FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047365

Facility Name: Odin Health Care Center

Address: 300 Green Street (Number) Odin (City) 62870 (Zip Code)

County: Marion

Telephone Number: 618-775-6444 **Fax #** 618-775-6964

HFS ID Number:

Date of Initial License for Current Owners: 10/06/2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Martha McDaniel **Telephone Number:** 832-467-6317
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Chris Stenger
(Title) Vice President of Planning and Reimbursement

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,255	5,208	7,657	32,120	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,255	5,208	7,657	32,120	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.89%

D. How many bed-hold days during this year were paid by the Department?
28 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 01/01/2005

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 7,019

Medicare Intermediary Trailblazer

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	169,835	10,372	13,783	193,990		193,990		193,990			1
2	Food Purchase		155,524		155,524		155,524	(125)	155,399			2
3	Housekeeping	126,798	11,067	4,578	142,443		142,443		142,443			3
4	Laundry	49,059	8,588		57,647		57,647		57,647			4
5	Heat and Other Utilities			124,734	124,734		124,734	(6,430)	118,304			5
6	Maintenance	30,206	71,774	8,283	110,263		110,263	11,992	122,255			6
7	Other (specify):*			7,660	7,660		7,660		7,660			7
8	**TOTAL General Services**	375,898	257,325	159,038	792,261		792,261	5,437	797,698			8
	B. Health Care and Programs											
9	Medical Director			12,772	12,772		12,772		12,772			9
10	Nursing and Medical Records	1,509,020	117,825	14,711	1,641,556		1,641,556		1,641,556			10
10a	Therapy	703,596	68,771	240	772,607		772,607		772,607			10a
11	Activities	29,401	6,670	3,693	39,764		39,764		39,764			11
12	Social Services	43,674	115	2,314	46,103		46,103		46,103			12
13	CNA Training											13
14	Program Transportation	15,486	4,595	4,720	24,801		24,801		24,801			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,301,177	197,976	38,450	2,537,603		2,537,603		2,537,603			16
	C. General Administration											
17	Administrative	97,581			97,581		97,581		97,581			17
18	Directors Fees			500	500		500		500			18
19	Professional Services			6,143	6,143		6,143	(3,724)	2,419			19
20	Dues, Fees, Subscriptions & Promotions			27,730	27,730		27,730	1,984	29,714			20
21	Clerical & General Office Expenses	189,341	17,223	357,538	564,102		564,102	(121,871)	442,231			21
22	Employee Benefits & Payroll Taxes			576,503	576,503		576,503	14,434	590,937			22
23	Inservice Training & Education											23
24	Travel and Seminar			21,218	21,218		21,218	53,114	74,332			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			74,675	74,675		74,675	136,672	211,347			26
27	Other (specify):*											27
28	**TOTAL General Administration**	286,922	17,223	1,064,307	1,368,452		1,368,452	80,609	1,449,061			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,963,997	472,524	1,261,795	4,698,316		4,698,316	86,046	4,784,362			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Odin Health Care Center #0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			73,813	73,813		73,813	(6,976)	66,837			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(1,961)	(1,961)		(1,961)	10,412	8,451			32
33	Real Estate Taxes			53,648	53,648		53,648	(57,446)	(3,798)			33
34	Rent-Facility & Grounds			725,851	725,851		725,851		725,851			34
35	Rent-Equipment & Vehicles			123	123		123	13,730	13,853			35
36	Other (specify):*							15,772	15,772			36
37	**TOTAL Ownership**			851,474	851,474		851,474	(24,508)	826,966			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		237,246	25,617	262,863		262,863	12,350	275,213			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,202	54,202		54,202		54,202			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		237,246	79,819	317,065		317,065	12,350	329,415			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,963,997	709,770	2,193,088	5,866,855		5,866,855	73,888	5,940,743			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: 01/01/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,430)	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	(6,976)	30		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	(125)	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	(32)	24		19
20	Contributions	(250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,724)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,266)	21		24
25	Fund Raising, Advertising and Promotional	(38,293)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (80,096)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	416,557		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 416,557		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 336,461		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Odin Health Care Center

