FOR BHF USE

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: SSC Odin Operating Company LLC dba 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 01/01/2011 to 12/31/2011 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) 04/25/2012 (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 SSC Odin Operating Company LLC dba Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	18,592	4,035	8,123	30,750	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,592	4,035	8,123	30,750	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.10%

D. How many bed-hold days during this year were paid by the Department?
1 (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 _____ and days of care provided _____

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: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number SSC Odin Operating Company LLC dba Odi # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	173,973	10,840	13,126	197,939		197,939		197,939			1
2	Food Purchase		167,996		167,996		167,996	(109)	167,887			2
3	Housekeeping	120,881	11,577	5,231	137,689		137,689		137,689			3
4	Laundry	46,353	10,434		56,787		56,787		56,787			4
5	Heat and Other Utilities			129,897	129,897		129,897	(8,849)	121,048			5
6	Maintenance	30,690	73,405	12,480	116,575		116,575	14,395	130,970			6
7	Other (specify):*			5,887	5,887		5,887		5,887			7
8	**TOTAL General Services**	371,897	274,252	166,621	812,770		812,770	5,437	818,207			8
	B. Health Care and Programs											
9	Medical Director			12,104	12,104		12,104		12,104			9
10	Nursing and Medical Records	1,482,574	98,251	13,033	1,593,858		1,593,858		1,593,858			10
10a	Therapy	776,418	78,957		855,375		855,375		855,375			10a
11	Activities	27,518	4,959	3,654	36,131		36,131		36,131			11
12	Social Services	48,036		2,375	50,411		50,411		50,411			12
13	CNA Training											13
14	Program Transportation	14,411	4,436	4,400	23,247		23,247		23,247			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,348,957	186,603	35,566	2,571,126		2,571,126		2,571,126			16
	C. General Administration											
17	Administrative	99,307			99,307		99,307		99,307			17
18	Directors Fees			500	500		500		500			18
19	Professional Services			598,404	598,404		598,404	(1,585)	596,819			19
20	Dues, Fees, Subscriptions & Promotions			31,335	31,335		31,335	(7,373)	23,962			20
21	Clerical & General Office Expenses	170,398	16,677	341,845	528,920		528,920	(77,887)	451,033			21
22	Employee Benefits & Payroll Taxes			577,809	577,809		577,809	16,458	594,267			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,255	14,255		14,255	54,257	68,512			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			90,995	90,995		90,995	(495,481)	(404,486)			26
27	Other (specify):*											27
28	**TOTAL General Administration**	269,705	16,677	1,655,143	1,941,525		1,941,525	(511,611)	1,429,914			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,990,559	477,532	1,857,330	5,325,421		5,325,421	(506,174)	4,819,247			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 SSC Odin Operating Company LLC dba Odin Health Care (#0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			79,213	79,213		79,213		79,213			30
31	Amortization of Pre-Op. & Org.			7,004	7,004		7,004		7,004			31
32	Interest			(4,406)	(4,406)		(4,406)	10	(4,396)			32
33	Real Estate Taxes			181,134	181,134		181,134	47,426	228,560			33
34	Rent-Facility & Grounds			725,851	725,851		725,851		725,851			34
35	Rent-Equipment & Vehicles			865	865		865	13,082	13,947			35
36	Other (specify):*							17,606	17,606			36
37	**TOTAL Ownership**			989,661	989,661		989,661	78,124	1,067,785			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		192,168	38,776	230,944		230,944	16,752	247,696			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		192,168	92,979	285,147		285,147	16,752	301,899			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,990,559	669,700	2,939,970	6,600,229		6,600,229	(411,298)	6,188,931			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 SSC Odin Operating Company LLC dba Odin Health Ca # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(325)			4
5	Telephone, TV & Radio in Resident Rooms	(8,849)	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	(109)	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	(13)	24		19
20	Contributions	(300)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,585)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,059)	21		24
25	Fund Raising, Advertising and Promotional	(8,686)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(8,403)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (57,329)		$	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)	436,017		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 436,017		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 378,688		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	x		(78)	10	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ (78)		47

