

Facility Name & ID Number SSC Odin Operating Company LLC, dba Odin Healthcare Center

0047365 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	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	99	Skilled (SNF)	99	36,135	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	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	22,462	3,020	6,739	32,221	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,462	3,020	6,739	32,221	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.17%

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

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

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 139 and days of care provided _____

Medicare Intermediary Novitas Solutions Inc

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number SSC Odin Operating Company LLC, dba Od # 0047365 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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		1,885	434,769	436,654	436,654	(120,184)	316,470			1
2	Food Purchase		5,652		5,652	5,652	120,126	125,778			2
3	Housekeeping		9,001	116,579	125,580	125,580		125,580			3
4	Laundry		6,306	76,405	82,711	82,711		82,711			4
5	Heat and Other Utilities			105,609	105,609	105,609	(5,373)	100,236			5
6	Maintenance	42,283	60,761	8,246	111,290	111,290	23,865	135,155			6
7	Other (specify):*			5,353	5,353	5,353		5,353			7
8	TOTAL General Services	42,283	83,605	746,961	872,849	872,849	18,434	891,283			8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000	18,000		18,000			9
10	Nursing and Medical Records	1,698,978	104,313	21,306	1,824,597	1,824,597	254,891	2,079,488			10
10a	Therapy	853,467	105,990	343	959,800	959,800		959,800			10a
11	Activities	35,519	5,867	4,035	45,421	45,421		45,421			11
12	Social Services	58,964	89	2,344	61,397	61,397		61,397			12
13	CNA Training										13
14	Program Transportation	30,926	4,926	5,988	41,840	41,840		41,840			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,677,854	221,185	52,016	2,951,055	2,951,055	254,891	3,205,946			16
	C. General Administration										
17	Administrative	93,321			93,321	93,321	4,605	97,926			17
18	Directors Fees			893	893	893		893			18
19	Professional Services			7,919	7,919	7,919	20,784	28,703			19
20	Dues, Fees, Subscriptions & Promotions			48,506	48,506	48,506	647	49,153			20
21	Clerical & General Office Expenses	142,361	18,363	1,042,273	1,202,997	1,202,997	(1,035,325)	167,672			21
22	Employee Benefits & Payroll Taxes			470,370	470,370	470,370	35,510	505,880			22
23	Inservice Training & Education										23
24	Travel and Seminar			25,867	25,867	25,867	24,327	50,194			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			107,968	107,968	107,968	(77,716)	30,252			26
27	Other (specify):* Franchise Tax			300	300	300		300			27
28	TOTAL General Administration	235,682	18,363	1,704,096	1,958,141	1,958,141	(1,027,168)	930,973			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,955,819	323,153	2,503,073	5,782,045	5,782,045	(753,843)	5,028,202			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.

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	
	D. Ownership											
30	Depreciation			720,686	720,686		720,686	(654,898)	65,788			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,142,767	1,142,767		1,142,767	22,305	1,165,072			32
33	Real Estate Taxes			56,162	56,162		56,162	(59,707)	(3,545)			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							33,383	33,383			36
37	TOTAL Ownership			1,919,615	1,919,615		1,919,615	(658,917)	1,260,698			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		207,842	33,454	241,296		241,296		241,296			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			173,441	173,441		173,441		173,441			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		207,842	206,895	414,737		414,737		414,737			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,955,819	530,995	4,629,583	8,116,397		8,116,397	(1,412,760)	6,703,637			45

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

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	(5,403)	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	(58)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,510)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(652,020)	21		24
25	Fund Raising, Advertising and Promotional	(18,006)	21		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	(1,163,860)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,841,857)		\$	30

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)	429,097		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 429,097		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,412,760)		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

BHF USE ONLY							
48		49		50		51	52

SSC Odin Operating Company LLC, dba Odin Healthcare Center

ID# 0047365

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Back Office Services	\$ (368,124)	21	1
2	Prof Liability Insurance Adj	(81,131)	26	2
3	Depreciation Adj - Capital Lease Depr	(654,898)	30	3
4	Reclass Raw Food Expense	(120,184)	1	4
5	Reclass Raw Food Expense	120,184	2	5
6	Real Estate Accrual Adj	(59,707)	33	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
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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	(1,163,860)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SSC Odin Operating Company LLC, dba Odin Healthcare C