ID# 0047365

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Back Office Services	$ (331,307)	21	1
2	Professional Liability	126,395	26	2
3	Real Estate Tax - Accrual Adj	(57,660)	33	3
4				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**	(262,572)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odin Health Care Center **#** 0047365 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(125)	0	0	0	0	0	0	0	0	0	0	(125)	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	(6,430)	0	0	0	0	0	0	0	0	0	0	(6,430)	5
6	Maintenance	0	11,992	0	0	0	0	0	0	0	0	0	11,992	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,555)	11,992	0	0	0	0	0	0	0	0	0	5,437	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	(3,724)	0	0	0	0	0	0	0	0	0	0	(3,724)	19
20	Fees, Subscriptions & Promotions	0	1,984	0	0	0	0	0	0	0	0	0	1,984	20
21	Clerical & General Office Expenses	(394,116)	272,245	0	0	0	0	0	0	0	0	0	(121,871)	21
22	Employee Benefits & Payroll Taxes	0	14,434	0	0	0	0	0	0	0	0	0	14,434	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(32)	53,146	0	0	0	0	0	0	0	0	0	53,114	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	126,395	10,277	0	0	0	0	0	0	0	0	0	136,672	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(271,477)	352,086	0	0	0	0	0	0	0	0	0	80,609	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(278,032)	364,078	0	0	0	0	0	0	0	0	0	86,046	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Odin Health Care Center # 0047365 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,976)	0	0	0	0	0	0	0	0	0	0	(6,976)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	10,412	0	0	0	0	0	0	0	0	0	10,412	32
33	Real Estate Taxes	(57,660)	214	0	0	0	0	0	0	0	0	0	(57,446)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	13,730	0	0	0	0	0	0	0	0	0	13,730	35
36	Other (specify):*	0	15,772	0	0	0	0	0	0	0	0	0	15,772	36
37	TOTAL Ownership	(64,636)	40,128	0	0	0	0	0	0	0	0	0	(24,508)	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	12,350	0	0	0	0	0	0	0	0	0	12,350	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	12,350	0	0	0	0	0	0	0	0	0	12,350	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(342,668)	416,556	0	0	0	0	0	0	0	0	0	73,888	45

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SSC Equity Holdings, LLC	100	Montebello Health Care Center	Hamilton			
		Nature Trail Health Care Center	Mount Vernon			
		Odin Health Care Center	Odin			
		Westchester Health and Rehab Center	Westchester			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	SSC Equity Holdings, LLC	100.00%	$	$	1
2	V	6	Repair and Maintenance		SSC Equity Holdings, LLC	100.00%	11,992	11,992	2
3	V	39	Professional Services		SSC Equity Holdings, LLC	100.00%	12,350	12,350	3
4	V	20	Fee, Subscriptions & Promos		SSC Equity Holdings, LLC	100.00%	1,984	1,984	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%	272,245	272,245	6
7	V	24	Travel & Seminar		SSC Equity Holdings, LLC	100.00%	53,146	53,146	7
8	V	26	Insurance		SSC Equity Holdings, LLC	100.00%	10,277	10,277	8
9	V	36	Depreciation		SSC Equity Holdings, LLC	100.00%	15,772	15,772	9
10	V	33	Taxes - Property		SSC Equity Holdings, LLC	100.00%	214	214	10
11	V	35	Rental and Lease		SSC Equity Holdings, LLC	100.00%	13,730	13,730	11
12	V	32	Interest Income/Expense		SSC Equity Holdings, LLC	100.00%	10,412	10,412	12
13	V	22	Payroll Taxes		SSC Equity Holdings, LLC	100.00%	14,434	14,434	13
14	Total			$			$ 416,556	$ * 416,556	14

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 01/01/2010 Ending: 2/31/2010

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										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	TOTALS					$	$		$	25

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Odin Health Care Center **#** 0047365 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	112,442	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.)	$	54,322	2
3. Under or (over) accrual (line 2 minus line 1).	$	(58,120)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	54,322	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.	$	(3,798)	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	149,498	8
	2006	137,090	9
	2007	53,043	10
	2008	55,046	11
	2009	54,322	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$		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.

