FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0047365

Facility Name: Odin Health Care Center

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

County: Marion

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 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) Senior 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: 01/01/2016 Ending: 12/31/2016

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	21,184	3,778	6,318	31,280	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,184	3,778	6,318	31,280	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.33%

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)
NA

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	14,588	2,294	409,592	426,474		426,474	(112,606)	313,868			1
2	Food Purchase		705		705		705	116,604	117,309			2
3	Housekeeping		8,258	115,280	123,538		123,538		123,538			3
4	Laundry		5,797	75,765	81,562		81,562		81,562			4
5	Heat and Other Utilities			97,254	97,254		97,254	(4,840)	92,414			5
6	Maintenance	42,340	76,241	8,037	126,618		126,618	21,440	148,058			6
7	Other (specify):*			4,438	4,438		4,438		4,438			7
8	**TOTAL General Services**	56,928	93,295	710,366	860,589		860,589	20,598	881,187			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,536,374	96,526	12,331	1,645,231		1,645,231	235,173	1,880,404			10
10a	Therapy	733,767	55,758	287	789,812		789,812		789,812			10a
11	Activities	30,704	5,726	3,705	40,135		40,135		40,135			11
12	Social Services	64,629		2,264	66,893		66,893		66,893			12
13	CNA Training											13
14	Program Transportation	16,937	2,248	5,393	24,578		24,578		24,578			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,382,411	160,258	41,980	2,584,649		2,584,649	235,173	2,819,822			16
	C. General Administration											
17	Administrative	98,838			98,838		98,838	4,617	103,455			17
18	Directors Fees			381	381		381		381			18
19	Professional Services			23,516	23,516		23,516	24,032	47,548			19
20	Dues, Fees, Subscriptions & Promotions			36,909	36,909		36,909	(9,308)	27,601			20
21	Clerical & General Office Expenses	140,978	11,342	788,792	941,112		941,112	(772,003)	169,109			21
22	Employee Benefits & Payroll Taxes			396,342	396,342		396,342	29,640	425,982			22
23	Inservice Training & Education											23
24	Travel and Seminar			25,134	25,134		25,134	21,905	47,039			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			77,595	77,595		77,595	1,925	79,520			26
27	Other (specify):* Franchise Tax							300	300			27
28	**TOTAL General Administration**	239,816	11,342	1,348,669	1,599,827		1,599,827	(698,892)	900,935			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,679,155	264,895	2,101,015	5,045,065		5,045,065	(443,121)	4,601,944			29

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

Facility Name & ID Number Odin Health Care Center #0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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			303,607	303,607		303,607	(163,541)	140,066			30
31	Amortization of Pre-Op. & Org.			4,295	4,295		4,295		4,295			31
32	Interest			262,661	262,661		262,661	22,112	284,773			32
33	Real Estate Taxes			127,051	127,051		127,051	26	127,077			33
34	Rent-Facility & Grounds			929,074	929,074		929,074		929,074			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							28,289	28,289			36
37	TOTAL Ownership			1,626,688	1,626,688		1,626,688	(113,114)	1,513,574			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		164,908	29,343	194,251		194,251		194,251			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			211,820	211,820		211,820		211,820			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		164,908	241,163	406,071		406,071		406,071			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,679,155	429,803	3,968,866	7,077,824		7,077,824	(556,235)	6,521,589			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: 01/01/2016 Ending: 12/31/2016

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,870)	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	(70)	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	(237)	21		18
19	Entertainment	(198)	24		19
20	Contributions	(450)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,791)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(434,832)	21		24
25	Fund Raising, Advertising and Promotional	4,068	1		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(9,947)	20		28
29	Other-Attach Schedule	(503,088)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (952,415)		$	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)	396,180		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 396,180		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (556,235)		37