0047365

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(120,184)	0	0	0	0	0	0	0	0	0	0	(120,184)	1
2	Food Purchase	120,126	0	0	0	0	0	0	0	0	0	0	120,126	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	(5,403)	30	0	0	0	0	0	0	0	0	0	(5,373)	5
6	Maintenance	0	23,865	0	0	0	0	0	0	0	0	0	23,865	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,461)	23,895	0	0	0	0	0	0	0	0	0	18,434	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	254,891	0	0	0	0	0	0	0	0	0	254,891	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	254,891	0	0	0	0	0	0	0	0	0	254,891	16
	C. General Administration													
17	Administrative	0	4,605	0	0	0	0	0	0	0	0	0	4,605	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,510)	23,294	0	0	0	0	0	0	0	0	0	20,784	19
20	Fees, Subscriptions & Promotions	0	647	0	0	0	0	0	0	0	0	0	647	20
21	Clerical & General Office Expenses	(1,038,150)	2,825	0	0	0	0	0	0	0	0	0	(1,035,325)	21
22	Employee Benefits & Payroll Taxes	0	35,510	0	0	0	0	0	0	0	0	0	35,510	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	24,327	0	0	0	0	0	0	0	0	0	24,327	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(81,131)	3,415	0	0	0	0	0	0	0	0	0	(77,716)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,121,791)	94,623	0	0	0	0	0	0	0	0	0	(1,027,168)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,127,252)	373,409	0	0	0	0	0	0	0	0	0	(753,843)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SSC Odin Operating Company LLC, dba Odin Healthcare C # 0047365 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	(654,898)	0	0	0	0	0	0	0	0	0	0	(654,898)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	22,305	0	0	0	0	0	0	0	0	0	22,305	32
33	Real Estate Taxes	(59,707)	0	0	0	0	0	0	0	0	0	0	(59,707)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	33,383	0	0	0	0	0	0	0	0	0	33,383	36
37	TOTAL Ownership	(714,605)	55,688	0	0	0	0	0	0	0	0	0	(658,917)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,841,857)	429,097	0	0	0	0	0	0	0	0	0	(1,412,760)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Illinois Holdco LLC</u>	<u>100</u>	<u>Montebello Health Care Center</u>	<u>Hamilton</u>	<u>SSC Equity Holdings LLC</u>		<u>Holding Company</u>
		<u>Nature Trail Health Care Center</u>	<u>Mount Vernon</u>	<u>SSC Administrative Services LLC</u>		<u>Back Office Service</u>
		<u>Odin Health Care Center</u>	<u>Odin</u>	<u>SSC Consulting Services LLC</u>		<u>Consulting Services</u>
		<u>Westchester Health Care Center</u>	<u>Westchester</u>			

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<u>5 Utilities</u>	\$	<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	\$ <u>30</u>	\$	<u>30</u> 1
2	V	<u>6 Repair and Maintenance</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>23,865</u>		<u>23,865</u> 2
3	V	<u>19 Professional Services</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>23,294</u>		<u>23,294</u> 3
4	V	<u>20 Fee, Subscriptions and Promos</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>647</u>		<u>647</u> 4
5	V	<u>10 Nursing & Medical Records</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>254,891</u>		<u>254,891</u> 5
6	V	<u>21 Clerical & Gen Office Exp</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>2,825</u>		<u>2,825</u> 6
7	V	<u>24 Travel & Seminar</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>24,327</u>		<u>24,327</u> 7
8	V	<u>26 Insurance</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>3,415</u>		<u>3,415</u> 8
9	V	<u>36 Depreciation</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>33,383</u>		<u>33,383</u> 9
10	V	<u>17 Communications</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>4,605</u>		<u>4,605</u> 10
11	V	<u>35 Rental and Lease</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>			11
12	V	<u>32 Interest Income/Expense</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>22,305</u>		<u>22,305</u> 12
13	V	<u>22 Payroll Taxes</u>		<u>SSC Equity Holdings LLC</u>	<u>100.00%</u>	<u>35,510</u>		<u>35,510</u> 13
14	Total		\$			\$ <u>429,097</u>	\$ *	<u>429,097</u> 14

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

Facility Name & ID Number SSC Odin Operating Company LLC, dba Odin Healthcare Center # 0047365 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holdings Company LLC	100	Cedar Crest	Montgomery				1
2			Fairview Health & Rehab Center	Birmingham				2
3			Montrose Bay Healthcare Center	Fairhope				3
4			South Haven Health & Rehab Center	Montgomery				4
5			Warren Manor	Selma				5
6			Woodley Manor	Montgomery				6
7			Excell Health Care Center	Oakland				7
8			Flagship Health care Center	Newport Beach				8
9			Tarzana Health & Rehab Center	Tarzana				9
10			Diamond Ridge Health Care Center	Pittsburgh				10
11			Courtyard Care Center	San Jose				11
12			Mission Carmichael Health Care Center	Carmichael				12
13			AlpineLiving Center	Thornton				13
14			Boulder Manor	Boulder				14
15			Pearl Street Health Care Center	Englewood				15
16			Applewood Living Center	Longmont				16
17			Fort Collins Health Care Center	Fort Collins				17
18			Spring Creek Healthcare Center	Fort Collins				18
19			Berthoud Living Center	Berthoud				19
20			Sierra Vista Health Care Center	Loveland				20
21			Windsor Health Care Center	Windsor				21
22			San Juan Living Center	Montrose				22
23			Four Corners Health Care Center	Durango				23
24			Palisade Living Center	Palisade				24
25			Colonial Columns Nursing Center	Colorado Springs				25
26			Cedarwood Health Care Center	Colorado Springs				26
27			Minnequa Medicenter	Pueblo				27
28			Terrace Gaedens Healthcare Center	Colorado Springs				28
29			Aspen Living Cente	Colorado Springs				29
30			Belmont Lodge	Pueblo				30

