FOR BHF USE							

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. **IDPH License ID Number:** 0047365

Facility Name: Odin Health Care Center

Address: 300 Green St (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 01/01/2012 to 12/31/2012 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: 01/01/2012 Ending: 12/31/2012

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	36,234	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	36,234	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	17,819	4,627	8,143	30,589	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,819	4,627	8,143	30,589	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.42%

D. How many bed-hold days during this year were paid by the Department?
5 (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 7,050

Medicare Intermediary Novitas Solutions Inc

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	171,203	11,932	11,884	195,019		195,019		195,019			1
2	Food Purchase		163,514		163,514		163,514	(218)	163,296			2
3	Housekeeping	121,577	11,320	4,185	137,082		137,082		137,082			3
4	Laundry	48,101	10,760		58,861		58,861		58,861			4
5	Heat and Other Utilities			103,281	103,281		103,281	1,534	104,815			5
6	Maintenance	21,043	52,496	10,698	84,237		84,237	19,381	103,618			6
7	Other (specify):*			4,631	4,631		4,631		4,631			7
8	TOTAL General Services	361,924	250,022	134,679	746,625		746,625	20,697	767,322			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,465,190	87,820	12,763	1,565,773		1,565,773	319,677	1,885,450			10
10a	Therapy	743,615	35,650	248	779,513		779,513		779,513			10a
11	Activities	29,652	3,926	3,680	37,258		37,258		37,258			11
12	Social Services	49,964		2,388	52,352		52,352		52,352			12
13	CNA Training											13
14	Program Transportation	13,368	3,513	47	16,928		16,928		16,928			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,301,789	130,909	31,126	2,463,824		2,463,824	319,677	2,783,501			16
	C. General Administration											
17	Administrative	95,315			95,315		95,315	13,940	109,255			17
18	Directors Fees			525	525		525		525			18
19	Professional Services			225,115	225,115		225,115	24,062	249,177			19
20	Dues, Fees, Subscriptions & Promotions			23,297	23,297		23,297	(4,489)	18,808			20
21	Clerical & General Office Expenses	116,817	15,462	369,995	502,274		502,274	100,588	602,862			21
22	Employee Benefits & Payroll Taxes			767,053	767,053		767,053	12,696	779,749			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,180	12,180		12,180	48,880	61,060			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			116,246	116,246		116,246	(24,122)	92,124			26
27	Other (specify):*											27
28	TOTAL General Administration	212,132	15,462	1,514,411	1,742,005		1,742,005	171,555	1,913,560			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,875,845	396,393	1,680,216	4,952,454		4,952,454	511,929	5,464,383			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	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			85,946	85,946		85,946	6,337	92,283			30
31	Amortization of Pre-Op. & Org.			7,004	7,004		7,004		7,004			31
32	Interest			(3,369)	(3,369)		(3,369)	(122)	(3,491)			32
33	Real Estate Taxes			120,439	120,439		120,439	(1,543)	118,896			33
34	Rent-Facility & Grounds			725,851	725,851		725,851	19,035	744,886			34
35	Rent-Equipment & Vehicles			123	123		123		123			35
36	Other (specify):*							38,118	38,118			36
37	TOTAL Ownership			935,994	935,994		935,994	61,825	997,819			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		173,334	46,430	219,764		219,764		219,764			39
40	Barber and Beauty Shops		26		26		26		26			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			304,547	304,547		304,547		304,547			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		173,360	350,977	524,337		524,337		524,337			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,875,845	569,753	2,967,187	6,412,785		6,412,785	573,754	6,986,539			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: 01/01/2012 Ending: 12/31/2012

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	(96)	2		4
5	Telephone, TV & Radio in Resident Rooms	1,526	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	(122)	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	(34)	24		19
20	Contributions	220	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(79,004)	21		24
25	Fund Raising, Advertising and Promotional	(5,917)	20		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)**	$ (83,427)		$	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)	504,402	21	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 504,402		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 420,975		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

STATE OF ILLINOIS

Odin Health Care Center

ID# 0047365

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Back Office Service Fees	$ (328,049)	21	1
2	Professional Liability Insurance Adj	(25,746)	26	2
3	Real Estate Tax Accural Adj	(1,543)	33	3
4	Remove Rent Averaging	19,035	34	4
5	Adjust Health Insurance to Actual	(21,657)	22	5
6	Adjust Depreciation to Actual	6,337	30	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**	(351,623)		49

