

Facility Name & ID Number Odin Health Care Center

0047365 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	20,813	5,635	6,151	32,599	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,813	5,635	6,151	32,599	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.21%

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

22 (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 4,894

Medicare Intermediary Novitas

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

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	183,856	11,216	10,002	205,074		205,074		205,074		1
2	Food Purchase		185,216		185,216		185,216	(158)	185,058		2
3	Housekeeping	33,358	9,412	85,561	128,331		128,331		128,331		3
4	Laundry	14,263	9,932	55,490	79,685		79,685		79,685		4
5	Heat and Other Utilities			106,169	106,169		106,169	(4,254)	101,915		5
6	Maintenance	38,881	60,872	9,111	108,864		108,864	23,308	132,172		6
7	Other (specify):*			4,313	4,313		4,313		4,313		7
8	TOTAL General Services	270,358	276,648	270,646	817,652		817,652	18,896	836,548		8
	B. Health Care and Programs										
9	Medical Director			15,500	15,500		15,500		15,500		9
10	Nursing and Medical Records	1,519,066	106,588	45,884	1,671,538		1,671,538	274,112	1,945,650		10
10a	Therapy	685,948	29,191	6,913	722,052		722,052		722,052		10a
11	Activities	24,519	5,200	679	30,398		30,398		30,398		11
12	Social Services	52,335	7	2,203	54,545		54,545		54,545		12
13	CNA Training										13
14	Program Transportation	14,056	3,793	(1,572)	16,277		16,277		16,277		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,295,924	144,779	69,607	2,510,310		2,510,310	274,112	2,784,422		16
	C. General Administration										
17	Administrative	94,936			94,936		94,936	6,923	101,859		17
18	Directors Fees			525	525		525		525		18
19	Professional Services			6,787	6,787		6,787	10,188	16,975		19
20	Dues, Fees, Subscriptions & Promotions			29,713	29,713		29,713	623	30,336		20
21	Clerical & General Office Expenses	133,735	9,944	453,830	597,509		597,509	(474,240)	123,269		21
22	Employee Benefits & Payroll Taxes			450,099	450,099		450,099	34,671	484,770		22
23	Inservice Training & Education										23
24	Travel and Seminar			23,724	23,724		23,724	44,148	67,872		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			107,035	107,035		107,035	70,593	177,628		26
27	Other (specify):*							300	300		27
28	TOTAL General Administration	228,671	9,944	1,071,713	1,310,328		1,310,328	(306,794)	1,003,534		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,794,953	431,371	1,411,966	4,638,290		4,638,290	(13,786)	4,624,504		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:

01/01/2014

Ending:

12/31/2014

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			118,284	118,284	118,284	(164)	118,120				30
31	Amortization of Pre-Op. & Org.			4,686	4,686	4,686		4,686				31
32	Interest			(6,132)	(6,132)	(6,132)	24,270	18,138				32
33	Real Estate Taxes			131,383	131,383	131,383	2,546	133,929				33
34	Rent-Facility & Grounds			1,060,036	1,060,036	1,060,036	(92,293)	967,743				34
35	Rent-Equipment & Vehicles			123	123	123		123				35
36	Other (specify):*						45,195	45,195				36
37	TOTAL Ownership			1,308,380	1,308,380	1,308,380	(20,446)	1,287,934				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		125,493	20,065	145,558	145,558		145,558				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			222,414	222,414	222,414		222,414				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		125,493	242,479	367,972	367,972		367,972				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,794,953	556,864	2,962,825	6,314,642	6,314,642	(34,232)	6,280,410				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: 01/01/2014