Facility Name & ID Number SSC Odin Operating Company LLC, dba Odin Healthcare Center # 0047365 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Centennial Heathcare Center	Greeley				1
2			Kenton Manor	Greeley				2
3			Stering Living Center	Sterling				3
4			Sunset Manor	Brush				4
5			Yuma Life Care Center	Yuma				5
6			Jewell Care Center of Denver	Denver				6
7			Monaco Parkway	Denver				7
8			Garden Square at Spring Creek	Fort Collins				8
9			Pendleton Health & Rehab	Mystic				9
10			Bride Brook Health & Rehab	Niantic				10
11			Brian Center Nursing Care Austell	Austill				11
12			Brian Center Health & Rehab Canton	Canton				12
13			Northeast Atlanta Healty & Rehab	Atlanta				13
14			Brighton Place West	Topeka				14
15			Indian Creek Healht Care Center	Overland Park				15
16			SE Massachusetts Health & Rehab	New Bedford				16
17			Methuen Health & Rehab Center	Methuen				17
18			Patuxent River Health & Rehab Center	Laurel				18
19			Arcola Heathh & Rehab Center	Silver Spring				19
20			Glen Burnie Health & Rehab Center	Glen Burnie				20
21			Overlea Health & Rehab Center	Baltimore				21
22			Bethesda Health & Rehab Center	Bethesda				22
23			Summit Park Health & Rehab Center	Catonsville				23
24			North Arundel Health & Rehab Center	Glen Burnie				24
25			Bel Air Health & Rehab Center	Bel Air				25
26			Forest Hill Health & Rehab Center	Forest Hill				26
27			Heritage Harbour Health & Rehab Center	Annapolis				27
28			Cambridge East	Madison Heights				28
29			Cambridge North	Clawson				29
30			Cambridge South	Beverly Hills				30

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STATE OF ILLINOIS

Facility Name & ID Number SSC Odin Operating Company LLC, dba Odin Healthcare Center # 0047365 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Clarkston	Clarkston				1
2			Clinton-Aire Healthcare Center	Clinton Township				2
3			Crestmont NursingCare Center	Fenton				3
4			Heritage Manor	Flint				4
5			Hope Health Care Center	Westland				5
6			Warren Woods Health Care Center	Warren				6
7			Superior Woods Health Care Center	Ypsilanti				7
8			Countrybrook Living Center	Brook Haven				8
9			Brian Center Health & Rehab Eden	Eden				9
10			Brian Center Nursing Care Lexington	Lexington				10
11			Brian Center Health & Rehab Hickory East	Hickory				11
12			Brian Center Health & Rehab Wilson	Wilson				12
13			Randolph Health & Rehab Center	Asheboro				13
14			Brian Center Health & Rehab Winston Salem	Winston Salem				14
15			Brian Center Health & Rehab Charlotte	Charlotte				15
16			Brian Center Health & Rehab Windsor	Windsor				16
17			Maple Leaf Health Care	Statesville				17
18			Brian Center Health & Rehab Weaverville	Weaverville				18
19			Brian Center Health & Rehab Lincolnton	Lincolnton				19
20			Brian Center Health & Rehab Wallace	Wallace				20
21			Brian Center Health & Rehab Monroe	Monroe				21
22			Brian Center Health & Rehab Durham	Durham				22
23			Brian Center Health & Rehab Goldsboro	Goldsboro				23
24			Brian Center Health & Rehab Cabarrus	Concord				24
25			Brian Center Nursing Care Shamrock	Charlotte				25
26			Brian Center Nursing Care Hickory	Hickory				26
27			Brian Center Health & Rehab Center Waynesvi	Waynesville				27
28			Brian Center Health & Rehab Clayton	Clayton				28
29			Brian Center Health & Rehab Brevard	Brevard				29
30			Brian Center Health & Rehab Yanceyville	Yanceyville				30

