

Facility Name & ID Number Odin Health Care Center0047365

0047365 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	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	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>18,926</u>	<u>5,847</u>	<u>6,653</u>	<u>31,426</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,926</u>	<u>5,847</u>	<u>6,653</u>	<u>31,426</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.97%

D. How many bed-hold days during this year were paid by the Department? 119 (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

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

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 Date 01/01/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 99 and days of care provided 5,944

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	164,144	11,994	12,794	188,932		188,932		188,932		1
2	Food Purchase		147,251		147,251		147,251	(136)	147,115		2
3	Housekeeping	118,848	9,893	3,116	131,857		131,857		131,857		3
4	Laundry	48,336	9,565		57,901		57,901		57,901		4
5	Heat and Other Utilities			104,136	104,136		104,136	(5,373)	98,763		5
6	Maintenance	27,899	55,855	7,953	91,707		91,707	11,817	103,524		6
7	Other (specify):*			7,869	7,869		7,869		7,869		7
8	TOTAL General Services	359,227	234,558	135,868	729,653		729,653	6,308	735,961		8
	B. Health Care and Programs										
9	Medical Director			11,087	11,087		11,087		11,087		9
10	Nursing and Medical Records	1,436,966	104,222	12,149	1,553,337		1,553,337		1,553,337		10
10a	Therapy	637,610	65,343		702,953		702,953		702,953		10a
11	Activities	30,451	5,468	3,595	39,514		39,514		39,514		11
12	Social Services	34,722	307	2,287	37,316		37,316		37,316		12
13	CNA Training										13
14	Program Transportation	16,281	3,569	(613)	19,237		19,237		19,237		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,156,030	178,909	28,505	2,363,444		2,363,444		2,363,444		16
	C. General Administration										
17	Administrative	95,057			95,057		95,057		95,057		17
18	Directors Fees			500	500		500		500		18
19	Professional Services			33,546	33,546		33,546	(30,449)	3,097		19
20	Dues, Fees, Subscriptions & Promotions			19,582	19,582		19,582	1,007	20,589		20
21	Clerical & General Office Expenses	166,706	13,666	255,834	436,206		436,206	(58,314)	377,892		21
22	Employee Benefits & Payroll Taxes			511,685	511,685		511,685	12,312	523,997		22
23	Inservice Training & Education										23
24	Travel and Seminar			(1,263)	(1,263)		(1,263)	35,729	34,466		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			94,156	94,156		94,156	65,548	159,704		26
27	Other (specify):*										27
28	TOTAL General Administration	261,763	13,666	914,040	1,189,469		1,189,469	25,833	1,215,302		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,777,020	427,133	1,078,413	4,282,566		4,282,566	32,141	4,314,707		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:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			40,281	40,281		40,281		40,281			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(6,629)	(6,629)		(6,629)	24,596	17,967			32
33	Real Estate Taxes			57,700	57,700		57,700	260	57,960			33
34	Rent-Facility & Grounds			725,851	725,851		725,851		725,851			34
35	Rent-Equipment & Vehicles			123	123		123	12,890	13,013			35
36	Other (specify):*							17,967	17,967			36
37	TOTAL Ownership			817,326	817,326		817,326	55,713	873,039			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		172,852	23,585	196,437		196,437	12,557	208,994			39
40	Barber and Beauty Shops			492	492		492		492			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,204	54,204		54,204		54,204			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		172,852	78,281	251,133		251,133	12,557	263,690			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,777,020	599,985	1,974,020	5,351,025		5,351,025	100,411	5,451,436			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(5,373)	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	(136)	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	(96)	24		19
20	Contributions	(300)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(30,449)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	51,081	21		24
25	Fund Raising, Advertising and Promotional	(22,636)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(28)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (7,937)		\$	30

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	2	
		Amount	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)	353,628		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 353,628		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 345,691		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	52

Odin Health Care Center

ID# 0047365

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Back Office Service Fees	\$ (302,776)	21	1
2	Professional Liability	57,496	26	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(245,280)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odin Health Care Center# 0047365