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

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

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

Odin Health Care Center

ID# 0047365

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Depreciation Adj (Remove Cap Lease Depr)	$ (163,541)	30	1
2	Reclass Franchise Tax	(300)	33	2
3	Reclass Franchise Tax	300	27	3
4	Real Estate Accrual Adjustment	326	33	4
5	Back Office Service Fee	(339,815)	21	5
6	Professional Liability Insurance		26	6
7	Reclass Raw Food	(116,674)	1	7
8	Reclass Raw Food	116,674	2	8
9	Adjust Travel Expense	(58)	24	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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32				32
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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**	(503,088)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(112,606)	0	0	0	0	0	0	0	0	0	0	(112,606)	1
2	Food Purchase	116,604	0	0	0	0	0	0	0	0	0	0	116,604	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	(4,870)	30	0	0	0	0	0	0	0	0	0	(4,840)	5
6	Maintenance	0	21,440	0	0	0	0	0	0	0	0	0	21,440	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(872)	21,470	0	0	0	0	0	0	0	0	0	20,598	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	235,173	0	0	0	0	0	0	0	0	0	235,173	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	235,173	0	0	0	0	0	0	0	0	0	235,173	16
	C. General Administration													
17	Administrative	0	4,617	0	0	0	0	0	0	0	0	0	4,617	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,791)	26,823	0	0	0	0	0	0	0	0	0	24,032	19
20	Fees, Subscriptions & Promotions	(9,947)	639	0	0	0	0	0	0	0	0	0	(9,308)	20
21	Clerical & General Office Expenses	(775,334)	3,331	0	0	0	0	0	0	0	0	0	(772,003)	21
22	Employee Benefits & Payroll Taxes	0	29,640	0	0	0	0	0	0	0	0	0	29,640	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(256)	22,161	0	0	0	0	0	0	0	0	0	21,905	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,925	0	0	0	0	0	0	0	0	0	1,925	26
27	Other (specify):*	300	0	0	0	0	0	0	0	0	0	0	300	27
28	TOTAL General Administration	(788,028)	89,136	0	0	0	0	0	0	0	0	0	(698,892)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(788,900)	345,779	0	0	0	0	0	0	0	0	0	(443,121)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Odin Health Care Center **#** 0047365 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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	(163,541)	0	0	0	0	0	0	0	0	0	0	(163,541)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	22,112	0	0	0	0	0	0	0	0	0	22,112	32
33	Real Estate Taxes	26	0	0	0	0	0	0	0	0	0	0	26	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	28,289	0	0	0	0	0	0	0	0	0	28,289	36
37	**TOTAL Ownership**	(163,515)	50,401	0	0	0	0	0	0	0	0	0	(113,114)	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)**	(952,415)	396,180	0	0	0	0	0	0	0	0	0	(556,235)	45

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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
Illinois Holdco, LLC	100	Montebello Health Care Center	Hamilton	SSC Equity Holdings LLC		Holding Company
		Nature Trail Health Care Center	Mount Vernont	SSC Administrative Services LLC		Back Office Service
		Odin Health Care Center	Odin	SSC Consultng Services LLC		Consulting Services
		Westchester Health Care 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%	$ 30	$ 30	1
2	V	6	Repair and Maintenance		SSC Equity Holdings LLC	100.00%	21,440	21,440	2
3	V	19	Professional Services		SSC Equity Holdings LLC	100.00%	26,823	26,823	3
4	V	20	Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	639	639	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	235,173	235,173	5
6	V	21	Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	3,331	3,331	6
7	V	24	Travel & Seminar		SSC Equity Holdings LLC	100.00%	22,161	22,161	7
8	V	26	Insurance		SSC Equity Holdings LLC	100.00%	1,925	1,925	8
9	V	36	Depreciation		SSC Equity Holdings LLC	100.00%	28,289	28,289	9
10	V	17	Communications		SSC Equity Holdings LLC	100.00%	4,617	4,617	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%	22,112	22,112	12
13	V	22	Payroll Taxes		SSC Equity Holdings LLC	100.00%	29,640	29,640	13
14	Total			$			$ 396,180	$ * 396,180	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: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

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Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

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Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

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Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

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Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

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Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Park Highlands Health Care Center	Athens				1
2			Pleasant Springs Health Care Center	Mount Pleasant				2
3			Sweeny Health Care Center	Sweeny				3
4			Texoma Health Care Center	Sherman				4
5			The Park in Plano	Plano				5
6			Ashland Health & Rehab	Ashland				6
7			Southpointe Health Care Center	Greenfield				7
8			Virginia Highlands Health & Rehab Center	Germantown				8
9			Grande Prairie Health & Rehab Center	Pleasant Prairie				9
10			Pleasant Valley Health Care Center	Derry				10
11			The Village at Alameda	Albuquerque				11
12			Hobbs Healthcare Center	Hobbs				12
13			Lake Mead Health Care Center	Henderson				13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 [ ]

