FOR BHF USE

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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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 6187756444 **Fax #** 6187756964

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 01/01/2020 to 12/31/2020 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) SVP Operations Finance

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: 01/01/2020 Ending: 12/31/2020

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	15,292	3,625	7,194	26,111	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,292	3,625	7,194	26,111	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.06%

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

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

Medicare Intermediary Novitas

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		2,213	450,732	452,945		452,945	(97,394)	355,551			1
2	Food Purchase		(235)		(235)		(235)	95,996	95,761			2
3	Housekeeping		9,378	129,335	138,713		138,713		138,713			3
4	Laundry		6,906	84,173	91,079		91,079		91,079			4
5	Heat and Other Utilities			89,254	89,254		89,254	(7,790)	81,464			5
6	Maintenance	52,275	80,055	9,240	141,570		141,570	23,141	164,711			6
7	Other (specify):*			15,232	15,232		15,232		15,232			7
8	**TOTAL General Services**	52,275	98,317	777,966	928,558		928,558	13,953	942,511			8
	B. Health Care and Programs											
9	Medical Director			18,030	18,030		18,030		18,030			9
10	Nursing and Medical Records	1,966,430	189,036	61,593	2,217,059		2,217,059	221,571	2,438,630			10
10a	Therapy	764,610	56,552	645	821,807		821,807		821,807			10a
11	Activities	78,016	3,004	4,208	85,228		85,228		85,228			11
12	Social Services	37,627		2,399	40,026		40,026		40,026			12
13	CNA Training											13
14	Program Transportation	47,405	3,266	4,174	54,845		54,845		54,845			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,894,088	251,858	91,049	3,236,995		3,236,995	221,571	3,458,566			16
	C. General Administration											
17	Administrative	127,382		7,652	135,034		135,034	3,731	138,765			17
18	Directors Fees			525	525		525		525			18
19	Professional Services			41,739	41,739		41,739	8,713	50,452			19
20	Dues, Fees, Subscriptions & Promotions			44,411	44,411		44,411	(21,090)	23,321			20
21	Clerical & General Office Expenses	126,726	12,164	723,349	862,239		862,239	(637,973)	224,266			21
22	Employee Benefits & Payroll Taxes			564,425	564,425		564,425	31,761	596,186			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,875	11,875		11,875	(7,423)	4,452			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			394,263	394,263		394,263	(271,604)	122,659			26
27	Other (specify):*											27
28	**TOTAL General Administration**	254,108	12,164	1,788,239	2,054,511		2,054,511	(893,885)	1,160,626			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,200,471	362,339	2,657,254	6,220,064		6,220,064	(658,361)	5,561,703			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: 01/01/2020 Ending: 12/31/2020

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			450,881	450,881		450,881	(52,615)	398,266			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			642,109	642,109		642,109	35,609	677,718			32
33	Real Estate Taxes			61,938	61,938		61,938	4,348	66,286			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							26,775	26,775			36
37	**TOTAL Ownership**			1,154,928	1,154,928		1,154,928	14,117	1,169,045			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		156,114	21,472	177,586		177,586		177,586			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			193,836	193,836		193,836		193,836			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		156,114	215,308	371,422		371,422		371,422			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,200,471	518,453	4,027,490	7,746,414		7,746,414	(644,244)	7,102,170			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: 01/01/2020 Ending: 12/31/2020