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STATE OF ILLINOIS

Facility Name & ID Number SSC Odin Operating Company LLC, dba Odin Healthcare Center # 0047365 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Brian Center Health & Rehab Hertfort	Hertford				1
2			Brian Center Health & Rehab Spruce Pine	Spruce Pine				2
3			Brian Center Health & Rehab Hendersonville	Hendersonville				3
4			Brian Center Health & Rehab Salisbury	Salisbury				4
5			Mariner Health Care of Wilmington	Wilmington				5
6			Silver Stream Health & Rehab	Wilmington				6
7			Kenansville Health & Rehab	Kenansville				7
8			Charlotte Apts	Charlotte				8
9			Forest City Health & Rehab	Forest City				9
10								10
11								11
12								12
13								13
14								14
15								15
16			North Hills Health & Rehab	Wexford				16
17			West Hills Health & Rehab	Coraopolis				17
18			Broomall Health & Rehab	Broomall				18
19			Seneca Health & Rehab	Seneca				19
20			Sumter East Health & Rehab	Sumter				20
21			Golden Age Inman	Inman				21
22			Inman Healthcare	Inman				22
23			Lebanon Health & REhab	Lebanon				23
24			Greenhills Health & Rehab	Nashville				24
25			Norris Health & Rehab	Andersonville				25
26			Newport Health & Rehab	Newport				26
27			Cheyenne Healthcare	Cheyenne				27
28			Poplar Living Center	Casper				28
29			Sheridan Manor	Sheridan				29
30			Huntington Health Care	Huntington				30

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STATE OF ILLINOIS

Facility Name & ID Number SSC Odin Operating Company LLC, dba Odin Healthcare Center # 0047365 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Bastrop Nursing Center	Bastrop				1
2			Care Inn of La Grange	La Grange				2
3			Kountze Nursing Center	Kountze				3
4			Retama Manor Nursing Center San Antonio No	San Antonio				4
5			Retama Manor Nursing Center San Antonio We	San Antonio				5
6			Retama Manor Nursing Center Alice	Alice				6
7			Retama Manor Nursing Center Edinburg	Edinburg				7
8			Retama Manor Nursing Center Harlingen	Harlingen				8
9			Retama Manor Nursing Center Jourdanton	Jourdanton				9
10			Retama Manor Nursing Center Laredo South	Laredo				10
11			Retama Manor Nursing Center Laredo West	Laredo				11
12			Retama Manor Nursing Center McAllen	McAllen				12
13			Retama Manor Nursing Center Pleasanton Nort	Pleasanton				13
14			Retama Manor Nursing Center Pleasanton Sout	Pleasanton				14
15			Retama Manor Nursing Center Rio Grande City	Rio Grande City				15
16			Retama Manor Nursing Center Robstown	Robstown				16
17			Retama Manor Nursing Center Weslaco	Weslaco				17
18			Weatherford health Care Center	Weatherford				18
19			Peach Tree Place	Weatherford				19
20			Retama Manor Nursing Center Raymondville	Raymondville				20
21			Memorial City Health and Rehab	Houston				21
22			Jacinto City Healthcare Center	Houston				22
23			Spring Branch Healthcare Center	Houston				23
24			Retama Manor Nursing Center Corpus Christi	Corpus Christi				24
25			Downtown Health & Rehab	Fort Worth				25
26			Lakeshore Village Healthcare Center	Waco				26
27			Deer Creek of Wimberley	Wimberley				27
28			La Paloma Nursing Center	San Diego				28
29			Pine Arbor	Silsbee				29
30			Las Palmas Healthcare Center	McAllen				30

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STATE OF ILLINOIS

Facility Name & ID Number SSC Odin Operating Company LLC, dba Odin Healthcare Center # 0047365 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Hilltop Village	Kerville				1
2			Silver Creek Manor	San Antonio				2
3			Alpine Terrace	Kerrville				3
4			Edgewater Care Center	Kerrville				4
5			Arlington Heights Health & Rehab	Fort Worth				5
6			The Meadows Health & Rehab	Dallas				6
7			Northgate Health & Rehab	San Antonio				7
8			Interlochen Health & Rehab	Arlington				8
9			First Colony Health & Rehab	Missouri City				9
10			Cypresswood Health & Rehab	Houston				10
11			Northwest Health & Rehab	Houston				11
12			The Westbury Place	Houston				12
13			Westchase Health & Rehab	Houston				13
14			Woodwind Lakes Health & Rehab	Houston				14
15			Pasadena Care Center	Pasadena				15
16			Bay Villa	Bay City				16
17			Alice Health care Center	Alice				17
18			Bangs Nursing Home	Bangs				18
19			Brazosview	Richmond				19
20			Courtyards at Fort Worth	Fort Worth				20
21			Faith Memorial	Pasadena				21
22			Golden Years	Marlin				22
23			Greenview Manor	Waco				23
24			Hillview Health & Rehab	Goldthwaite				24
25			Levelland Health Care	Levelland				25
26			Longmeadow Health Care	Justin				26
27			Memorial Medical Nursing Center	San Antonio				27
28			Mount Pleasant	Mount Pleasant				28
29			North Park Health & Rehab	McKinney				29
30			Pampa Health Care Center	Pampa				30