2009 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 832-467-6317 FAX #: 832-467-6983

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-11-400-001	4 Acres: PT SE SE - 300 Green St	$ 54,322.12	$ 54,322.12
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,322.12	$ 54,322.12

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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: Zoneline Heat/Cool Units			2005	1,119	131	5	131		1,119	9
10	Use Tax - 2: Zoneline Heat/Cool Units			2005	70	8	5	8		70	10
11	Fascia Board Repair			2005	3,520	302	11.66	302		1,634	11
12	Vents for Isolation Rooms, Handicap Tubs/Sinks & Whirlpoo			2005	37,013	3,219	11.5	3,219		16,897	12
13	Sewer Line Reapirs - Add Pipe			2005	1,620	141	11.5	141		739	13
14	Main Sewer Line Repair			2005	534	46	11.5	46		244	14
15	Inspect Main Trunk Line			2005	316	27	11.5	27		144	15
16	4: Smoke Detectors			2005	641	64	10	64		337	16
17	10 Ton Condenser - A/C Unit			2005	1,402	122	11.5	122		640	17
18	Ruud Air Handler - Installation			2005	1,622	141	11.5	141		740	18
19	Installation Valve, Hand Wash Sink			2005	1,306	114	11.5	114		596	19
20	Use Tax - Zoneline Heat/Cool Unit			2005	35	6	5	6		35	20
21	Zoneline Heat/Cool Unit			2005	566	104	5	104		566	21
22	Water Heater			2005	6,350	635	10	635		3,228	22
23											23
24	Zoneline Heat/Cool Unit			2006	508	102	5	102		474	24
25	Use Tax - Zoneline Heat/Cool Unit			2006	31	6	5	6		29	25
26	A/C in Dietary			2006	3,465	693	5	693		3,234	26
27	Wallpaper and Handrails			2006	5,632	1,126	5	1,126		5,163	27
28	Handrails			2006	4,442	423	10.5	423		1,974	28
29	Paging/Music Broadcast System			2006	1,438	144	10	144		659	29
30	Wallpaper and Handrails			2006	5,632	1,126	5	1,126		4,881	30
31	2: Thru Wall Heat/Cool Units			2006	1,120	224	5	224		952	31
32	Use Tax - 2 Thru Wall Heat/Cool Units			2006	71	14	5	14		60	32
33											33
34	Paint and Wallpaper			2007	463	47	9.83	47		188	34
35	Use Tax - paint and Wallpaper			2007	30	3	9.83	3		12	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Wallpaper	2007	$ 1,679	$ 336	5	$ 336	$	$ 1,371	37
38	Interior Renovation - Floors, Walls	2007	7,454	771	9.66	771		2,956	38
39	Flooring	2007	6,540	671	9.75	671		2,627	39
40	Paint and Wallpaper	2007	326	65	5	65		255	40
41	Paint and Wallpaper	2007	21	4	5	4		17	41
42	Interior Renovation - Floors, Walls	2007	3,140	322	9.75	322		1,262	42
43	Zoneline Heat/Cool	2007	1,179	127	9.25	127		435	43
44	7.5 Ton A/C Unit	2007	6,860	742	9.25	742		2,534	44
45	40: Cubicle Curtains	2007	2,308	462	5	462		1,539	45
46	10: Cubicle Curtains	2007	565	113	5	113		386	46
47	Replace RTU Compressor	2007	1,140	124	9.17	124		415	47
48									48
49	Nurse Call Station	2008	20,592	2,331	8.83	2,331		6,994	49
50	Generator Relay Switches	2008	3,567	408	8.75	408		1,189	50
51	Steel Door with Tempered Glass	2008	1,025	123	8.33	123		307	51
52	Install New Door and Frame	2008	560	67	8.42	67		172	52
53	Vinyl Fence and Gates	2008	10,697	1,337	8	1,337		2,897	53
54	7.5 Ton Gas/Elec Rooftop Unit	2008	5,850	739	7.92	739		1,539	54
55									55
56	Grant for Landscape	2009	4,923	609	8.08	609		1,370	56
57	Grant for Landscape	2009	738	91	8.08	91		205	57
58	12 X 24 Lofted Barn	2009	4,804	607	7.92	607		1,264	58
59	Irrigation System	2009	3,350	419	8	419		907	59
60	SS Sink w/ Drainboard	2009	1,130	154	7.33	154		231	60
61	Wall Cabinet	2009	2,345	320	7.33	320		480	61
62	Commercial Dryer Install	2009	1,181	165	7.17	165		220	62
63	Grant for Landscaping	2009	11,872	1,716	6.92	1,716		1,860	63
64	Zoneline Heat/Cool Unit	2009	686	110	7	110		121	64
65									65
66	37 Resident Room Refub	2010	14,300	1,788	6.67	1,788		1,788	66
67	2: Zonline Heat/Cool Units	2010	1,283	235	5	235		235	67
68	Stroage Pad & Sidewalks	2010	4,800	547	6.59	547		547	68
69									69
70	TOTAL (lines 4 thru 69)		$ 203,859	$ 24,471		$ 24,471	$	$ 80,738	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 203,859	$ 24,471		$ 24,471	$	$ 80,738	1
2	Front Entrance Sidewalk	2010	9,600	1,094	6.58	1,094		1,094	2
3	Employee Entrance Maglock	2010	2,071	236	6.58	236		236	3
4	Replace Awning	2010	1,000	114	6.58	114		114	4
5	Lights, Conf Room	2010	1,500	136	6.42	136		136	5
6	Replace Awning	2010	2,705	308	6.58	308		308	6
7	Dietary Renovation	2010	108,405	20,168	7.17	20,168		20,168	7
8	Sprinklers Dietary	2010	1,421	278	7.25	278		278	8
9	Rooftop Unit Compressor	2010	1,527	121	6.33	121		121	9
10	3: Zoneline Heat/Cool Units	2010	1,877	156	5	156		156	10
11	Rooftop Unit Compressor	2010	11,210	606	6.17	606		606	11
12	Satellite Dish	2010	8,148	226	6	226		226	12
13	Satellite Dish	2010	10,151	143	5.92	143		143	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	TOTAL (lines 1 thru 33)		$ 363,474	$ 48,057		$ 48,057	$	$ 104,324	34