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(136)	0	0	0	0	0	0	0	0	0	0	(136)	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	(5,373)	0	0	0	0	0	0	0	0	0	0	(5,373)	5
6	Maintenance	0	11,817	0	0	0	0	0	0	0	0	0	11,817	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,509)	11,817	0	6,308	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(30,449)	0	0	0	0	0	0	0	0	0	0	(30,449)	19
20	Fees, Subscriptions & Promotions	(28)	1,035	0	0	0	0	0	0	0	0	0	1,007	20
21	Clerical & General Office Expenses	(274,631)	216,317	0	0	0	0	0	0	0	0	0	(58,314)	21
22	Employee Benefits & Payroll Taxes	0	12,312	0	0	0	0	0	0	0	0	0	12,312	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(96)	35,825	0	0	0	0	0	0	0	0	0	35,729	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	57,496	8,052	0	0	0	0	0	0	0	0	0	65,548	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(247,708)	273,541	0	25,833	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(253,217)	285,358	0	32,141	29								

STATE OF ILLINOIS

Facility Name & ID Number Odin Health Care Center# 0047365

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	24,596	0	0	0	0	0	0	0	0	0	24,596	32
33	Real Estate Taxes	0	260	0	0	0	0	0	0	0	0	0	260	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	12,890	0	0	0	0	0	0	0	0	0	12,890	35
36	Other (specify):*	0	17,967	0	0	0	0	0	0	0	0	0	17,967	36
37	TOTAL Ownership	0	55,713	0	55,713	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	12,557	0	0	0	0	0	0	0	0	0	12,557	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	12,557	0	12,557	44								
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(253,217)	353,628	0	100,411	45								

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	5 Utilities	\$	SSC Equity Holdings LLC	100.00%	\$		1	
2	V	6 Repair and Maintenance		SSC Equity Holdings LLC	100.00%	11,817	11,817	2	
3	V	39 Professional Services		SSC Equity Holdings LLC	100.00%	12,557	12,557	3	
4	V	20 Fee, Subscriptions & Promos		SSC Equity Holdings LLC	100.00%	1,035	1,035	4	
5	V	10 Nursing & Medical Records		SSC Equity Holdings LLC	100.00%			5	
6	V	21 Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	216,317	216,317	6	
7	V	24 Travel & Seminar		SSC Equity Holdings LLC	100.00%	35,825	35,825	7	
8	V	26 Insurance		SSC Equity Holdings LLC	100.00%	8,052	8,052	8	
9	V	36 Depreciation		SSC Equity Holdings LLC	100.00%	17,967	17,967	9	
10	V	33 Taxes - Property		SSC Equity Holdings LLC	100.00%	260	260	10	
11	V	35 Rental and Lease		SSC Equity Holdings LLC	100.00%	12,890	12,890	11	
12	V	32 Interest Income/Expense		SSC Equity Holdings LLC	100.00%	24,596	24,596	12	
13	V	22 Payroll Taxes		SSC Equity Holdings LLC	100.00%	12,312	12,312	13	
14	Total		\$			353,628	\$ *	353,628	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:

01/01/2009

Ending:

12/31/2009

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

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization SSC Equity Holdings LLC
 Street Address 5300 W Sam Houston Parkway N, Ste 100
 City / State / Zip Code Houston, TX 77041
 Phone Number (832 467 6000
 Fax Number (832 467 6983

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities			\$	\$		0	1
2	6	Repair and Maintenance						11,817	2
3	39	Professional Services						12,557	3
4	20	Fee, Subscriptions & Promos						1,035	4
5	10	Nursing & Medical Records						0	5
6	21	Clerical & Gen Office Exp						216,317	6
7	24	Travel & Seminar						35,825	7
8	26	Insurance						8,052	8
9	36	Depreciation						17,967	9
10	33	Taxes - Property						260	10
11	35	Rental and Lease						12,890	11
12	32	Interest Income/Expense						24,596	12
13	22	Payroll Taxes						12,312	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				\$	\$		353,628	25

Facility Name & ID Number

Odin Health Care Center

0047365

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	109,728	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.)		\$	55,246	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(54,482)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	112,442	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.		\$	57,960	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	47,077	8	
	2005	149,498	9	
	2006	137,090	10	
	2007	53,043	11	
	2008	55,046	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008 \$		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.

