

Facility Name & ID Number Odin Health Care Center

0047365 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,234</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>20,288</u>	<u>3,687</u>	<u>8,204</u>	<u>32,179</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,288</u>	<u>3,687</u>	<u>8,204</u>	<u>32,179</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.81%

D. How many bed-hold days during this year were paid by the Department? 79 (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 01/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 99 and days of care provided 7,743

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	166,149	10,299	12,318	188,766		188,766		188,766		1
2	Food Purchase		154,492		154,492		154,492	(44)	154,448		2
3	Housekeeping	123,681	10,582		134,263		134,263		134,263		3
4	Laundry	47,624	6,054		53,678		53,678		53,678		4
5	Heat and Other Utilities			135,529	135,529		135,529	(5,118)	130,411		5
6	Maintenance	28,469	46,917	6,679	82,065	(587)	81,478	11,536	93,014		6
7	Other (specify):*			9,520	9,520		9,520		9,520		7
8	TOTAL General Services	365,923	228,344	164,046	758,313	(587)	757,726	6,374	764,100		8
	B. Health Care and Programs										
9	Medical Director			12,359	12,359		12,359		12,359		9
10	Nursing and Medical Records	1,511,001	127,553	11,077	1,649,631		1,649,631		1,649,631		10
10a	Therapy	643,415	71,947	280	715,642		715,642		715,642		10a
11	Activities	33,157	4,420	3,978	41,555		41,555		41,555		11
12	Social Services	37,345	190	2,114	39,649		39,649		39,649		12
13	CNA Training										13
14	Program Transportation	15,495	4,160	3,167	22,822		22,822		22,822		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,240,413	208,270	32,975	2,481,658		2,481,658		2,481,658		16
	C. General Administration										
17	Administrative	93,819			93,819		93,819		93,819		17
18	Directors Fees			500	500		500		500		18
19	Professional Services			40,242	40,242		40,242		40,242		19
20	Dues, Fees, Subscriptions & Promotions			21,937	21,937		21,937	(196)	21,741		20
21	Clerical & General Office Expenses	159,307	14,393	372,573	546,273		546,273	(237,304)	308,969		21
22	Employee Benefits & Payroll Taxes			403,962	403,962		403,962	13,036	416,998		22
23	Inservice Training & Education			24,681	24,681		24,681		24,681		23
24	Travel and Seminar			9,260	9,260		9,260	26,448	35,708		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			75,425	75,425		75,425	7,367	82,792		26
27	Other (specify):*										27
28	TOTAL General Administration	253,126	14,393	948,580	1,216,099		1,216,099	(190,649)	1,025,450		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,859,462	451,007	1,145,601	4,456,070	(587)	4,455,483	(184,275)	4,271,208		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: 1/1/2007
Ending: 12/31/2007

Facility Name & ID Number +Facility # 0039586

Meals - adjustment

32,179 Days (Total Patient days)
3 Mult (3 meals a day)
96,537 Sub total
0 meals to employess (reported by facility)
96,537 Add Sub
154,492 Divide -Pg 3, line 2, column 2
1.60 Cost per day

1.60 Cost per day

0 mult - meal to employees

- = adjust for pg 3, line 2, column 7

Personal Cable TV - in patient rooms

860040000004100 5,118

Sales Tax - adjustment

154,492 Total Food Cost (page 3,Line 2, col 2)
1.01
0.01 Mult
1,530 Sub total
5.73% Mult (Pvt pay div by total census)/2
44 = adjust for nonallowable sale tax
for page 5A, Line 13

Reclassification V

Page 3 Line 6 col 01

Repair & Maint <> Vehicles<>Default<>Prod<>Transp 830010000003850 (587) Reclass From
70% 838
Page 4 line 38 587 Reclass to

Page 3 Line 14 col 01

Salaries <> Regular<>Driver<>Transport Non<>Emergency 700000750403850 - Reclass From
Salaries Overtime/Dbf Time<>Driver<>Transport Non<>Emerger 700500750403850 - Reclass From
Vacation Pay <> Earned Lve Acc.<>Default<>Prod<>Transport N 730012000003850 - Reclass From
(0 x 70% & 30%) 70% is Medical 30% is activities - total