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STATE OF ILLINOIS

Facility Name & ID Number SSC Odin Operating Company LLC, dba Odin Healthcare Center # 0047365 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Park Highlands Health Care Center	Athens				1
2			Pleasant Springs Health Care Center	Mount Pleasant				2
3			Sweeny Health Care Center	Sweeny				3
4			Texoma Health Care Center	Sherman				4
5			The Park in Plano	Plano				5
6			Ashland Health & Rehab	Ashland				6
7			Southpointe Health Care Center	Greenfield				7
8			Virginia Highlands Health & Rehab Center	Germantown				8
9			Grande Prairie Health & Rehab Center	Pleasant Prairie				9
10			Pleasant Valley Health Care Center	Derry				10
11			The Village at Alameda	Albuquerque				11
12			Hobbs Healthcare Center	Hobbs				12
13			Lake Mead Health Care Center	Henderson				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

Facility Name & ID Number SSC Odin Operating Company LLC, dba Oc # 0047365 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 SSC Odin Operating Company LLC, dba Odin Healthcare # 0047365 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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 W Sam Houston Pkwy N Ste 100
 City / State / Zip Code Houston, TX 77041
 Phone Number (832-467-6000
 Fax Number (832-467-6984

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			\$	\$ 30		\$ 1
2	6	Repair and Maintenance				23,865		2
3	19	Professional Services				23,294		3
4	20	Fee, Subscriptions and Promos				647		4
5	10	Nursing & Medical Records				254,891		5
6	21	Clerical & Gen Office Exp				2,825		6
7	24	Travel & Seminar				24,327		7
8	26	Insurance				3,415		8
9	36	Drpreiation				33,383		9
10	17	Communications				4,605		10
11	35	Rental and Lease						11
12	32	Interest Income/Expense				22,305		12
13	22	Payroll Taxes				35,510		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				\$	\$ 429,097		\$ 25

Facility Name & ID Number SSC Odin Operating Company LLC, dba Od

0047365

Report Period Beginning:

01/01/2017

Ending:

12/31/2017

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

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 2016 report.		\$	127,077	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.)		\$	67,070	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(60,007)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	56,462	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.		\$	(3,545)	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	118,896	8
	2013	123,646	9
	2014	123,623	10
	2015	124,735	11
	2016	60,070	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SSC Odin Operating Company LLC, dba Odin Healthcare Ce COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0047365

CONTACT PERSON REGARDING THIS REPORT Martha McDaniel

TELEPHONE 832 467 6317 FAX #: 832 467 6984

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>10-11-400-001</u>	<u>4 Acres - PT SE SE</u>	\$ <u>67,070.00</u>	\$ <u>67,070.00</u>
2. _____	<u>300 Green St</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>67,070.00</u></u>	\$ <u><u>67,070.00</u></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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 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.

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

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). NA

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Land, 1, 2, 3, 4. Row 2: 1, 2, 3, 4, 1. Row 3: 2, 3, 4, 1, 2. Row 4: 3, TOTALS, 3, 4, 3.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	2005	1975	\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	2: Zonline Heat/Cool Units	2005		1,119		5			1,119	9
10	Use Tax - 2: Zonline Heat/Cool Units	2005		70		5			70	10
11	Fascia Board Repair	2005		3,520		11.66			3,520	11
12	Vents for Isolation Rooms, Handicap Tubs/Sinks & Whirlpool	2005		37,013		11.5			37,013	12
13	Sewer Line Reapirs - Add Pipe	2005		1,620		11.5			1,620	13
14	Main Sewer Line Repair	2005		534		11.5			534	14
15	Inspect Main Trunk Line	2005		316		11.5			316	15
16	4: Smoke Detectors	2005		641		10			641	16
17	10 Ton Condenser - A/C Unit	2005		1,402		11.5			1,402	17
18	Ruud Air Handler - Installation	2005		1,622		11.5			1,622	18
19	Installation Valve, Hand Wash Sink	2005		1,306		11.5			1,306	19
20	Use Tax - Zonline Heat/Cool Unit	2005		35		5			35	20
21	Zonline Heat/Cool Unit	2005		566		5			566	21
22	Water Heater	2005		6,350		10			6,350	22
23										23
24	Zonline Heat/Cool Unit	2006		508		5			508	24
25	Use Tax - Zonline Heat/Cool Unit	2006		31		5			31	25
26	A/C in Dietary	2006		3,465		5			3,465	26
27	Wallpaper and Handrails	2006		5,632		5			5,632	27
28	Handrails	2006		4,442		10.5			4,442	28
29	Paging/Music Broadcast System	2006		1,438		10			1,438	29
30	Wallpaper and Handrails	2006		5,632		5			5,632	30
31	2: Thru Wall Heat/Cool Units	2006		1,120		5			1,120	31
32	Use Tax - 2 Thru Wall Heat/Cool Units	2006		71		5			71	32
33										33
34	Paint and Wallpaper	2007		463		9.83			463	34
35	Use Tax - paint and Wallpaper	2007		30		9.83			30	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

