	1,577	158	10	158		1,052		41
42										42
43	3: Wanderguard Auto 24Hr timer #144	2002	250	25	10	25		167		43
44	Cr Inv# 10017115 - 1: Auto 24 Hr timer #145	2002	(76)	(8)	10	(8)		(51)		44
45	Wanderguard System Unst'l #146	2002	2,680	268	10	268		2,355		45
46	6: Zoneline Heat/ Cool Units #5017	2002	4,111	822	5	822		4,590		46
47	Use Tax 6: Zoneline Heat/ Cool Units #5018	2002	260	52	5	52		290		47
48	Repair to Damage Brick #5030	2002	5,000	333	15	333		1,084		48
49	Arch fee -Upgrade to Skilled St #5033	2002	1,928	129	15	129		676		49
50										50
51	Prefinished Slab Door #5034	2003	495	33	15	33		168		51
52	SteelDoor w/Window # 5035	2003	693	35	20	35		177		52
53	15: Vinyl Rplc Window -Intsl # 5036	2003	7,500	500	15	500		2,542		53
54	Sentricon colony Elim -instl # 5051	2003	8,890	889	10	889		4,223		54
55	Arch/Eng Fee Skilled Care # 5054	2003	5,143	342	15	342		1,597		55
56	Cable - remote -WanderGuard system # 5059	2003	2,546	255	10	255		1,677		56
57	2: Maglock -WanderGuard # 5063	2003	(2,338)	(234)	10	(234)		(1,773)		57
58	6: Zoneline a/C Units A/C Heat Units # 5056	2003	3,434	687	5	687		3,091		58
59	Use Tax -6: Zoneline a/C Units A/C Heat Units # 5056	2003	216	43	5	43		194		59
60	2: Window Shutters - Fire Saftey # 5069	2003	3,376	225	15	225		1,013		60
61	Rpr 2 Floors Drain -Kitchen # 5079	2003	1,750	88	20	88		388		61
62	Rplc 91 Gal Gas Waterheater #5082	2003	2,380	238	10	238		952		62
63										63
64	Fire Sentinel-Dr Release Device	2004	1,948	141	15	141		564		64
65	Wet Sprinkler Svst Instl	2004	8,226	329	25	329		1,316		65
66	UseTax - Fire Sentinel A Door	2004	107	8	15	8		32		66
67	Engineering Services	2004	3,639	182	15	182		728		67
68	Fire Suppression Svst	2004	1,961	114	10	114		456		68
69	6: Zoneline Heat/ Cool Units	2004	3,434	143	10	143		572		69
70	TOTAL (lines 4 thru 69)		\$ 4,368,808	\$ 154,078		\$ 154,078	\$	\$ 1,810,445		70

\*\*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:

01/01/2007 Ending: 12/31/2007

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,368,808	\$ 154,078		\$ 154,078	\$	\$ 1,810,445	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		4,545	4
5	Sewer Line Repairs, Add Pipe	2005	1,664	33	25	33		99	5
6	Repairs Main Sewer Line	2005	550	11	20	11		33	6
7	Inspect Main Trunk Line	2005	325	7	20	7		21	7
8	4:Smoke Detectors	2005	675	23	10	23		69	8
9	Tile & Security Alarm Oxygen	2005	232	5	15	5		15	9
10	10 Ton Seer Condenser/AC Unit	2005	1,450	32	15	32		96	10
11	Ruud Air Handler-Instl	2005	1,650	14	20	14		42	11
12	2:Zoneline Heat/Cool Units	2005	1,119	93	15	93		279	12
13	Fascia Board Repair	2005	3,520	98	15	98		294	13
14	Vents for Isolation Rooms, Handicap Tubs/Sinks & Whirlpool	2005	37,013	617	25	617		1,851	14
15	Sewerline Repairs, Add Pipe	2005	1,620	16	15	16		48	15
16	Repairs Main Sewer Line	2005	534	7	15	7		21	16
17	Inspect Main Trunk Line	2005	316	4	10	4		12	17
18	4:Smokie Dectors	2005	641	16	10	16		48	18
19									19
20	10 Ton Condenser-A/C Unit	2005	1,402	23	15	23		69	20
21	Ruud Air handler-Instalation	2005	1,622	20	20	20		60	21
22	Use Tax-2: Zoneline Heat/ Cool Units	2005	70	6	5	6		18	22
23									23
24	Zoneline Heat/Cool Unit	2006	508	68	5	68		136	24
25	Use Tax-Zoneline Heat/Cool Unit	2006	31	4	5	4		8	25
26	A/C in Dietary	2006	3,465	462	5	462		924	26
27	Wallpaper & Handrails	2006	5,632	657	5	657		1,314	27
28	Handrails	2006	4,442	282	11	282		564	28
29	Paging/Music Broadcast System	2006	1,438	84	10	84		168	29
30	Wallpaper & Handrails	2006	5,632	375	5	375		751	30
31	2:Thru Wall Heat/Cool Units	2006	1,120	56	5	56		112	31
32	Use Tax - 2: Thru Wall Heat / Cool	2006	71	4	5	4		7	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,484,733	\$ 158,619		\$ 158,619	\$	\$ 1,822,076	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:

01/01/2007 Ending: 12/31/2007

**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 12B, Carried Forward	\$ 4,484,733	\$ 158,619		\$ 158,619	\$	\$ 1,822,076		1
2	Paint and Wallpaper for Renovation	2007 463	47	9.8	47	(0)	47		2
3	Use Tax: Paint & Wallpaper Renovation	2007 30	3	9.8	3	(0)	3		3
4	Wallpaper	2007 1,679	364	4.6	364	0	364		4
5	Interior Renovation	2007 7,454	643	11.6	643	0	643		5
6	Flooring For interior Renovation	2007 6,540	615	10.6	615	0	615		6
7	Paint and Wallpaper Interior Renovation	2007 326	60	5	60	0	60		7
8	Paint and Wallpaper Interior Renovation	2007 21	4	5	4	0	4		8
9	Interior Renovation	2007 3,140	295	10.6	295	(0)	295		9
10	Zoneline Heat/ Cool	2007 1,179	53	22	53	(0)	53		10
11	7.5 Ton AC Unit	2007 6,860	309	22	309	(0)	309		11
12	40: Cubicle Curtains	2007 2,308	154	15	154	0	154		12
13	10: Cubicle Curtains	2007 565	47	12	47	(0)	47		13
14	Replace RTU Compressor	2007 1,140	41	9.16	41	(0)	41		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	TOTAL (lines 1 thru 33)	\$ 4,516,437	\$ 161,254		\$ 161,254	\$ 0	\$ 1,824,711		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:

**01/01/2007**

Ending:

**12/31/2007**

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	\$ 319,863	\$ 23,661	\$ 23,661	\$ 0		\$ 230,870	71
72	Current Year Purchases	4,479	377	377			377	72
73	Fully Depreciated Assets	(10,944)						73
74								74
75	TOTALS	\$ 313,399	\$ 24,038	\$ 24,038	\$ 0		\$ 231,247	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	\$ 5,962	\$ 5,962			\$ 40,166	76
77										77
78										78
79										79
80	TOTALS			\$ 40,166	\$ 5,962	\$ 5,962			\$ 40,166	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)	\$ 4,950,745	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 191,254	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,879	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,096,124	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	\$ 1,301	86
87	O/H Allocation 08/01/1997	1,035	52	490	87
88	O/H Allocation 10/01/1997	117	6	92	88
89					89
90					90
91	TOTALS	\$ 3,731	\$ 187	\$ 1,883	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: SSC Submaster Holdings LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
 If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	99	01/01/2005	\$ 612,242	20		3
4	Additions						4
5							5
6							6
7	<b>TOTAL</b>	99		\$ 612,242			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.	<u>/2008</u>	\$ <u>                    </u>
13.	<u>/2009</u>	\$ <u>                    </u>
14.	<u>/2010</u>	\$ <u>                    </u>

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

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

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

15. Is Movable equipment rental included in building rental?  YES  NO  
 16. Rental Amount for movable equipment: \$ 17,817 Description: See Attached Schedule 14.1

(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	<b>TOTAL</b>		\$	\$	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: 1/1/2007

Page -14.1

Facility Name & ID Number

Odin Healthcare Center

# 0039503

Ending: 12/31/2007

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	7,804.00	03/10/03
Lease Exp - Eqpt - <> Default <> Prod Oxygen	84100000002022	Concentrators	67.00	03/10/03
Lease Exp - Eqpt - <> Default <> Equip Rental	84100000002102		110.00	03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Activities	84100000007000			03/11/03
Lease Exp - Eqpt - Nonmedical <> Default <> Dietary	84100000007030	Diswasher	910.00	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	8,926.00	03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plant	84100000008210	SNF Supplies		03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	84100000008220			04/35/03
Lease Exp - Other <> Default <> Administrative	84102000008100			03/21/03
			17,817.00 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. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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 of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a - 3	7707	hrs	\$ 244,956							7,707	\$ 244,956	1
2	Licensed Speech and Language Development Therapist	10a - 3	3693	hrs	125,261							3,693	125,261	2
3	Licensed Recreational Therapist	10a - 3		hrs										3
4	Licensed Physical Therapist	10a - 3	7252	hrs	205,490							7,252	205,490	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 prescripts						176,233			176,233	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	<b>TOTAL</b>				\$ 575,707			\$		\$ 176,233		18,652	\$ 751,940	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: **01/01/2007**