Activities Page 3 line 11 - Reclass to

Medical Page 4 line 38 - Reclass to

Page 4 Line 35 Rent col 03

Lease Exp <> Vehicles<>Default<>Prod<>Transport Non<>Eme 841005000003850 - Reclass From
(0 x 70% = 0 lease for Medical)
Page 4 line 38 - Reclass to

STATE OF ILLINOIS

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

Facility Name & ID Number Nature Trail Healthcare Center # 0039586

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

<u>Operating Expense - pg 3 Line 7</u>		<u>Amount</u>
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	800019000008000	4,982
Infectious Waste Disposal <> Default <> Physical Plant	800019000008210	0
Garbage Service<>Default<>Prod<>Physical Plant	810002000008210	4,538
<u>Garbage Service <> Default <> Physical Plant</u>	<u>810072000008210</u>	<u>0</u>
		<u>9,520</u>

<u>Health Care Program - pg 3 Line 15</u>		<u>Amount</u>
Salaries - Regular <> Non Supervisor <> HHA (General)	700000700203500	0
		<u>0</u>

<u>General & Administrative - Line 27</u>		<u>Amount</u>
N/A		
		<u>0</u>

<u>Inservice Education - Line 23 Column 3 (over \$2,000)</u>		<u>Amount</u>

<u>Back Office Services Fees - Admin - Pg 3, Line 21</u>		<u>Amount</u>
	927100000008100	310,046

Facility Name & ID Number Odin Health Care Center

#0047365

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	D. Ownership										
30	Depreciation			30,938	30,938		30,938	(6,979)	23,959		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			(320)	(320)		(320)	29,116	28,796		32
33	Real Estate Taxes			(31,023)	(31,023)		(31,023)	84,688	53,665		33
34	Rent-Facility & Grounds			725,851	725,851		725,851		725,851		34
35	Rent-Equipment & Vehicles			11,774	11,774		11,774	12,656	24,430		35
36	Other (specify):*							25,640	25,640		36
37	TOTAL Ownership			737,220	737,220		737,220	145,121	882,341		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation					587	587		587		38
39	Ancillary Service Centers		186,661	37,935	224,596		224,596	29,796	254,392		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			54,351	54,351		54,351		54,351		42
43	Other (specify):*		250		250		250		250		43
44	TOTAL Special Cost Centers		186,911	92,286	279,197	587	279,784	29,796	309,580		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,859,462	637,918	1,975,107	5,472,487		5,472,487	(9,358)	5,463,129		45

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

Facility Name & ID Number Odin Health Care Center

0047365

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(5,118)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8)	21		18
19	Entertainment	(6)	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	(123,408)	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	(196)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (128,780)		\$	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)	371,713		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 371,713		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 242,933		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Odin Health Care Center

ID# 0047365

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Back Office Management Fees	\$ (310,046)	21	1
2	Marketing Wages (70%)	(19,331)	21	2
3	Adjust Property Tax to Actual	84,066	33	3
4	Adjustment to Depreciation	(6,979)	30	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(252,290)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odin Health Care Center# 0047365

Report Period Beginning:

01/01/2008

Ending:

12/31/2008**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	(44)	0	0	0	0	0	0	0	0	0	0	(44)	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	(5,118)	0	0	0	0	0	0	0	0	0	0	(5,118)	5
6	Maintenance	0	11,536	0	0	0	0	0	0	0	0	0	11,536	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,162)	11,536	0	6,374	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	(196)	0	0	0	0	0	0	0	0	0	0	(196)	20
21	Clerical & General Office Expenses	(452,793)	215,489	0	0	0	0	0	0	0	0	0	(237,304)	21
22	Employee Benefits & Payroll Taxes	0	13,036	0	0	0	0	0	0	0	0	0	13,036	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6)	26,454	0	0	0	0	0	0	0	0	0	26,448	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	7,367	0	0	0	0	0	0	0	0	0	7,367	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(452,995)	262,346	0	(190,649)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(458,157)	273,882	0	(184,275)	29								