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

Name of Related Organization: SSC Equity Holdings LLC
Street Address: 5300 W Sam Houston Pkwy N Ste 100
City / State / Zip Code: Houston, TX 77041
Phone Number: (832-467-6000
Fax Number: (832-467-6984

	1 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				$ 30	$		$	1
2	6	Repair and Maintenance				21,440				2
3	19	Professional Services				26,823				3
4	20	Fee, Subscriptions and Promos				639				4
5	10	Nursing & Medical Records				235,173				5
6	21	Clerical & Gen Office Exp				3,331				6
7	24	Travel & Seminar				22,161				7
8	26	Insurance				1,925				8
9	36	Drpreiation				28,289				9
10	17	Communications				4,617				10
11	35	Rental and Lease								11
12	32	Interest Income/Expense				22,112				12
13	22	Payroll Taxes				29,640				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					$ 396,180	$		$	25

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 122,369	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.)		$ 124,735	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,366	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 124,711	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.		$ 127,077	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	117,603	8
	2012	118,896	9
	2013	123,646	10
	2014	123,623	11
	2015	124,735	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 #: 832 467-6984

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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	$ 124,735.00	$ 124,735.00
2.		300 Green St	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 124,735.00	$ 124,735.00

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/2016 Ending: 12/31/2016

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).

NA

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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				9
10	Use Tax - 2: Zoneline Heat/Cool Units			2005	70		5				10
11	Fascia Board Repair			2005	3,520	285	11.66	285			11
12	Vents for Isolation Rooms, Handicap Tubs/Sinks & Whirlpoo			2005	37,013	3,038	11.5	3,038			12
13	Sewer Line Reapirs - Add Pipe			2005	1,620	133	11.5	133			13
14	Main Sewer Line Repair			2005	534	44	11.5	44			14
15	Inspect Main Trunk Line			2005	316	26	11.5	26			15
16	4: Smoke Detectors			2005	641		10				16
17	10 Ton Condenser - A/C Unit			2005	1,402	115	11.5	115			17
18	Ruud Air Handler - Installation			2005	1,622	133	11.5	133			18
19	Installation Valve, Hand Wash Sink			2005	1,306	107	11.5	107			19
20	Use Tax - Zoneline Heat/Cool Unit			2005	35		5				20
21	Zoneline Heat/Cool Unit			2005	566		5				21
22	Water Heater			2005	6,350		10				22
23											23
24	Zoneline Heat/Cool Unit			2006	508		5				24
25	Use Tax - Zoneline Heat/Cool Unit			2006	31		5				25
26	A/C in Dietary			2006	3,465		5				26
27	Wallpaper and Handrails			2006	5,632		5				27
28	Handrails			2006	4,442	385	10.5	385			28
29	Paging/Music Broadcast System			2006	1,438	60	10	60			29
30	Wallpaper and Handrails			2006	5,632		5				30
31	2: Thru Wall Heat/Cool Units			2006	1,120		5				31
32	Use Tax - 2 Thru Wall Heat/Cool Units			2006	71		5				32
33											33
34	Paint and Wallpaper			2007	463	43	9.83	43			34
35	Use Tax - paint and Wallpaper			2007	30	3	9.83	3			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: 01/01/2016 Ending: 12/31/2016