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	(1,331)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,837)	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	(67)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	312	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,743)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(238,697)	21		24
25	Fund Raising, Advertising and Promotional	(10,797)	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)**	$ (268,160)		$	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)	392,106		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 392,106		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 123,946		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: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Back Office Services	$ (402,926)	21	1
2	Prof Liability Insurance Adjustment	(283,651)	26	2
3	Depreciation Adj = Capital Lease Days	(52,615)	30	3
4	Reclass Raw Food Expense	(97,394)	1	4
5	Reclass Raw Food Expense	97,394	2	5
6	Real Estate Accrual Adj	4,348	33	6
7	Adjust Travel Expense	(22,549)	24	7
8	Non Allowable Advertsing	(10,797)	20	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
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28				28
29				29
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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**	(768,190)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(97,394)	0	0	0	0	0	0	0	0	0	0	(97,394)	1
2	Food Purchase	95,996	0	0	0	0	0	0	0	0	0	0	95,996	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	(7,837)	47	0	0	0	0	0	0	0	0	0	(7,790)	5
6	Maintenance	0	23,141	0	0	0	0	0	0	0	0	0	23,141	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,235)	23,188	0	0	0	0	0	0	0	0	0	13,953	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	221,571	0	0	0	0	0	0	0	0	0	221,571	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	221,571	0	0	0	0	0	0	0	0	0	221,571	16
	C. General Administration													
17	Administrative	0	3,731	0	0	0	0	0	0	0	0	0	3,731	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,743)	18,456	0	0	0	0	0	0	0	0	0	8,713	19
20	Fees, Subscriptions & Promotions	(21,594)	504	0	0	0	0	0	0	0	0	0	(21,090)	20
21	Clerical & General Office Expenses	(641,311)	3,338	0	0	0	0	0	0	0	0	0	(637,973)	21
22	Employee Benefits & Payroll Taxes	0	31,761	0	0	0	0	0	0	0	0	0	31,761	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(22,549)	15,126	0	0	0	0	0	0	0	0	0	(7,423)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(283,651)	12,047	0	0	0	0	0	0	0	0	0	(271,604)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(978,848)	84,963	0	0	0	0	0	0	0	0	0	(893,885)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(988,083)	329,722	0	0	0	0	0	0	0	0	0	(658,361)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Odin Health Care Center # 0047365 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

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	(52,615)	0	0	0	0	0	0	0	0	0	0	(52,615)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	35,609	0	0	0	0	0	0	0	0	0	35,609	32
33	Real Estate Taxes	4,348	0	0	0	0	0	0	0	0	0	0	4,348	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	26,775	0	0	0	0	0	0	0	0	0	26,775	36
37	**TOTAL Ownership**	(48,267)	62,384	0	0	0	0	0	0	0	0	0	14,117	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,036,350)	392,106	0	0	0	0	0	0	0	0	0	(644,244)	45

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 Vernon	SSC Administrative Services LLC		Back Office Service
		Odin Health Care Center	Odin	SSC Consulting Services LLC		Consulting Services
		Westchester Healthcare Center0	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%	$ 47	$ 47	1
2	V	6	Repair and Maintenance		SSC Equity Holdings LLC	100.00%	23,141	23,141	2
3	V	19	Professional Services		SSC Equity Holdings LLC	100.00%	18,456	18,456	3
4	V	20	Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	504	504	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	221,571	221,571	5
6	V	21	Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	3,338	3,338	6
7	V	24	Travel & Seminar		SSC Equity Holdings LLC	100.00%	15,126	15,126	7
8	V	26	Insurance		SSC Equity Holdings LLC	100.00%	12,047	12,047	8
9	V	36	Depreciation		SSC Equity Holdings LLC	100.00%	26,775	26,775	9
10	V	17	Communications		SSC Equity Holdings LLC	100.00%	3,731	3,731	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%	35,609	35,609	12
13	V	22	Payroll Taxes		SSC Equity Holdings LLC	100.00%	31,761	31,761	13
14	Total			$			$ 392,106	$ * 392,106	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: 01/01/2020 Ending: 12/31/2020