Ending:

**12/31/2007**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2007**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 550	\$	1
2	Cash-Patient Deposits	109,009		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	655,112		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	149		6
7	Other Prepaid Expenses	123,077		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 887,896	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	36,749		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	111,107		15
16	Equipment, at Historical Cost	38,028		16
17	Accumulated Depreciation (book methods)	(31,178)		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):	62,457		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 217,162	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,105,058	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 149,857	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	233,658		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	110,196		32
33	Accrued Interest Payable			33
34	Deferred Compensation	46,195		34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Sch. 17.1</u>	1,097		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 541,004	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Sch. 17.1</u>	129,554		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 129,554	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 670,558	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 434,500	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,105,058	\$	48

\*(See instructions.)

STATE OF ILLINOIS

Report Period Beginning: 1/1/2007 Page -17.1

Facility Name & ID Number Odin Healthcare Center # 0039503

Ending: 12/31/2007

SUPPLEMENTAL SCHEDULE OF ASSETS & LIABILITIES

<u>OTHER CURRENT ASSETS:</u>	<u>AMOUNT</u>	<u>OTHER CURRENT LIABILITIES:</u>	<u>AMOUNT</u>
		Benefits Dedctns - EmployeeEmployee Dedctns 401K MarinerDefault-Dept	201400201460000 0.00 17 36-1
		Misc Dedctns - EmployeeFlexible Spending AccountDefault-Dept	201500201510000 0.00
		Misc Dedctns - EmployeeUnion DuesDefault-Dept	201500201520000 0.00
		Misc Dedctns - EmployeeMiscellaneousDefault-Dept	201500201530000 0.00
		Accrued OtherAccrued OtherDefault-Dept	221000221220000 66.30
		Accrued OtherPC Maintenance AccrualDefault-Dept	221000221040000 0.00
		Accrued OtherAccrued Legal FeesDefault-Dept	221000221230000 0.00
		Accrued OtherTelephone Maintenance AccrualDefault-Dept	221000221280000 0.00
		Accrued OtherEngineering ReserveDefault-Dept	221000221420000 0.00
		Accrued TaxesOther TaxesDefault-Dept	220100220110000 1.00
		Accrued TaxesState Sales & UseDefault-Dept	220100220130000 1,178.59
		Accrued TaxesCity Sales & UseDefault-Dept	220100220140000 51.34
		Franchise Tax PayableFranchise TaxDefault-Dept	226200226200000 (200.00)

Total 0 Difference

Reconcile with schedule XV, line 9:

OTHER NON-CURRENT ASSETS: pg 17 line 23 Col 1

Leasehold RightsContract RightsDefault-Dept	185200185200000 20,677.21
Leasehold RightsContract RightsDefault-Dept	185200185210000 41,779.62
Asset ClearingPS AM Capital Expenditures-FSRealty	174900171008220 0.00
Asset ClearingPS AM Capital Expenditures SSCRealty	174900171018220 0.00

Total 62,457 Difference

Reconcile with schedule XV, line 23:

Total 1,097 Difference

Reconcile with schedule XV, line 36:

OTHER NON-CURRENT LIABILITIES::

I/C - Interunit Asset Transfer-Default-Dept-Default-Prod	240500000000000 (498,725)
Intercompany Revolver - SSC-Default-Dept-Default-Prod	260000210140000 (10,503) 17 43-1
L/T Benefits Reserve-Default-Dept-PLGL Post-Petition Claim	260000210160000 79,455
Other Non-Current Lby-Default-Dept-Deferred CLO Gain/Lo:	260500225030000 365,710
Other Non-Current Lby <-> Rent Accrual <-> Default	260500260540000 193,616

Total 129,553 Difference

Reconcile with schedule XV, line 43:

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>4,153,987</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Correct Prior Year - Intercompany Payable/Receivable</b>	<b>(3,962,752)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>191,235</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>243,264</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>243,264</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>434,499</b>	<b>24</b> *