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	$	$	$	37
38	Interior Renovation - Floors, Walls	2007	7,454	701	9.66	701			38
39	Flooring	2007	6,540	610	9.75	610			39
40	Paint and Wallpaper	2007	326		5				40
41	Paint and Wallpaper	2007	21		5				41
42	Interior Renovation - Floors, Walls	2007	3,140	293	9.75	293			42
43	Zoneline Heat/Cool	2007	1,179	116	9.25	116			43
44	7.5 Ton A/C Unit	2007	6,860	674	9.25	674			44
45	40: Cubicle Curtains	2007	2,308		5				45
46	10: Cubicle Curtains	2007	566		5				46
47	Replace RTU Compressor	2007	1,140	113	9.17	113			47
48									48
49	Nurse Call Station	2008	20,592	2,117	8.83	2,117			49
50	Generator Relay Switches	2008	3,567	370	8.75	370			50
51	Steel Door with Tempered Glass	2008	1,025	112	8.33	112			51
52	Install New Door and Frame	2008	560	60	8.42	60			52
53	Vinyl Fence and Gates	2008	10,697	1,114	8	1,114			53
54	7.5 Ton Gas/Elec Rooftop Unit	2008	5,850	670	7.92	670			54
55									55
56	Grant for Landscape	2009	4,923	553	8.08	553			56
57	Grant for Landscape	2009	739	83	8.08	83			57
58	12 X 24 Lofted Barn	2009	4,804	550	7.92	550			58
59	Irrigation System	2009	3,350	380	8	380			59
60	SS Sink w/ Drainboard	2009	1,130	140	7.33	140			60
61	Wall Cabinet	2009	2,345	290	7.33	290			61
62	Commercial Dryer Install	2009	1,181	149	7.17	149			62
63	Grant for Landscaping	2009	11,872	1,555	6.92	1,555			63
64	Zoneline Heat/Cool Unit	2009	686	88	7	88			64
65									65
66	Repair, replace, and paint drywall in 37 resident rooms	2010	14,300	1,942	6.67	1,942			66
67	2: Zonline Heat/Cool Units	2010	1,283		5				67
68	Stroage Pad & Sidewalks	2010	4,800	660	6.59	660			68
69									69
70	TOTAL (lines 4 thru 69)		$ 203,861	$ 17,712		$ 17,712	$	$	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: 01/01/2016 Ending: 12/31/2016

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		$ 203,861	$ 17,712		$ 17,712	$	$	1
2	Front Entrance Sidewalk	2010	9,600	1,320	6.58	1,320			2
3	Employee Entrance Maglock	2010	2,071	285	6.58	285			3
4	Replace Awning	2010	1,000	138	6.58	138			4
5	Lights, Conf Room	2010	1,500	212	6.42	212			5
6	Replace Awning	2010	2,705	372	6.58	372			6
7	Refurb Dietary-flooring, ceilings, appliances, plumbing, elec	2010	108,405	13,706	7.17	13,706			7
8	Sprinklers Dietary	2010	1,421	175	7.25	175			8
9	Rooftop Unit Compressor	2010	1,527	218	6.33	218			9
10	3: Zoneline Heat/Cool Units	2010	1,877		5				10
11	Rooftop Unit Compressor	2010	11,210	1,644	6.17	1,644			11
12	Satellite Dish	2010	8,148	1,228	6	1,228			12
13	Satellite Dish	2010	10,151	1,551	5.92	1,551			13
14									14
15	Roof Leak Repair	2011	13,500	2,063	5.92	2,063			15
16	Roof Lead Rpair	2011	3,541	534	6	534			16
17	Remote Annunciator Panel	2011	687	105	5.92	105			17
18	Wire Remote Annunciator Panel	2011	505	75	6.08	75			18
19	3: PTAC 12K BTU	2011	1,836	153	5	153			19
20	Panic Bars for Doors	2011	1,523	97	5.67	97			20
21	Replace Flooring due to Water Damage	2011	54,170	9,559	5.5	9,559			21
22	PTAC Walls - Replaced wood with stone	2011	3,980	713	5.42	713			22
23	3: Zoneline Heat/Cool Units	2011	2,097	35	5	35			23
24									24
25	Kitchen Walls Rebuild	2012	20,490	3,783	5.25	3,783			25
26	Kitchen Walls Rebuild	2012	11,798	2,283	5	2,283			26
27	3: PTAC Units	2012	1,951	442	5	442			27
28									28
29	Norstar Phone System	2013	11,373	2,843	4	2,843			29
30	Roof Repairs	2013	5,250	1,500	3.5	1,500			30
31	Attic Roof Access Down Payment	2013	1,825	534	3.5	534			31
32	Attic Sprinklers Request 1	2013	36,600	10,712	35	10,712			32
33									33
34	TOTAL (lines 1 thru 33)		$ 534,602	$ 73,992		$ 73,992	$	$	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: 01/01/2016 Ending: 12/31/2016