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	Excell Health Care Center	Oakland				1
2			Flagship Heath care Center	Newport Beach				2
3			Tarzana Health & Rehab Center	Tarzana				3
4			Diamond Ridge Health Care Center	Pittsburgh				4
5			Courtyard Care Center	San Jose				5
6			Mission Carmichael Health Care Center	Carmichael				6
7			AlpineLiving Center	Thornton				7
8			Boulder Manor	Boulder				8
9			Pearl Street Health Care Center	Englewood				9
10			Applewood Living Center	Longmont				10
11			Fort Collins Health Care Center	Fort Collins				11
12			Spring Creek Healthcare Center	Fort Collins				12
13			Berthoud Living Center	Berthoud				13
14			Sierra Vista Health Care Center	Loveland				14
15			Windsor Health Care Center	Windsor				15
16			San Juan Living Center	Montrose				16
17			Four Corners Health Care Center	Durango				17
18			Palisade Living Center	Palisade				18
19			Colonial Columns Nursing Center	Colorado Springs				19
20			Cedarwood Health Care Center	Colorado Springs				20
21			Minnequa Medicenter	Pueblo				21
22			Terrace Gaedens Healthcare Center	Colorado Springs				22
23			Aspen Living Cente	Colorado Springs				23
24			Centennial Heathcare Center	Greeley				24
25			Kenton Manor	Greeley				25
26			Stering Living Center	Sterling				26
27			Sunset Manor	Brush				27
28			Yuma Life Care Center	Yuma				28
29			Jewell Care Center of Denver	Denver				29
30			Monaco Parkway	Denver				30

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		Garden Square at Spring Creek	Fort Collins				1
2			Pendleton Health & Rehab	Mystic				2
3			Bride Brook Health & Rehab	Niantic				3
4			Brian Center Nursing Care Austell	Austll				4
5			Brian Center Health & Rehab Canton	Canton				5
6			Northeast Atlanta Healty & Rehab	Atlanta				6
7			Brighton Place West	Topeka				7
8			Indian Creek Healht Care Center	Overland Park				8
9			SE Massachusetts Health & Rehab	New Bedford				9
10			Methuen Health & Rehab Center	Methuen				10
11			Patuxent River Health & Rehab Center	Laurel				11
12			Arcola Heatlh & Rehab Center	Silver Spring				12
13			Glen Burnie Health & Rehab Center	Glen Burnie				13
14			Overlea Health & Rehab Center	Baltimore				14
15			Bethesda Health & Rehab Center	Bethesda				15
16			Summit Park Health & Rehab Center	Catonsville				16
17			North Arundel Health & Rehab Center	Glen Burnie				17
18			Bel Air Health & Rehab Center	Bel Air				18
19			Forest Hill Health & Rehab Center	Forest Hill				19
20			Heritage Harbour Health & Rehab Center	Annapolis				20
21			Cambridge East	Madison Heights				21
22			Cambridge North	Clawson				22
23			Cambridge South	Beverly Hills				23
24			Clarkston	Clarkston				24
25			Clinton-Aire Healthcare Center	Clinton Township				25
26			Crestmont NursingCare Center	Fenton				26
27			Heritage Manor	Flint				27
28			Hope Health Care Center	Westland				28
29			Warren Woods Health Care Center	Warren				29
30			Superior Woods Health Care Center	Ypsilanti				30

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Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Countrybrook Living Center	Brook Haven				1
2			Brian Center Health & Rehab Eden	Eden				2
3			Brian Center Nursing Care Lexington	Lexington				3
4			Brian Center Health & Rehab Hickory East	Hickory				4
5			Brian Center Health & Rehab Wilson	Wilson				5
6			Randolph Health & Rehab Center	Asheboro				6
7			Brian Center Health & Rehab Winston Salem	Winston Salem				7
8			Brian Center Health & RehabCharlotte	Charlotte				8
9			Brian Center Health & Rehab Windsor	Windsor				9
10			Maple Leaf Health Care	Statesville				10
11			Brian Center Health & Rehab Weaverville	Weaverville				11
12			Brian Center Health & Rehab Lincolnton	Lincolnton				12
13			Brian Center Health & Rehab Wallace	Wallace				13
14			Brian Center Health & Rehab Monroe	Monroe				14
15			Brian Center Health & RehabDurham	Durham				15
16			Brian Center Health & Rehab Goldsboro	Goldsboro				16
17			Brian Center Health & Rehab Cabarrus	Concord				17
18			Brian Center Nursing Care Shamrock	Charlotte				18
19			Brian Center Nursing Care Hickory	Hickory				19
20			Brian Center Health & Rehab Center Waynesvi	Waynesville				20
21			Brian Center Health & Rehab Clayton	Clayton				21
22			Brian Center Health & Rehab Brevard	Bervard				22
23			Brian Center Health & Rehab Yanceyville	Yanceyville				23
24			Brian Center Health & Rehab Hertfort	Hertford				24
25			Brian Center Health & Rehab Spruce Pine	Spruce Pine				25
26			Brian Center Health & Rehab Hendersonville	Hendersonville				26
27			Brian Center Health & Rehab Salisbury	Salisbury				27
28			Mariner Health Care of Wilmington	Wilmington				28
29			Silver Stream Health & Rehab	Wilmington				29
30			Kenansville Health & Rehab	Kenansville				30