Ending: 12/31/2014

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	(4,299)	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	(158)	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	(125)	24		19
20	Contributions	(50)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(450)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(128,608)	21		24
25	Fund Raising, Advertising and Promotional	(38,248)	21		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	(342,845)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (514,783)		\$	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)	480,551		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 480,551		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (34,232)		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: 01/01/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Back Office Services Fees	\$ (318,234)	21	1
2	Professional Liability Insurance Adj	65,000	26	2
3	Real Estate Tax Accrual Adjustment	2,846	33	3
4	Remove Rent Averaging	(92,293)	34	4
5	Adjust Health Insurance to Actual		22	5
6	Adjust Depreciation to Actual	(164)	30	6
7	Reclass Franchise Tax	(300)	33	7
8	Reclass Franchise Tax	300	27	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		(342,845)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odin Health Care Center# 0047365

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	(158)	0	0	0	0	0	0	0	0	0	0	(158)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,299)	45	0	0	0	0	0	0	0	0	0	(4,254)	5
6	Maintenance	0	23,308	0	0	0	0	0	0	0	0	0	23,308	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,457)	23,353	0	18,896	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	274,112	0	0	0	0	0	0	0	0	0	274,112	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	274,112	0	274,112	16								
	C. General Administration													
17	Administrative	0	6,923	0	0	0	0	0	0	0	0	0	6,923	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(450)	10,638	0	0	0	0	0	0	0	0	0	10,188	19
20	Fees, Subscriptions & Promotions	0	623	0	0	0	0	0	0	0	0	0	623	20
21	Clerical & General Office Expenses	(485,140)	10,900	0	0	0	0	0	0	0	0	0	(474,240)	21
22	Employee Benefits & Payroll Taxes	0	34,671	0	0	0	0	0	0	0	0	0	34,671	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(125)	44,273	0	0	0	0	0	0	0	0	0	44,148	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	65,000	5,593	0	0	0	0	0	0	0	0	0	70,593	26
27	Other (specify):*	300	0	0	0	0	0	0	0	0	0	0	300	27
28	TOTAL General Administration	(420,415)	113,621	0	(306,794)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(424,872)	411,086	0	(13,786)	29								

STATE OF ILLINOIS

Facility Name & ID Number Odin Health Care Center# 0047365

Report Period Beginning:

01/01/2014 Ending:

Summary B

12/31/2014

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	(164)	0	0	0	0	0	0	0	0	0	0	(164)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	24,270	0	0	0	0	0	0	0	0	0	24,270	32
33	Real Estate Taxes	2,546	0	0	0	0	0	0	0	0	0	0	2,546	33
34	Rent-Facility & Grounds	(92,293)	0	0	0	0	0	0	0	0	0	0	(92,293)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	45,195	0	0	0	0	0	0	0	0	0	45,195	36
37	TOTAL Ownership	(89,911)	69,465	0	(20,446)	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)	(514,783)	480,551	0	(34,232)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SSC Equity Holdings LLC		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		Operations and Con
		Westchester Health and Rehab Center	Westchester			
		Brentwood Sub Acute Healthcare Center	Burbank			

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	SSC Equity Holdings LLC	100.00%	\$ 45	\$ 45	1
2	V	6 Repair and Maintenance		SSC Equity Holdings LLC	100.00%	23,308	23,308	2
3	V	19 Professional Services		SSC Equity Holdings LLC	100.00%	10,638	10,638	3
4	V	20 Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	623	623	4
5	V	10 Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	274,112	274,112	5
6	V	21 Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	10,900	10,900	6
7	V	24 Travel & Seminar		SSC Equity Holdings LLC	100.00%	44,273	44,273	7
8	V	26 Insurance		SSC Equity Holdings LLC	100.00%	5,593	5,593	8
9	V	36 Depreciation		SSC Equity Holdings LLC	100.00%	45,195	45,195	9
10	V	17 Communications		SSC Equity Holdings LLC	100.00%	6,923	6,923	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%	24,270	24,270	12
13	V	22 Payroll Taxes		SSC Equity Holdings LLC	100.00%	34,671	34,671	13
14	Total		\$			\$ 480,551	\$ * 480,551	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:

01/01/2014

Ending:

12/31/2014

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Odin Health Care Center

0047365

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

Facility Name & ID Number

Odin Health Care Center

0047365

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

Facility Name & ID Number

Odin Health Care Center

0047365

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	Brian Center Health & Rehab Hertfort	Hertfort				1
2			Brian Center Health & Rehab Spruce Pine	Spruce Pine				2
3			Brian Center Health & Rehab Hendersonville	Hendersonville				3
4			Brian Center Health & Rehab Salisbury	Salisbury				4
5			Mariner Health Care of Wilmington	Wilmington				5
6			Silver Stream Health & Rehab	Wilmington				6
7			Kenansville Health & Rehab	Kenansville				7
8			Charlotte Apts	Charlotte				8
9			Forest City Health & Rehab	Forest City				9
10			Arbor Manor Living Center	Fremont				10
11			Crete Manor	Crete				11
12			Haven Home	Kenesaw				12
13			Pawnee Manor	Pawnee City				13
14			Pierce Manor	Pierce				14
15			West Point Living Center	West Point				15
16			North Hills Health & Rehab	Wexford				16
17			West Hills Health & Rehab	Coraopolis				17
18			Broomall Health & Rehab	Broomall				18
19			Seneca Health & Rehab	Senaca				19
20			Sumter East Health & Rehab	Sumter				20
21			Golden Age Inman	Inman				21
22			Inman Healthcare	Inman				22
23			Lebanon Health & REhab	Lebanon				23
24			Greenhills Health & Rehab	Nashville				24
25			Norris Health & Rehab	Andersonville				25
26			Newport Health & Rehab	Newport				26
27			Cheyenne Healthcare	Cheyenne				27
28			Poplar Living Center	Casper				28
29			Sheridan Manor	Sheridan				29
30			Huntington Health Care	Huntington				30

Facility Name & ID Number

Odin Health Care Center

0047365

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

Facility Name & ID Number

Odin Health Care Center

0047365

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

This page may also be used to list the Board of Directors for non-profit facilities. In the "Ownership %", enter "BOD".

IF THIS PAGE IS NOT NEEDED, YOU MAY HIDE IT SO IT WILL NOT PRINT

Hide Sheet

STATE OF ILLINOIS

Page 6-Supplemental

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

UnHide Pg6-Supp2

	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	Park Highlands Health Care Center	Athens			
2			Pleasant Springs Health Care Center	Mount Pleasant			
3			Sweeny Health Care Center	Sweeny			
4			Texoma Health Care Center	Sherman			
5			The Park in Plano	Plano			
6			Ashland Health & Rehab	Ashland			
7			Southpointe Health Care Center	Greenfield			
8			Virginia Highlands Health & Rehab Center	Germantown			
9			Grande Prairie Health & Rehab Center	Pleasant Prairie			
10			Pleasant Valley Health Care Center	Derry			
11			The Village at Alameda	Albuquerque			
12			Hobbs Healthcare Center	Hobbs			
13			Lake Mead Health Care Center	Henderson			
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							

ESS	
	1
	2
	3
	4
	5
	6
	7
	8
	9
	10
	11
	12
	13
	14
	15
	16
	17
	18
	19
	20
	21
	22
	23
	24
	25
	26
	27
	28
	29
	30

Facility Name & ID Number Odin Health Care Center # 0047365 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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:

01/01/2014

Ending: 2/31/2014

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

Name of Related Organization

SSC Equity Holdings LLC

Street Address

5300 W Sam Houston Pkwy N Ste 100

City / State / Zip Code

Houston, TX 77041

Phone Number

(832-467-6000

Fax Number

(832-467-6983

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

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			\$ 45	\$		\$	1
2	6	Repair and Maintenance			23,308				2
3	19	Professional Services			10,638				3
4	20	Fee, Subscriptions and Promos			623				4
5	10	Nursing & Medical Records			274,112				5
6	21	Clerical & Gen Office Exp			10,900				6
7	24	Travel & Seminar			44,273				7
8	26	Insurance			5,593				8
9	36	Drpreiation			45,195				9
10	17	Communications			6,923				10
11	35	Rental and Lease							11
12	32	Interest Income/Expense			24,270				12
13	22	Payroll Taxes			34,671				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				\$ 480,551	\$		\$	25