STATE OF ILLINOIS

Facility Name & ID Number Odin Health Care Center

0047365

Report Period Beginning:

01/01/2008 Ending:

Summary B

12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(6,979)	0	0	0	0	0	0	0	0	0	0	(6,979)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	29,116	0	0	0	0	0	0	0	0	0	29,116	32
33	Real Estate Taxes	84,066	622	0	0	0	0	0	0	0	0	0	84,688	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	12,656	0	0	0	0	0	0	0	0	0	12,656	35
36	Other (specify):*	0	25,640	0	0	0	0	0	0	0	0	0	25,640	36
37	TOTAL Ownership	77,087	68,034	0	145,121	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	29,796	0	0	0	0	0	0	0	0	0	29,796	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	29,796	0	29,796	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(381,070)	371,712	0	(9,358)	45								

Facility Name & ID Number Odin Health Care Center

0047365

Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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						

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%	11,536	11,536	2
3	V	39 Professional Services		SSC Equity Holdings, LLC	100.00%	29,796	29,796	3
4	V	20 Fees, Subscriptions & Promos		SSC Equity Holdings, LLC	100.00%			4
5	V	10 Nursing & Medical Records		SSC Equity Holdings, LLC	100.00%			5
6	V	21 Clerical & Gen Office Exp		SSC Equity Holdings, LLC	100.00%	215,489	215,489	6
7	V	24 Travel & Seminar		SSC Equity Holdings, LLC	100.00%	26,454	26,454	7
8	V	26 Insurance		SSC Equity Holdings, LLC	100.00%	7,367	7,367	8
9	V	36 Depreciation		SSC Equity Holdings, LLC	100.00%	25,640	25,640	9
10	V	33 Taxes - Property		SSC Equity Holdings, LLC	100.00%	622	622	10
11	V	35 Rental & Leasing		SSC Equity Holdings, LLC	100.00%	12,656	12,656	11
12	V	32 Interest Income/Expense		SSC Equity Holdings, LLC	100.00%	29,116	29,116	12
13	V	22 Payroll Taxes		SSC Equity Holdings, LLC	100.00%	13,036	13,036	13
14	Total		\$			\$ 371,712	\$ * 371,712	14

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

STATE OF ILLINOIS

Facility Name & ID Number

Odin Health Care Center

0047365

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**Related Illinois Nursing Homes
as of 12/31/2008**

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
SSC Equity Holdings, LLC	Montebello Health Care Center	6006316
	Nature Trail Health Care Center	6006498
	Odin Health Care Center	6006878
	Westchester Health Care Center	6012173

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Odin Health Care Center

0047365 Report Period Beginning: 01/01/2008

Ending: 2/31/2008

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

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

Name of Related Organization SSC Equity Holdings, LLC
 Street Address 5300 West Sam Houston Pwy N Ste 100
 City / State / Zip Code Houston, TX 77041
 Phone Number (832)467-6000
 Fax Number (832)467-6114

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			\$	\$		0	1
2	6	Repair and Maintenance						11,536	2
3	39	Professional Services						29,796	3
4	20	Fees, Subscriptions & Promos						0	4
5	10	Nursing and Medical Records						0	5
6	21	Clerical & General Office Exp						215,489	6
7	24	Travel and Seminars						26,454	7
8	26	Insurance						7,367	8
9	36	Depreciation						25,640	9
10	33	Taxes - Property						622	10
11	35	Rental and Leasing						12,656	11
12	32	Interest Income/Expense						29,116	12
13	22	Payroll Taxes						13,036	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				\$	\$		371,712	25

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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	193,794	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.)		\$	53,043	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(140,751)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	109,728	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	(31,023)	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	41,411	8	
	2004	47,077	9	
	2005	149,498	10	
	2006	137,090	11	
	2007	53,043	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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, please call the Bureau of Health Finance at (217) 782-1630.