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Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Charlotte Apts	Charlotte				1
2			Forest City Health & Rehab	Forest City				2
3			North Hills Health & Rehab	Wexford				3
4			West Hills Health & Rehab	Coraopolis				4
5			Broomall Health & Rehab	Broomall				5
6			Seneca Health & Rehab	Senaca				6
7			Sumter East Health & Rehab	Sumter				7
8			Golden Age Inman	Inman				8
9			Inman Healthcare	Inman				9
10			Lebanon Health & REhab	Lebanon				10
11			Greenhills Health & Rehab	Nashville				11
12			Norris Health & Rehab	Andersonville				12
13			Newport Health & Rehab	Newport				13
14			Cheyenne Healthcare	Cheyenne				14
15			Poplar Living Center	Casper				15
16			Sheridan Manor	Sheridan				16
17			Huntington Health Care	Huntington				17
18			Bastrop Nursing Center	Bastrop				18
19			Care Inn of La Grange	La Grange				19
20			Kountze Nursing Center	Kountze				20
21			Retama Manor Nursing Center San Antonio No	San Antonio				21
22			Retama Manor Nursing Center San Antonio We	San Antonio				22
23			Retama Manor Nursing Center Alice	Alice				23
24			Retama Manor Nursing Center Edinburg	Edinburg				24
25			Retama Manor Nursing Center Harlingen	Harlingen				25
26			Retama Manor Nursing Center Jourdanton	Jourdanton				26
27			Retama Manor Nursing Center Laredo South	Laredo				27
28			Retama Manor Nursing Center Laredo West	Laredo				28
29			Retama Manor Nursing Center McAllen	McAllen				29
30			Retama Manor Nursing Center Pleasanton Nort	Pleasanton				30

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Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Retama Manor Nursing Center Pleasanton Sout	Pleasanton				1
2			Retama Manor Nursing Center Rio Grande City	Rio Grande City				2
3			Retama Manor Nursing Center Robstown	Robstown				3
4			Retama Manor Nursing Center Weslaco	Weslaco				4
5			Weatherford health Care Center	Weatherford				5
6			Peach Tree Place	Weatherford				6
7			Retama Manor Nursing Center Raymondville	Raymondville				7
8			Memorial City Health and Rehab	Houston				8
9			Jacinto City Healthcare Center	Houston				9
10			Spring Branch Healthcare Center	Houston				10
11			Retama Manor Nursing Center Corpus Christi I	Corpus Christi				11
12			Downtown Health & Rehab	Fort Worth				12
13			Lakeshore Village Healthcare Center	Waco				13
14			Deer Creek of Wimberley	Wimberley				14
15			La Paloma Nursing Center	San Diego				15
16			Pine Arbor	Silsbee				16
17			Las Palmas Healthcare Center	McAllen				17
18			Hilltop Village	Kerville				18
19			Silver Creek Manor	San Antonio				19
20			Alpine Terrace	Kerrville				20
21			Edgewater Care Center	Kerrville				21
22			Arlington Heights Health & Rehab	Fort Worth				22
23			The Meadows Health & Rehab	Dallas				23
24			Northgate Health & Rehab	San Antonio				24
25			Interlochen Health & Rehab	Arlington				25
26			First Colony Health & Rehab	Missouri City				26
27			Cypresswood Health & Rehab	Houston				27
28			Northwest Health & Rehab	Houston				28
29			The Westbury Place	Houston				29
30			Westchase Health & Rehab	Houston				30