STATE OF ILLINOIS Summary A

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(218)	0	0	0	0	0	0	0	0	0	0	(218)	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	1,526	8	0	0	0	0	0	0	0	0	0	1,534	5
6	Maintenance	0	19,381	0	0	0	0	0	0	0	0	0	19,381	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,308	19,389	0	0	0	0	0	0	0	0	0	20,697	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	319,677	0	0	0	0	0	0	0	0	0	319,677	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	319,677	0	0	0	0	0	0	0	0	0	319,677	16
	C. General Administration													
17	Administrative	0	13,940	0	0	0	0	0	0	0	0	0	13,940	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	24,062	0	0	0	0	0	0	0	0	0	24,062	19
20	Fees, Subscriptions & Promotions	(5,917)	1,428	0	0	0	0	0	0	0	0	0	(4,489)	20
21	Clerical & General Office Expenses	97,569	3,019	0	0	0	0	0	0	0	0	0	100,588	21
22	Employee Benefits & Payroll Taxes	(21,657)	34,353	0	0	0	0	0	0	0	0	0	12,696	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(34)	48,914	0	0	0	0	0	0	0	0	0	48,880	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(25,746)	1,624	0	0	0	0	0	0	0	0	0	(24,122)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	44,215	127,340	0	0	0	0	0	0	0	0	0	171,555	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	45,523	466,406	0	0	0	0	0	0	0	0	0	511,929	29

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	6,337	0	0	0	0	0	0	0	0	0	0	6,337	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(122)	0	0	0	0	0	0	0	0	0	(122)	32
33	Real Estate Taxes	(1,543)	0	0	0	0	0	0	0	0	0	0	(1,543)	33
34	Rent-Facility & Grounds	19,035	0	0	0	0	0	0	0	0	0	0	19,035	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	38,118	0	0	0	0	0	0	0	0	0	38,118	36
37	TOTAL Ownership	23,829	37,996	0	0	0	0	0	0	0	0	0	61,825	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	69,352	504,402	0	0	0	0	0	0	0	0	0	573,754	45

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	Utilities	$	SSC Equity Holdings LLC	100.00%	$ 8	$ 8	1
2	V	6	Repair and Maintenance		SSC Equity Holdings LLC	100.00%	19,381	19,381	2
3	V	19	Professional Services		SSC Equity Holdings LLC	100.00%	24,062	24,062	3
4	V	20	Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	1,428	1,428	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	319,677	319,677	5
6	V	21	Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	3,019	3,019	6
7	V	24	Travel & Seminar		SSC Equity Holdings LLC	100.00%	48,914	48,914	7
8	V	26	Insurance		SSC Equity Holdings LLC	100.00%	1,624	1,624	8
9	V	36	Drpreiation		SSC Equity Holdings LLC	100.00%	38,118	38,118	9
10	V	17	Communications		SSC Equity Holdings LLC	100.00%	13,940	13,940	10
11	V	35	Rental and Lease		SSC Equity Holdings LLC	100.00%			11
12	V	32	Interest Income/Expense		SSC Equity Holdings LLC	100.00%	(122)	(122)	12
13	V	22	Payroll Taxes		SSC Equity Holdings LLC	100.00%	34,353	34,353	13
14	Total			$			$ 504,402	$ * 504,402	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: 01/01/2012 Ending: 12/31/2012

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 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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: 01/01/2012 Ending: 2/31/2012

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 [X] NO [ ]

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: (862-467-6000
Fax Number: (832-467-6983

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

	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				$	$		$ 8	1
2	6	Repair and Maintenance							19,381	2
3	19	Professional Services							24,062	3
4	20	Fee, Subscriptions and Promos							1,428	4
5	10	Nursing & Medical Records							319,677	5
6	21	Clerical & Gen Office Exp							3,019	6
7	24	Travel & Seminar							48,914	7
8	26	Insurance							1,624	8
9	36	Drpreiation							38,118	9
10	17	Communications							13,940	10
11	35	Rental and Lease								11
12	32	Interest Income/Expense							(122)	12
13	22	Payroll Taxes							34,353	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					$	$		$ 504,402	25

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Odin Health Care Center **#** 0047365 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2011 report.	$	165,122	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.)	$	118,896	2
3. Under or (over) accrual (line 2 minus line 1).	$	(46,226)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	$	123,483	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.	$	77,257	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	53,043	8
	2008	55,046	9
	2009	54,322	10
	2010	117,603	11
	2011	117,603	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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	$ 118,896.00	$ 118,896.00
2.		300 Green St	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 118,896.00	$ 118,896.00

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 01/01/2012 Ending: 12/31/2012