2007 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 Martha McDaniel

TELEPHONE 832 467 637 FAX #: 832 467 6324

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>PT SE SE</u>	\$ <u>53,043.20</u>	\$ <u>53,043.20</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>53,043.20</u>	\$ <u>53,043.20</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,801 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **Odin Health Care Center**# **0047365**

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2005	1975	\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		2: Zonline Heat/Cool Units		2005	1,119	224	5	224		765	9
10		Use Tax - 2: Zonline Heat/Cool Units		2005	70	14	5	14		48	10
11		Fascia Board Repair		2005	3,520	302	11.66	302		1,031	11
12		Vents for Isolation Rooms, Handicap Tubs/Sinks & Whirlpool		2005	37,013	3,219	11.5	3,219		10,460	12
13		Sewer Line Reapirs - Add Pipe		2005	1,620	141	11.5	141		458	13
14		Main Sewer Line Repair		2005	534	46	11.5	46		151	14
15		Inspect Main Trunk Line		2005	316	27	11.5	27		89	15
16		4: Smoke Detectors		2005	641	64	10	64		208	16
17		10 Ton Condenser - A/C Unit		2005	1,402	122	11.5	122		396	17
18		Ruud Air Handler - Installation		2005	1,622	141	11.5	141		459	18
19		Installation Valve, Hand Wash Sink		2005	1,306	114	11.5	114		369	19
20		Use Tax - Zonline Heat/Cool Unit		2005	35	7	5	7		21	20
21		Zonline Heat/Cool Unit		2005	566	113	5	113		349	21
22		Water Heater		2005	6,350	635	10	635		1,958	22
23											23
24		Zonline Heat/Cool Unit		2006	508	102	5	102		271	24
25		Use Tax - Zonline Heat/Cool Unit		2006	31	6	5	6		17	25
26		A/C in Dietary		2006	3,465	693	5	693		1,848	26
27		Wallpaper and Handrails		2006	5,632	1,126	5	1,126		2,910	27
28		Handrails		2006	4,442	423	10.5	423		1,128	28
29		Paging/Music Broadcast System		2006	1,438	144	10	144		371	29
30		Wallpaper and Handrails		2006	5,632	1,126	5	1,126		2,628	30
31		2: Thru Wall Heat/Cool Units		2006	1,120	224	5	224		504	31
32		Use Tax - 2 Thru Wall Heat/Cool Units		2006	71	14	5	14		32	32
33											33
34		Paint and Wallpaper		2007	463	47	9.83	47		94	34
35		Use Tax - paint and Wallpaper		2007	30	3	9.83	3		6	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number **Odin Health Care Center**# **0047365**

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	Wallpaper	2007	\$ 1,679	\$ 336	5	\$ 336	\$	\$ 700	37
38	Interior Renovation - Floors, Walls	2007	7,454	771	9.66	771		1,414	38
39	Flooring	2007	6,540	671	9.75	671		1,286	39
40	Paint and Wallpaper	2007	326	65	5	65		125	40
41	Paint and Wallpaper	2007	21	4	5	4		8	41
42	Interior Renovation - Floors, Walls	2007	3,140	322	9.75	322		617	42
43	Zoneline Heat/Cool	2007	1,179	127	9.25	127		181	43
44	7.5 Ton A/C Unit	2007	6,860	742	9.25	742		1,051	44
45	40: Cubicle Curtains	2007	2,308	462	5	462		615	45
46	10: Cubicle Curtains	2007	565	113	5	113		160	46
47	Replace RTU Compressor	2007	1,140	124	9.17	124		166	47
48									48
49	Nurse Call Station	2008	20,592	2,331	8.83	2,331		2,331	49
50	Generator Relay Switches	2008	3,567	374	8.75	374		374	50
51	Steel Door with Tempered Glass	2008	1,025	61	8.33	61		61	51
52	Install New Door and Frame	2008	560	39	8.42	39		39	52
53	Vinyl Fence and Gates	2008	10,697	223	8	223		223	53
54	7.5 Ton Gas/Elec Rooftop Unit	2008	5,850	62	7.92	62		62	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 152,447	\$ 15,904		\$ 15,904	\$	\$ 35,983	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: 01/01/2008 Ending: 12/31/2008