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STATE OF ILLINOIS

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Woodwind Lakes Health & Rehab	Houston				1
2			Pasadena Care Center	Pasadena				2
3			Bay Villa	Bay City				3
4			Alice Health care Center	Alice				4
5			Bangs Nursing Home	Bangs				5
6			Brazosview	Richmond				6
7			Courtyards at Fort Worth	Fort Worth				7
8			Faith Memorial	Pasadena				8
9			Golden Years	Marlin				9
10			Greenview Manor	Waco				10
11			Hillview Health & Rehab	Goldthwaite				11
12			Levelland Health Care	Levelland				12
13			Longmeadow Health Care	Justin				13
14			Memorial Medical Nursing Center	San Antonio				14
15			Mount Pleasant	Mount Pleasant				15
16			North Park Health & Rehab	McKinney				16
17			Pampa Health Care Center	Pampa				17
18			Park Highlands Health Care Center	Athens				18
19			Pleasant Springs Health Care Center	Mount Pleasant				19
20			Sweeny Health Care Center	Sweeny				20
21			Texoma Health Care Center	Sherman				21
22			The Park in Plano	Plano				22
23			Ashland Health & Rehab	Ashland				23
24			Southpointe Health Care Center	Greenfield				24
25			Virginia Highlands Health & Rehab Center	Germantown				25
26			Grande Prairie Health & Rehab Center	Pleasant Prairie				26
27			Pleasant Valley Health Care Center	Derry				27
28			The Village at Alameda	Albuquerque				28
29			Hobbs Healthcare Center	Hobbs				29
30			Lake Mead Health Care Center	Henderson				30

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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: 01/01/2020 Ending: 2/31/2020

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
Phone Number: (832 467 6000
Fax Number: (832 467 6384

	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				$	$		$ 47	1
2	6	Repair and Maintenance							23,141	2
3	19	Professional Services							18,456	3
4	20	Fee, Subscriptions and Promos							504	4
5	10	Nursing & Medical Records							221,571	5
6	21	Clerical & Gen Office Exp							3,338	6
7	24	Travel & Seminar							15,126	7
8	26	Insurance							12,047	8
9	36	Drpreiation							26,775	9
10	17	Communications							3,731	10
11	35	Rental and Lease								11
12	32	Interest Income/Expense							35,609	12
13	22	Payroll Taxes							31,761	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					$	$		$ 392,106	25

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 120,085	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.)		$ 65,986	2
3. Under or (over) accrual (line 2 minus line 1).		$ (54,099)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 61,638	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.		$ 7,539	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	124,735	8
	2016	60,070	9
	2017	68,002	10
	2018	68,058	11
	2019	65,986	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 713 201 4017 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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	$ 65,986.00	$ 65,986.00
2.		300 Green St	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 65,986.00	$ 65,986.00

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 _____ 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 01/01/2020 Ending: 12/31/2020

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).