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$	5	\$	\$	\$ 1,679	37
38	Interior Renovation - Floors, Walls	2007	7,454		9.66			7,454	38
39	Flooring	2007	6,540		9.75			6,540	39
40	Paint and Wallpaper	2007	326		5			326	40
41	Paint and Wallpaper	2007	21		5			21	41
42	Interior Renovation - Floors, Walls	2007	3,140		9.75			3,140	42
43	Zonline Heat/Cool	2007	1,179		9.25			1,179	43
44	7.5 Ton A/C Unit	2007	6,860		9.25			6,860	44
45	40: Cubicle Curtains	2007	2,308		5			2,308	45
46	10: Cubicle Curtains	2007	566		5			566	46
47	Replace RTU Compressor	2007	1,140		9.17			1,140	47
48									48
49	Nurse Call Station	2008	20,592		8.83			20,592	49
50	Generator Relay Switches	2008	3,567		8.75			3,567	50
51	Steel Door with Tempered Glass	2008	1,025		8.33			1,025	51
52	Install New Door and Frame	2008	560		8.42			560	52
53	Vinyl Fence and Gates	2008	10,697		8			10,697	53
54	7.5 Ton Gas/Elec Rooftop Unit	2008	5,850		7.92			5,850	54
55									55
56	Grant for Landscape	2009	4,923		8.08			4,923	56
57	Grant for Landscape	2009	739		8.08			739	57
58	12 X 24 Lofted Barn	2009	4,804		7.92			4,804	58
59	Irrigation System	2009	3,350		8			3,350	59
60	SS Sink w/ Drainboard	2009	1,130		7.33			1,130	60
61	Wall Cabinet	2009	2,345		7.33			2,345	61
62	Commercial Dryer Install	2009	1,181		7.17			1,181	62
63	Grant for Landscaping	2009	11,872		6.92			11,872	63
64	Zonline Heat/Cool Unit	2009	686		7			686	64
65									65
66	Repair, replace, and paint drywall in 37 resident rooms	2010	14,300		6.67			14,300	66
67	2: Zonline Heat/Cool Units	2010	1,283		5			1,283	67
68	Stroage Pad & Sidewalks	2010	4,800		6.59			4,800	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 203,861	\$		\$	\$	\$ 203,861	70

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

Facility Name & ID Number SSC Odin Operating Company LLC, dba Odin Healthcare Center # 0047365 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 203,861	\$		\$	\$	\$ 203,861	1
2	Front Entrance Sidewalk	2010	9,600		6.58			9,600	2
3	Employee Entrance Maglock	2010	2,071		6.58			2,071	3
4	Replace Awning	2010	1,000		6.58			1,000	4
5	Lights, Conf Room	2010	1,500		6.42			1,500	5
6	Replace Awning	2010	2,705		6.58			2,705	6
7	Refurb Dietary-flooring, ceilings, appliances, plumbing, elec	2010	108,405		7.17			108,405	7
8	Sprinklers Dietary	2010	1,421		7.25			1,421	8
9	Rooftop Unit Compressor	2010	1,527		6.33			1,527	9
10	3: Zonline Heat/Cool Units	2010	1,877		5			1,877	10
11	Rooftop Unit Compressor	2010	11,210		6.17			11,210	11
12	Satellite Dish	2010	8,148		6			8,148	12
13	Satellite Dish	2010	10,151		5.92			10,151	13
14									14
15	Roof Leak Repair	2011	13,500		5.92			13,500	15
16	Roof Lead Rpair	2011	3,541		6			3,541	16
17	Remote Annunciator Panel	2011	687		5.92			687	17
18	Wire Remote Annunciator Panel	2011	505		6.08			505	18
19	3: PTAC 12K BTU	2011	1,836		5			1,836	19
20	Panic Bars for Doors	2011	1,523	97	5.67	97		1,523	20
21	Replace Flooring due to Water Damage	2011	54,170		5.5			54,170	21
22	PTAC Walls - Replaced wood with stone	2011	3,980		5.42			3,980	22
23	3: Zonline Heat/Cool Units	2011	2,097		5			2,097	23
24									24
25	Kitchen Walls Rebuild	2012	20,490		5.25			20,490	25
26	Kitchen Walls Rebuild	2012	11,798		5			11,798	26
27	3: PTAC Units	2012	1,951		5			1,951	27
28									28
29	Norstar Phone System	2013	11,373		4			11,373	29
30	Roof Repairs	2013	5,250		3.5			5,250	30
31	Attic Roof Access Down Payment	2013	1,825		3.5			1,825	31
32	Attic Sprinklers Request 1	2013	36,600		35			36,600	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 534,602	\$ 97		\$ 97	\$	\$ 534,602	34