STATE OF ILLINOIS

SSC Odin Operating Company LLC dba Odin Health Care Center

ID# 0047365

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Back Office Services	$ (334,106)	21	1
2	Professional Liability	(503,474)	26	2
3	Real Estate Taxes - Accrual Adj	47,269	33	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(790,311)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SSC Odin Operating Company LLC dba Odin Health Care (# 0047365 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(109)	0	0	0	0	0	0	0	0	0	0	(109)	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	(8,849)	0	0	0	0	0	0	0	0	0	0	(8,849)	5
6	Maintenance	0	14,395	0	0	0	0	0	0	0	0	0	14,395	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,958)	14,395	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	(1,585)	0	0	0	0	0	0	0	0	0	0	(1,585)	19
20	Fees, Subscriptions & Promotions	(8,403)	1,030	0	0	0	0	0	0	0	0	0	(7,373)	20
21	Clerical & General Office Expenses	(372,151)	294,264	0	0	0	0	0	0	0	0	0	(77,887)	21
22	Employee Benefits & Payroll Taxes	0	16,458	0	0	0	0	0	0	0	0	0	16,458	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(13)	54,270	0	0	0	0	0	0	0	0	0	54,257	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(503,474)	7,993	0	0	0	0	0	0	0	0	0	(495,481)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(885,626)	374,015	0	0	0	0	0	0	0	0	0	(511,611)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(894,584)	388,410	0	0	0	0	0	0	0	0	0	(506,174)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SSC Odin Operating Company LLC dba Odin Health Care # 0047365 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	10	0	0	0	0	0	0	0	0	0	10	32
33	Real Estate Taxes	47,269	157	0	0	0	0	0	0	0	0	0	47,426	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	13,082	0	0	0	0	0	0	0	0	0	13,082	35
36	Other (specify):*	0	17,606	0	0	0	0	0	0	0	0	0	17,606	36
37	**TOTAL Ownership**	47,269	30,855	0	0	0	0	0	0	0	0	0	78,124	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	16,752	0	0	0	0	0	0	0	0	0	16,752	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	16,752	0	0	0	0	0	0	0	0	0	16,752	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(847,315)	436,017	0	0	0	0	0	0	0	0	0	(411,298)	45

Facility Name & ID Number SSC Odin Operating Company LLC dba Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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
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. [X] 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	Utiliites	$	SSC Equity Holdings LLC	100.00%	$	$	1
2	V	6	Repair and Maintenance		SSC Equity Holdings LLC	100.00%	14,395	14,395	2
3	V	39	Professional Services		SSC Equity Holdings LLC	100.00%	16,752	16,752	3
4	V	20	Fee, Subscriptons and Promos		SSC Equity Holdings LLC	100.00%	1,030	1,030	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%	294,264	294,264	6
7	V	24	Travel & Seminar		SSC Equity Holdings LLC	100.00%	54,270	54,270	7
8	V	26	Insurance		SSC Equity Holdings LLC	100.00%	7,993	7,993	8
9	V	36	Depreciation		SSC Equity Holdings LLC	100.00%	17,606	17,606	9
10	V	33	Taxes - Property		SSC Equity Holdings LLC	100.00%	157	157	10
11	V	35	Rental and Lease		SSC Equity Holdings LLC	100.00%	13,082	13,082	11
12	V	32	Interest Income/Expense		SSC Equity Holdings LLC	100.00%	10	10	12
13	V	22	Payroll Taxes		SSC Equity Holdings LLC	100.00%	16,458	16,458	13
14	Total			$			$ 436,017	$ * 436,017	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 Health Care Center # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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27								27
28								28
29								29
30								30

Facility Name & ID Number SSC Odin Operating Company LLC dba Od # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 SSC Odin Operating Company LLC dba Odin Health Care # 0047365 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 6983

	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	5	Utilities				$	$		$	1
2	6	Repair & Maintenance							14,395	2
3	39	Professional Services							16,752	3
4	20	Fee, Subscriptions & Promos							1,030	4
5	10	Nursing & Medical Records								5
6	21	Clerical & Gen Office Exp							294,264	6
7	24	Travel & Seminar							54,270	7
8	26	Insurance							7,993	8
9	36	Depreciation							17,606	9
10	33	Taxes - Property							157	10
11	35	Rental & Lease							13,082	11
12	32	Interest Income/Expense							10	12
13	22	Payroll Taxes							16,458	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					$	$		$ 436,017	25

Facility Name & ID Number SSC Odin Operating Company LLC dba Odi # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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**		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							$	$			$	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 SSC Odin Operating Company LLC dba Odin Health Care Center # 0047365 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 54,322	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.)		$ 117,603	2
3. Under or (over) accrual (line 2 minus line 1).		$ 63,281	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 165,122	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.		$ 228,403	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	137,090	8
	2007	53,043	9
	2008	55,046	10
	2009	54,322	11
	2010	117,603	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SSC Odin Operating Company LLC dba Odin Health Care Ce 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 2010 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 2010.