N/A

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		11.66			3,520	11
12	Vents for Isolation Rooms, Handicap Tubs/Sinks & Whirlpool			2005	37,013		11.5			37,013	12
13	Sewer Line Reapirs - Add Pipe			2005	1,620		11.5			1,620	13
14	Main Sewer Line Repair			2005	534		11.5			534	14
15	Inspect Main Trunk Line			2005	316		11.5			316	15
16	4: Smoke Detectors			2005	641		10			641	16
17	10 Ton Condenser - A/C Unit			2005	1,402		11.5			1,402	17
18	Ruud Air Handler - Installation			2005	1,622		11.5			1,622	18
19	Installation Valve, Hand Wash Sink			2005	1,306		11.5			1,306	19
20	Use Tax - 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		10			6,350	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		10.5			4,442	28
29	Paging/Music Broadcast System			2006	1,438		10			1,438	29
30	Wallpaper and Handrails			2006	5,632		5			5,632	30
31	2: Thru Wall Heat/Cool Units			2006	1,120		5			1,120	31
32	Use Tax - 2 Thru Wall Heat/Cool Units			2006	71		5			71	32
33											33
34	Paint and Wallpaper			2007	463		9.83			463	34
35	Use Tax - paint and Wallpaper			2007	30		9.83			30	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$		$	$	$ 203,861	1
2	Front Entrance Sidewalk	2010	9,600		6.58			9,600	2
3	Employee Entrance Maglock	2010	2,071		6.58			2,071	3
4	Replace Awning	2010	1,000		6.58			1,000	4
5	Lights, Conf Room	2010	1,500		6.42			1,500	5
6	Replace Awning	2010	2,705		6.58			2,705	6
7	Refurb Dietary-flooring, ceilings, appliances, plumbing, elec	2010	108,405		7.17			108,405	7
8	Sprinklers Dietary	2010	1,421		7.25			1,421	8
9	Rooftop Unit Compressor	2010	1,527		6.33			1,527	9
10	3: Zoneline Heat/Cool Units	2010	1,877		5			1,877	10
11	Rooftop Unit Compressor	2010	11,210		6.17			11,210	11
12	Satellite Dish	2010	8,148		6			8,148	12
13	Satellite Dish	2010	10,151		5.92			10,151	13
14									14
15	Roof Leak Repair	2011	13,500		5.92			13,500	15
16	Roof Lead Rpair	2011	3,541		6			3,541	16
17	Remote Annunciator Panel	2011	687		5.92			687	17
18	Wire Remote Annunciator Panel	2011	505		6.08			505	18
19	3: PTAC 12K BTU	2011	1,836		5			1,836	19
20	Panic Bars for Doors	2011	1,523		5.67			854	20
21	Replace Flooring due to Water Damage	2011	54,170		5.5			54,170	21
22	PTAC Walls - Replaced wood with stone	2011	3,980		5.42			3,980	22
23	3: Zoneline Heat/Cool Units	2011	2,097		5			2,097	23
24									24
25	Kitchen Walls Rebuild	2012	20,490		5.25			20,490	25
26	Kitchen Walls Rebuild	2012	11,798		5			11,798	26
27	3: PTAC Units	2012	1,951		5			1,951	27
28									28
29	Norstar Phone System	2013	11,373		4			11,373	29
30	Roof Repairs	2013	5,250		3.5			5,250	30
31	Attic Roof Access Down Payment	2013	1,825		3.5			1,825	31
32		2013	36,600		35			36,600	32
33									33
34	TOTAL (lines 1 thru 33)		$ 534,602	$		$	$	$ 533,933	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: 01/01/2020 Ending: 12/31/2020

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	$		$	$	$ 533,933	1
2	Attic Roof Access Balance Due	2013	1,825		3.4			1,825	2
3	Attic Sprinklers Final	2013	1,000		3.4			1,000	3
4	Vinyl Fence	2013	2,055		3.4			2,055	4
5									5
6	Polycom Phones	2014	521		3			521	6
7	Concrete at A Wing - 50% Deposit	2014	3,250	271	12	271		1,782	7
8	Concrete at A Wing - Balance	2014	3,250	271	12	271		1,782	8
9	5: PTAC Units	2014	3,410	398	5	398		3,410	9
10	Kitchen Hood Exhaust Ductwork	2014	3,795	380	10	380		2,467	10
11	Concrete Pavement Repair and Restripe - Parking Lot	2014	8,679	744	11.67	744		4,649	11
12									12
13	Cabinets, Countertops and Hardware	2015	5,089	459	11.08	459		2,602	13
14	Evaporator Coil	2015	1,477	133	11.08	133		754	14
15	5: PTAC Resistance Heat	2015	3,410		5			3,410	15
16	Water HEater	2015	6,572	657	10	657		3,614	16
17	Htr Booster 6 Gal	2015	2,326	233	10	233		1,202	17
18									18
19	Replaced Shower in Resident Room - drywall and bathwrap	2016	3,750	338	11	338		1,917	19
20	Remove and replace vinyl flooring in nurses station and hallway	2016	16,780	1,678	10	1,678		7,831	20
21	with plank flooring. Also in main lobby and dining room	2016	16,780	1,678	10	1,678		7,831	21
22	NRPA 80 Fire Door Inspections	2016	5,428	538	10	538		2,512	22
23	Replaced 146 resdient room doors and 10 fire rated doors	2016	56,975	5,697	10	5,697		26,114	23
24	PTAC Resistance Heater	2016	2,724	545	5	545		2,406	24
25									25
26	Cabinet - Nursing Station	2017	12,038	793	15	793		3,025	26
27	Replace Fire Rated Door	2017	28,488	1,442	19.75	1,442		5,769	27
28	Duro Last Roofing	2017	109,964	10,996	10	10,996		42,456	28
29	6: GE Zoneline PTAC 230V	2017	4,213	842	5	842		3,113	29
30	Nurses Station Countertop	2017	9,638	643	15	643		2,463	30
31	A.O. Smith 100 Gal Water Heather	2017	6,000	600	10	600		2,250	31
32	CMBS Parking Lot Overlay	2017	13,600	1,700	8	1,700		5,950	32
33	146: Fire Rated Doors Replacement	2017	28,487	1,493	19.08	1,493		4,976	33
34	TOTAL (lines 1 thru 33)		$ 896,126	$ 32,529		$ 32,529	$	$ 683,619	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: 01/01/2020 Ending: 12/31/2020