Facility Name & ID Number Odin Health Care Center

0047365

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **Odin Health Care Center**# **0047365**

Report Period Beginning:

01/01/2009

Ending:

12/31/2009**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		2005	1975	\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		2: Zonline Heat/Cool Units	2005		1,119	224	5	224		989	9
10		Use Tax - 2: Zonline Heat/Cool Units	2005		70	14	5	14		61	10
11		Fascia Board Repair	2005		3,520	302	11.66	302		1,333	11
12		Vents for Isolation Rooms, Handicap Tubs/Sinks & Whirlpool	2005		37,013	3,219	11.5	3,219		13,679	12
13		Sewer Line Reapirs - Add Pipe	2005		1,620	141	11.5	141		599	13
14		Main Sewer Line Repair	2005		534	46	11.5	46		197	14
15		Inspect Main Trunk Line	2005		316	27	11.5	27		117	15
16		4: Smoke Detectors	2005		641	64	10	64		273	16
17		10 Ton Condenser - A/C Unit	2005		1,402	122	11.5	122		518	17
18		Ruud Air Handler - Installation	2005		1,622	141	11.5	141		600	18
19		Installation Valve, Hand Wash Sink	2005		1,306	114	11.5	114		483	19
20		Use Tax - Zonline Heat/Cool Unit	2005		35	7	5	7		28	20
21		Zonline Heat/Cool Unit	2005		566	113	5	113		462	21
22		Water Heater	2005		6,350	635	10	635		2,593	22
23											23
24		Zonline Heat/Cool Unit	2006		508	102	5	102		373	24
25		Use Tax - Zonline Heat/Cool Unit	2006		31	6	5	6		23	25
26		A/C in Dietary	2006		3,465	693	5	693		2,541	26
27		Wallpaper and Handrails	2006		5,632	1,126	5	1,126		4,036	27
28		Handrails	2006		4,442	423	10.5	423		1,551	28
29		Paging/Music Broadcast System	2006		1,438	144	10	144		515	29
30		Wallpaper and Handrails	2006		5,632	1,126	5	1,126		3,755	30
31		2: Thru Wall Heat/Cool Units	2006		1,120	224	5	224		728	31
32		Use Tax - 2 Thru Wall Heat/Cool Units	2006		71	14	5	14		46	32
33											33
34		Paint and Wallpaper	2007		463	47	9.83	47		141	34
35		Use Tax - paint and Wallpaper	2007		30	3	9.83	3		9	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:

01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Wallpaper	2007	\$ 1,679	\$ 336	5	\$ 336	\$	\$ 1,035	37
38	Interior Renovation - Floors, Walls	2007	7,454	771	9.66	771		2,185	38
39	Flooring	2007	6,540	671	9.75	671		1,956	39
40	Paint and Wallpaper	2007	326	65	5	65		190	40
41	Paint and Wallpaper	2007	21	4	5	4		12	41
42	Interior Renovation - Floors, Walls	2007	3,140	322	9.75	322		939	42
43	Zonline Heat/Cool	2007	1,179	127	9.25	127		308	43
44	7.5 Ton A/C Unit	2007	6,860	742	9.25	742		1,792	44
45	40: Cubicle Curtains	2007	2,308	462	5	462		1,077	45
46	10: Cubicle Curtains	2007	565	113	5	113		273	46
47	Replace RTU Compressor	2007	1,140	124	9.17	124		290	47
48									48
49	Nurse Call Station	2008	20,592	2,331	8.83	2,331		4,662	49
50	Generator Relay Switches	2008	3,567	408	8.75	408		781	50
51	Steel Door with Tempered Glass	2008	1,025	123	8.33	123		184	51
52	Install New Door and Frame	2008	560	67	8.42	67		105	52
53	Vinyl Fence and Gates	2008	10,697	1,337	8	1,337		1,560	53
54	7.5 Ton Gas/Elec Rooftop Unit	2008	5,850	738	7.92	738		801	54
55									55
56	Grant for Landscape	2009	4,923	761	8.08	761		761	56
57	Grant for Landscape	2009	738	114	8.08	114		114	57
58	12 X 24 Lofted Barn	2009	4,804	657	7.92	657		657	58
59	Irrigation System	2009	3,350	488	8	488		488	59
60	SS Sink w/ Drainboard	2009	1,130	77	7.33	77		77	60
61	Wall Cabinet	2009	2,345	160	7.33	160		160	61
62	Commercial Dryer Install	2009	1,181	55	7.17	55		55	62
63	Grant for Landscaping	2009	11,872	143	6.92	143		143	63
64	Landscaping	2009	2,261	27	6.92	27		27	64
65	ZonlineHeat Cool Unit	2009	686	11	15	11		11	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 185,737	\$ 20,312		\$ 20,312	\$	\$ 56,296	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:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 68,907	\$ 8,925	\$ 8,925			\$ 28,082	71
72	Current Year Purchases	54,000	4,037	4,037			4,037	72
73	Fully Depreciated Assets	(7,299)						73
74								74
75	TOTALS	\$ 115,608	\$ 12,962	\$ 12,962			\$ 32,119	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$		7	\$	76
77								7		77
78								7		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)	\$ 301,345	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,274	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 33,274	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)	\$ 88,415	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SMV Property Holdings, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1975</u>	<u>99</u>	<u>1/1/2005</u>	\$ <u>725,851</u>	<u>12</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		<u>99</u>		\$ <u>725,851</u>			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: _____ *