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 Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	368	11.66	368		2,304	11
12	Vents for Isolation Rooms, Handicap Tubs/Sinks & Whirlpoo			2005	37,013	3,915	11.5	3,915		24,031	12
13	Sewer Line Reapirs - Add Pipe			2005	1,620	171	11.5	171		1,052	13
14	Main Sewer Line Repair			2005	534	57	11.5	57		347	14
15	Inspect Main Trunk Line			2005	316	33	11.5	33		205	15
16	4: Smoke Detectors			2005	641	64	10	64		465	16
17	10 Ton Condenser - A/C Unit			2005	1,402	148	11.5	148		910	17
18	Ruud Air Handler - Installation			2005	1,622	172	11.5	172		1,053	18
19	Installation Valve, Hand Wash Sink			2005	1,306	138	11.5	138		848	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		4,498	22
23											23
24	Zoneline Heat/Cool Unit			2006	508		5			508	24
25	Use Tax - Zoneline Heat/Cool Unit			2006	31		5			31	25
26	A/C in Dietary			2006	3,465		5			3,465	26
27	Wallpaper and Handrails			2006	5,632		5			5,632	27
28	Handrails			2006	4,442	423	10.5	423		2,820	28
29	Paging/Music Broadcast System			2006	1,438	144	10	144		947	29
30	Wallpaper and Handrails			2006	5,632		5			5,632	30
31	2: Thru Wall Heat/Cool Units			2006	1,120		5			1,120	31
32	Use Tax - 2 Thru Wall Heat/Cool Units			2006	71		5			71	32
33											33
34	Paint and Wallpaper			2007	463	47	9.83	47		282	34
35	Use Tax - paint and Wallpaper			2007	30	3	9.83	3		18	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: 01/01/2012 Ending: 12/31/2012

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	$	5	$	$	$ 1,679	37
38	Interior Renovation - Floors, Walls	2007	7,454	771	9.66	771		4,498	38
39	Flooring	2007	6,540	671	9.75	671		3,969	39
40	Paint and Wallpaper	2007	326	5	5	5		326	40
41	Paint and Wallpaper	2007	21		5			21	41
42	Interior Renovation - Floors, Walls	2007	3,140	322	9.75	322		1,906	42
43	Zoneline Heat/Cool	2007	1,179	127	9.25	127		690	43
44	7.5 Ton A/C Unit	2007	6,860	742	9.25	742		4,017	44
45	40: Cubicle Curtains	2007	2,308	308	5	308		2,308	45
46	10: Cubicle Curtains	2007	565	66	5	66		565	46
47	Replace RTU Compressor	2007	1,140	124	9.17	124		663	47
48									48
49	Nurse Call Station	2008	20,592	2,331	8.83	2,331		11,656	49
50	Generator Relay Switches	2008	3,567	408	8.75	408		2,004	50
51	Steel Door with Tempered Glass	2008	1,025	123	8.33	123		553	51
52	Install New Door and Frame	2008	560	67	8.42	67		305	52
53	Vinyl Fence and Gates	2008	10,697	1,337	8	1,337		5,571	53
54	7.5 Ton Gas/Elec Rooftop Unit	2008	5,850	739	7.92	739		3,017	54
55									55
56	Grant for Landscape	2009	4,923	609	8.08	609		2,588	56
57	Grant for Landscape	2009	738	91	8.08	91		388	57
58	12 X 24 Lofted Barn	2009	4,804	607	7.92	607		2,478	58
59	Irrigation System	2009	3,350	419	8	419		1,745	59
60	SS Sink w/ Drainboard	2009	1,130	154	7.33	154		540	60
61	Wall Cabinet	2009	2,345	320	7.33	320		1,119	61
62	Commercial Dryer Install	2009	1,181	165	7.17	165		549	62
63	Grant for Landscaping	2009	11,872	1,716	6.92	1,716		5,292	63
64	Zoneline Heat/Cool Unit	2009	686	97	7	97		315	64
65									65
66	Repair, replace, and paint drywall in 37 resident rooms	2010	14,300	2,145	6.67	2,145		6,078	66
67	2: Zonline Heat/Cool Units	2010	1,283	257	5	257		748	67
68	Stroage Pad & Sidewalks	2010	4,800	729	6.59	729		2,005	68
69									69
70	TOTAL (lines 4 thru 69)		$ 203,859	$ 21,768		$ 21,768	$	$ 125,622	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: 01/01/2012 Ending: 12/31/2012