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

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 534,602	\$ 97		\$ 97	\$	\$ 534,602	1
2	Attic Roof Access Balance Due	2013	1,825		3.4			1,825	2
3	Attic Sprinklers Final	2013	1,000		3.4			1,000	3
4	Vinyl Fence	2013	2,055		3.4			2,055	4
5									5
6	Polycom Phones	2014	521		3			521	6
7	Concrete at A Wing - 50% Deposit	2014	3,250	271	12	271		970	7
8	Concrete at A Wing - Balance	2014	3,250	270	12	270		970	8
9	5: PTAC Units	2014	3,410	682	5	682		2,330	9
10	Kitchen Hood Exhaust Ductwork	2014	3,795	380	10	380		1,328	10
11	Concrete Pavement Repair and Restripe - Parking Lot	2014	8,679	744	11.67	744		2,417	11
12									12
13	Cabinets, Countertops and Hardware	2015	5,089	459	11.08	459		1,224	13
14	Evaporator Coil	2015	1,477	133	11.08	133		355	14
15	5: PTAC Resistance Heat	2015	3,410	682	5	682		1,705	15
16	Water HEater	2015	6,572	657	10	657		1,643	16
17	Htr Booster 6 Gal	2015	2,326	233	10	233		504	17
18									18
19	Replaced Shower in Resident Room - drywall and bathwrap	2016	3,750	338	11	338		902	19
20	Remove and replace vinyl flooring in nurses station and hallway	2016	16,780	1,678	10	1,678		2,797	20
21	with plank flooring. Also in main lobby and dining room	2016	16,780	1,678	10	1,678		2,797	21
22	NRPA 80 Fire Door Inspections	2016	5,428	538	10	538		897	22
23	Replaced 146 resident room doors and 10 fire rated doors	2016	56,975	5,697	10	5,697		9,021	23
24	PTAC Resistance Heater	2016	2,724	545	5	545		772	24
25									25
26	Cabinet - Nursing Station	2017	12,038	820	15	820		820	26
27	Replace Fire Rated Door	2017	28,488	1,442	19.75	1,442		1,442	27
28	Duro Last Roofing	2017	109,964	9,164	10	9,164		9,164	28
29	6: GE Zoneline PTAC 230V	2017	4,213	585	5	585		585	29
30	Nurses Station Countertop	2017	9,638	535	15	535		535	30
31	A.O. Smith 100 Gal Water Heather	2017	6,000	450	10	450		450	31
32	CMBS Parking Lot Overlay	2017	13,600	850	8	850		850	32
33	146: Fire Rated Doors Replacement	2017	28,487	498	19.08	498		498	33
34	TOTAL (lines 1 thru 33)		\$ 896,126	\$ 29,426		\$ 29,426	\$	\$ 584,979	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 347,180	\$ 21,451	\$ 21,451	\$		\$ 241,543	71
72	Current Year Purchases	34,612	4,419	4,419			4,419	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 381,792	\$ 25,870	\$ 25,870	\$		\$ 245,962	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	2016 Ford Van	2016	\$ 52,460	\$ 10,492	\$ 10,492	\$	5	\$ 19,235	76
77										77
78										78
79										79
80	TOTALS			\$ 52,460	\$ 10,492	\$ 10,492	\$		\$ 19,235	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)	\$ 1,330,378	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 65,788	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 65,788	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)	\$ 850,176	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 Equity 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>10/11/2013</u>	\$	<u>12</u>		<u>3</u>
4	Additions							<u>4</u>
5								<u>5</u>
6								<u>6</u>
7	TOTAL		99		\$			7

10. Effective dates of current rental agreement:

Beginning 06/02/2014

Ending 05/31/2026

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

Fiscal Year Ending Annual Rent

12.	<u>/2018</u>	\$ <u>1,180,651</u>
13.	<u>/2019</u>	\$ <u>1,180,651</u>
14.	<u>/2020</u>	\$ <u>1,180,651</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			\$	\$	<u>17</u>
18					<u>18</u>
19					<u>19</u>
20					<u>20</u>
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			
		1	2	3	4
		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
					Units	Cost					
1	Licensed Occupational Therapist	10a-03	9737	hrs	\$ 332,201		\$	9,737	\$ 332,201	1	
2	Licensed Speech and Language Development Therapist	10a-03	2720	hrs	121,542			2,720	121,542	2	
3	Licensed Recreational Therapist	10a-03		hrs						3	
4	Licensed Physical Therapist	10a-03	11251	hrs	398,697			11,251	398,697	4	
5	Physician Care			visits						5	
6	Dental Care			visits						6	
7	Work Related Program			hrs						7	
8	Habilitation			hrs						8	
9	Pharmacy	39		# of prescrpts			207,842		207,842	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				\$ 852,440		\$ 207,842	23,708	\$ 1,060,282	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 SSC Odin Operating Company LLC, dba Odin Healthcare (# 0047365) Report Period Beginning: 01/01/2017 Ending: 12/31/2017
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 550	\$	1
2	Cash-Patient Deposits	70,650		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,396,185		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	683		6
7	Other Prepaid Expenses	3,055		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,471,123	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,412		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	14,048,585		15
16	Equipment, at Historical Cost	381,793		16
17	Accumulated Depreciation (book methods)	(1,668,978)		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>Asset Clearing</u>	1,775		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,768,587	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,239,710	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 216,988	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	283,868		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	118,896		32
33	Accrued Interest Payable			33
34	Deferred Compensation	42,554		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accuals</u>	122,907		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 785,213	\$	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>CLO & Intercompany</u>	10,966,200		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,966,200	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,751,413	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,488,297	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,239,710	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,247,705	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,247,705	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(759,408)	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)	\$ (759,408)	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)	\$ 2,488,297	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number SSC Odin Operating Company LLC, dba Odin Hea # 0047365 Report Period Beginning: 01/01/2017Ending: 12/31/2017**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			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 25,644,673	1
2	Discounts and Allowances for all Levels	(20,635,687)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,008,986	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,173,187	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,173,187	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	(679)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	173,674	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 172,995	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 Vending</u>	1,821	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,821	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,356,989	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	872,849	31
32	Health Care	2,951,055	32
33	General Administration	1,957,841	33
B. Capital Expense			
34	Ownership	1,919,915	34
C. Ancillary Expense			
35	Special Cost Centers	241,296	35
36	Provider Participation Fee	173,441	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,116,397	40
41	Income before Income Taxes (line 30 minus line 40)**	(759,408)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (759,408)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,943,602	44
45	Private Pay - Net Inpatient Revenue	578,894	45
46	Medicare - Net Inpatient Revenue	1,432,855	46
47	Other-(specify) <u>HMO/Ins</u>	30,051	47
48	Other-(specify) <u>VA/Hospice/Charity</u>	23,584	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,008,986	49