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

STATE OF ILLINOIS

Facility Name & ID Number Odin Health Care Center

# 0047365

Report Period Beginning: 01/01/2007

Ending: 12/31/2007 Page 19

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,048,610	1
2	Discounts and Allowances for all Levels	(2,023,521)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,025,089	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,203,425	6
7	Oxygen	26,613	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,230,038	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	276,751	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,065	19
20	Radiology and X-Ray	11,911	20
21	Other Medical Services	8,271	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 333,000	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Misc Receipts See Attached Sch.19.1	349	28
28a	Misc Receipts See Attached Sch.19.1	2,297	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,646	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,590,773	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	710,508	31
32	Health Care	2,390,594	32
33	General Administration	1,143,065	33
<b>B. Capital Expense</b>			
34	Ownership	828,034	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	275,308	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,347,509	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	243,264	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 243,264	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: 1/1/2007 Page -19.1  
Ending: 12/31/2007

Facility Name & ID Number Odin Healthcare Center # 0039503

**SUPPLEMENATAL INCOME SCHEDULE**

<u>DESCRIPTION - Line 19 26a 1 &amp; 19 28 1</u>	<u>AMOUNT</u>	
Miscellaneous Receipts<-Default<-Prod<-Administrative 600057000008100	349	
General Rental Receipts<-Default<-Prod<-Administrative 600060000008100		
Miscellaneous Receipts<-Default<-Prod<-Vending 600057000004102		
	<u>349.00</u>	Difference
Reconcile with schedule XVII, line 28:	<b>349</b>	0

<u>DESCRIPTIONS - Line 19 28 1</u>		
Miscellaneous Receipts<-Default<-Prod<-Vending 600057000004102	2,297	
	<u>2,297</u>	Difference
Reconcile with schedule XVII, line 28a:	<b>2,297</b>	-

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

# 0047365

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

## 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	1,667	1,834	\$ 50,613	\$ 27.60	1
2	Assistant Director of Nursing	1,944	2,088	49,471	23.69	2
3	Registered Nurses	15,726	17,244	350,838	20.35	3
4	Licensed Practical Nurses	18,685	20,733	359,201	17.33	4
5	CNAs & Orderlies	66,989	72,179	644,109	8.92	5
6	CNA Trainees					6
7	Licensed Therapist	17,201	10,496	590,195	56.23	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,786	1,986	22,521	11.34	9
10	Activity Assistants	1,210	1,419	9,981	7.03	10
11	Social Service Workers	1,896	3,009	37,603	12.50	11
12	Dietician					12
13	Food Service Supervisor	1,854	2,086	28,544	13.68	13
14	Head Cook	6,695	7,180	59,424	8.28	14
15	Cook Helpers/Assistants	8,446	9,141	72,759	7.96	15
16	Dishwashers					16
17	Maintenance Workers	1,943	2,093	27,649	13.21	17
18	Housekeepers	12,769	14,111	114,527	8.12	18
19	Laundry	5,300	5,981	45,548	7.62	19
20	Administrator	1,822	2,088	89,878	43.05	20
21	Assistant Administrator					21
22	Other Administrative	5,703	6,190	114,322	18.47	22
23	Office Manager					23
24	Clerical	2,618	3,175	38,743	12.20	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	1,666	1,961	20,815	10.61	31
32	Other Health Care Case Mgmt Coord.					32
33	Other(specify) <u>Transportation</u>	1,395	1,508	12,376	8.21	33
34	TOTAL (lines 1 - 33)	177,315	186,502	\$ 2,739,117 *	\$ 14.69	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	240	\$ 12,194	1-3	35
36	Medical Director	72	13,500	9-3	36
37	Medical Records Consultant	32	2,106	10-3	37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	192	3,351	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	36	2,110	11-3	44
45	Social Service Consultant	36	2,111	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	608	\$ 35,371		49

## C. CONTRACT NURSES

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

**XIX. 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 A. Smith	Administrator		\$ 92,645	Workers' Compensation Insurance	\$ 87,883	IDPH License Fee	\$ 3,808	
				Unemployment Compensation Insurance	59,623	Advertising: Employee Recruitment	3,808	
				FICA Taxes	199,486	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	113,295	Patient Background Checks	3,410	
				Employee Meals		Dues	8,260	
				Illinois Municipal Retirement Fund (IMRF)*		Other Licenses	1,218	
				Pension / Retirement	6,478	Home Office	2,939	
				Insurance Life	3,501	Total Advertising	5,984	
				Other Benefits	3,289			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 92,645	Home Office Benefits/PR Taxes	11,212	Less: Public Relations Expense ( )		
B. Administrative - Other						Non-allowable advertising	(5,763)	
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)	\$ 484,767	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 19,856	
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	\$ 706
							In-State Travel	13,806
							Home Office	18,045
							Seminar Expense	5,825
							Entertainment Expense	(21)
							(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	\$ 38,361

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Odin Health Care Center# 0047365Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Health Care Association \$5,820.41
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? N/A
- (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. \$ 18,174 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. N/A
- (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. \$ 54,204  
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.