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

10. Effective dates of current rental agreement:

Beginning 01/01/2005

Ending 12/31/2016

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

Fiscal Year Ending Annual Rent

12. 12/2010 \$ 725,851

13. 12/2011 \$ 725,851

14. 12/2012 \$ 725,851

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	7666 hrs	\$ 260,090		\$	\$	7,666	\$ 260,090	1
2	Licensed Speech and Language Development Therapist	10a-3	2068 hrs	83,460				2,068	83,460	2
3	Licensed Recreational Therapist	10a-3	hrs							3
4	Licensed Physical Therapist	10a-3	8505 hrs	280,579				8,505	280,579	4
5	Physician Care	39	visits							5
6	Dental Care	39	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				172,852		172,852	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			\$ 624,129		\$	\$ 172,852	18,239	\$ 796,981	14

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

Facility Name & ID Number Odin Health Care Center# 0047365Report Period Beginning: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(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	112,385		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	663,680		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	190,811		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 967,426	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	36,765		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	297,063		15
16	Equipment, at Historical Cost	115,608		16
17	Accumulated Depreciation (book methods)	(88,415)		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): <u>Leasehold rights</u>	46,270		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 407,291	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,374,717	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 114,921	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	272,335		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,580		31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,246		32
33	Accrued Interest Payable			33
34	Deferred Compensation	46,195		34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Miscellaneous</u>	2,566		36
37	<u>Rounding</u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 523,843	\$	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	<u>Intercompany</u>	(1,008,259)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (1,008,259)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (484,416)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,859,127	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,374,711	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,111,342	1
2	Restatements (describe):	41,458	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,152,800	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	706,327	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)	\$ 706,327	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)	\$ 1,859,127	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Odin Health Care Center# 0047365Report Period Beginning: 01/01/2009Ending: 12/31/2009

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,166,629	1
2	Discounts and Allowances for all Levels	(1,698,156)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,468,473	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,244,355	6
7	Oxygen	13,999	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,258,354	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	1,574	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	277,976	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,765	19
20	Radiology and X-Ray	9,892	20
21	Other Medical Services	14,055	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 330,262	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	<u>Misc Receipts - Admin</u>	70	28
28a	<u>Misc Receipts - Vending</u>	193	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 263	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,057,352	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	729,653	31
32	Health Care	2,363,444	32
33	General Administration	1,189,469	33
B. Capital Expense			
34	Ownership	817,326	34
C. Ancillary Expense			
35	Special Cost Centers	196,929	35
36	Provider Participation Fee	54,204	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,351,025	40
41	Income before Income Taxes (line 30 minus line 40)**	706,327	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 706,327	43