Facility Name & ID Number

Odin Health Care Center

0047365

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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 bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.		\$	120,800		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.)		\$	123,646		2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,846		3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	131,083		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.		\$	133,929		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	54,046	8	FOR BHF USE ONLY	
	2010	54,322	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	117,603	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	118,896	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	123,646	12	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Odin Health Care Center COUNTY Marion
 FACILITY IDPH LICENSE NUMBER 0047365
 CONTACT PERSON REGARDING THIS REPORT Martha McDaniel
 TELEPHONE 832-467-6317 FAX #: 832-467-6983

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-11-400-001</u>	<u>4 Acres - PT SE SE</u>	\$ <u>123,646.00</u>	\$ <u>123,646.00</u>
2. _____	<u>300 Green St</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>123,646.00</u></u>	\$ <u><u>123,646.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.**

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. (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:

01/01/2014 Ending:

12/31/2014

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		5			1,119	9
10		Use Tax - 2: Zonline Heat/Cool Units	2005		70		5			70	10
11		Fascia Board Repair	2005		3,520	311	11.66	311		2,925	11
12		Vents for Isolation Rooms, Handicap Tubs/Sinks & Whirlpool	2005		37,013	3,315	11.5	3,315		30,660	12
13		Sewer Line Reapirs - Add Pipe	2005		1,620	145	11.5	145		1,342	13
14		Main Sewer Line Repair	2005		534	48	11.5	48		442	14
15		Inspect Main Trunk Line	2005		316	28	11.5	28		261	15
16		4: Smoke Detectors	2005		641	64	10	64		593	16
17		10 Ton Condenser - A/C Unit	2005		1,402	125	11.5	125		1,161	17
18		Ruud Air Handler - Installation	2005		1,622	145	11.5	145		1,344	18
19		Installation Valve, Hand Wash Sink	2005		1,306	117	11.5	117		1,082	19
20		Use Tax - Zonline Heat/Cool Unit	2005		35		5			35	20
21		Zonline Heat/Cool Unit	2005		566		5			566	21
22		Water Heater	2005		6,350	635	10	635		5,768	22
23											23
24		Zonline Heat/Cool Unit	2006		508		5			508	24
25		Use Tax - Zonline 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	420	10.5	420		3,637	28
29		Paging/Music Broadcast System	2006		1,438	144	10	144		1,234	29
30		Wallpaper and Handrails	2006		5,632		5			5,632	30
31		2: Thru Wall Heat/Cool Units	2006		1,120		5			1,120	31
32		Use Tax - 2 Thru Wall Heat/Cool Units	2006		71		5			71	32
33											33
34		Paint and Wallpaper	2007		463	47	9.83	47		373	34
35		Use Tax - paint and Wallpaper	2007		30	3	9.83	3		24	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:

01/01/2014 Ending:

12/31/2014

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$	5	\$	\$	\$ 1,679	37
38	Interior Renovation - Floors, Walls	2007	7,454	764	9.66	764		5,988	38
39	Flooring	2007	6,540	665	9.75	665		5,265	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	319	9.75	319		2,528	42
43	Zoneline Heat/Cool	2007	1,179	126	9.25	126		937	43
44	7.5 Ton A/C Unit	2007	6,860	735	9.25	735		5,451	44
45	40: Cubicle Curtains	2007	2,308		5			2,308	45
46	10: Cubicle Curtains	2007	566		5			565	46
47	Replace RTU Compressor	2007	1,140	123	9.17	123		904	47
48									48
49	Nurse Call Station	2008	20,592	2,309	8.83	2,309		16,166	49
50	Generator Relay Switches	2008	3,567	404	8.75	404		2,793	50
51	Steel Door with Tempered Glass	2008	1,025	122	8.33	122		790	51
52	Install New Door and Frame	2008	560	66	8.42	66		434	52
53	Vinyl Fence and Gates	2008	10,697	1,337	8	1,337		8,246	53
54	7.5 Ton Gas/Elec Rooftop Unit	2008	5,850	731	7.92	731		4,448	54
55									55
56	Grant for Landscape	2009	4,923	603	8.08	603		3,768	56
57	Grant for Landscape	2009	739	91	8.08	91		564	57
58	12 X 24 Lofted Barn	2009	4,804	601	7.92	601		3,653	58
59	Irrigation System	2009	3,350	414	8	414		2,555	59
60	SS Sink w/ Drainboard	2009	1,130	152	7.33	152		838	60
61	Wall Cabinet	2009	2,345	316	7.33	316		1,739	61
62	Commercial Dryer Install	2009	1,181	163	7.17	163		869	62
63	Grant for Landscaping	2009	11,872	1,696	6.92	1,696		8,621	63
64	Zoneline Heat/Cool Unit	2009	686	96	7	96		503	64
65									65
66	Repair, replace, and paint drywall in 37 resident rooms	2010	14,300	2,119	6.67	2,119		10,240	66
67	2: Zonline Heat/Cool Units	2010	1,283	257	5	257		1,262	67
68	Stroage Pad & Sidewalks	2010	4,800	720	6.59	720		3,420	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 203,861	\$ 20,476		\$ 20,476	\$	\$ 165,976	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:

01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	
1	Totals from Page 12A, Carried Forward		\$ 203,861	\$ 20,476		\$ 20,476	\$	\$ 165,976	1
2	Front Entrance Sidewalk	2010	9,600	1,440	6.58	1,440		6,840	2
3	Employee Entrance Maglock	2010	2,071	311	6.58	311		1,476	3
4	Replace Awning	2010	1,000	150	6.58	150		713	4
5	Lights, Conf Room	2010	1,500	231	6.42	231		1,058	5
6	Replace Awning	2010	2,705	406	6.58	406		1,927	6
7	Refurb Dietary-flooring, ceilings, appliances, plumbing, elec	2010	108,405	14,952	7.17	14,952		79,746	7
8	Sprinklers Dietary	2010	1,421	191	7.25	191		1,056	8
9	Rooftop Unit Compressor	2010	1,527	238	6.33	238		1,071	9
10	3: Zonline Heat/Cool Units	2010	1,877	375	5	375		1,658	10
11	Rooftop Unit Compressor	2010	11,210	1,794	6.17	1,794		7,772	11
12	Satellite Dish	2010	8,148	1,339	6	1,339		5,581	12
13	Satellite Dish	2010	10,151	1,692	5.92	1,692		6,908	13
14									14
15	Roof Leak Repair	2011	13,500	2,250	5.92	2,250		9,188	15
16	Roof Lead Rpair	2011	3,541	582	6	582		2,425	16
17	Remote Annunciator Panel	2011	687	115	5.92	115		468	17
18	Wire Remote Annunciator Panel	2011	505	82	6.08	82		348	18
19	3: PTAC 12K BTU	2011	1,836	367	5	367		1,316	19
20	Panic Bars for Doors	2011	1,523	97	5.67	97		371	20
21	Replace Flooring due to Water Damage	2011	54,170	9,559	5.5	9,559		35,051	21
22	PTAC Walls - Replaced wood with stone	2011	3,980	713	5.42	713		2,554	22
23	3: Zonline Heat/Cool Units	2011	2,097	419	5	419		1,643	23
24									24
25	Kitchen Walls Rebuild	2012	20,490	3,783	5.25	3,783		12,925	25
26	Kitchen Walls Rebuild	2012	11,798	2,283	5	2,283		7,231	26
27	3: PTAC Units	2012	1,951	442	5	442		1,067	27
28									28
29	Norstar Phone System	2013	11,373	2,843	4	2,843		5,687	29
30	Roof Repairs	2013	5,250	1,500	3.5	1,500		2,250	30
31	Attic Roof Access Down Payment	2013	1,825	534	3.5	534		757	31
32	Attic Sprinklers Request 1	2013	36,600	10,712	35	10,712		15,176	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 534,602	\$ 79,876		\$ 79,876	\$	\$ 380,239	34