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 12C, Carried Forward		$ 896,126	$ 32,529		$ 32,529	$	$ 683,619	1
2	4: GE Zoneline PTAC 230V	2018	2,809	562	5	562		1,639	2
3	3: GE Zoneline PTAC	2018	2,107	421	5	421		1,053	3
4									4
5	Shower Room Demo and Rebuild - Tile, Shower Heads, Pan, Sinks	2019	20,351	1,357	15	1,357		2,488	5
6	New Roof - Maintenance Bldg	2019	5,880	588	10	588		1,029	6
7	Landscaping and Lighting - Sign	2019	4,125	413	10	413		722	7
8	CMBS Asphalt Parking Lot - Driveway	2019	24,920	3,115	8	3,115		5,192	8
9	3 Ton 13 SEER A/C & Evaporator Coil	2019	3,535	707	5	707		1,119	9
10	3: GE Zoneline PTAC 230V	2019	2,151	480	5	480		645	10
11	100 Overbed LED Lights	2019	28,301	2,830	10	2,830		4,009	11
12									12
13	7: Roam Alert System Parts and Install	2020	18,475	2,715	10	2,715		2,715	13
14	5: GE Zoneline PTAC 230V	2020	3,708	643	5	643		643	14
15	Commerical Garbage Disposal	2020	1,310	175	5	175		175	15
16	Drainage System and Grading	2020	60,061	1,823	16	1,823		1,823	16
17	6 inch Gutter and Downspout System	2020	8,465	260	16	260		260	17
18	6: GE Zoneline PTAC 230 V	2020	4,450	148	5	148		148	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,086,774	$ 48,766		$ 48,766	$	$ 707,279	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: 01/01/2020 Ending: 12/31/2020

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	$ 387,024	$ 19,477	$ 19,477	$		$ 19,477	71
72	Current Year Purchases	10,704	493	493			493	72
73	Fully Depreciated Assets	(12,822)						73
74								74
75	TOTALS	$ 384,906	$ 19,970	$ 19,970	$		$ 19,970	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)	$ 1,471,680	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 68,736	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 68,736	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)	$ 727,249	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: 01/01/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SSC Equity Holdings LLC

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1975	99	10/11/2013	$	12		3
4	Additions							4
5								5
6								6
7	TOTAL		99		$ **			7

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

9. Option to Buy: ☐ YES ☒ NO Terms: *

10. Effective dates of current rental agreement:
Beginning 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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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-03	8274	hrs	$ 307,561		$	$	8,274	$ 307,561	1
2	Licensed Speech and Language Development Therapist	10a-03	1792	hrs	75,189				1,792	75,189	2
3	Licensed Recreational Therapist	10a-03		hrs							3
4	Licensed Physical Therapist	10a-03	10435	hrs	373,519				10,435	373,519	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				156,114		156,114	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				$ 756,269		$	$ 156,114	20,501	$ 912,383	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: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 700	$	1
2	Cash-Patient Deposits	(34,507)		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	610,121		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	496		6
7	Other Prepaid Expenses	4,132		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 580,942	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	66,412		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	7,730,945		15
16	Equipment, at Historical Cost	384,906		16
17	Accumulated Depreciation (book methods)	(3,171,888)		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):	5,144		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,015,519	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,596,461	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 854,969	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	509,629		30
31	Accrued Taxes Payable (excluding real estate taxes)	102,230		31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,219		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		54,804		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,585,851	$	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		2,267,273		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,267,273	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,853,124	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,743,337	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,596,461	$	48