	(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 -	$ 117,602.88	$ 117,602.88
2.		300 Green St	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 117,602.88	$ 117,602.88

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 SSC Odin Operating Company LLC dba Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [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).

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number SSC Odin Operating Company LLC dba Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		5			1,119	9
10	Use Tax - 2: Zoneline Heat/Cool Units			2005	70		5			70	10
11	Fascia Board Repair			2005	3,520	302	11.66	302		1,936	11
12	Vents for Isolation Rooms, Handicap Tubs/Sinks & Whirlpoo			2005	37,013	3,219	11.5	3,219		20,116	12
13	Sewer Line Reapirs - Add Pipe			2005	1,620	141	11.5	141		880	13
14	Main Sewer Line Repair			2005	534	46	11.5	46		290	14
15	Inspect Main Trunk Line			2005	316	27	11.5	27		172	15
16	4: Smoke Detectors			2005	641	64	10	64		401	16
17	10 Ton Condenser - A/C Unit			2005	1,402	122	11.5	122		762	17
18	Ruud Air Handler - Installation			2005	1,622	141	11.5	141		882	18
19	Installation Valve, Hand Wash Sink			2005	1,306	114	11.5	114		710	19
20	Use Tax - Zoneline Heat/Cool Unit			2005	35		5			35	20
21	Zoneline Heat/Cool Unit			2005	566		5			566	21
22	Water Heater			2005	6,350	635	10	635		3,863	22
23											23
24	Zoneline Heat/Cool Unit			2006	508	34	5	34		508	24
25	Use Tax - Zoneline Heat/Cool Unit			2006	31	2	5	2		31	25
26	A/C in Dietary			2006	3,465	231	5	231		3,465	26
27	Wallpaper and Handrails			2006	5,632	469	5	469		5,632	27
28	Handrails			2006	4,442	423	10.5	423		2,397	28
29	Paging/Music Broadcast System			2006	1,438	144	10	144		803	29
30	Wallpaper and Handrails			2006	5,632	751	5	751		5,632	30
31	2: Thru Wall Heat/Cool Units			2006	1,120	168	5	168		1,120	31
32	Use Tax - 2 Thru Wall Heat/Cool Units			2006	71	11	5	11		71	32
33											33
34	Paint and Wallpaper			2007	463	47	9.83	47		235	34
35	Use Tax - paint and Wallpaper			2007	30	3	9.83	3		15	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 SSC Odin Operating Company LLC dba Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 308	5	$ 308	$	$ 1,679	37
38	Interior Renovation - Floors, Walls	2007	7,454	771	9.66	771		3,727	38
39	Flooring	2007	6,540	671	9.75	671		3,298	39
40	Paint and Wallpaper	2007	326	65	5	65		320	40
41	Paint and Wallpaper	2007	21	4	5	4		21	41
42	Interior Renovation - Floors, Walls	2007	3,140	322	9.75	322		1,584	42
43	Zoneline Heat/Cool	2007	1,179	127	9.25	127		563	43
44	7.5 Ton A/C Unit	2007	6,860	742	9.25	742		3,275	44
45	40: Cubicle Curtains	2007	2,308	462	5	462		2,000	45
46	10: Cubicle Curtains	2007	565	113	5	113		499	46
47	Replace RTU Compressor	2007	1,140	124	9.17	124		539	47
48									48
49	Nurse Call Station	2008	20,592	2,331	8.83	2,331		9,325	49
50	Generator Relay Switches	2008	3,567	408	8.75	408		1,596	50
51	Steel Door with Tempered Glass	2008	1,025	123	8.33	123		430	51
52	Install New Door and Frame	2008	560	67	8.42	67		238	52
53	Vinyl Fence and Gates	2008	10,697	1,337	8	1,337		4,234	53
54	7.5 Ton Gas/Elec Rooftop Unit	2008	5,850	739	7.92	739		2,278	54
55									55
56	Grant for Landscape	2009	4,923	609	8.08	609		1,979	56
57	Grant for Landscape	2009	738	91	8.08	91		297	57
58	12 X 24 Lofted Barn	2009	4,804	607	7.92	607		1,871	58
59	Irrigation System	2009	3,350	419	8	419		1,326	59
60	SS Sink w/ Drainboard	2009	1,130	154	7.33	154		385	60
61	Wall Cabinet	2009	2,345	320	7.33	320		799	61
62	Commercial Dryer Install	2009	1,181	165	7.17	165		384	62
63	Grant for Landscaping	2009	11,872	1,716	6.92	1,716		3,576	63
64	Zoneline Heat/Cool Unit	2009	686	97	7	97		218	64
65									65
66	Repair, replace, and paint drywall in 37 resident rooms	2010	14,300	2,145	6.67	2,145		3,933	66
67	2: Zonline Heat/Cool Units	2010	1,283	257	5	257		492	67
68	Stroage Pad & Sidewalks	2010	4,800	729	6.59	729		1,276	68
69									69
70	TOTAL (lines 4 thru 69)		$ 203,859	$ 23,117		$ 23,117	$	$ 103,853	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 Health Care Center # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 23,117		$ 23,117	$	$ 103,853	1
2	Front Entrance Sidewalk	2010	9,600	1,458	6.58	1,458		2,552	2
3	Employee Entrance Maglock	2010	2,071	315	6.58	315		551	3
4	Replace Awning	2010	1,000	152	6.58	152		266	4
5	Lights, Conf Room	2010	1,500	234	6.42	234		370	5
6	Replace Awning	2010	2,705	411	6.58	411		719	6
7	Refurb Dietary-flooring, ceilings, appliances, plumbing, elec	2010	108,405	15,126	7.17	15,126		35,295	7
8	Sprinklers Dietary	2010	1,421	196	7.25	196		474	8
9	Rooftop Unit Compressor	2010	1,527	241	6.33	241		362	9
10	3: Zoneline Heat/Cool Units	2010	1,877	375	5	375		532	10
11	Rooftop Unit Compressor	2010	11,210	1,818	6.17	1,818		2,424	11
12	Satellite Dish	2010	8,148	1,358	6	1,358		1,584	12
13	Satellite Dish	2010	10,151	1,715	5.92	1,715		1,859	13
14									14
15	Roof Leak Repair	2011	13,500	2,472	5.92	2,472		2,472	15
16	Roof Lead Rpair	2011	3,541	688	6	688		688	16
17	Remote Annunciator Panel	2011	687	126	5.92	126		126	17
18	Wire Remote Annunciator Panel	2011	505	104	6.08	104		104	18
19	3: PTAC 12K BTU	2011	1,836	214	5	214		214	19
20	Panic Bars for Doors	2011	1,523	224	5.67	224		224	20
21	Replace Flooring due to Water Damage	2011	54,170	6,566	5.5	6,566		6,566	21
22	PTAC Walls - Replaced wood with stone	2011	3,980	429	5.42	429		429	22
23	3: Zoneline Heat/Cool Units	2011	2,097	384	5	384		384	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)		$ 445,313	$ 57,723		$ 57,723	$	$ 162,048	34