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 115,608	$ 15,177	$ 15,177	$		$ 44,579	71
72	Current Year Purchases	35,912	3,603	3,603			3,603	72
73	Fully Depreciated Assets							73
74	Current Year Retirements	(2,717)						74
75	TOTALS	$ 148,803	$ 18,780	$ 18,780	$		$ 48,182	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)	$ 512,277	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 66,837	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 66,837	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)	$ 152,506	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SMV Property Holdings, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ 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:	1975	99	01/01/2005	$ 725,851	12		3
4	Additions							4
5								5
6								6
7	TOTAL		99		$ 725,851 **			7

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

9. Option to Buy: ☐ YES ☒ NO Terms: *

10. Effective dates of current rental agreement:
Beginning 01/01/2005
Ending 12/31/2016

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

	Fiscal Year Ending	Annual Rent
12.	12/2011	$ 725,851
13.	12/2012	$ 725,851
14.	12/2013	$ 725,851

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Odin Health Care Center | STATE OF ILLINOIS # 0047365 | Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	8499	hrs	$ 290,718		$	$	8,499	$ 290,718	1
2	Licensed Speech and Language Development Therapist	10a-3	2076	hrs	83,416				2,076	83,416	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a-3	9757	hrs	327,235				9,757	327,235	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				237,246		237,246	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				$ 701,369		$	$ 237,246	20,332	$ 938,615	14

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

STATE OF ILLINOIS

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	91,382		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	510,236		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,575		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 603,743	$	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	363,474		15
16	Equipment, at Historical Cost	148,803		16
17	Accumulated Depreciation (book methods)	(152,507)		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):	41,443		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 437,978	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,041,721	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 99,285	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	307,234		30
31	Accrued Taxes Payable (excluding real estate taxes)	36,376		31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,322		32
33	Accrued Interest Payable			33
34	Deferred Compensation	46,195		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accruals	2,043		36
37	Rounding	(1)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 545,454	$	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	Intercompany Revolver	(2,125,366)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (2,125,366)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (1,579,912)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,621,633	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,041,721	$	48

***(See instructions.)**

Facility Name & ID Number Odin Health Care Center # 0047365 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,859,127	1
2	Restatements (describe):	(20,547)	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,838,580	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	783,053	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)**	$ 783,053	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)**	$ 2,621,633	24 *