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	$ 21,768		$ 21,768	$	$ 125,622	1
2	Front Entrance Sidewalk	2010	9,600	1,458	6.58	1,458		4,010	2
3	Employee Entrance Maglock	2010	2,071	315	6.58	315		865	3
4	Replace Awning	2010	1,000	152	6.58	152		418	4
5	Lights, Conf Room	2010	1,500	234	6.42	234		604	5
6	Replace Awning	2010	2,705	411	6.58	411		1,130	6
7	Refurb Dietary-flooring, ceilings, appliances, plumbing, elec	2010	108,405	15,126	7.17	15,126		50,421	7
8	Sprinklers Dietary	2010	1,421	196	7.25	196		670	8
9	Rooftop Unit Compressor	2010	1,527	241	6.33	241		603	9
10	3: Zoneline Heat/Cool Units	2010	1,877	375	5	375		907	10
11	Rooftop Unit Compressor	2010	11,210	1,818	6.17	1,818		4,242	11
12	Satellite Dish	2010	8,148	1,358	6	1,358		2,943	12
13	Satellite Dish	2010	10,151	1,716	5.92	1,716		3,574	13
14									14
15	Roof Leak Repair	2011	13,500	2,282	5.92	2,282		4,754	15
16	Roof Lead Rpair	2011	3,541	590	6	590		1,279	16
17	Remote Annunciator Panel	2011	687	116	5.92	116		242	17
18	Wire Remote Annunciator Panel	2011	505	83	6.08	83		187	18
19	3: PTAC 12K BTU	2011	1,836	367	5	367		581	19
20	Panic Bars for Doors	2011	1,523	(47)	5.67	(47)		177	20
21	Replace Flooring due to Water Damage	2011	54,170	2,462	5.5	2,462		9,028	21
22	PTAC Walls - Replaced wood with stone	2011	3,980	(22)	5.42	(22)		407	22
23	3: Zoneline Heat/Cool Units	2011	2,097	419	5	419		804	23
24									24
25	Kitchen Walls Rebuild	2012	20,490	5,529	5.25	5,529		5,529	25
26	Kitchen Walls Rebuild	2012	11,798	2,753	5	2,753		2,753	26
27	3: PTAC Units	2012	1,951	163	5	163		163	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 479,552	$ 59,863		$ 59,863	$	$ 221,913	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: 01/01/2012 Ending: 12/31/2012

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	$ 171,630	$ 31,162	$ 31,162	$		$ 100,834	71
72	Current Year Purchases	25,980	1,258	1,258			1,258	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 197,610	$ 32,420	$ 32,420	$		$ 102,092	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)	$ 677,162	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 92,283	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 92,283	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)	$ 324,005	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: 01/01/2012 Ending: 12/31/2012

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	$ 744,886	12		3
4	Additions							4
5								5
6								6
7	TOTAL		99		$ 744,886 **			7

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

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$ 774,681
13.	/2014	$ 805,668
14.	/2015	$ 837,895

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: *

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.

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

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-1	9065	hrs	$ 306,441		$	$	9,065	$ 306,441	1
2	Licensed Speech and Language Development Therapist	10a-1	2201	hrs	90,942				2,201	90,942	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a-1	12024	hrs	346,232				12,024	346,232	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				173,334		173,334	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				$ 743,615		$	$ 173,334	23,290	$ 916,949	14

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2012 (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	30,625		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,158,899		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	378		6
7	Other Prepaid Expenses	3,174		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,193,626	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	36,764		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	479,553		15
16	Equipment, at Historical Cost	197,610		16
17	Accumulated Depreciation (book methods)	(324,003)		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):	27,434		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 417,358	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,610,984	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 122,200	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	223,116		30
31	Accrued Taxes Payable (excluding real estate taxes)	37,187		31
32	Accrued Real Estate Taxes(Sch.IX-B)	118,896		32
33	Accrued Interest Payable			33
34	Deferred Compensation	80,037		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		114,927		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 696,363	$	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		(2,015,057)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (2,015,057)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (1,318,694)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,929,678	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,610,984	$	48

*(See instructions.)