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

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

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

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

Facility Name & ID Number **Odin Health Care Center**

0047365

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,631	2,045	\$ 56,138	\$ 27.45	1
2	Assistant Director of Nursing	1,449	1,537	35,770	23.27	2
3	Registered Nurses	9,776	11,105	255,288	22.99	3
4	Licensed Practical Nurses	22,886	25,375	428,311	16.88	4
5	CNAs & Orderlies	63,401	68,940	638,841	9.27	5
6	CNA Trainees					6
7	Licensed Therapist	16,290	18,252	637,610	34.93	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,032	2,088	21,626	10.36	9
10	Activity Assistants	868	1,046	8,825	8.44	10
11	Social Service Workers	2,520	2,857	34,722	12.15	11
12	Dietician					12
13	Food Service Supervisor	1,757	1,992	28,421	14.27	13
14	Head Cook	6,570	7,182	62,428	8.69	14
15	Cook Helpers/Assistants	7,693	8,427	73,295	8.70	15
16	Dishwashers					16
17	Maintenance Workers	1,810	1,904	27,899	14.65	17
18	Housekeepers	11,733	13,052	118,848	9.11	18
19	Laundry	5,421	5,860	48,336	8.25	19
20	Administrator	1,654	1,953	95,057	48.67	20
21	Assistant Administrator					21
22	Other Administrative	4,928	5,494	125,757	22.89	22
23	Office Manager					23
24	Clerical	2,738	3,127	40,949	13.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,672	1,912	22,617	11.83	31
32	Other Health Care(specify)	1,565	1,657	16,281	9.83	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	168,394	185,805	\$ 2,777,019 *	\$ 14.95	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 10,953	1-3	35
36	Medical Director		10,500	9-3	36
37	Medical Records Consultant		1,610	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,120	10-3	39
40	Physical Therapy Consultant			10a-3	40
41	Occupational Therapy Consultant			10a-3	41
42	Respiratory Therapy Consultant			10a-3	42
43	Speech Therapy Consultant			10a-3	43
44	Activity Consultant		2,327	11-3	44
45	Social Service Consultant		2,287	12-3	45
46	Other(specify) <u>Administrative</u>		36,940	10-3	46
47	<u>Xray & Laboratory</u>		21,277	39-3	47
48	<u>Dentist/Phisician/Psychiatrist</u>		923	39-3	48
49	TOTAL (lines 35 - 48)		\$ 91,937		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Mary A Smith	Administrator	0	\$ 95,057	Workers' Compensation Insurance	\$ 72,391	IDPH License Fee	\$		
				Unemployment Compensation Insurance	24,368	Advertising: Employee Recruitment			
				FICA Taxes	199,544	Health Care Worker Background Check	3,105		
				Employee Health Insurance	204,615	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Recruiting	4,576		
				Insurance Life	3,312	Non Allowable Advertising	3,196		
				Other Benefits	7,456	Dues	7,886		
				Overhead Benefits	12,312	Other Licences	792		
						Subscriptions	1,035		
						Less: Public Relations Expense (
						Non-allowable advertising	(28)		
						Yellow page advertising	28		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 95,057	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
(List each licensed administrator separately.)				\$ 523,998		\$ 20,590			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$ 0			\$	Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL					
(Attach a copy of any management service agreement)				\$					
C. Professional Services				G. Schedule of Travel and Seminar**					
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
My Innerview	Resident/Family Surveys		\$ 409			\$	In-State Travel	10,136	
Servarus Corp	Survey Tracking		735				Entertainment	96	
Talx Corp	New Hire Reporting (PR)		581						
Point Right (LTCQ)	Data Integrity Svcs		1,372				Seminar Expense	(11,496)	
Legal	Legal		30,449				Home Office Allocation	35,825	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 33,546	TOTAL			\$	Entertainment Expense	(96)
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$			(agree to Sch. V, line 24, col. 8)		
							TOTAL		
							\$ 34,465		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Odin Health Care Center# 0047365Report Period Beginning: 01/01/2009 Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Assn 5214
- (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. \$ 19,064 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,204
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? _____
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BDO Seidman, LLC
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.