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

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

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

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

Facility Name & ID Number SSC Odin Operating Company LLC, dba Odin Healthcare (# 0047365

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

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	1,797	1,973	\$ 76,888	\$ 38.97	1
2	Assistant Director of Nursing	16	24	292	12.17	2
3	Registered Nurses	10,618	11,317	310,610	27.45	3
4	Licensed Practical Nurses	21,981	23,565	490,994	20.84	4
5	CNAs & Orderlies	63,750	67,189	790,820	11.77	5
6	CNA Trainees					6
7	Licensed Therapist	21,749	23,713	853,467	35.99	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,281	2,329	29,371	12.61	9
10	Activity Assistants	537	570	6,148	10.79	10
11	Social Service Workers	3,895	4,279	58,964	13.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,893	2,076	42,283	20.37	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,837	2,077	90,491	43.57	20
21	Assistant Administrator					21
22	Other Administrative	5,414	5,851	145,025	24.79	22
23	Office Manager					23
24	Clerical	9	9	166	18.44	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	2,051	2,170	29,374	13.54	31
32	Other Health C: Medicare Coord	2,388	2,444	30,926	12.65	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	140,216	149,586	\$ 2,955,819 *	\$ 19.76	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	\$ 313,373	1-3	35
36	Medical Director	18,000	9-3	36
37	Medical Records Consultant	180	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	9,772	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	343	10a-3	42
43	Speech Therapy Consultant			43
44	Activity Consultant	2,594	11-3	44
45	Social Service Consultant	2,344	12-3	45
46	Other(specify)	13,779	10-3	46
47	Xray & Laboratory	29,329	39-3	47
48	Dentist/Physician/Psychiatrist		39-3	48
49	TOTAL (lines 35 - 48)	\$ 389,714		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	
Morgan Mulvany	Administrator	0	\$ 93,321	Workers' Compensation Insurance	\$ 140,683	IDPH License Fee	\$	
		0		Unemployment Compensation Insurance	22,731	Advertising: Employee Recruitment	10,074	
				FICA Taxes	216,702	Health Care Worker Background Check	8,029	
				Employee Health Insurance	76,568	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Publications and Manuals	1,111	
				Employee Life Insurance	2,167	Dues	8,403	
				Other Benefits	11,519	Other Licenses	2,883	
				Home Office Payroll Taxes	35,510	Fees, Subscriptions and Promos	647	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,321	TOTAL (agree to Schedule V, line 22, col.8)		\$ 505,880	TOTAL (agree to Sch. V, line 20, col. 8)	
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	\$ 6,869
							In-State Travel	12,756
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense	6,242
C. Professional Services							Home Office Allocation	
Vendor/Payee	Type		Amount				24,327	
Cass Information Systems			\$ 868				Entertainment Expense ()	
Compsych	Employee Asst Program		901				(agree to Sch. V, line 24, col. 8)	
Barbara Metzdorff	Legal		1,700				\$ 50,194	
Engie Insight	Utility Management		119					
Equifax	Background		537					
Experian	Background/Property Search		313					
Healthlink			821					
Illinois State Police	Background		580					
LexisNexis			130					
NRC Health	Survey Program		568					
ProbateFinder/ProTitle	Property Search		1,050					
			332					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 7,919					

* Attach copy of IMRF notifications

**See instructions.

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 \$7,284
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,654 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 173,441
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. \$ _____ 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? Yes
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 0
 - d. Have vehicle usage logs been maintained? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BDO Seidman LLC (Corporate Level)
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. NA
Attach invoices and a summary of services for all architect and appraisal fees