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,707,324	1
2	Restatements (describe):	53,005	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,760,329	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	169,349	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)**	$ 169,349	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)**	$ 2,929,678	24 *

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,107,469	1
2	Discounts and Allowances for all Levels	(1,721,847)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,385,622	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,735,537	6
7	Oxygen	3,775	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,739,312	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	149	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	399,302	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,457	19
20	Radiology and X-Ray	21,350	20
21	Other Medical Services	8,927	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 456,185	23
	D. Non-Operating Revenue		
24	Contributions	470	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 470	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Vending	61	28
28a	Activities	484	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 545	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,582,134	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	746,625	31
32	Health Care	2,463,824	32
33	General Administration	1,742,005	33
	B. Capital Expense		
34	Ownership	935,994	34
	C. Ancillary Expense		
35	Special Cost Centers	219,790	35
36	Provider Participation Fee	304,547	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,412,785	40
41	**Income before Income Taxes (line 30 minus line 40)****	169,349	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 169,349	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,901,518	44
45	Private Pay - Net Inpatient Revenue	670,864	45
46	Medicare - Net Inpatient Revenue	1,634,794	46
47	Other-(specify) HMO/Ins	113,977	47
48	Other-(specify) VA/Hospice	64,469	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,385,622	49

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

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

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

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,800	2,087	$ 68,881	$ 33.00	1
2	Assistant Director of Nursing	1,700	2,079	43,669	21.00	2
3	Registered Nurses	13,890	15,190	318,849	20.99	3
4	Licensed Practical Nurses	17,824	20,079	348,004	17.33	4
5	CNAs & Orderlies	61,038	65,942	658,495	9.99	5
6	CNA Trainees					6
7	Licensed Therapist	19,840	23,289	743,615	31.93	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,732	2,120	22,851	10.78	9
10	Activity Assistants	693	693	6,801	9.81	10
11	Social Service Workers	3,503	3,975	49,964	12.57	11
12	Dietician					12
13	Food Service Supervisor	1,906	2,090	31,143	14.90	13
14	Head Cook	5,241	5,800	52,734	9.09	14
15	Cook Helpers/Assistants	8,967	9,728	87,326	8.98	15
16	Dishwashers					16
17	Maintenance Workers	1,185	1,317	21,043	15.98	17
18	Housekeepers	11,513	12,872	121,577	9.45	18
19	Laundry	4,834	5,423	48,101	8.87	19
20	Administrator	1,736	2,087	95,160	45.60	20
21	Assistant Administrator					21
22	Other Administrative	3,365	4,097	75,505	18.43	22
23	Office Manager			41,467		23
24	Clerical	2,775	3,077		0.00	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	1,937	2,167	27,292	12.59	31
32	Other Health Care(specify)	1,263	1,331	13,368	10.04	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	166,742	185,443	$ 2,875,845 *	$ 15.51	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 10,873	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,186	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		248	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,370	11-3	44
45	Social Service Consultant		2,388	12-3	45
46	Other(specify) Admin		250,906	10-3	46
47	Xray and Lab		23,943	39-3	47
48	Dentist/Physician/Psychiatrist		156	39-3	48
49	TOTAL (lines 35 - 48)		$ 309,070		49

C. CONTRACT NURSES

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

Facility Name & ID Number: Odin Health Care Center | # 0047365 | Report Period Beginning: 01/01/2012 | Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary A Smith	Administrator	0	$ 95,315
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 95,315

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	$ 763
Old Seville Exp Reduction Inc	Bio Waste Exp Reduction	324
ADP Inc	WOTC Tracking	824
CT Corp	Litigation Tracking	273
My Innerview	Resident Survey	280
Legal	Legal - GL PL Arbitration	204,978
TALX	Unemployment Comp Srvc	683
Healthlink	Bill Processing Mgd Care	9,799
Waste Reduction	Waste Reduction	1,567
GenPact	Reengineer Cost Analysis	5,611
LexisNexis	Risk Data Management	13
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 225,115

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,606
Unemployment Compensation Insurance	54,822
FICA Taxes	209,629
Employee Health Insurance	384,627
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Insurance Life	3,186
Other Benefits	10,526
Home Office PR Taxes	34,353
TOTAL (agree to Schedule V, line 22, col.8)	$ 779,749

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,710
Advertising: Employee Recruitment	3,655
Health Care Worker Background Check	3,185
(Indicate # of checks performed ____)	
Patient Background Checks	
Publications & Manuals	2,746
Other Licenses	2,084
Non Allowable Adv	5,917
Home Office Fees, Subscriptions	1,428
Less: Public Relations Expense	( )
Non-allowable advertising	(5,917)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,808

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,720
In-State Travel	6,238
Seminar Expense	4,188
Home Office Travel Expense	48,914
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 61,060

**See instructions.

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
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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:** **01/01/2012** **Ending:** **12/31/2012**

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 $5444**

(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. $ **18,812** 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. $ **304,547**
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. $ **96**

(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 (Corporate Level)**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.