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	\$ 38,028	\$ 5,553	\$ 5,553	\$		\$ 16,655	71
72	Current Year Purchases	23,581	2,502	2,502			2,502	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 61,608	\$ 8,055	\$ 8,055	\$		\$ 19,157	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 214,055	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,959	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,959	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)	\$ 55,140	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SSC Property Holdings, LLC

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1975</u>	<u>99</u>	<u>01/01/05</u>	\$ <u>725,851</u>	<u>12</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		99		\$ 725,851			7

10. Effective dates of current rental agreement:

Beginning 01/01/2005

Ending 12/31/2016

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

Fiscal Year Ending Annual Rent

12.	<u>12/2009</u>	\$ <u>725,851</u>
13.	<u>12/2010</u>	\$ <u>725,851</u>
14.	<u>12/2011</u>	\$ <u>725,851</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: \$ _____ 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10 a-1	6,527 hrs	\$ 220,783		\$	\$	6,527	\$ 220,783	1
2	Licensed Speech and Language Development Therapist	10 a-1	2,557 hrs	96,549				2,557	96,549	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10 a-1	8,192 hrs	253,606				8,192	253,606	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				186,661		186,661	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 570,938		\$	\$ 186,661	17,276	\$ 757,598	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Odin Health Care Center# 0047365Report Period Beginning: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 550	\$	1
2	Cash-Patient Deposits	4,879		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	696,965		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	179,624		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 882,018	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	36,765		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	152,447		15
16	Equipment, at Historical Cost	61,608		16
17	Accumulated Depreciation (book methods)	(55,139)		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): <u>Leasehold Rights</u>	55,452		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 251,133	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,133,151	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 145,618	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	237,413		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,138		31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,043		32
33	Accrued Interest Payable			33
34	Deferred Compensation	46,195		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		24,627		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 541,034	\$	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	<u>Intercompany</u>	(519,226)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (519,226)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 21,808	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,111,342	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,133,150	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 434,499	1
2	Restatements (describe):		2
3	Prior Year Adjustment	(53,280)	3
4	Rounding	(3)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 381,216	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	730,126	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)	\$ 730,126	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,111,342	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Odin Health Care Center# 0047365Report Period Beginning: 01/01/2008Ending: 12/31/2008**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	\$ 6,534,553	1
2	Discounts and Allowances for all Levels	(1,994,944)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,539,609	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,273,070	6
7	Oxygen	21,107	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,294,177	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	303,304	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,086	19
20	Radiology and X-Ray	11,277	20
21	Other Medical Services	16,473	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 367,140	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	<u>Misc Receipts - Admin</u>	129	28
28a	<u>Misc Receipts - Vending</u>	1,558	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,687	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,202,613	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	758,313	31
32	Health Care	2,481,658	32
33	General Administration	1,216,099	33
B. Capital Expense			
34	Ownership	737,220	34
C. Ancillary Expense			
35	Special Cost Centers	224,596	35
36	Provider Participation Fee	54,351	36
D. Other Expenses (specify):			
37	<u>Franchise Tax</u>	250	37
38	<u>Rounding</u>		38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,472,487	40
41	Income before Income Taxes (line 30 minus line 40)**	730,126	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 730,126	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: 1/1/2008
Ending: 12/31/2008

Facility Name & ID Number Odin Healthcare Center # 0039586

SUPPLEMENTAL SCHEDULE - OTHER INCOME

DESCRIPTION - Page 19, Line 28	Account Number	Amount
Miscellaneous ReceiptsDefault-ProdAdministrative	600057000008100	(128.60)
General Rental ReceiptsDefault-ProdAdministrative	600060000008100	0.00
Reconcile with Schedule XVII, Line 28		(128.60)