***(See instructions.)**

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,430,114	1
2	Restatements (describe):	7	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,430,121	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	313,216	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)**	$ 313,216	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)**	$ 1,743,337	24 *

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 21,602,694	1
2	Discounts and Allowances for all Levels	(15,664,938)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,937,756	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,946,841	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,946,841	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	(714)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	173,920	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 173,206	23
	D. Non-Operating Revenue		
24	Contributions	530	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 530	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	General Rental Receipts	1,297	28
28a	Misc Receipts Vending		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,297	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,059,630	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	928,558	31
32	Health Care	3,236,995	32
33	General Administration	2,054,511	33
	B. Capital Expense		
34	Ownership	1,154,928	34
	C. Ancillary Expense		
35	Special Cost Centers	177,586	35
36	Provider Participation Fee	193,836	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,746,414	40
41	**Income before Income Taxes (line 30 minus line 40)****	313,216	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 313,216	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) HMO/Ins		47
48	Other-(specify) VA/Hospice/Charity		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	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: 01/01/2020 Ending: 12/31/2020

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	1,847	2,032	$ 90,437	$ 44.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,179	13,944	530,141	38.02	3
4	Licensed Practical Nurses	16,402	17,999	502,164	27.90	4
5	CNAs & Orderlies	44,887	47,906	804,567	16.79	5
6	CNA Trainees					6
7	Licensed Therapist	17,769	20,602	764,610	37.11	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,991	3,190	64,608	20.25	9
10	Activity Assistants	989	1,047	13,408	12.81	10
11	Social Service Workers	1,839	2,103	37,627	17.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,911	2,108	52,275	24.80	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,911	2,135	119,771	56.10	20
21	Assistant Administrator					21
22	Other Administrative	4,259	4,901	134,337	27.41	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,189	2,369	39,121	16.51	31
32	Other Health Care(specify)	2,182	2,389	47,405	19.84	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,355	122,725	$ 3,200,471 *	$ 26.08	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		$ 449,017	1-3	35
36	Medical Director		18,030	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		11,058	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		645	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,853	11-3	44
45	Social Service Consultant		2,399	12-3	45
46	Other(specify)		46,550	10-3	46
47	Administrative		17,427	39.3	47
48	Laboratory & Xray				48
49	TOTAL (lines 35 - 48)		$ 547,979		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: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Morgan R Mulvany	Administrator	0	$ 127,382
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 127,382

B. Administrative - Other

Description	Amount
Internal Chargeouts	$ 7,652
TOTAL (agree to Schedule V, line 17, col. 3)	$ 7,652
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Debra Terry	Legal	$ 23,655
Accelerate Consulting		5,000
Equifax	Backgroud	715
Experian	Background/Property Search	285
LexisNexis	Resource Services	24
Avalere Health		443
ProbateFinder/ProTitle	Property Search	193
Docusign Inc		73
Mgmt & Network		375
Pinnacle Quality Insight		1,056
NRC Health		177
Legal Consulting		9,743
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 41,739

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,442
Unemployment Compensation Insurance	14,377
FICA Taxes	230,915
Employee Health Insurance	253,010
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	189
Other Benefits	23,492
Home Office Payroll Taxes	31,761
TOTAL (agree to Schedule V, line 22, col.8)	$ 596,186

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,616
Health Care Worker Background Check	5,396
(Indicate # of checks performed)	
Patient Background Checks	
Publications and Manuals	1,951
Dues	9,141
Other Licenses	5,510
Fees, Subscriptions and Promos	504
Less: Public Relations Expense	( )
Non-allowable advertising	(10,797)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,321

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,452
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,452

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 $7,931**

(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. $ **17,484** 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?
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. $ **193,836**
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. $ **Yes**
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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