**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 Healt # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 148,803	$ 18,798	$ 18,798	$		$ 66,980	71
72	Current Year Purchases	22,827	2,693	2,693			2,693	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 171,630	$ 21,491	$ 21,491	$		$ 69,673	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				$	$	$	$		$	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)	$ 616,943	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 79,214	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 79,214	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)	$ 231,721	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 SSC Odin Operating Company LLC dba Odin Health Care # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [X] 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 [X] 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.	12/2012	$ 725,851
13.	12/2013	$ 725,851
14.	12/2014	$ 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 SSC Odin Operating Company LLC dba Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 SSC Odin Operating Company LLC dba Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$ 315,834		$	$		$ 315,834	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs	124,903					124,903	2
3	Licensed Recreational Therapist	10a-3	hrs							3
4	Licensed Physical Therapist	10a-3	hrs	332,756					332,756	4
5	Physician Care	39	visits							5
6	Dental Care	39	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				192,168		192,168	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			$ 773,493		$	$ 192,168		$ 965,661	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 Health Care (# 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	49,411		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	894,397		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,025		6
7	Other Prepaid Expenses	770		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 946,153	$	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	445,314		15
16	Equipment, at Historical Cost	171,631		16
17	Accumulated Depreciation (book methods)	(231,720)		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):	54,928		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 476,918	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,423,071	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 139,334	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	304,111		30
31	Accrued Taxes Payable (excluding real estate taxes)	37,426		31
32	Accrued Real Estate Taxes(Sch.IX-B)	117,603		32
33	Accrued Interest Payable			33
34	Deferred Compensation	80,035		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		1,918		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 680,427	$	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		(1,964,680)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (1,964,680)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (1,284,253)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,707,324	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,423,071	$	48