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 12B, Carried Forward		$ 534,602	$ 73,992		$ 73,992	$	$	1
2	Attic Roof Access Balance Due	2013	1,825	534	3.4	534			2
3	Attic Sprinklers Final	2013	1,000	300	3.4	300			3
4	Vinyl Fence	2013	2,055	617	3.4	617			4
5									5
6	Polycom Phones	2014	521	169	3	169			6
7	Concrete at A Wing - 50% Deposit	2014	3,250	271	12	271			7
8	Concrete at A Wing - Balance	2014	3,250	271	12	271			8
9	5: PTAC Units	2014	3,410	682	5	682			9
10	Kitchen Hood Exhaust Ductwork	2014	3,795	380	10	380			10
11	Concrete Pavement Repair and Restripe - Parking Lot	2014	8,679	744	11.67	744			11
12									12
13	Cabinets, Countertops and Hardware	2015	5,089	459	11.08	459			13
14	Evaporator Coil	2015	1,477	133	11.08	133			14
15	5: PTAC Resistance Heat	2015	3,410	682	5	682			15
16	Water HEater	2015	6,572	657	10	657			16
17	Htr Booster 6 Gal	2015	2,326	233	10	233			17
18									18
19	Replaced Shower in Resident Room - drywall and bathwrap	2016	3,750	564	11	564			19
20	Remove and replace vinyl flooring in nurses station and hallway	2016	16,780	1,119	10	1,119			20
21	with plank flooring. Also in main lobby and dining room	2016	16,780	1,119	10	1,119			21
22	NRPA 80 Fire Door Inspections	2016	5,428	359	10	359			22
23	Replaced 146 resdient room doors and 10 fire rated doors	2016	56,975	3,324	10	3,324			23
24	PTAC Resistance Heater	2016	2,724	227	5	227			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)		$ 683,698	$ 86,836		$ 86,836	$	$	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: 01/01/2016 Ending: 12/31/2016

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	$ 280,806	$ 37,759	$ 37,759	$		$ 213,364	71
72	Current Year Purchases	66,474	6,728	6,728			6,728	72
73	Fully Depreciated Assets	(100)						73
74								74
75	TOTALS	$ 347,180	$ 44,487	$ 44,487	$		$ 220,092	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	Resident Transportation	2016 Ford Van	2016	$ 52,460	$ 8,743	$ 8,743	$	5	$ 8,743	76
77										77
78										78
79										79
80	TOTALS			$ 52,460	$ 8,743	$ 8,743	$		$ 8,743	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,083,338	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 140,066	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 140,066	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)	$ 228,835	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: 01/01/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1975	99	10/11/2013	$ 929,074	12		3
4	Additions							4
5								5
6								6
7	TOTAL		99		$ 929,074 **			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 06/02/2014
Ending 05/31/2026

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$ 1,180,651
13.	/2018	$ 1,180,651
14.	/2019	$ 1,180,651

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

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

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	8342	hrs	$ 292,563		$	$	8,342	$ 292,563	1
2	Licensed Speech and Language Development Therapist	10a-3	2135	hrs	89,792				2,135	89,792	2
3	Licensed Recreational Therapist	10a-3	10739	hrs	349,323				10,739	349,323	3
4	Licensed Physical Therapist			hrs							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				164,908		164,908	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				$ 731,678		$	$ 164,908	21,216	$ 896,586	14

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

STATE OF ILLINOIS

Facility Name & ID Number Odin Health Care Center **#** 0047365 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	52,895		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,507,495		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,100		6
7	Other Prepaid Expenses	4,808		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,567,848	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,412		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	13,836,157		15
16	Equipment, at Historical Cost	347,180		16
17	Accumulated Depreciation (book methods)	(948,290)		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):	10,249		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 13,250,708	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,818,556	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 224,958	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	317,161		30
31	Accrued Taxes Payable (excluding real estate taxes)	129,804		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	43,792		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accruals	161,887		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 877,602	$	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		10,693,249		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 10,693,249	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 11,570,851	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,247,705	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,818,556	$	48

***(See instructions.)**

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,523,040	1
2	Restatements (describe):	8	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,523,048	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(275,343)	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)**	$ (275,343)	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)**	$ 3,247,705	24 *