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

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

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	\$ 79,876		\$ 79,876	\$	\$ 380,239	1
2	Attic Roof Access Balance Due	2013	1,825	533	3.4	534	1	757	2
3	Attic Sprinklers Final	2013	1,000	300	3.4	300		400	3
4	Vinyl Fence	2013	2,055	617	3.4	617		822	4
5									5
6	Polycom Phones	2014	521	183	3	183		183	6
7	Concrete at A Wing - 50% Deposit	2014	3,250	158	12	158		158	7
8	Concrete at A Wing - Balance	2014	3,250	158	12	158		158	8
9	5: PTAC Units	2014	3,410	284	5	284		284	9
10	Kitchen Hood Exhaust Ductwork	2014	3,795	190	10	190		190	10
11	Concrete Pavement Repair and Restripe - Parking Lot	2014	8,679	186	11.67	186		186	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	TOTAL (lines 1 thru 33)		\$ 562,387	\$ 82,485		\$ 82,486	\$ 1	\$ 383,377	34

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

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	\$ 218,351	\$ 30,633	\$ 30,633	\$		\$ 140,840	71
72	Current Year Purchases	30,220	5,001	5,001			5,001	72
73	Fully Depreciated Assets	(24,451)						73
74								74
75	TOTALS	\$ 224,120	\$ 35,634	\$ 35,634	\$		\$ 145,841	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)	\$ 786,507	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 118,119	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 118,120	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 529,218	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: 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:	<u>1975</u>	<u>99</u>	<u>10/11/2013</u>	\$ <u>967,743</u>	<u>12</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		99		\$ 967,743			7

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. /2015 \$ 882,910

13. /2016 \$ 900,568

14. /2017 \$ 927,585

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

* 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.

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost						
							5	5				
1	Licensed Occupational Therapist	10a-03	7721 hrs	\$ 261,405		\$	\$	7,721	\$ 261,405	1		
2	Licensed Speech and Language Development Therapist	10a-03	2093 hrs	84,075				2,093	84,075	2		
3	Licensed Recreational Therapist	10a-03	hrs							3		
4	Licensed Physical Therapist	10a-03	10934 hrs	340,468				10,934	340,468	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					125,493	125,493	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			\$ 685,948		\$	\$ 125,493	20,748	\$ 811,441	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: 01/01/2014

Ending:

12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(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	(124,019)		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,123,033		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	374		6
7	Other Prepaid Expenses	28,665		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,028,603	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	262,771		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	562,387		15
16	Equipment, at Historical Cost	224,120		16
17	Accumulated Depreciation (book methods)	(529,848)		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):	8,981		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 528,411	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,557,014	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 126,808	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	291,839		30
31	Accrued Taxes Payable (excluding real estate taxes)	(12)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	132,278		32
33	Accrued Interest Payable			33
34	Deferred Compensation	29,950		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accruals</u>	108,337		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 689,200	\$	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>CLO & Intercompany</u>	(2,161,983)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (2,161,983)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (1,472,783)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,029,797	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,557,014	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,559,815	1
2	Restatements (describe):	(279,279)	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,280,536	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	51,973	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)	(302,712)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (250,739)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,029,797	24 *

* This must agree with page 17, line 47.