***(See instructions.)**

Facility Name & ID Number SSC Odin Operating Company LLC dba Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,621,633	1
2	Restatements (describe):	32,739	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,654,372	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	52,952	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)**	$ 52,952	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)**	$ 2,707,324	24 *

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

Facility Name & ID Number SSC Odin Operating Company LLC dba Odin Heal # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 6,219,479	1
2	Discounts and Allowances for all Levels	(1,924,347)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,295,132	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,766,926	6
7	Oxygen	4,955	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,771,881	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	985	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	478,387	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	49,834	19
20	Radiology and X-Ray	29,047	20
21	Other Medical Services	27,806	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 586,059	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.)	64	27
28		46	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 110	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,653,182	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	812,770	31
32	Health Care	2,571,126	32
33	General Administration	1,941,525	33
	B. Capital Expense		
34	Ownership	989,662	34
	C. Ancillary Expense		
35	Special Cost Centers	230,944	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,600,230	40
41	**Income before Income Taxes (line 30 minus line 40)****	52,952	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 52,952	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 SSC Odin Operating Company LLC dba Odin Health Care # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	1,851	2,072	$ 63,191	$ 30.50	1
2	Assistant Director of Nursing	1,872	2,064	45,640	22.11	2
3	Registered Nurses	13,631	14,614	329,455	22.54	3
4	Licensed Practical Nurses	19,259	21,684	386,970	17.85	4
5	CNAs & Orderlies	62,365	67,175	630,586	9.39	5
6	CNA Trainees					6
7	Licensed Therapist	21,052	23,499	776,418	33.04	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,961	2,081	22,273	10.70	9
10	Activity Assistants	529	529	5,245	9.91	10
11	Social Service Workers	3,354	3,686	48,036	13.03	11
12	Dietician					12
13	Food Service Supervisor	1,943	2,091	31,330	14.98	13
14	Head Cook	4,476	5,077	45,336	8.93	14
15	Cook Helpers/Assistants	10,010	10,907	97,308	8.92	15
16	Dishwashers					16
17	Maintenance Workers	1,838	2,083	30,690	14.73	17
18	Housekeepers	11,371	12,827	120,881	9.42	18
19	Laundry	4,619	5,072	46,353	9.14	19
20	Administrator	1,832	2,080	99,066	47.63	20
21	Assistant Administrator					21
22	Other Administrative	4,796	5,427	127,032	23.41	22
23	Office Manager					23
24	Clerical	3,160	3,561	43,608	12.25	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	1,925	2,130	26,733	12.55	31
32	Other Health Care(specify)	1,257	1,385	14,411	10.41	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,101	190,044	$ 2,990,562 *	$ 15.74	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		$ 11,927	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant			10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,637	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,395	11-3	44
45	Social Service Consultant		2,375	12-3	45
46	Other(specify)		617,869	10-3	46
47			21,778	39-3	47
48			833	39-3	48
49	TOTAL (lines 35 - 48)		$ 674,814		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 SSC Odin Operating Company LLC dba Odin Healt # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary A. Smith	Administrator	0	$ 99,307
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,307

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	$ 1,497
Old Seville Waste Consulting	Bio Waste Exp Reduction	739
Illinois State Police	Patient Background Checks	890
ADP Inc	WOTC Tracking	1,450
Healthlink	Bill Processing/Mgd Care	11,453
CT Corp	Litigation Tracking	282
My Innerview	Resident Survey	832
Point Right	Data Intregrity Audit	300
Legal	Legal - GL PL Arbitration	580,962
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 598,405

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,007
Unemployment Compensation Insurance	48,041
FICA Taxes	212,670
Employee Health Insurance	226,854
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	2,772
Other Employee Benefits	9,465
Home Office Benefits Allocation	16,458
TOTAL (agree to Schedule V, line 22, col.8)	$ 594,267

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	5,990
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	2,866
Dues	10,069
Other Licenses	1,822
Publications & Manuals	3,214
Less: Public Relations Expense	( )
Non-allowable advertising	(0)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,961

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 5,605
In-State Travel	5,243
Seminar Expense	3,407
Home Office Allocation Travel/Seminar	54,270
Entertainment Expense	(13)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 68,512

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SSC Odin Operating Company LLC dba Odin Health Ca # 0047365 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 SSC Odin Operating Company LLC dba Odin Health Care Center # 0047365 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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 $9,987**

(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. $ **22,967** 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. $ **54,203**
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? **Yes** Indicate the amount. $ **325**

(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.