DESCRIPTION - Page 19, Line 28a	Account Number	Amount
Miscellaneous ReceiptsDefault-ProdVending	600057000004102	(1,557.61)
Reconcile with Schedule XVII, Line 28a		(1,557.61)

Facility Name & ID Number Odin Health Care Center

0047365

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

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	1,706	2,108	\$ 56,584	\$ 26.84	1
2	Assistant Director of Nursing	1,824	2,144	50,784	23.69	2
3	Registered Nurses	13,435	14,908	317,006	21.26	3
4	Licensed Practical Nurses	21,936	24,191	421,420	17.42	4
5	CNAs & Orderlies	63,809	69,228	641,831	9.27	5
6	CNA Trainees					6
7	Licensed Therapist	17,391	19,627	643,415	32.78	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,938	2,096	23,900	11.40	9
10	Activity Assistants	1,087	1,199	9,258	7.72	10
11	Social Service Workers	2,712	2,920	37,345	12.79	11
12	Dietician					12
13	Food Service Supervisor	1,907	2,091	29,397	14.06	13
14	Head Cook	5,282	5,809	48,743	8.39	14
15	Cook Helpers/Assistants	9,780	10,688	88,008	8.23	15
16	Dishwashers					16
17	Maintenance Workers	1,894	2,116	28,469	13.45	17
18	Housekeepers	13,008	14,542	123,681	8.51	18
19	Laundry	5,435	5,849	47,624	8.14	19
20	Administrator	1,674	2,096	94,136	44.91	20
21	Assistant Administrator					21
22	Other Administrative	5,413	6,101	113,687	18.63	22
23	Office Manager					23
24	Clerical	3,282	3,675	44,933	12.23	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	1,845	2,097	23,745	11.32	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transportation</u>	1,735	1,923	15,495	8.06	33
34	TOTAL (lines 1 - 33)	177,093	195,408	\$ 2,859,461 *	\$ 14.63	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	273	\$ 11,458	1-3	35
36	Medical Director	64	12,000	9-3	36
37	Medical Records Consultant	30	1,489	10-3	37
38	Nurse Consultant		1,422	10-3	38
39	Pharmacist Consultant		3,698	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	37	2,116	11-3	44
45	Social Service Consultant	37	2,114	12-3	45
46	Other(specify)				46
47	<u>X-Ray</u>		11,181	39-3	47
48	<u>Lab</u>		22,243	39-3	48
49	TOTAL (lines 35 - 48)	441	\$ 67,721		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: 01/01/2008

Ending: 12/31/2008

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	0	\$ 93,819	Workers' Compensation Insurance	\$ 94,761	IDPH License Fee	\$ 2,432		
				Unemployment Compensation Insurance	26,616	Advertising: Employee Recruitment	3,939		
				FICA Taxes	207,814	Health Care Worker Background Check	4,478		
				Employee Health Insurance	64,499	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Yellow Pages Ad	196		
				Employee Life Insurance	3,552	Non Allowable Advertising	3,792		
				Other Benefits	6,720	Dues	5,011		
				Home Office Allocation - Payroll Taxes	13,036	Subscriptions	2,089		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 93,819						
(List each licensed administrator separately.)									
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description	Amount			Description	Line #	Amount	Description	Amount	
	\$					\$			
							Out-of-State Travel	\$ 9,260	
							In-State Travel		
							Seminar Expense	26,454	
							Entertainment Expense	(6)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type	Amount							
CT Corp System		\$ 234							
Dawson Construction	Construction & Design	38,821							
My Innerview	Surveys - Resident, etc	349							
Press Ganey	Research	16							
Secretary of State	Filing Fees	250							
Talx Corp	Unemployment Services	555							
Viotech Publishing	TLC Program Services	18							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 40,242						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Odin Health Care Center**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? X
- (2) Are there any dues to nursing home associations included on the cost report? X
If YES, give association name and amount. Illinois Health Care Association \$5,011
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? 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? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,374 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. \$ 54,351
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BDO Seidman, LLC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit is in process
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