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		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 6,039,762	1	
2	Discounts and Allowances for all Levels	(1,453,175)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,586,587	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	1,484,521	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,484,521	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		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	275,464	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	10,181	19	
20	Radiology and X-Ray	1,529	20	
21	Other Medical Services	6,394	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 293,568	23	
D. Non-Operating Revenue				
24	Contributions	200	24	
25	Interest and Other Investment Income***		25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 200	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	Miscellaneous Receipts	1,739	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,739	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,366,615	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	817,652	31	
32	Health Care	2,510,310	32	
33	General Administration	1,310,328	33	
B. Capital Expense				
34	Ownership	1,308,380	34	
C. Ancillary Expense				
35	Special Cost Centers	145,558	35	
36	Provider Participation Fee	222,414	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,314,642	40	
41	Income before Income Taxes (line 30 minus line 40)**	51,973	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 51,973	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,571,927	44
45	Private Pay - Net Inpatient Revenue	833,081	45
46	Medicare - Net Inpatient Revenue	1,078,743	46
47	Other-(specify) <u>HMO/Ins</u>	39,021	47
48	Other-(specify) <u>VA/Hospice</u>	63,815	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,586,587	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: 01/01/2014

Ending: 12/31/2014

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	1,619	2,091	\$ 66,726	\$ 31.91	1
2	Assistant Director of Nursing	1,795	2,011	45,647	22.70	2
3	Registered Nurses	11,795	12,859	276,918	21.53	3
4	Licensed Practical Nurses	19,844	22,044	383,742	17.41	4
5	CNAs & Orderlies	66,997	72,211	718,695	9.95	5
6	CNA Trainees					6
7	Licensed Therapist	17,912	20,772	685,948	33.02	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,159	2,220	24,519	11.04	9
10	Activity Assistants					10
11	Social Service Workers	3,681	4,199	52,335	12.46	11
12	Dietician					12
13	Food Service Supervisor	1,867	2,079	31,027	14.92	13
14	Head Cook	5,624	6,221	57,577	9.26	14
15	Cook Helpers/Assistants	9,655	10,661	95,252	8.93	15
16	Dishwashers					16
17	Maintenance Workers	1,867	2,083	38,881	18.67	17
18	Housekeepers	3,056	3,727	33,358	8.95	18
19	Laundry	1,316	1,653	14,263	8.63	19
20	Administrator	1,715	2,091	94,936	45.40	20
21	Assistant Administrator					21
22	Other Administrative	5,513	6,223	132,382	21.27	22
23	Office Manager					23
24	Clerical	41	97	1,352	13.94	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	1,948	2,165	27,339	12.63	31
32	Other Health Care(specify)	1,294	1,402	14,056	10.03	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,698	176,809	\$ 2,794,953 *	\$ 15.81	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	\$ 8,789	1-3	35
36	Medical Director	15,500	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	7,407	10-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	132	10a-3	42
43	Speech Therapy Consultant			43
44	Activity Consultant	(765)	11-3	44
45	Social Service Consultant	2,203	12-3	45
46	Other(specify) <u>Admin</u>	14,065	10-3	46
47	<u>X/Ray & Lab</u>	16,304	39-3	47
48	<u>Dentist/Physician/Psychiatrist</u>	684	39-3	48
49	TOTAL (lines 35 - 48)	\$ 64,319		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 Ann Smith	Administrator		\$ 94,936	Workers' Compensation Insurance	\$ 88,877	IDPH License Fee	\$	
				Unemployment Compensation Insurance	43,911	Advertising: Employee Recruitment	5,988	
				FICA Taxes	202,099	Health Care Worker Background Check	2,147	
				Employee Health Insurance	106,563	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Publications and Manuals	1,009	
				Life Insurance	1,684	Professional Dues	7,044	
				Other Benefits	6,965	Other Licenses	2,965	
				Home Office Payroll Taxes	34,671			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,936	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
						Less: Public Relations Expense ()		
						Non-allowable advertising 11,183		
						Yellow page advertising ()		
						TOTAL (agree to Sch. V, line 20, col. 8) \$ 30,336		
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
	\$					\$	Out-of-State Travel	\$ 1,507
							In-State Travel	11,413
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense	10,679
							Home Office Travel and Seminar	44,273
							Entertainment Expense (0)	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 67,872

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Odin Health Care Center# 0047365Report Period Beginning: 01/01/2014 Ending: 12/31/2014**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 \$5925
- (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? 12 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,777 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? X YES _____ 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. \$ 222,414
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? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BDO Seidman LLC (Corporate Level)
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.