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,483,615	1
2	Discounts and Allowances for all Levels	(1,807,293)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,676,322	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,446,431	6
7	Oxygen	12,641	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,459,072	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	1,184	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	434,848	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,182	19
20	Radiology and X-Ray	22,801	20
21	Other Medical Services	25,406	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 514,421	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Receipts	93	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 93	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,649,908	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	792,261	31
32	Health Care	2,537,603	32
33	General Administration	1,368,452	33
	B. Capital Expense		
34	Ownership	851,474	34
	C. Ancillary Expense		
35	Special Cost Centers	262,863	35
36	Provider Participation Fee	54,202	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,866,855	40
41	**Income before Income Taxes (line 30 minus line 40)****	783,053	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 783,053	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.**

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,124	2,327	$ 63,176	$ 27.15	1
2	Assistant Director of Nursing	1,623	2,010	46,148	22.96	2
3	Registered Nurses	10,327	11,683	261,403	22.37	3
4	Licensed Practical Nurses	21,854	24,181	426,791	17.65	4
5	CNAs & Orderlies	66,131	71,906	685,738	9.54	5
6	CNA Trainees					6
7	Licensed Therapist	18,291	20,524	703,596	34.28	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,999	2,087	21,962	10.52	9
10	Activity Assistants	759	774	7,439	9.61	10
11	Social Service Workers	3,063	3,377	43,674	12.93	11
12	Dietician					12
13	Food Service Supervisor	1,839	2,067	29,927	14.48	13
14	Head Cook	6,248	6,792	59,730	8.79	14
15	Cook Helpers/Assistants	8,235	9,091	80,178	8.82	15
16	Dishwashers					16
17	Maintenance Workers	1,893	2,089	30,206	14.46	17
18	Housekeepers	12,074	13,527	126,798	9.37	18
19	Laundry	5,296	5,685	49,059	8.63	19
20	Administrator	1,839	2,087	97,423	46.68	20
21	Assistant Administrator					21
22	Other Administrative	5,594	6,185	142,269	23.00	22
23	Office Manager					23
24	Clerical	3,208	3,621	47,230	13.04	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	1,881	2,124	25,764	12.13	31
32	Other Health Care(specify)	1,431	1,544	15,486	10.03	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	175,709	193,681	$ 2,963,997 *	$ 15.30	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 12,543	1-3	35
36	Medical Director		12,405	9-3	36
37	Medical Records Consultant			10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,050	10-3	39
40	Physical Therapy Consultant			10a-3	40
41	Occupational Therapy Consultant			10a-3	41
42	Respiratory Therapy Consultant		240	10a-3	42
43	Speech Therapy Consultant			10a-3	43
44	Activity Consultant		2,400	11-3	44
45	Social Service Consultant		2,314	12-3	45
46	Other(specify) Administrative		13,152	10-3	46
47	X/Ray & Laboratory		22,560	39-3	47
48	Dentist/Physician/Psychiatrist		111	39-3	48
49	TOTAL (lines 35 - 48)		$ 71,775		49

C. CONTRACT NURSES

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary A Smith	Administrator	0	$ 97,423
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,423

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sevarus Corp	Survey Tracking	$ 1,461
Old Seville Waste Consulting	Bio Waste Exp Reduction	728
Illinois State Police	Patient Background Cks	230
Legal	Legal	3,724
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 6,143

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 119,286
Unemployment Compensation Insurance	27,535
FICA Taxes	210,586
Employee Health Insurance	204,599
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	2,838
Other Emoloyee Benefits	11,659
TOTAL (agree to Schedule V, line 22, col.8)	$ 576,503

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,324
Health Care Worker Background Check	3,259
(Indicate # of checks performed)	
Patient Background Checks	
Non Allowable Advertising	7,622
Dues	5,140
Other Licenses	1,523
Publications/Subscriptions	2,860
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	2
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,730

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	16,344
Entertainment	32
Seminar Expense	4,842
Home Office Allocation	53,146
Entertainment Expense	(32)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 74,332

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Odin Health Care Center **#** 0047365 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 Assn $5,105**

(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. $ **25,492** 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. $ **54,202**
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? **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?
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. $

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

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

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