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 16,990,578	1
2	Discounts and Allowances for all Levels	(12,090,858)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,899,720	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,693,236	6
7	Oxygen	269	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,693,505	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	(1,270)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	205,825	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,267	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 206,822	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Receipts	2,434	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,434	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,802,481	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	860,589	31
32	Health Care	2,584,649	32
33	General Administration	1,599,827	33
	B. Capital Expense		
34	Ownership	1,626,688	34
	C. Ancillary Expense		
35	Special Cost Centers	194,251	35
36	Provider Participation Fee	211,820	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,077,824	40
41	**Income before Income Taxes (line 30 minus line 40)****	(275,343)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (275,343)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,916,090	44
45	Private Pay - Net Inpatient Revenue	608,379	45
46	Medicare - Net Inpatient Revenue	1,271,956	46
47	Other-(specify) HMO/Ins	20,231	47
48	Other-(specify) VA/Charity	83,064	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,899,720	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: 01/01/2016 Ending: 12/31/2016

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	1,904	2,096	$ 74,753	$ 35.66	1
2	Assistant Director of Nursing	1,248	1,320	30,829	23.36	2
3	Registered Nurses	8,329	8,808	209,070	23.74	3
4	Licensed Practical Nurses	22,262	24,038	459,759	19.13	4
5	CNAs & Orderlies	61,886	65,830	736,300	11.18	5
6	CNA Trainees					6
7	Licensed Therapist	19,023	21,240	733,767	34.55	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,162	2,308	27,091	11.74	9
10	Activity Assistants	356	356	3,613	10.15	10
11	Social Service Workers	363	3,982	64,629	16.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	496	665	5,016	7.54	14
15	Cook Helpers/Assistants	953	1,232	9,572	7.77	15
16	Dishwashers					16
17	Maintenance Workers	1,904	2,087	42,340	20.29	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,936	2,096	91,176	43.50	20
21	Assistant Administrator					21
22	Other Administrative	5,045	5,751	142,636	24.80	22
23	Office Manager					23
24	Clerical	337	337	6,004	17.82	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					31
32	Other Health Care(specify)	1,805	2,121	25,663	12.10	32
33	Other(specify)	1,430	1,549	16,937	10.93	33
34	TOTAL (lines 1 - 33)	131,439	145,816	$ 2,679,155 *	$ 18.37	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		$ 291,162	1-3	35
36	Medical Director		18,000	9-3	36
37	Medical Records Consultant		165	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,709	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		287	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,264	11-3	44
45	Social Service Consultant		2,264	12-3	45
46	Other(specify) Admin		27,019	10-3	46
47	Xray		12,616	39-3	47
48	Laboratory		13,366	39-3	48
49	TOTAL (lines 35 - 48)		$ 374,852		49

C. CONTRACT NURSES

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Morgan Mulvany	Administrator	0	$ 98,838
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,838

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
Cass Information Sys	Expense Mgmt/Unemploy	$ 1,488
Compsych	Employee Assistance Prog	1,107
Duane Morris	Legal Services	2,771
Ecova Inc	Utility Management	119
Equifax	Background Checks	528
Experian Health Inc	Care Management	360
Healthlink Inc	Medical Management	228
LexisNexis	Risk Data Management	29
National Research Corp	Quality Care Analysis	1,152
RC Tax Consulting	Tax Management	15,734
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 23,516

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 83,612
Unemployment Compensation Insurance	25,770
FICA Taxes	195,855
Employee Health Insurance	79,299
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	2,019
Other Benefits	9,787
Home Office Payroll Taxes	29,640
TOTAL (agree to Schedule V, line 22, col.8)	$ 425,982

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	$
Advertising: Employee Recruitment	7,757
Health Care Worker Background Check	7,491
(Indicate # of checks performed)	
Patient Background Checks	
Publications and Manuals	980
Professional Dues	8,269
Other Licenses	2,465
Fees, Subscriptions and Promos	639
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,601

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 5,313
In-State Travel	13,769
Seminar Expense	5,796
Home Office Allocation	22,161
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 47,039

**See instructions.

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $7,204**

(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. $ **14,888** 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. $ **211,820**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **NA**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **NA**
Attach invoices and a summary of services for all architect and appraisal fees